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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ACTIVITY RECORD FOR BILLING

Name : ______________________________

CUV-00172369 IP5-00175026
Baby PEMULA SAMAIRA GRETCHEN
30-01-2021 5 Y 4 M 12 D (F)
Dr. SIRISHA RANI

UHID No. : ______ Consultant: ___________ Dept : __________

Date of Adm ________ Date of Discharge : _________ Time: _________

Room / Bed No : __________ Ward : __________ Suggested Billable bed type : _______________

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/6/26	12:55 pm	ER	oncology	pooja

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
11/6	CBP OP		

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
11/6	Infusion Pump	3:40pm		9653348	[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
11/6/26	chemotherapy	(1)	9653827	[signature]
11/6/26	Blood transfusion (EFP)			

ANY OTHER INFORMATION

....

....

....

....

....

....

Date : 11/6/24 Time : 4pm Prepared By : [signature]

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
[signature]	ONC		

CUV-00172369 IP5-00175026
Baby PEMULA SAMAIRA GRETCHEN
30-01-2021 5 Y 4 M 12 D (F)
Dr. SIRISHA RANI

ADMISSION CRITERIA – ONCOLOGY

Admission / Transfer from:

☐ Emergency ☐ Outpatient (OPD) ☐ Ward ☐ Operation Theater ☐ Others: ....

Tick (✓) any of the following criteria requiring admission / transfer to ONCOLOGY

- ☑ For Chemotherapy-Day Care or IP Admission as per the Type of Chemotherapy
- ☐ Febrile Neutropenias (ANC <500 cells / mm3)
- ☐ Netropenic Enterocolitis
- ☐ Mucositis Induced Significant Diarrohea or Pain
- ☐ Neurological Complications (like Seizures, Bleeding, Thrombosis) that can arise while on Chemotherapy Treatment or at the Time of Presentation and also for other Systemic Problems like Pancreatitis during Chemotherapy
- ☐ Management of Oncological Emergencies
- ☐ Bleeding Problems (where it is indicated)
- ☐ Evaluation and Management of Severe Anemias
- ☐ Day Care Admissions for PRBC Transfusions
- ☐ Evaluation and Management of Sick Children who come with Hematological Problems like Severe Anemia like Autoimmune Hemolytic Anemia/ Bleeding/ Others
- ☐ Primary Immunodeficiency Disorders with Infections that Warrants Hospitalisation
- ☐ Management and Evaluation of Hemophagocytic LymphoHisticytosis
- ☐ Any Systemic Disorders with Significant Hematological issues like JRA / SLE with Secondary HLH

Signature of the Doctor: ....[signature]..........

Name of the Doctor: ....Suvarni..........

Date & Time: 11/6/26 @ 1:20pm

Patient Sticker

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DISCHARGE CRITERIA – ONCOLOGY

Discharge to:

☐ HDU / Step down ICU ☐ Ward ☐ Outside Facility ☑ Others: ....

Tick (✓) any of the following criteria requiring discharge / transfer from ONCOLOGY

☑ Completion of chemotherapy, with no debilitating side effects.

☐ Resolution of febrile episode, with no fever>24hrs and Absolute Neutrophil count (ANC)> 500cells/mm3.

☐ Admitted patients - Once the admitting problem gets resolved or made a plan to manage further on out-patient basis.

Signature of the Doctor: ...[signature]...

Name of the Doctor : ...Sunni...

Date & Time: ...11/6/26 @ 5pm...

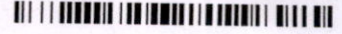
Rainbow Children's Hospital | BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175026 **Admit Date** : 11-Jun-2026 **Admit Time** : 12:07 PM **UHID** : CUV-00172369

Patient Details :

Patient Name	: Baby PEMULA SAMAIRA GRETCHEN	**Age**	: 5 Y 4 M 12 D
Guardian	: Mr PEMULA PRUDHVI PORUS	**DOB**	: 30-01-2021
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H NO 35-3-69(36) SANJAY GANDHI COLONY, Ongole Prakasam Andhra Pradesh INDIA 523001	**Phone No**	: 9849044877/ 7330730449
		E-mail	: PEMULA.PRUDHVI@GMAIL.COM

Admission Details :

Bed Type	: BASINET	**Bed No**	: CRDL HO DC 1-1	**Ward Name**	: 1F-HEMATO-ONCOLOGY
Room No	: CRDL HO DC 1-1	**Admission Type**	: First Visit		

Contact Details :

