ACTIVITY RE

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 7 D (F)
Dr. SIVA NARAYANA REDDY

Name: ----------

UHID No : ------ ---- Consultant : ------------------------- Dept : pediatrics

Date of Admission : 8/6/26 ---- Time : -------------- Date of Discharge : ---------------- Time: -----------

Room / Bed No : 134 ------- Ward : 1st floor --- Suggested Billable bed type : ------------------------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/6/26	@3:50pm	ER	134	Lom

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
8/6/26	CBP, CRP, B/C/S, S/E, S.Cr		
	Calcium, magnesium	26019695	Lam
	Covid Rat - Neg	26019696	Lam
	RBS - 93 mg/dl	26019698	Lam
	Urine c/s, C/C	26019717.	[signature]
	Dengue NS1 + IgM	26019728	
	Cross checked by [signature]		9/6/26
10/6	CBP CRP	26019848	[signature]
	Cross checked by [illegible] 10/6 @ 9AM.		

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
8/06	Infusion pump	4:30pm	9/6 @ 6pm	3088108	[signature]
	Cross	Checked	by	[signature] 9/6/26	

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
8/6/26	IV placement	1	3088107	[illegible]
	Cross checked by [illegible] 9/6/26			

ANY OTHER INFORMATION

covid Rest -> Neg

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
	1st floor [illegible]		

Name	Baby CH.VAMIKA	UHID	VIH-00205727
Father/Guardian	Mr CH.PRAVEEN KUMAR	Age/Gender	1 Y 4 M 9 D/Female
Address	THURKAPALLY(V) SHAMIRPET(M)MEDCHAL(D), Shamirpet, Hyderabad, Telangana, INDIA, 500078		
IP No	IP-00060272	Admission Date	08-06-2026
Ref Doctor	SELF	Discharge Date	10-06-2026

DISCHARGE SUMMARY

Consultant: Dr. SIVA NARAYANA REDDY VENNAPUSA
DCH, DNB, FELLOWSHIP IN NEONATOLOGY
SENIOR CONSULTANT PEDIATRICS
48300

Diagnosis: Simple febrile seizure

History: Baby CH. VAMIKA is a 1 Y 4 M 9 D girl presented with the history of moderate grade fever since 3 days, one episode of seizure activity in the form of stiffening of limbs, clenching of teeth lasting for about 5-10 minutes followed by post-ictal drowsiness lasted for one hour. For the above complaints, she was treated at nearby hospital but in view of persistence of symptoms, she was admitted at Rainbow Children's Hospital for further management.

Outside Investigations: Complete blood picture done on 06.06.2026 showed hemoglobin 10.5 gm%, white blood cells count of 6,300 cells/cumm, platelet count of 1.89 lakhs/cumm and C-reactive protein was 35 mg/l. Widal was negative.

Examination: She was febrile (100.3^{o}F), maintaining saturations at room air. HR- 140/min, BP- 90/70 mmHg and RR 29/min. On auscultation of chest, air entry was bilaterally equal. Heart sounds were normal and there was no murmur. Abdomen was soft without organomegaly. Bowel sounds were heard. Neurologically, she was conscious and alert. Examination of other systems including spine was normal.

Weight on admission : 8.6 kgs.
Investigations: Enclosed.

Management: She was admitted in the ward and started on intravenous fluids and intravenous antibiotics. She was started on prophylaxis with Tab. Clobazam. She was treated symptomatically with antacids.

Her complete blood picture showed hemoglobin 10.8 gm%, white blood cells count of 6,260 cells/cumm, platelet count of 1.60 lakhs/cumm and C-reactive protein was 21 mg/l. Serum electrolytes, calcium, magnesium and creatinine were normal. Dengue NS1 & IgM were non-reactive. Blood culture was sterile after 24 hours of incubation. CUE was normal. Urine culture was sterile.

During the hospital stay, child was seen by Dr. P. Sindhura, Consultant Pediatric Neurologist, who advised Tablet Frisium. In case of recurrent of seizure, to start Injection Levetiracetam and plan to do MRI brain and CSF analysis. IF irritability persists and increased CRP, SOS CSF analysis.

Parents were counselled regarding the nature of febrile seizures and measures to reduce fever during future febrile episodes. They were also educated regarding use of intranasal Midazolam spray for termination of future seizure episodes, if any.

Her vitals were regularly monitored. Repeat hemogram done on 10.06.2026 showed hemoglobin 10.4 gm%, white blood cells count of 7,170 cells/cumm, platelet count of 1.87 lakhs/cumm and C-reactive protein was 5 mg/l. Her fever spikes and other symptoms gradually settled. 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.

Advice:

1. Diet as advised.
2. Syrup Cefixime (5ml=100mg) 2ml, 12th hourly for 3 days (Refrigerate after reconstitution).
3. Syrup Lupizyme 2.5ml, 12th hourly for 14 days.
4. Syrup Bevon, 5ml once daily for 1 month.
5. Kindly consult Dr. Siva Narayan Reddy, Senior Consultant Pediatrics, after 3 days in OPD with prior appointment (This consultation will be charged).

Febrile Seizure Prophylaxis

1. Syrup Paracetamol (5ml=240mg), 2.5ml for fever >99.6*F (maximum 4-6 hourly).
2. Tepid sponging SOS if fever >102*F.
3. Tablet Clobazam (5mg), 1/2 tablet twice daily for 3 days every time with fever.
4. Midazolam nasal spray (1.25mg/puff), 1 puff intranasal (into each nostril in sitting position) for future seizures more then 3 minutes.

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

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

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

Name	Baby CH.VAMIKA	UHID	VIH-00205727

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 by doctor ....in the language that I understand and I have understood the same.

Name :   Signature :

Relationship with patient :

This summary has been explained by :

Summary prepared by: Dr. B. Prashanthi
DEO   : MD Younus Pasha

Registrar/Resident/C.M.O

Dr. SIVA NARAYANA REDDY VENNAPUSA
DCH, DNB, FELLOWSHIP IN NEONATOLOGY
SENIOR CONSULTANT PEDIATRICS
48300

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 CH.VAMIKA	Inpatient No.	: IP-00060272
Age/Gender	: 1 Y 4 M 7 D/ Female	Admit Date	: 08-06-2026
Ward/Bed	: N 0 GF-EMERGENCY/ ER 103	Discharge Date	:

Investigation	Result	Unit		Biological Reference Interval
CALCIUM (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED Order Date :08-06-2026 14:42		
CALCIUM (Arsenazo dye)	9.1	mg/dl		8.7 - 10.8

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 :08-06-2026 14:42		
HEMOGLOBIN (Colorimetry)	10.8	g/dL		10.5 - 13.5
RBC COUNT (DC detection method)	4.36	10^12/L		3.7 - 5.6
PCV/HCT (Calculated)	**31.4**	**VOL%**	L	33 - 49
MCV (Calculated)	72.0	fL		70 - 86
MCH (Calculated)	24.8	pg/cells		23 - 31
MCHC (Calculated)	34.5	g/dL		30 - 36
RDW-CV (Calculated)	14.4	%		11.5 - 16
PLATELET COUNT (DC Detection Method)	160	10^9/L		150 - 450
MPV (Calculated)	7.8	fL		6.5 - 10
WBC COUNT (DC Detection Method)	6.26	10^9/L		6 - 17
Differential Count				
NEUTROPHILS (Microscopy, Leishman stain)	30	%		15 - 35
LYMPHOCYTES (Microscopy, Leishman stain)	62	%		45 - 76
MONOCYTES (Microscopy, Leishman stain)	07	%		4 - 12
EOSINOPHILS (Microscopy, Leishman stain)	01	%		1 - 7
PERIPHERAL SMEAR (Microscopy, Leishman stain)	**RBC : NORMOCYTIC / HYPOCHROMIC WBC : MORPHOLOGY NORMAL PLATELETS : ADEQUATE ON SMEAR**			

