Rainbow® Children's Hospital
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MLC

ACTIVITY RECORD FOR BILLING

VIH-00205726 IP-00060271
Master JAKSH AVADHUTH PONNALA
19-11-2023 2 Y 6 M 20 D (M)
Dr. KODICHERLA VISHNU VARDHAN

Name: ----

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

Date of Ad ... : -------------- Date of Discharge : ---------------- Time: -----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/6/26	2:30pm	ER	PICU	[signature]

Cross Consultation Visit

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

INVESTIGATIONS

MLC

Date	Investigations	Order No.	Sign
8/6/	RBS - 72 mg/dl	26019687	
	ABG		
	CBP / SE Cr	26019685	
	Urea / LFT		
	HIV	26019690	
8/6/26	ECG	26009172	Neha
	Cross checked by Neha 8/6/26		

MEDICAL EQUIPMENT (WARD & ICU)

MLC

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
8/7/26	invasive monitor	3pm	8/7/26	~~3088063~~	Neha.
	infusion pump		5pm		
	cross checked by		Neha	8/6/26	
				7pm	

PROCEEDURE MLC

Date	Proceedure	Quantity	Order No.	Signature
8/6/26	IV Placement	1	308865	
	Cross checked by		Neha	8/6/26 7pm

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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Rainbow Children's Hospital - Secunderabad

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

ADMISSION SHEET

MLC

Registration Details :

Admission No : IP-00060271 **Admit Date** : 08-Jun-2026 **Admit Time** : 01:31 PM **UHID** : VIH-00205726

Patient Details :

Patient Name : Master JAKSH AVADHUTH PONNALA
Age : 2 Y 6 M 20 D
Guardian : Mr DR. MINIL PONNALA
DOB : 19-11-2023
Gender : Male
Religion :
Occupation :
Martial Status :
Address (H) : PLOT NO 108/3, RK ENCLAVE JYOTHI COLONY, SEC-BAD Trimulgherry Hyderabad Telangana INDIA 500015
Phone No : 9959546834
E-mail : na@gmail.com

Admission Details :

Bed Type : SHARED WARD **Bed No** : ER 102 **Ward Name** : N 0 GF-EMERGENCY
Room No : ER 102 **Admission Type** : First Visit

Contact Details :

Name : Mr DR. MINIL PONNALA
Relationship : Father
Contact Address : PLOT NO 108/3, RK ENCLAVE JYOTHI COLONY, SEC-BAD Trimulgherry Hyderabad Telangana INDIA 500015
Phone No : 9959546834

Signature

Doctor Details :

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

Payment Details :

Deposit Amount : 0.00
Payment Mode : Cash
Payor Name : SELFPAY

VIH-00205726 IP-00060271
Master JAKSH AVADHUTH PONNALA
19-11-2023 2 Y 6 M 20 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26	C/S/B Plw fellow	
3:30pm	Accidental ingestion of syrup [illegible]	
	Activated charcoal given	
	no fresh complaints	
	Child alert [illegible] afebrile	
	CVS S1S2 (+)	
	Pulse (R)	Rx
	HR 108	1) Continue monitoring
	Bp 106/64 [illegible]	2) plan to start orally after 6pm if no complaints
	RS BAE (+) Clear	
	RR - 28	
	P/A :- Soft	Noted by Supriya 8/6/26 @ 3:30Pm
		[illegible]

VIH-00205726 IP-00060271
Master JAKSH AVADHUTH PONNALA
19-11-2023 2 Y 6 M 20 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26	C/b Dr Atheel Rizwan	
	Accidental ingestion of Syrup [illegible]	
	Child alert	
	[illegible]	
6:13pm	[illegible]	HR 110
	Vitals stable	SpO_2: 96
	Rx	
Noted by Supriya 8/6/26 @ 6:50pm	→ Start orally → Shift to room / ward	Dr Tejaswini
8/6/26	Counselling by Dr Atheel Rizwan to father, mother	
	Usually they cause QT prolongation need to monitor the child today	
6:15pm	[FATHER] (mother) Tejaswini	Dr Tej
8/6/26	C/b/o Dr Vishnu Sir	
	advice → duplicate	Dr Tejaswini
6:50pm		

Rainbow Children's Hospital
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TEL NO :040-42462200, Ext 2000,2001,2002
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GENERAL CONSENT FOR TREATMENT

MLC

Patient Name:	**Master JAKSH AVADHUTH PONNALA**	**Age :**	**2 Y 6 M 20 D**
IP No:	**IP-00060271**	**Sex:**	**Male**
Consultant:	**Dr. KODICHERLA VISHNU VARDHAN REDDY**	**Ward/Bed No:**	**N 0 GF-EMERGENCY/ER 102**

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 ;so 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.