Name	: Mr PEMULA PRUDHVI PORUS	**Relationship**	: Father
Contact Address	: H NO 35-3-69(36) SANJAY GANDHI COLONY, Ongole Prakasam Andhra Pradesh INDIA 523001	**Phone No**	: 9849044877 /

Signature

Doctor Details :

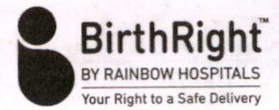
Doctor Name	: Dr. SIRISHA RANI	**Specialisation**	: HEMATO ONCOLOGY
Referral Doctor	: Self	**Phone No**	:
Co-Consultant	:		

Payment Details :

Payment Mode	: Cash	**Deposit Amount**	: 0.67
		Payor Name	: HEALTH INSURANCE TPA OF INDIA LTD

Printed Date / Time : 11/06/2026 12:08 Printed By : 020675

CUV-00172369 IP5-00175026
Baby PEMULA SAMAIRA GRETCHEN
30-01-2021 5 Y 4 M 12 D (F)
Dr. SIRISHA RANI



RESULT SHEET

Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : ....

....

....

....

Radiology : USG : ....

X-Ray : ....

ECHO : ....

CT : ....

MRI ....

Others (ECG, Contrast Studies etc.,) : ....

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DRUG CHART

Date of Admission: 11/6/26 Drug Allergies: .... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).

- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line / 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 :				Date ▸ Time ▾
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

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

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

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

Baby PEMULA SAMAIRA GRETCHEN
30-01-2021 5 Y 4 M 12 D (F)
Dr. SIRISHA RANI

REGULAR PRESCRIPTIONS

Weight. 16.3kg Ward. ....

DRUG : Inj ONDANSETRON				Date ▸ Time ▾	11/6
Dose	Route	Frequency	Start Date	10am	2pm [struck out]
3mg	IV	BD	11/6/26		
Name & Signature of the Doctor Starting the Drugs: Dr Ramya					
Additional Instructions:				10pm	
Daily Doctor's Endorsement by a Sign					

DRUG : Syp. DOMPERIDONE				Date ▸ Time ▾
Dose	Route	Frequency	Start Date	
3ml	PO	TID	11/6/26	
Name & Signature of the Doctor Starting the Drugs: Dr Ramya				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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

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

30-01-2021 5 Y 4 M 12 D (F)
Dr. SIRISHA RANI

Weight. 16.3Kg Ward ONCO

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.	

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
11/6/26	2pm	Inj AVIL	0.5ml	IV	[signature]	Veena / Sowmya
11/6/26	2pm	Inj HYDROCORTISONE	30mg	IV	[signature]	Veena / Sowmya
11/6/26	2pm	FFP transfusion	1unit over 30min	IV	[signature]	Veena / Sowmya
11/6/26	2:30pm	Inj LASIX	10mg	IV	[signature]	Veena / Arun

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

CUV-00172369 IP5-00175026
Baby PEMULA SAMAIRA GRETCHEN
30-01-2021 5 Y 4 M 12 D (F)
Dr. SIRISHA RANI

Baby PEMULA SAMAIRA GRETCHEN
CUV-00172369 IP5-00175026

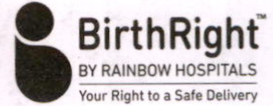
I.V. FLUIDS CHART

Weight. 16.3kg 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

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

CUV-00172369 IP5-00175026
Baby PEMULA SAMAIRA GRETCHEN
30-01-2021 5 Y 4 M 12 D (F)
Dr. SIRISHA RANI



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: ER Shifted to: Hematonco.

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Syp. Septran	5ml	PO	BD		☐C ☐DC
2	Syp. Zincovit	5ml	PO	OD		☐C ☐DC
3	Syp. Calcimax plus	5ml	PO	OD		☐C ☐DC
4						☐C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : [signature] Dr. Ramya

Date & Time : 11/6/26, 12:30pm.

Nurse Name & Signature: Pooja

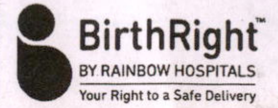
Date & Time : 11/6/26 @ 12:30 pm

Docu. No. : RCHBH /FRM / GENERAL / 090

CUV-00172369 IP5-00175026
Baby PEMULA SAMAIRA GRETCHEN
30-01-2021 5 Y 4 M 12 D (F)
Dr. SIRISHA RANI

CHEMOTHERAPY PRESCRIPTION

All the chemotherapy medications are high risk / high alert drugs.
While administering chemotherapy drugs watch for nausea, vomiting, rashes, urine output and any local extravasation of the drug.