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 :08-06-2026 14:42		

PatientName	: Baby CH.VAMIKA		**Inpatient No.**	: IP-00060272
Age/Gender	: 1 Y 4 M 7 D/ Female		**Admit Date**	: 08-06-2026
Ward/Bed	: N 0 GF-EMERGENCY/ ER 103		**Discharge Date**	:

Investigation	Result	Unit		Biological Reference Interval
CRP (Immunoturbidimetry)	**21**	**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 :08-06-2026 14:42
CREATININE (Enzymatic)	0.3	mg/dl		0.03 - 0.5

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit		Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)				TEST RESULT STATUS : REPORT AUTHORISED Order Date :08-06-2026 14:42
SODIUM (Direct ISE)	140	mmol/L		134 - 143
POTASSIUM (Direct ISE)	**5.6**	**mmol/L**	H	3.7 - 5
CHLORIDE (Direct ISE)	106	mmol/L		98 - 108

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

PatientName	: Baby CH.VAMIKA	Inpatient No.	: IP-00060272
Age/Gender	: 1 Y 4 M 7 D/ Female	Admit Date	: 08-06-2026
Ward/Bed	: N 0 GF-EMERGENCY/ ER 103	Discharge Date	:

Investigation	Result	Unit	Biological Reference Interval
MAGNESIUM (Specimen : SERUM)			**TEST RESULT STATUS : REPORT AUTHORISED** Order Date :08-06-2026 14:42
MAGNESIUM (Formazon dye)	2.0	mg/dl	1.6 - 2.6

Dr. RASHIDA MAHREEN, MBBS,MD

Reg No : HMC13081

DISCHARGE SUMMARY

PatientName	: Baby CH.VAMIKA	**Inpatient No.**	: IP-00060272
Age/Gender	: 1 Y 4 M 7 D/ Female	**Admit Date**	: 08-06-2026
Ward/Bed	: N 0 GF-EMERGENCY/ ER 103	**Discharge Date**	:

Investigation	Result	Unit		Biological Reference Interval
COVID ANTIGEN RAPID TEST (Specimen : SWAB)				TEST RESULT STATUS : REPORT ENTERED Order Date :08-06-2026 14:42
COVID ANTIGEN RAPID TEST	negative			

Investigation	Result	Unit		Biological Reference Interval
COMPLETE URINE EXAMINATION (Specimen : URINE)				TEST RESULT STATUS : REPORT AUTHORISED Order Date :08-06-2026 16:50
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)	NIL			NIL
GLUCOSE (GOD POD method)	NIL			NIL
KETONE BODIES (Acetoacetic acid reaction)	NEGATIVE			NEGATIVE
BILE SALTS (Hay's Sulfur Test)	ABSENT			ABSENT
BILE PIGMENTS (Diazo reaction)	ABSENT			ABSENT
NITRITE (Reflectance Photometry)	NEGATIVE			NEGATIVE
BLOOD (Peroxidase reaction)	ABSENT			ABSENT
LEUCOCYTES (Esterase reaction)	NEGATIVE			NEGATIVE
MICROSCOPY				
PUS CELLS	**4 - 6**	**HPF**	L	0 - 5
EPITHELIAL CELLS	**2 - 4**	**HPF**	L	0 - 5
RBCS.	NIL	HPF		0 - 2

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 :10-06-2026 05:13
HEMOGLOBIN (Colorimetry)	**10.4**	**g/dL**	L	10.5 - 13.5
RBC COUNT (DC detection method)	4.16	10^12/L		3.7 - 5.6
PCV/HCT (Calculated)	**29.8**	**VOL%**	L	33 - 49
MCV (Calculated)	71.7	fL		70 - 86
MCH (Calculated)	25.1	pg/cells		23 - 31
MCHC (Calculated)	35.0	g/dL		30 - 36

This is an interim report. The final report will be released after 24 hours

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,

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

PatientName	: Baby CH.VAMIKA		Inpatient No.	: IP-00060272
Age/Gender	: 1 Y 4 M 9 D/ Female		Admit Date	: 08-06-2026
Ward/Bed	: N 0 GF-EMERGENCY/ ER 103		Discharge Date	:

Investigation	Result	Unit	Flag	Biological Reference Interval
RDW-CV (Calculated)	14.1	%		11.5 - 16
PLATELET COUNT (DC Detection Method)	187	10^9/L		150 - 450
MPV (Calculated)	7.9	fL		6.5 - 10
WBC COUNT (DC Detection Method)	7.17	10^9/L		6 - 17
Differential Count				
NEUTROPHILS (Microscopy, Leishman stain)	**12**	%	L	15 - 35
LYMPHOCYTES (Microscopy, Leishman stain)	**81**	%	H	45 - 76
MONOCYTES (Microscopy, Leishman stain)	05	%		4 - 12
EOSINOPHILS (Microscopy, Leishman stain)	02	%		1 - 7
PERIPHERAL SMEAR (Microscopy, Leishman stain)	**RBC : NORMOCYTIC / HYPOCHROMIC MICROCYTES(+)** **WBC : TC NORMAL WITH RELATIVE LYMPHOCYTES** **PLATELETS : ADEQUATE**			

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
C REACTIVE PROTEIN (Specimen : SERUM)			**TEST RESULT STATUS : REPORT AUTHORISED** Order Date :10-06-2026 05:13
CRP (Immunoturbidimetry)	5.0	mg/L	<10

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Laboratory Report

Baby CH.VAMIKA

1 Y 4 M 9 D

Female

IP-00060272

VIH-00205727

Dr. SIVA NARAYANA REDDY VENNAPUSA

8106813346

VI26019695

08-06-2026 02:48 PM

08-06-2026 03:36 PM

N 0 GF-EMERGENCY / ER 103

BLOOD CULTURE AND SENSITIVITY (Specimen :BLOOD)

RESULT

TEST RESULT STATUS : REPORT ENTERED

Culture: -

Initial Report: No growth after 24 hrs of incubation

..... **End of the Report** .....

Baby CH.VAMIKA	8106813346
1 Y 4 M 9 D	VI26019717
Female	08-06-2026 04:51 PM
IP-00060272	08-06-2026 05:21 PM
VIH-00205727	10-06-2026 09:11 AM
SIVA NARAYANA REDDY VENNAPUSA	N 1F-FIRST FLOOR / MSW 134

URINE CULTURE AND SENSITIVITY (Specimen :URINE)

RESULT

Gross examination: Yellow in colour, clear.