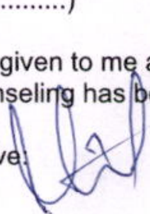
I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal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

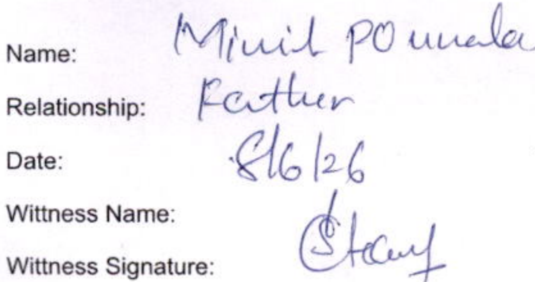
"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process 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 ;arance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.................)

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:





Name: Minil POnnala
Relationship: Father
Date: 8/6/26 Time: 1:31 pm.
Wittness Name:
Wittness Signature:

Patient Address:
PLOT NO 108/3, RK ENCLAVE JYOTHI COLONY, SEC-BAD Trimulgherry Hyderabad Telangana INDIA 500015

Ref. No. : F / HW / CON / HIV / 08

CONSENT FORM FOR HIV

MLC

Patient Name : Mast. Jaksh Avadhutu Age : 2y6m

Gender : M☑ F☐ - IP No : 60271 Marital Status : —

Ward / Bed No. : ER IP/OP No. : 60271 Date : 8/6/

I have to say that I have been counseled about the test and the reason for undergoing the test has been clearly explained to me. I have also been explained about the implications of the test result-positive, negative or indeterminate All the details pertaining to HIV, its transmission, testing procedure Its limitations and interpretation of the results have been explained to me in language that I can understand.

I, hereby give my willful consent for the HIV test to be conducted on me in order to ascertain my HIV sero status. The status of my HIV test will be confidential

Patient Attendant :

Signature : [signature]

Name : Minu

Relationship with Patient: FATHER.

Date & Time : 8/6/26 @ 2pm

Parent (when patient is minor) :

Signature : ....

Name : ....

Relation : ....

Date & Time : ....

OR (Next to kin in case of unconscious patient) :

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

Relation : .... Date & Time : ....

I, certify that the Consent form for the HIV test has been signed in my presence and patient has been given pre-test counseling and post-test counseling is ensured by me and my team.

Doctor :

Signature : [signature]

Name : Dr. Vishwaje

Date & Time : 8/6/26 @ 2pm.

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హెచ్.ఐ.వీ పరీక్ష అంగీకార పత్రం

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

వివాహస్థితి .... వార్డు / బెడ్ నెంబర్...

హెచ్.ఐ.వి టెస్ట్ గురించి నాకు అవగాహన కల్పించటమైనదనియు మరియు పరీక్ష చేయించుకోవలసిన కారణము నాకు స్పష్టముగా వివరించటమైనది అప నేను చెప్పుచున్నాను. ఈ టెస్ట్ ఫలితం యొక్క పర్యవసానాలకు పాజిటివ్, నెగిటివ్ లేక నిర్ధారణ విధానము, దాని పరిమితులు మరియు ఫలితాల వివరణకు నాకు అర్థమయ్యే భాషలో వివరించారు.

నా హెచ్.ఐ.వి. రోగిస్థితి అంచనా వేయటానికి నాపై జరుపబడే టెస్టుకు నేను ఇష్టపూర్వకంగా తెలుపుతున్నాను. నా హెచ్.ఐ.వి. పరీక్ష ఫలితం రహస్యంగా వుంచాలి.

రోగి	సాక్షి
సంతకము:	సంతకము: ....
పేరు:	పేరు: ....
బంధము:	బంధము: ....
తేదీ మరియు సంతకము:	తేదీ మరియు సమయము: ....

(రోగి అపస్మారక స్థితిలో వున్నచో అతని దగ్గరి రక్త బంధువు)

పేరు:..	సంతకము: ....
సంబంధము :	తేదీ మరియు సంతకము: ....

హెచ్.ఐ.వి. టెస్ట్ అంగీకార పత్రంపై నా సమక్షంలో సంతకం చేయబడిన దనియు, టెస్టుకు ముందు ఇవ్వవలసిన సలహా ఇవ్వబడిన దనియు మరియు టెస్ట్ తర్వాత ఇవ్వవలసిన అవగాహన ఖచ్చితంగా ఇవ్వగలమని నేను నా బృందం ధృవీకరిస్తున్నాము.

డాక్టర్ ....

సంతకము ....

పేరు ....

తేదీ మరియు సమయము ....

VIH-00205726 IP-00060271
Master JAKSH AVADHUTH PONNALA
19-11-2023 2 Y 6 M 20 D (M)
Dr. KODICHERLA VISHNU VARDHAN

MLC

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DRUG CHART

Date of Admission: 8/6/26 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 ....