Sheet No. :	Weight (kg) : 16.2kg	Body Surface Area: 0.69	Diagnosis: B-ALL	Protocol: BFM

DATE	TIME	Composition of Chemotherapy (if infusion, mention ml / hr = Mcg / kg / min. etc.)	DOSE	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
12/6/26	3pm	INJ VINCRISTINE	0.9 mg	IV	IV 10 ml NS over 10 mins	[signature]	Pooja / Anu	12/6	[signature]	Pooja / Anu
12/6/26	3pm.	INJ DOXORUBICIN IN 300ml/3hrs @ 100ml/hr	16 mg	IV	IV	[signature]	Pooja / Anu	11/6	[signature]	[signature] / Pooja

CUV-00172369 IP5-00175026
Baby PEMULA SAMAIRA GRETCHEN
30-01-2021 5 Y 4 M 12 D (F)
Dr. SIRISHA RANI

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

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Parameter	Entry
Date : 11/6 ... Time:	2pm
Doctor / Nurse / Family Concern?	
Temperature (°F) (scale 104–94)	98.6F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 190–50)	100/60
Note: BP does not score in early warning scoring	
Heart Rate (Number)	100/min
Resp. Rate (bpm) (Over 1 Minute) * (scale 70–10)	
Resp Rate (Number)	26/m
Resp Distress — Mod/ Severe	
Resp Distress — None / Mild	
Receiving O_2 (l/min)	
O_2 Saturations (%)	100%
Conscious Level — Normal	C
Conscious Level — Altered	
GCS *	15/15
TOTAL SCORE — Number of shaded boxes	0
Pain Score	0
Observer's Initials	[illegible]

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

Pratiksha Rainbow Children's Hospital
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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)

Patient Stic

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30-01-2021 5 Y 4 M 12 D (F)
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FLUID CHART

Sheet No. : ....(1)....

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				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
11/6	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	

Patient Sticker

FLUID CHART

Sheet No. : ....

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

Date	Time	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	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**	

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

NURSING CARE RECORD

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

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Your Right to a Safe Delivery

Shift: ☑ Morning ☑ Afternoon ☐ Night

Date: 11/6/26

Assessment: Patient came for FFP.

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
1:30 pm ⇒	Assess general condition of patient	2pm	Assessed general condition of patient	⇒ Maintaining fluid balance.
2:30 pm ⇒	Improve activity tolerance	3pm	Improving activity tolerance	
3:30 pm ⇒	Maintain nutritional status	4pm	Maintaining nutritional status	
4:30 pm ⇒	Maintain personal hygiene	5pm	Maintaining personal hygiene	
5:30 pm ⇒	Prevent Infection.	6pm	Preventing Infections.	

Re-Assessment: NA

Special Notes: NA

Nurse Signature: Veena Nurse Name: Veena. Date & Time: 11/6/26

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: ....

Assessment: ....

....

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: ....

....

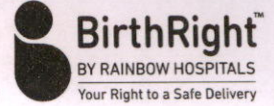
Special Notes: ....

....

Nurse Signature: .... Nurse Name: .... Date & Time: ....

Docu. No: RCHBH /FRM / CLINICAL / 148

Patient Sticker



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. S.R Department: ~~On~~ ward Date of Admission: 11/6/26

SITUATION		
Diagnosis: chemotherapy.	Any Infection: ☐ Yes ☐ No ☑ Not Known	If Yes Specify: ....

Section	Item	ER 12:55 pm	Oncology				
BACKGROUND	Area / Shift Time	ER 12:55 pm	Oncology				
	Medical Condition (Any special condition to be noted):	NA	NA				
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.2°F	98.1°F				
	Res:	24 bpm	24 b/m				
	SpO_2:	100%	98%.				
	Pulse:	112 Bpm	110.				
	BP:	98/55	100/58				
	Fall Risk Score:	10	10				
	Pain Score:	0	0				
Recommendations	Safety Needs:	Yes	side rails				
	Physiotherapy	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	NA	NA				
	Special Diet:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	NA	NA				
	Post Operative Procedure Special Orders:	NA	NA				
	Handed Over By Name :	pooja	Veena				
	Signature :	[signature]	[signature]				
	Date:	11/6/26	11/6				
	Time:	1:00 pm	@12:30pm.				
	Taken Over By Name :	Veena	D/C				
	Signature :	[signature]					
	Date:	11/6/26					
	Time:	1:20 pm					

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: .... Department: .... Date of Admission: ....