Gram stained smear: Shows no polymorphs or organisms

Culture: No growth after 24 hrs of incubation

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

Dr. RANGANATHAN N. IYER MD FRCPATH DNB DPB
(CONSULTANT MICROBIOLOGIST)

Dr. VIJENDRA KAWLE
MD DNB
CONSULTANT MICROBIOLOGIST
Reg No :68234

MC-7373

Laboratory Report

Patient Name	Baby CH.VAMIKA	Patient Ph. No	8106813346
Age	1 Y 4 M 8 D	Requisition No	VI26019728
Gender	Female	Collected on	08-06-2026 06:19 PM
IP / Bill No.	IP-00060272	Received on	08-06-2026 07:10 PM
UHID No.	VIH-00205727	Reported on	09-06-2026 08:32 AM
Ref Doctor	Dr. SIVA NARAYANA REDDY VENNAPUSA	Ward/Bed No	N 1F-FIRST FLOOR / MSW 134

DENGUE NS1 + DENGUE IGM (Specimen :SERUM)

RESULT

TEST RESULT STATUS : REPORT AUTHORISED

DENGUE NSI

REPORT : NOT DETECTED (2.2 PANBIO UNITS)

NEGATIVE: < 9 PANBIO UNITS
EQUIVOCAL : 9 - 11 PANBIO UNITS
POSITIVE: > 11 PANBIO UNITS

METHODOLOGY: ELISA

DENGUE IgM

REPORT : NON REACTIVE (4.5 PANBIO UNITS)

NEGATIVE: < 9 PANBIO UNITS
EQUIVOCAL : 9 - 11 PANBIO UNITS
POSITIVE: > 11 PANBIO UNITS

METHODOLOGY: ELISA

Dr. VIJENDRA KAWLE MD DNS
(CONSULTANT MICROBIOLOGIST)

Dr. RANGANATHAN N. IYER MD FRCPATH DNB DPB
(CONSULTANT MICROBIOLOGIST)

..... End of the Report .....

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.
TEL NO :040-42462200, Ext 2000,2001,2002
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP-00060272 **Admit Date** : 08-Jun-2026 **Admit Time** : 02:03 PM **UHID** : VIH-00205727

Patient Details :

Patient Name	: Baby CH.VAMIKA	**Age**	: 1 Y 4 M 7 D
Guardian	: Mr CH.PRAVEEN KUMAR	**DOB**	: 01-02-2025 01:00 AM
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: THURKAPALLY(V) SHAMIRPET(M)MEDCHAL(D) Shamirpet Hyderabad Telangana INDIA 500078	**Phone No**	: 8106813346/ 8143518758
		E-mail	: na@gmail.com

Admission Details :

Bed Type	: SHARED WARD	**Bed No**	: ER 103	**Ward Name**	: N 0 GF-EMERGENCY
Room No	: ER 103	**Admission Type**	: First Visit		

Contact Details :

Name	: Mr CH.PRAVEEN KUMAR	**Relationship**	: Father
Contact Address	: THURKAPALLY(V) SHAMIRPET(M)MEDCHAL(D) Shamirpet Hyderabad Telangana INDIA 500078	**Phone No**	: ~~8706813346~~ / 8143518758 8106813346

ch.praveen kumar
Signature

Doctor Details :

Doctor Name	: Dr. SIVA NARAYANA REDDY VENNAPUSA	**Specialisation**	: GENERAL PEDIATRICS
Referral Doctor	: SELF	**Phone No**	:
Co-Consultant	:		

Payment Details :

		Deposit Amount	: 0.00
Payment Mode	: Cash	**Payor Name**	: CARE HEALTH INSURANCE LIMITED

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 7 D (F)
Dr. SIVA NARAYANA REDDY

Rainbow Children's Hospital | BirthRight by Rainbow Hospitals

wt:- 8.6 kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Baby. Vamika Age : 1y 6M Gender: ☐ Male ☑ Female

Date : 8/6/26 Time of Arrival : 1:14pm

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

Source of Information : ☑ Parents ☐ Others (Specify)

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 100.3°F PR: 143b/m BP: 107/77(80) RR: 20b/m SpO_2: 100%

Chief Complaints: fever x 4days Today seizures 1 episodes 10:30AM

INITIAL PHYSIOLOGICAL CATEGORIZATION	INITIAL PHYSIOLOGICAL STATUS
Appearance: ☑ Normal ☐ Sick Looking Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding Work of Breathing: ☑ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea	☑ Stable ☐ Unstable : ☐ Not – Life - Threatening ☐ Life – Threatening

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☑ Level 4 : LESS URGENT : Significant illness but not life threatening	☑ 60 min
☐ Level 5 : NON – URGENT : May receive care when convenient	☐ 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Ch. Kavya
Signature of Parent / Guardian

Triage Completion Time : 1:18pm

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☑ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☑ No
3. Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☑ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☐ **Not applicable**

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☑ No

   If yes, State Location: ....

2. Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☑ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough

☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.

☐ The patient should be given a surgical mask immediately, if not already wearing one.

☐ Both patient and triage staff should perform hand hygiene.

☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Swathi

Signature of Triage Nurse : [signature]

Date & Time : 8/6/26 @ 1:18pm

Patient Name : Baby. CH.VAMIKA UHID : VIH-00205727 IPD : IP-00060272 Gender : Female Age : 1 Y 4 M 7 D

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 7 D (F)
Dr. SIVA NARAYANA REDDY

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 8/6/26 Time of arrival : 1:19.pm

Chief Complaints: fever sine xudays seizerus 1episode 10:34Am RBS: —

Height : — Weight : 8-6kg BMI : — Head Circumference (<2 years) —

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: —

If yes , identify ....

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

☐ Character — ☐ Location — ☐ Frequency — ☐ Duration —

RISK FOR FALL:

☑ If patient is < 6 years tick below fall risk intervention directly

☐ If Patient is > 6 years Assess the below parameters

	Yes	No
History of Falling: within past 3 months	☐	☑
Ambulatory Aids:		
• Wheelchair	☐	☑
• Uses furniture for support	☐	☑
Gait/Transferring:		
• Bedrest / immobile	☐	☑
• Weak	☐	☑
• Impaired	☐	☑
Mental Status: Forgets limitations	☐	☑

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

☐ Escort while ambulating
☐ Assist Patient
☑ Educate patient and family on fall precautions/prevention

Functional Screening: ☑ No Abnormalities Detected

☐ Mobility Problem
☐ Walking Problem
☐ Developmental Delay
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

....

Nutritional Screening: ☑ No Abnormalities Detected

☐ Underweight
☐ Overweight
☐ Feeding Problem
☐ Special diet
☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☑ No

If Yes Consultant Notified: — (Date/Time): —

Social History: Lives With family

Siblings in household ☑ Yes ☐ No (if yes How Many?) 1

Time of Initial assessment completed by ER Nurse : 1:23 pm

Patient Name : Baby. CH.VAMIKA UHID : VIH-00205727 IPD : IP-00060272 Gender : Female Age : 1 Y 4 M 7 D

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

Time	Nursing Notes
1:14pm	* patient Came to ER
1:18pm	* vital checked & Recorded
1:22pm	* Doctor seen the patient & adviced admission
2:03pm	* Admission process Done
3:10pm	* Iv placement Done
3:15pm	* collected the Samples & Send to Lab
3:15pm	* RBS => 93 mg/dl, COVID RAT -> Negative
3:25pm	* Test dose given in ER (inj. ceftriaxone)
	* patient shifted to ward

Samples collected by: Br. Samuel — Time: 3:10PM

Samples sent by : Ss. Rajyalakshmi — Time: 3:15PM

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
3:18pm	Tab. Lobazam	oral	2.5mg (off tablets)	Dr. Vishwaja	AS

Condition of patient at time of shift - out	Details of Shift - out
HR: 140 b/m BP: 107/70 (88) CFT: <2sec	Shift - out from ER to: 134
RR: 22 b/m SPO₂: 100%	Time of Shift - out: 8/6/26 @ 3:50pm
GCS: 15/15 Temperature: 98.4°F	Handover given to: (Nurse's Name) Sr. Manisha by Aschitha
Pain Score: 0	
Repeat RBS (if applicable): —	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): Iv placement Done