IP-00060271
Master JAKSH AVADHUTH PONNALA
19-11-2023 2 Y 6 M 20 D (M)
Dr. KODICHERLA VISHNU VARDHAN

MLC

REGULAR PRESCRIPTIONS

Weight. 15 kg Ward. PICU

DRUG : INJ. ONDENSETRON				Date ▸ Time ▾
Dose	Route	Frequency	Start Date	
3mg	IV	8 Hourly	8/06	
Name & Signature of the Doctor Starting the Drugs: Dr. Jayashree				
Additional Instructions: 0.1–0.2 mg/kg/dose ① day				
Daily Doctor's Endorsement by a Sign				

Dr [signature]

DRUG : INJ. PANTOPRAZOLE				Date ▸ Time ▾
Dose	Route	Frequency	Start Date	
15 mg	IV	ONCE DAILY	9/06	
Name & Signature of the Doctor Starting the Drugs: Dr Jayashree				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

Dr [signature]

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				

Patient Sticker

MLC

Weight. 15 kg Ward. PICU

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.	

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
8/6/26	2pm	INJ ONDENSETRON	3mg	IV	[signature]	[signature]
8/6/26	2pm	INJ PANTOPRAZOLE	15mg	IV	[signature]	[signature]
8/6/26	12.50pm	ACTIVATED CHARCOAL	15g	NG Tube	[signature]	[signature]

[signature] 8/6

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I.V. FLUIDS CHART

Weight. 15kg Ward. PICU

		...nposition 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
8/6/26	2:45 pm	2nf DNS (2/3)	IV	35	[signature]	Supriya / Neha	9/6/26	[signature]	[signature]

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

VIH-00205726 IP-00060271
Master JAKSH AVADHUTH PONNALA
19-11-2023 2 Y 6 M 20 D (M)
Dr. KODICHERLA VISHNU VARDHAN

Patient Name : Mast. Jaksh Avadooth UHID ender : Male Age : 2 Y

Patient Sticker

MLC

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 8/6/26 Time of arrival : 1:37pm

Chief Complaints: Accidental ingestion of mantra syp 60ml RBS: 72mg/dl

Height : — Weight : 15kg 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 : 1:41pm

VIH-00205726 IP-00060271
Master JAKSH AVADHUTH PONNALA
19-11-2023 2 Y 6 M 20 D (M)
Dr. KODICHERLA VISHNU VARDHAN

Patient Name : Mast. Jaksh Avadooth UHID : ... nder : Male Age : 2 Y

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

MLC

Time	Nursing Notes
1:32 pm	* patient Came to ER
1:36 pm	* vital checked & Recorded
1:40 pm	* Doctor seen the patient & case D/w.
1:45 pm	PICU fellows.
2:00 pm	* Gastric lavage done in ER
2:4 pm	* Charcoal given
2:8 pm	* Blood samples collect sent to lab
	* patient shifted to PICU

Samples collected by: } Jyothi Rani — Time: @ 2:5 pm
Samples sent by : } — Time: @ 2:7 pm

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
12:50 PM	charcoal	NG	15 gm	} vishwaja	[signature]

Condition of patient at time of shift - out :	Details of Shift - out
HR: 100 b/M BP: 102/66 (72) CFT: >3 sec	Shift - out from ER to: PICU
RR: 20 b/M SPO$_2$: 100%	Time of Shift - out: 8/6/26 @ 2:30pm
GCS: 15/15 Temperature : 96.2°F	Handover given to: Sr. Supriya (Nurse's Name) by Architha
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 : Architha — Signature of the Nurse : [signature]

Date & Time : 8/6/26 @ 2:30 pM

VIH-00205726 IP-00060271
Master JAKSH AVADHUTH PONNALA
19-11-2023 2 Y 6 M 20 D (M)
Dr. KODICHERLA VISHNU VARDHAN

Patient Name : Mast. Jaksh Avadooth UHID : nder : Male Age : 2 Y

Patient Sticker

MLC

wt:- 15 kg
RBS: - 72 mg/dl

EMERGENCY ROOM TRIAGE FORM

Patient's Name : master. Jaksh Avadooth Age : 2Y Gender: ☑ Male ☐ Female

Date : 8/6/26 Time of Arrival : 1:32 pm

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

Source of Information : ☑ Parents ☐ Others (Specify)

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 98.2°F PR: 103 b/M BP: 105/66 (72) RR: 26 b/M SpO₂: 100%.

Chief Complaints: Accidental ingestion of mantra syp. 60ml

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

Tejasvi
Signature of Parent / Guardian

Triage Completion Time : 1:35 pm

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 @ 1:35 pm

Docu. No. : RCH /FRM / CLINICAL / 085