SITUATION	Diagnosis:			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

CUV-00172369 IP5-00175026
Baby PEMULA SAMAIRA GRETCHEN
30-01-2021 5 Y 4 M 12 D (F)
Dr. SIRISHA RANI

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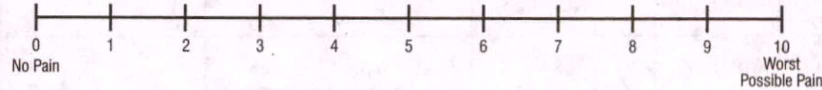
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/6/26	12:30 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

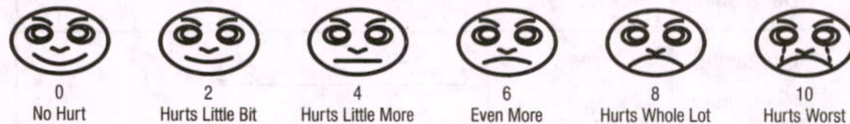
Re-assessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years



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

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

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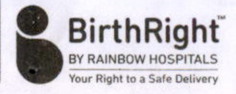
30-01-2021 5 Y 4 M 12 D
Dr. SIRISHA RANI (F)

BRADEN 'Q' SCALE



				Date : / Time :	11/6 12:30			
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			
"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			
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			
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			
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			
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			
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			
				TOTAL SCORE	28			
				Evaluator's Name	pooja			

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

Docu. No. : RCHBH /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

JV-00172369 IP5-00175026
Baby PEMULA SAMAIRA GRETCHEN
30-01-2021 5 Y 4 M 12 D (F)
Dr. SIRISHA RANI

Patient Sti...

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 11/6	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3				
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	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				
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	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				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	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				
	Total		10				

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

	Intervention						
	Bed in low position		yes				
	Call device within reach		yes				
	Wheels Locked		yes				
	Room free of clutter		yes				
	Adequate lighting		yes		✓		
	Wheel chair support		no				
	Other Intervention(s) Specify		no				
	Nurse's Name:		pooja				
	Signature:		[signature]				
	Date:		11/6				
	Time:		12:30 pm				

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 1:20pm Mode of Arrival: by walk Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction — Body Weight: 16.3kg Kg

~~No~~ yes Height: .... cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
NA	NA	Came for chemotherapy.

Family History: Healthy family

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: .... Length: .... Head Circumference (< 2 years): ....

Temp.: 98.6F HR: 106b/m RR: 26b/m BP: 100/60(71)mmHg

Pain Score: - Specify Site: .... (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☑ Yes ☐ No Score: 10 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

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

Character of Pain .... Location .... 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): ....

Cultural & Spiritual Needs: ☐ Yes ☐ No if Yes specify .... Inform consultant for positive criteria.

Social History: Lives With ....parents..

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

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 ....parents...

Nurse Signature: ....

Nurse Name: ....Veery...

Date: ....11/6/21..

Time: ....1:20pm..

CUV-00172369 IP5-00175026
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CONSENT FOR BLOOD TRANSFUSION

Name: pemula samaira gretchen Age: 5Y Gender: Male ☐ Female ☑

UHID.No : 172369 Date: 11/6/24

Type of Blood Product:

☑ Fresh Frozen Plasma	☐ Packed Red Blood Cells	☐ Random Donor Platelets
☐ Cryoprecipitate	☐ Single Donor Platelet	☐ Whole Blood
☐ Albumin	☐ Red Blood Cell	☐ Others ....

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

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

....

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

Patient (Or Patient Relative / Guardian):

Signature: [signature]

Name: A. Roopa

Date & Time 11/6/26 at 2pm

Doctor (Who is talking the consent)

Signature: [signature]

Name: Sravani

Date & Time 11/6/26 at 2pm

Witness

Signature: [signature]

Name: A. Roopa

Date & Time 11/6/26 at 2pm

Doc. No. : RCHBH/ FRM / CLINICAL / 014

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రక్త మార్పిడి కొరకు అంగీకార పత్రము

రోగి పేరు: .... వయస్సు: .... లింగము ☐ పురుషుడు ☐ స్త్రీ

UHID. సంఖ్య : .... తేదీ: ....

రక్త ఉత్పత్తి రకాలు:

☐ తాజా ఘనీభవించిన ప్లాస్మా	☐ ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు	☐ Random Donor Platelets
☐ క్రయోప్రెసిపిటేట్	☐ ఒకే ధాత ప్లేటిలెట్స్	☐ Whole Blood
☐ మొత్తం రక్తం	☐ ఎర్ర రక్త కణం	☐ ఇతరులు....................