Name of the Nurse : Aschitha

Signature of the Nurse : AS

Date & Time : 8/6/26 @ 3:50pM

PATIENT TRANSFER FORM

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
VIH-00205727 IP-00060272 Baby CH.VAMIKA 01-02-2025 1 Y 4 M 7 D (F) Dr. SIVA NARAYANA REDDY	8/6/26 @	8/6/26 @ 3:50PM
	Transfer Ordered by Dr. Vishwasa	**Reason for Transfer** Admission
From Unit ER	**To Unit** 134	**Information to Attendant** Yes ☑ No ☐
Number of Sheets in Clinical File 28	**Number of Imaging Films** —	**Personal belongings including clinical documents. If any handed over to attendant** Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Samuel [signature]	Dr. Vishwasa

Patient & Clinical Records Received by : Manasa

Date & Time of Patient Received : 8/6/26 @ 4:00PM

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

Docu. No. : RCH /FRM / CLINICAL / 102

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1Y4M7D (F)
Dr. SIVA NARAYANA REDDY

Nursing General Admission Assessment Form For Pediatrics

Diagnosis: febrile seizures

Arrival Time: 4:00 pm Mode of Arrival: by mother hold Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: NO

Body Weight: 8.6 Kg

Height: .... cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
yes	Nil	yes admitted for AFI

Family History: Nil

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: 8.6 kg Length: — Head Circumference (< 2 years): —

Temp.: 98.6°F HR: 120 b/m RR: 27 b/m BP: 100/60 (70)

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

Fall Risk Assessment: ☑ Yes ☐ No Score: 14 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 27) (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: Nil Location: Nil Frequency: Nil Duration: Nil

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: ......Nil...... (Date/Time): ......–......

Social History: Lives With ......family......

Siblings in household ☐ Yes ☑ No (if yes How Many?) ......0......

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......

Nurse's Name: ......Manasa...... Date: ......8/6/26...... Time: ......4:15pm...... Signature

PEDIATRIC IN-PATIENT MEDICAL RECORD

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 7 D (F)
Dr. SIVA NARAYANA REDDY

Patient Name: ____________________

UHID ID: ____________________

Department: ____________________

Consultant: ____________________

VIH-00205727 IP-00060272
Baby CH.VAMIKA 1 Y 4 M 9 D (F)
01-02-2025
Dr. SIVA NARAYANA REDDY

Pediatric Multiorgan History & Physical Examination

Name : Vamika. Age/Sex 16 months /F

Information given by: Mother, father Relationship

Chief Presenting Complaints & Duration (Chronologically)

c/o Fever since 3days.
1 episode of seizure activity - today morning

History of present illness :

Child presented with
c/o Fever since 2days
intermediate grade
↓ Relieving on medications.

NO H/O cough, cold

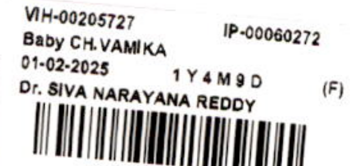
Consulted outside hospital.
Started on NS Bolus - 100ml stat
Inj Monocef 400mg BD
Inj Amikacin 60mg OD } 2days.

↓

Today morning - 1 episode of seizure activity @ 10:30 AM.
c̄ stiffening of limbs
Clenching of teeth.
lasting for 5-10 min.
post seizures - drowsiness - 1hour.

1st time seizure episode

On presentation - child irritable
conscious.
No active seizure.


VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 9 D (F)
Dr. SIVA NARAYANA REDDY

Pediatric Multiorgan History & Physical Examination

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

H/o admission for AFI - took IV antibiotics. - 2months back

6/6/26 (outside)

Hb : 10.5 Widal : S Typhi 'O' 1:20
RBC - 4.4 S Typhi 'H' 1:40.
WBC - 6,300
N - 44%
L - 46%
CRP - 35mg/dl
plt : 1.89 lakhs

Birth & Neonatal History:

Term / 3kg / CIAB / admission for Jaundice

NCM 3°

Birth & Socio Economic History:

About Father :
About Mother : Class III
Any additional Information :

Developmental History :

Appropriate for age in all domains

Immunization History :

Received upto date

(P.T.O.)

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 7 D (F)
Dr. SIVA NARAYANA REDDY

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 8.6kg (Centile _____)

On Examination :

Temperature : 100.8°F Pulse Rate : 143/min B.P. 90/72 SPO2 100%

Resp.rate and type of breathing : 29/min

Rash ⊝

Lymphadenopathy ⊝

Oedema : ⊝

Allergies (if any): ⊝

Respiratory System :

Inspection (any s/o distress) : Ⓝ

Air entry & breath sounds : B/L AE ⊕

Any addes sounds : NO

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

Cardiovascular System :

Inspection of procordium : Ⓝ

Heart Sounds : S1S2 ⊕

Any murmur : NO

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

Per Abdomen :

Inspection Ⓝ

Palpation : soft

Ausculation : BS ⊕

Spine : Ⓝ External Genitelia :

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

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 7 D (F)
Dr. SIVA NARAYANA REDDY

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : intact

Motor System:

Nutriton : } (N)

Tone: } (N) Power 4/5 all limbs

Co-ordinator : } (N)

Posture :

Involuntary Movements : (−)

Reflexes : +

DTR +2 **Superficials:**

Plantars flexor

Sensory System : +

Bladder / Bowel : NO incontinence

Clinical Summary & Diagnostic:

Febrile seizures. (1st episode)

(P.T.O.)

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 7 D (F)
Dr. SIVA NARAYANA REDDY

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: To prevent complications.

Desired goals of the treatment : To treat current condition

D/w Dr. Sivasir, Dr. NSK Sir

Planned Labs:

- CBP, CRP
- CUE ×
- B/C/S, S/E, S.creat
- U/C/S ×
- $S.Ca^{+2}$
- $S.Mg^{+2}$
- Extrapack - ①.

Planned Management

RBS - 93mg/dl

1) IV fluids
2) Inj Ceftriaxone
3) Inj Amikacin
3) Inj Esomeprazole
4) Neuro c/o

Noted by Archith
8/6/26 @ 3:30pm

Signature of the Doctor: [signature]
Name of the Doctor: Dr. Vishwaja
Date & Time: 8/6/26

Signature of the Consultant: [signature]
Name of the Consultant: Dr. [illegible]
Date & Time: 8/6/26 6pm

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 7 D (F)
Dr. SIVA NARAYANA REDDY

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26 5PM	C/S/B Resident	
	Simple febrile seizure.	
	O/E Active	
	CVS - S1S2 (N)	Plan
	RS - BLAE (N)	
	PA - soft	- Contd IV fluids
	my Stable	- Inj ceftriaxone
		- Inj Amikacin
		- Inj esomeprazole
		- Tab Amisium
	Neuro C/N - done	
		- Dengue NS1 & IgM to send
		Noted by Manasa 8/6 @ 7pm
		Dr. Sh...

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 8 D (F)
Dr. SIVA NARAYANA REDDY

PROGRESS NOTES AND DOCTOR'S ORDER

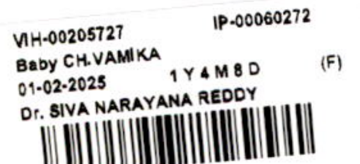
Date & Time	Progress Notes	Doctor's Order
9/6/25 8am	S/B Resident	
	Acc- Simple febrile seizures.	
	No fever spikes	
	Other concerns	
	O/E Child Alert	
	Euthermic	
	Vitals stable	
	CVS-S1S2 (+)	
Dr. [illegible] 9/6/25 CUS	RS -BAE (+)	
	P/A- soft	
		Plan
		1) Trace dengue NS1, IgM
		2) Inj ceftriaxone - 2nd dose
		3) Inj Amikacin - 2nd dose
		4) Tab frisium - 2nd dose
		5) CBG / CRP T/m
	noted by manasa 9/6 em	Dr. Vishnuteja

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/26 4:00pm	C/c/B Resident	
	Dx: Simple febrile seizure.	
	No fever spikes	
	No other concern.	
O/I Better	O/E	
	Child Alert	
	Vitals stable	
	CVS: S1S2 (+)	
Dr. prashanthi	RS: B/L AE (+)	Plan
	P/A: Soft	
	CNS: NAD	– Inj. ceftriaxone – D2
		Inj. Amikacin – D2
Dengue NS1 – Not detected		– Tab. Frisium – 3rd dose
Igm – Non reactive.		– CBP, CRP – T/m.
		Trace Bld c/s u/c/s.
		Noted by Srikanth 9/6/26 @ 7PM

Docu. No. : RCH /FRM / CLINICAL / 088

(P.T.O)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/26 9:30 AM	C/C/B Resident	
	No fever spikes. No other concerns.	
O/I - Better. 4/O - Adequate.	O/E	
	Child Alert & Active. Vitals stable	
B/C - No growth after 24hrs.	CVS: S1S2 (+) RS: B/L AE (+) P/A: soft CNS: NAD.	Plan
4/C - No growth after 24hrs.		- Trace cultures.
Dr. Prathusha		- Inj. Ceftriaxone - D2
		- Inj. Amikacin - D2
Dr. [illegible] 10/6/26 10A		- Tab. [illegible] (4 doses)
Noted by Indu 10/6/26 @10:30AM	Hemogram. 2. TMT - BD - x1/week. Bronze x1/week	- Monitor vitals
		- Inform (SOS)

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1Y4M7D (F)
Dr. SIVA NARAYANA REDDY

NURSING SHIFT HAND OVER FORM

SITUATION

Diagnosis: Febrile Seizures (1st episode)

Any Infection: ☐ Yes ☐ No ☑ Not Known
If Yes Specify: –

Surgery / Procedure: Nill

Post OP Day:

BACKGROUND Date / Shift	8/6/26 ER	8/6 E	8/6 N	9/6 M	9/6/26 E	9/6/26 Night
Medical Condition (Any special condition to be noted):	Nil	Nil	Nill	—	—	—
Diet:		S.diet	S.diet	S diet	S.diet	S.diet
ASSESSMENT Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA	RA	RA
Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
Vital Signs: Temp:	98.4°F	98.6°F	98.6°F	98.2°F	98.6°F	98.6°F
Res:	22b/m	26b/m	20b/m	22b/m	26b/m	22b/m
SpO_2:	100%	98%	98%	99%	98%	100%
Pulse:	140b/m	120b/m	104b/m	110b/m	116b/m	110b/m
BP:	107/70(88)	100/60(70)	107/63	72/45(55)	86/56(66)	107/76(89)
LOC:	Conscious	Conscious	conscious	conscious	Conscious	Conscious
Fall Risk Score:	"0"	0	0	0	0	"0"
Pain Score:	"0"	0	'0'	0	0	0
Skin Integrity	Intact	Intact	Intact	Intact	Intact	Intact
Recommendations Safety Needs:	☐ Yes ☑ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No
Physiotherapy:	Nil	Nil	Nill	—	—	Nil
Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
Special Diet:		Nil	Nil	—	—	Nil
Critical Lab Test / Values:	Nil	Nil	Nill	—	—	Nil
Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
ADL (Dependent / Non Dependent):	Dependent	Dependent	dependent	dependent	Dependent	Dependent
Post Operative Procedure Special Orders:	Nil	Nil	Nill	—	—	—
Handed Over By Name :	Aradhitha	Manasa	Anitha	Manasa	Sreelatha	Subhan
Signature / ID :	AS/02064	F01959	[illegible]	F01959	G5751	F7444
Date:	8/6/26	8/6	9/6	9/6	9/6/26	10/6/26
Time:	@3:50pm	@8pm	@8am	@2pm	@5pm	@8am
Taken Over By Name :	Manasa	Anitha	Manasa	Sreelatha	Subhan	Indu
Signature / ID :	F01959	[illegible]	F01959	G5751	F7444	8606608
Date:	8/6	8/6	9/6	9/6/2026	9/6	10/6/26
Time:	@4:00pm	8pm	@8AM	2pm	@8pm	@8am

Docu. No. : RCH /FRM / CLINICAL / 097

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 8 D (F)
Dr. SIVA NARAYANA REDDY

NURSING SHIFT HAND OVER FORM

SITUATION

Diagnosis: febrile seizers

Any Infection: ☐ Yes ☑ No ☐ Not Known
If Yes Specify: nil

Surgery / Procedure: nil

Post OP Day: nil

Section	Date / Shift	10/6/26 M					
BACKGROUND	Medical Condition (Any special condition to be noted):	nil					
	Diet:	s. diet					
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	RA					
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.1°F					
	Res:	25 b/m					
	SpO_2:	98°/.					
	Pulse:	112 b/m					
	BP:	100/60(70)					
	LOC:	consious					
	Fall Risk Score:	10					
	Pain Score:	0					
	Skin Integrity	Intact					
Recommendations	Safety Needs:	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	nil					
	Others Specify:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	s. diet					
	Critical Lab Test / Values:	nil					
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	depended					
	Post Operative Procedure Special Orders:	nil					
	Handed Over By Name :	Indu					
	Signature / ID :	606608					
	Date:	10/6					
	Time:	@10.30AM					
	Taken Over By Name :						
	Signature / ID :						
	Date:						
	Time:						

noted by Indu 10/6 @10:30AM

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 7 D (F)
Dr. SIVA NARAYANA REDDY

NURSING CARE RECORD

Date: 8/6

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ Any Others. Specify...... Nil
- ☑ Maintain Fluid Balance
- ☐ Meet Elimination Needs
- ☐ Improve Activity Tolerance
- ☐ Ensure Safety
- ☐ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety
- ☐ Maintain Skin Integrity
- ☐ Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon	4 PM	→ IV fluids on flow	4:30 PM	→ DNS 22ml/hr is maintained	→ To maintain hydration	→ patient is stable	[illegible]
Night	8pm 8pm	– Assessment – vitals		– Assessed the general condition – monitored vitals & recorded	– vitals are normal	– patient is stable.	Anitha 9/6/25 @8pm

Docu. No: RCH /FRM / CLINICAL / 148

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 7 D (F)
Dr. SIVA NARAYANA REDDY

NURSING CARE RECORD

Date: 9/6/26

Goals

- ☐ Maintain Airway and Oxygenation
- ☑ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ Any Others. Specify: Nil
- ☐ Maintain Fluid Balance
- ☐ Meet Elimination Needs
- ☐ Improve Activity Tolerance
- ☑ Ensure Safety
- ☑ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety
- ☐ Maintain Skin Integrity
- ☐ Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	9am	→ Ensure safety → maintain fluid Balance		→ provide side rails → maintain good nutrinal status	→ prevent infection & dehydration	→ Re-assessment done every 4th hourly vitals checked	manasa
Afternoon	3pm	→ maintain good nutritional status		→ provide solid foods	→ To maintain nutritional status	→ Patient is stable	Sreelekha 9/6/2026 @8pm
Night	9pm 10pm	maintain Personal hygiene → Ensure Safety	9pm	→ maintained Hand hygiene and hand washing → side rails kept up	→ To Prevent infection → Prevent from fall	→ Patient is stable	Subha 10/6 @8Am