నేను .... ఇందు మూలముగా రెయిన్బో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నపుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడీస్, హైపటైటీస్ బి సర్ఫేస్ యాంటిజన్, హైపటైటీస్ యాంటిబడీస్, మలేరియా మరియు సిఫ్లిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణిత కాల పరిమితి లో జరిగినప్పటికి పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలెత్తవచ్చు అని నేను అర్ధం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు ....

....

పైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి చికిత్స చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. చికిత్స చేస్తున్న సమయంలో అన్ని రకముల రక్తమార్పిడులకు (మొత్తం రక్తం / లేదా రక్త ఉత్పతులు ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ఫ్రెష్ ఫ్రోజెన్ ప్లాస్మా, క్రయోప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్ధమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెన్డెంట్)	సాక్షి
సంతకము	సంతకం ....
పేరు	పేరు ....
తేదీ మరియు సమయము	తేదీ మరియు సమయము ....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము ....

పేరు ....

Doc. No. : RCHBH/ FRM / CLINICAL / 014

CUV-00172369 IP5-00175026
Baby PEMULA SAMAIRA GRETCHEN
30-01-2021 5 Y 4 M 12 D (F)
Dr. SIRISHA RANI

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 11/6/26 Time: 2pm.

Blood Group of the Patient: O+ve Blood Group on the Blood Bag: O+ve

Blood Bank Issue No: BAH26-00971 Date of Collection: 20/4/26 Date of Expiry: 20/4/27

Date & Time of Starting Transfusion: 11/6/26 @2:10 pm Planned duration of Transfusion: 30 min.

Check for Correct Unit: ☑ Correct Patient: ☑

Blood products cross checked by: Nurse 1: Veena Nurse 2: Sowmya

Before starting transfusion vitals: Temp: .... HR .... RR: .... BP: .... SpO_2 ....

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO_2	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
11/6	15 Min	98b/t	98.1°F	110/80	98%	NA	NA	NA	NA
11/6	15 Min	102b/t	98.6°F	108/60	100%	NA	NA	NA	NA
[illegible]	30 Min								
	30 Min								
	30 Min								
	1 Hr								
	1 Hr								

Comments: No reaction

Name of the Incharge-Nurse: Saritha. Ma

Signature of the Incharge-Nurse: Saritha

Date & Time: 11/6/26 @ 2pm

Name of the Nurse: Veena

Signature of the Nurse: [signature]

Date & Time: 11/6/26 @ 2pm

Rain... ...pital Blood Centre, Ra... ...ildrens Hospital
D.No.8-2-1... ...03/1,2,3,4 & 5, 1st floor, Sy.N... ...1, 403/P, Road No.2,
Banjara Hills, Hyderabad, Tela... ...ana State
Lic.No. 46/HD/TS/2018/BB/G

FRESH FROZEN PLASMA B.P

Qty. 205 ml. Prepared from Whole human blood collected in 63 ml. of C.P.D./ SAGM Solution.

O

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

Unit No.: **BAH26-00971**
Blood Group: O Rh Positive
Collection Date: 20/Apr/2026
Expiry Date: 20/Apr/2027

1)administer Without Warming. 2)shake Gently Before Use.3)do Not Add Any Medication. 4)check Blood Group on Label & Recipient's Group and Name Before Administration. 5)use Sterile Transfusion Set With Filter. 6)do Not Dispense Without Prescription. 7)do Not Use if There is Any Visible Evidence. 8)store Between ... 9)resi... ...idual Plasm... ...er Bath Betw...

Issue Label / CrossMatching Report

Patient : **PEMULA SAMAIRA GRETCHEN**
Patient's Blood Group :O Rh Positive
Hosp/Dr :Rainbow Childrens Hospital,DR. SIRISHA RANI
UHID No.: CUV-00172369 Wd-Bed No.:

Product : FFP
Blood Group : O Rh Positive
Unit No.: **BAH26-00971**
XMatching Report:ABO Compatible
X-matched by: Premalatha

Issue Dt : 11/Jun/2026
Colln. Dt :20/Apr/2026
Exp. Dt :20/Apr/2027
Issued By : Premalatha

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

CONSENT FOR CHEMOTHERAPY

Patient Name : PEMULA SAMAIRA GRETCHEN Age : 5Y4M Gender : Male ☐ Female ☑

UHID No : CUV 00172369 Department : PHO & BMT Date : 11/6/26.