VIH-00205727 IP-00060272
Baby CH.VAMIKA 1 Y 4 M 8 D (F)
01-02-2025
Dr. SIVA NARAYANA REDDY

NURSING CARE RECORD

Date: 10/6/26

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ Any Others. Specify..........
- ☐ Maintain Fluid Balance
- ☐ Meet Elimination Needs
- ☐ Improve Activity Tolerance
- ☐ Ensure Safety
- ☐ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety
- ☐ Maintain Skin Integrity
- ☐ Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	10 Am	Discharge notes :-		Doctor came for rounds and advice for discharge			
Afternoon						noted by	Indu 10/6 @10:30AM
Night							

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 9 D (F)
Dr. SIVA NARAYANA REDDY

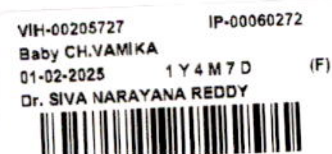
NURSING CARE RECORD

Date: ....

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Relieve Pain & Discomfort
- ☐ Maintain Fluid Balance
- ☐ Improve Activity Tolerance
- ☐ Maintain Good Nutritional Status
- ☐ Maintain Skin Integrity
- ☐ Maintain Personal Hygiene
- ☐ Prevent Infection
- ☐ Meet Elimination Needs
- ☐ Ensure Safety
- ☐ Early Ambulation Reduce Anxiety
- ☐ Patient & Family Education
- ☐ Identify Potential Complications
- ☐ Any Others. Specify...

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

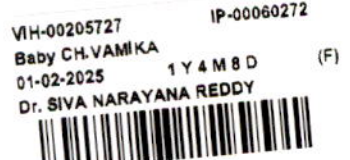


THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 8/6	DATE 8/6	DATE 9/6	DATE 9/6	DATE 9/6
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	1
Diagnosis	Neurological Diagnosis	4	4	4	4	4	4
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3	3	3	3	3	3
	Forget Limitations	2					
	Oriented to own ability	1					
Environmental Factors	History of Falls or Infant-Toddler Placed in Bed	4					
	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
	Total		16	16	16	16	16

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

Intervention							
Bed in low position		✓	✓	—	—	✓
Call device within reach		X	X	X	X	X
Wheels Locked		✓	✓	—	—	—
Room free of clutter		✓	✓	—	—	—
Adequate lighting		✓	✓	—	—	—
Wheel chair support		X	X	X	X	X
Other Intervention(s) Specify		X	X	X	X	X
Nurse's Name:		Sam	Anitha	Anitha	[illegible]	Sheeba
Signature:		[signature]	[signature]	[signature]	[signature]	[signature]
Date:		8/6	8/6	9/6	9/6	9/6/2025
Time:		3pM	11pm	7Am	3PM	7pm

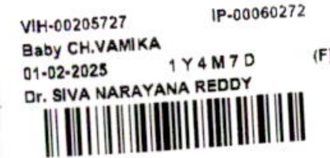


THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 10/6	DATE 10/6	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1			
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2	2	✓			
	Oriented to own ability	1					
Environmental Factors	History of Falls or Infant-Toddler Placed in Bed	4					
	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1			
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
	Total		12	12			

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position		✓	✓			
	Call device within reach		✗	✗			
	Wheels Locked		✓	✓			
	Room free of clutter		✓	✓			
	Adequate lighting		✓	✓			
	Wheel [illegible]		✗	✓			
	Other Intervention(s) Specify		✓	✓			
	Nurse's Name:		[illegible]	[illegible]			
	Signature:		[illegible]	[illegible]			
	Date:		10/6	10/6			
	Time:		8Am	11Am			



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	8/6 DAY-1			9/6 DAY-2			9/6 DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0	0	0	0	0			
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		–	–	–	–	–	–			
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		–	–	–	–	–	–			
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		–	–	–	–	–	–			
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		–	–	–	–	–	–			
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		–	–	–	–	–	–			
		Signature of the Nurse											

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : .... Name : ....

Signature of Ward In Charge :

Signature : .... Name : Elizabeth

Doc. No. : RCHBH/ FRM / CLINICAL /137

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 7 D (F)
Dr. SIVA NARAYANA REDDY

PAIN ASSESSMENT FORM

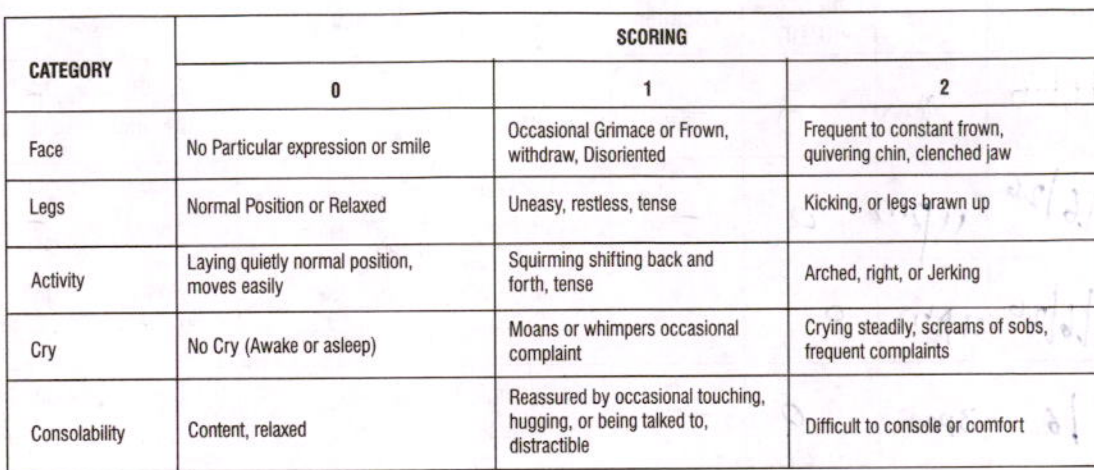
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
8/6/26	3PM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	— —	[signature]
8/6/26	11pm	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	— —	Anitha
9/6/26.	7Am	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	— —	Anitha
9/6	3pm	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	— —	[signature]
9/6/26	7pm	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	— —	Sreelekha
10/6	1Am	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Subha
10/6	6Am	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Subha
10/6	12pm	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Indu
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)



CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

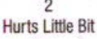
Numerical Pain Scale (Obstetric and Gynecology)

0 No Pain — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Worst Possible Pain

Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



0 No Hurt — 2 Hurts Little Bit — 4 Hurts Little More — 6 Even More — 8 Hurts Whole Lot — 10 Hurts Worst

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 7 D (F)
Dr. SIVA NARAYANA REDDY

BRADEN 'Q' SCALE

					Date :	8/6	8/6	9/6	9/6
					Time :	3pm	11pm	7Am	3pm
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.		4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
				TOTAL SCORE		28	28	28	28
				Evaluator's Name		[signature]	[signature]	[signature]	[signature]

Severe Risk : less than 9 \| High Risk : 10-12 \| Moderate Risk : 13-14 \| Mild Risk : 15-18 \| Not at Risk: 19-23

Docu. No. : RCH /FRM / CLINICAL / 119

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

Rainbow Children's Hospital

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.
TEL NO :040-42462200, Ext 2000,2001,2002
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	Baby CH.VAMIKA	Age :	1 Y 4 M 7 D
IP No:	IP-00060272	Sex:	Female
Consultant:	Dr. SIVA NARAYANA REDDY VENNAPUSA	Ward/Bed No:	N 0 GF-EMERGENCY/ER 103

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned ...) consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for ...urance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill ...rance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.................) Ch.praveen kumar

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative: Ch.praveen kumar

Name: CH PRAVEEN KUMAR
Relationship: father
Date: 08/06/26
Wittness Name: [illegible]
Wittness Signature: [illegible]

Time: 02:03 P.M

Patient Address:
THURKAPALLY(V) SHAMIRPET(M)
MEDCHAL(D) Shamirpet Hyderabad
Telangana INDIA 500078

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

CONSULTATION FORM

BirthRight BY RAINBOW HOSPITALS Your Right to a Safe Delivery | Madhukar Rainbow Children's Hospital It takes a lot to treat the little.

Doctor Name : Dr Sindhura

Date : 8/6/26 Hour : 6 PM

Hospital : RCH

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

Referred for : ☐ Opinion ☐ Co-Management ☐ Transfer of care

Date : 8/6/26 Time : 6PM By : ....

Reason for Consultant : [...] the particular need, especially in the absence of a second diagnosis:

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 8 D (F)
Dr. SIVA NARAYANA REDDY

Signature: M.D.

Report of Findings and Recommendations :

c/o
Fever x 3 days
paroxysmal event @ 10:30AM
eye closed
tonic posturing with clenching of teeth
intermittently jerks for 2 minutes
f/b post event drowsiness for 1 hour

3° CM [pedigree diagram]

Birth Hx - FT/NVD/2.5kg

Development Hx - Appropriate for age

Consultant :

Name : Dr. P. Sindhura Signature : P. Sindhura Date & Time : 8/6/26 6pm

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

O/E → HC - 44.5 cm

No NC markers

No dysmorphism

Pupils - B/L equal - reacting

fixing & tracking in all directions

(N) Tone

good all movements

DTR - +2

? febrile seizure ↓ eval.

Plan

- S-Ca^{++}, Mg^{++}, S. electrolytes

→ T. Frisium(5)
 1/2 — 0 — 1/2 — (2) days

→ If irritability persists & CRP is increasing
↓
SOS CSF analysis

- Watch for irritability

→ In case of seizure recurrence

→ Inj levetiracetam 160mg stat

⇒ MRI brain

⇒ CSF analysis

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 7 D (F)
Dr. SIVA NARAYANA REDDY

CH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 8/6 Time:	5	7	9	11	1	3	5	7
Doctor / Nurse / Family Concern?	pm	pm	pm	pm	Am	Am	Am	Am
Temperature (°F)	98.6°F	98.3°F	98.6°F	98.6°F	98.2°F	98.4°F	98.3°F	98.2°F
Heart Rate (bpm) and Blood Pressure (mmHg) *			94/58 (59)					90/58 (60)
Heart Rate (Number)	117	115	113	114	112	114	110	
Resp. Rate (bpm) (Over 1 Minute) *								
Resp Rate (Number)	26	25	25	24	22	22	20	
Resp Distress Mod/ Severe								
Resp Distress None / Mild								
Receiving O_2 (l/min)								
O_2 Saturations (%)	98	98	98	97	98	98	99	
Conscious Level Normal	N	N	N	N	N	N	N	
Conscious Level Altered								
GCS *	15	15	15	15	15	15	15	
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0	0	
Pain Score	0	0	0	0	0	0	0	
Observer's Initials	M	M	A	A	A	A	A	

Temperature scale: 104–94. Heart Rate / Blood Pressure scale: 190–50. Note: BP does not score in early warning scoring. Resp. Rate scale: 70–10.

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

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

Patient Sticker

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 8 D (F)
Dr. SIVA NARAYANA REDDY

c. No. : RCH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

Date: 9/6/26 Time:	9 AM	10 AM	12 AM	2 PM	4 PM	6 PM	10 PM	1 AM	4 AM	6 AM	8 AM
Doctor / Nurse / Family Concern?											
Temperature (°F)	98.1°F	97.2°F	98.0°F	98.6°F	98.0°F	98.0°F	97.2°F	98.6°F	98.6°F	98.6°F	98.6°F
Heart Rate (bpm) and Blood Pressure (mmHg) *		106/64 (76)			97/56 (70)		88/66 (73)			92/55 (64)	
Heart Rate (Number)	115	110	117	112	118	121	122	126	112	120	110
Resp. Rate (bpm) (over 1 Minute) *											
Resp Rate (Number)	27	28	28	27	28	26	20		28		24
Resp Distress: Mod/ Severe											
Resp Distress: None / Mild											
Receiving O_2 (l/min)											
O_2 Saturations (%)	98	99	98	98	99	98	99	100	96	98	96
Conscious Level: Normal	N	N	N	N	N	N	N	N	N	N	N
Conscious Level: Altered											
GCS *	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
Pain Score	0	0	0	0	0	0	0	0	0	0	0
Observer's Initials	Jm	[illegible]	Mk	Mk	8	8	SK	SK	SK	SK	SK

Note: BP does not score in early warning scoring

ACTIONS

NB: Scores 3 should be recorded overleaf

Score	Action
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.

Patient Sticker

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

No. : RCH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/6/26 Time:	9 Am	11 Am
Doctor / Nurse / Family Concern?		
Temperature (°F) (104–94)	98.6°F	
Heart Rate (bpm) and Blood Pressure (mmHg) * (190–50) Note: BP does not score in early warning scoring	100/70, 60	
Heart Rate (Number)	112	
Resp. Rate (bpm) (Over 1 Minute) * (70–10)		
Resp Rate (Number)	27	
Resp Distress — Mod/ Severe		
Resp Distress — None / Mild		
Receiving O_2 (l/min)		
O_2 Saturations (%)	98	
Conscious Level — Normal	N	
Conscious Level — Altered		
GCS *	15	
TOTAL SCORE Number of shaded boxes	0	
Pain Score	0	
Observer's Initials	[illegible]	

noted by Indu 10/6 @10:30am

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

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

Patient Sticker

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

FLUID CHART

Sheet No. : ①　　　　　　　　8/6/26

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

Date	Time	Intake: Nature of Fluid	Route: Mouth	Route: I.V	Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	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											
8/6	04:00 pm											Manasa
	05:00 pm		Dilly							✓	0	8/6
	06:00 pm		water	22ml								@7pm
	07:00 pm			22ml								
Total Intake : 44 ml						**Total Output :**						
	08:00 pm			22 ml								
	09:00 pm			22 ml						—		
	10:00 pm		Rice	22 ml								Anitha
8/6	11:00 pm		water	22 ml							0	
	12:00 am			22 ml						—		8/6
	01:00 am			22 ml								
Total Intake : 132 ml						**Total Output :**						
	02:00 am			22ml								
9/6	03:00 am			22ml						—		
	04:00 am		water	22ml								Anitha
	05:00 am			22 ml							0	
	06:00 am			22 ml						—		9/6
	07:00 am			22 ml								
Total Intake : 132 ml						**Total Output :**						