Type of Chemotherapy : Intravenous Chemo

The type of reactions, nature of the major risks and complications arising from the treatment despite precautions has been explained to me. These can include Bone Marrow depression with subsequent infections, bleeding, nausea, vomiting, diarrhea, mouth ulcers, alopecia, fever, phlebitis, ulceration at the site of injection organ injuries etc.

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

....

I understand that no promise of cure or freedom from risk can be given. During the course of treatment I will report any symptoms if they become bothersome.

I have read the above and have no further questions about the treatment to be given.

Patient Attendant :

Signature : [signature]

Name : A. Roopa

Relationship with Patient: Mother

Date & Time : 11/6/26 at 3PM

Witness :

Signature : [signature]

Name : A. Roopa

Date & Time : 11/6/26 at 3PM

Doctor (who is taking the consent):

Signature : [signature]

Name : Dr. Anurag

Date & Time : 11/6/26 at 3pm

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery.

కీమో థెరపీ కొరకు అంగీకారం

రోగి పేరు : .... వయస్సు .... లింగం పు ☐ స్త్రీ ☐

యు.హెచ్.ఐ.డి. .... రిజిస్ట్రేషన్ నెం.: ....విభాగము ....

తేదీ ....

కెమోథెరపీ రకాలు: ....

ఈ చికిత్స చేయు సమయములో తగు జాగ్రత్తలు తీసుకున్న సంభవించు వివిధ రకములైన ప్రమాదాలు తలెత్తే సమస్యల నాకు డాక్టర్ వివరించబడింది. వీటిలో ఎముక మజ్జ మాంద్యం, తదుపరి అంటువ్యాధులు, రక్తస్రావం, వికారం, వాంతులు, విరేచనాలు, నోటి పూతల, అలోపేసియా, జ్వరం, ఫ్లేబిటిస్, అవయవ గాయాలు, ఇంజెక్షన్ ఉన్న ప్రదేశంలో పుండ్లు మొదలైనవి కలగవచ్చు ఈ విధానం యొక్క ప్రయోజనాలు మరియు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు.

డాక్టర్ నీకు ఈ ప్రక్రియ వల్ల కలుగు లాభాలు మరియు ప్రత్యామ్నాయాలు వివరించారు ....

....

చికిత్స వల్ల కలుగు ఫలితాలు గురించి ఏ విధమైన వాగ్దానం ఇవ్వలేరని నేను అర్థం చేసుకున్నాను. చికిత్స సమయంలో ఏవైనా లక్షణాలు ఇబ్బందికరంగా ఉంటే నేను డాక్టర్ కి తెలియపరుస్తాను.

నేను చికిత్స గురించి పూర్తిగా తెలుసుకున్నాను, చికిత్స గురించి తదుపరి ప్రశ్నలు లేవు.

సహాయకుడు(అటెండెంట్)

సంతకము ....

పేరు ....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము ....

పేరు ....

సాక్షి

సంతకము ....

పేరు ....

తేదీ మరియు సమయము ....

CUV-00172369 IP5-00175026
Baby PEMULA SAMAIRA GRETCHEN
30-01-2021 5 Y 4 M 12 D (F)
Dr. SIRISHA RANI

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DISCHARGE PLANNING FORM

Nationality: Indian.

***NOTES:* * To be completed by a NURSE within (24) hours of admission.**

1. Anticipated Date of Discharge: 13/6/26

2. Destination Post Discharge: ☑ Home
   Family Members Notified (Person Contacted)

   ☐ Transfer
   Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☐ Family Home Care ☐ Home Professional Assistance

   ☑ Needs Assistance In:

			Remarks
☐ Medication	☑ Yes	☐ No	Need assistance.
☐ Bathing	☑ Yes	☐ No	
☐ Eating	☑ Yes	☐ No	
☐ Walking	☑ Yes	☐ No	
☐ Dressing	☑ Yes	☐ No	
☐ Toileting	☐ Yes	☑ No	

4. Nutritional Plan:
   ☑ Dietary Instruction Discussed with the:
   ☐ Patient ☑ Family Member ☐ Others: ....

5. Discharge Planning Discussed with the:
   ☐ Patient ☑ Family Member ☐ Others: ....

6. Patient/Family Educational Plan:
   ☐ Educational Topic/s: ....

   ☑ Patient's Educational Topic/s discussed with the:
   ☐ Patient ☑ Family Member ☐ Others: ....

Nurse Signature: Veena

Nurse Name: Veena

Date and Time: 11/6 @ 1:30pm