Total 24 hrs. Intake	308 ml

Total 24 hrs. Output	

FLUID CHART

Sheet No. : 2

9/6/26

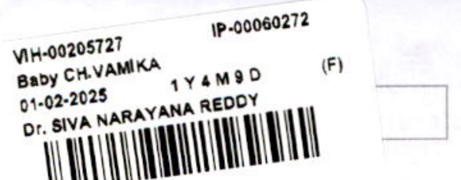
1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Nature of Fluid	Intake – Route: Mouth	Intake – Route: I.V	Intake – Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
9/6	08:00 am		Idly							✓		
	09:00 am		+	22 ml								Manasa
	10:00 am		water	22 ml								9/6
	11:00 am										0	@ 1pm
	12:00 pm			22 ml						✓		
	01:00 pm			22 ml								
Total Intake : 88 ml						**Total Output :** 2 times						
	02:00 pm			22 ml								Sreelaxmi
	03:00 pm			22 ml						✓		9/6/2026
	04:00 pm			22 ml							0	@ 8pm
	05:00 pm			22 ml								
	06:00 pm			22 ml						✓		
	07:00 pm			22 ml								
Total Intake : 132 ml						**Total Output :** 2 times						
9/6	08:00 pm											
	09:00 pm		Rice									
	10:00 pm		water									
	11:00 pm										0	Subha
	12:00 am									✓		9/6
	01:00 am											
Total Intake :						**Total Output :**						
10/6/26	02:00 am		[illegible]									
	03:00 am									✓		Subha
	04:00 am										0	10/6
	05:00 am											@ 7AM
	06:00 am											
	07:00 am									✓		
Total Intake :						**Total Output :**						

Total 24 hrs. Intake	220 ml

Total 24 hrs. Output	7 times

Docu. No. : RCH /FRM / CLINICAL / 092



FLUID CHART

Sheet No. : 8   10/6/26

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

Date	Time	Intake: Nature of Fluid	Route: Mouth	Route: I.V	Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
10/2/26	08:00 am									✓		
	09:00 am		Idly								0	Indu
	10:00 am		+									7-0-6
	11:00 am		water									
	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 :**						

noted by Indu 10/6 @10:30AM

Total 24 hrs. Intake		Total 24 hrs. Output	

Docu. No. : RCH /FRM / CLINICAL / 092

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 7 D (F)
Dr. SIVA NARAYANA REDDY

DRUG CHART

8.6 kg

Date of Admission: 08/06/26 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 / 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: SYP. PARACETAMOL				Date/Time
Dose	Route	Frequency	Start Date	
2.5 ml	PO	as required	8/6	
Doctor's Signature		Valid Period	Pharm.	
[signature]		max 6th hrly	[signature]	
Additional Instructions: 5ml = 240mg 15mg/kg/dose if temp > 100°F				

DRUG: INJ. LEVITERACETAM.				Date/Time
Dose	Route	Frequency	Start Date	
160 mg	IV	as required	8/6	
Doctor's Signature		Valid Period	Pharm.	
[signature]			[signature]	
Additional Instructions: if seizure (+) 20mg/kg/dose (loading dose)				

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

VERIFIED BY : Name .... Signature

VIH-00205727
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 7 D (F)
Dr. SIVA NARAYANA REDDY

REGULAR PRESCRIPTIONS

Weight. 8.6Kg Ward. ....

DRUG : INJ. CEFTRIAXONE

Dose	Route	Frequency	Start Date
430mg	IV	12th hourly	8/6

Name & Signature of the Doctor Starting the Drugs: Dr. Vishwaja

Additional Instructions: after test dose
50mg/kg/dose

Daily Doctor's Endorsement by a Sign

Date/Time	8/6	9/6	10/6
6AM	/	[signature]	[signature]
6PM	[signature]	[signature]	

DRUG : INJ. AMIKACIN

Dose	Route	Frequency	Start Date
60mg	IV	12th hourly	8/6

Name & Signature of the Doctor Starting the Drugs: Dr. Vishwaja.

Additional Instructions:
7.5mg/kg/dose

Daily Doctor's Endorsement by a Sign

Date/Time	8/6	9/6	10/6
6AM	/	[signature]	[signature]
6PM	[signature]	[signature]	

DRUG : INJ. ESOMEPRAZOLE

Dose	Route	Frequency	Start Date
8mg	IV	Once daily	8/6

Name & Signature of the Doctor Starting the Drugs: Dr. Vishwaja

Additional Instructions:
1mg/kg/dose

Daily Doctor's Endorsement by a Sign

Date/Time	8/6	9/6	10/6
6AM	[signature]	[signature]	[signature]

DRUG : TAB. FRISIUM (CLOBAZAM)

Dose	Route	Frequency	Start Date
1/2 tab	PO	12th hourly	8/6

Name & Signature of the Doctor Starting the Drugs: Dr. Vishwaja.

Additional Instructions: × 2days.
1tab = 5mg

Daily Doctor's Endorsement by a Sign

Date/Time	8/6	9/6	10/6
6AM		[signature]	[signature]
6PM	GIVEN IN ER	[signature]	

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 9 D (F)
Dr. SIVA NARAYANA REDDY

Weight. .... Ward. ....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
8/6	3:15 pm.	TAB. CLOBAZAM	2.5mg (1/2 tab)	PO	[signature]	Adithe / Jyothi

[signature] 8/6/26.

VERIFIED BY : Name .... Signature ....

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 7 D (F)
Dr. SIVA NARAYANA REDDY

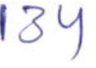
I.V. FLUIDS CHART

Weight. 8.6 kg Ward. ....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
8/6	4pm	DNS (2/3 M)	IV.	22ml/hr	[signature]	manisha / Sehya	10/6	[signature]	[signature]

VERIFIED BY : Name .... Signature ....

VIH-00205727 IP-00060272 4m.
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 7 D (F)
Dr. SIVA NARAYANA REDDY



NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 8/6/26 Time: 5PM

Weight: 8.6kgs Centile: <5 centile

Height: — Centile: —

Inference: underweight.

RDA: 1100 Kcal Calories: 1100 kcal Protein: 15-20gm /day

Diet Recommendations: Soft diet.

Re-Assesment:

Food Allergies: Nill Veg/Non-veg ✓ Both.

Diagnosis: febrile seizures (1st episode)

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: ch. Kavya (Mother)

GROWTH CHART (GIRLS)

Birth to 36 months: Girls
Length-for-age and Weight-for-age percentiles

2 to 20 years: Girls
Stature-for-age and Weight-for-age percentiles

Dietician's Name Vidhyadhari

Dietician's Signature

Docu. No. : RCH /FRM / CLINICAL / 161

(P.T.O.)

Daily Notes:

10/6/26 [illegible] [illegible]

IAM

Ref. No. F/INPR/12

VIH-00205727 IP-00060272
Baby CH.VAMIKA
01-02-2025 1 Y 4 M 7 D
Dr. SIVA NARAYANA REDDY (F)

Patient Name :

Registration No.:

134

MEDICATION

~~NEBULISATION~~ CHART

9/6/26

Date	Time	Drug	Nurse	Parents SIgnature
	00.00	6AM		
	1.00	Inj: Ceftrizone - 430mg - IV	[signature]	ch. Kavya
	2.00	Inj: Amikacin - 60mg - IV		
	3.00	Inj: Esomeprazole - 8mg - IV		
	4.00	T. Frisium 1/2 - Po		
	5.00			
	6.00			
	7.00			
	8.00	6PM		
	9.00	Inj: Ceftrizone - 430mg - IV	[signature]	ch. Kavya
	10.00	Inj: Amikacin - 60mg - IV		
	11.00	Tab. Frisium 1/2 - Po		
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			