ACTIVITY RECORD FOR BILLING

Name: VIH-00096429 IP-00060432
Master VISHWANATHA DHEERAJ
18-07-2014 11 Y 11 M 3 D (M)
Dr. PREETHAM KUMAR

UHID N ------------- Consultant : ------------------------- Dept : peadiatric

Date of ...me : -------------- Date of Discharge : ----------------- Time: -----------

Room / Bed No : --131------ Ward : --1st floor- Suggested Billable bed type : -------------------------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
21/6/26	9:30PM	ER	131	[signature]

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
21/6	Blood C/S ; Typhoid IgM	26021104	[illegible]
	CUE	26021112	[illegible]
	Cross checked by [illegible] 23/6 @ [illegible]		
	USG Abd	26009963	[illegible]
	CBP ; CRP	26021246	[illegible]
	Cross checked by [illegible]		✓

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
21/6	Infusion pump	9:19 pm	22/6/20[illegible] 21:5[illegible]	3093012	[illegible]

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
21/6/26	IV placement	(1)	3092018	[illegible]
	Cross checked by [illegible] 22/6 @ 2AM			

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

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

INSURANCE COPY

Name	Master VISHWANATHA DHEERAJ	UHID	VIH-00096429
Father/Guardian	Mr PRAVEEN KUMAR	Age/Gender	11 Y 11 M 5 D/Male
Address	FLAT NO 101, 1ST FLOOR SREE DHATRI RESIDENCY SADANA VIHAR KAPRA, Bhadas B.O, Hyderabad, Telangana, INDIA, 500094		
IP No	IP-00060432	Admission Date	21-06-2026
Ref Doctor	SELF	Discharge Date	23-06-2026

DISCHARGE SUMMARY

Consultant: Dr. PREETHAM KUMAR
MBBS,DNB(PEDS),DCH,FELLOW NEONATOLOGY
SENIOR CONSULTANT PEDIATRICS
39859

Diagnosis: Acute febrile illness

History: Master VISHWANATHA DHEERAJ is a 11 Y 11 M 5 D boy presented with history of moderate grade intermittent fever since 3 days prior to admission. For the above complaints, he was investigated and treated elsewhere, but in view of persistence of symptoms, he was admitted at Rainbow Children's Hospital for further management.

Outside Investigations: Complete blood picture done on 21.06.2026 showed hemoglobin 10.3 gm%, white blood cells count of 3,400 cells/cumm, platelet count of 1.85 lakhs/cumm and C-reactive protein was 122 mg/l. Serum electrolytes and creatinine were normal.

Examination: He was afebrile, maintaining saturations at room air. Heart rate-100/min, blood pressure - 110/80 mmHg and respiratory rate 21/min. On auscultation of chest, air entry was bilaterally equal with normal heart sounds and there was no murmur. Abdomen was soft without organomegaly. Bowel sounds were heard. Neurologically, he was conscious and oriented. Examination of other systems including spine was normal.

Weight on admission : 41 kgs.

Investigations: Enclosed.

Management: He was admitted in the ward and started on intravenous fluids and intravenous antibiotics. He was treated symptomatically with antacids.

His blood culture was sterile after 24 hours of incubation. Typhoid IgM was weakly positive. CUE showed 4-6 pus cells, albumin trace. Ultrasound abdomen showed mild splenomegaly, mild increase in wall thickness of caecum and terminal ileum - To rule out ileitis, mild ascites, appendix is normal.

His vitals were regularly monitored. His fever spikes gradually settled. Hemogram done on 23.06.2026 showed hemoglobin 12.1 gm%, white blood cells count of 4,450 cells/cumm, platelet count of 2.52 lakhs/cumm and C-reactive protein was 22 mg/l. He remained hemodynamically stable during the hospital stay and is being discharged with the following advice.

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

Advice:

1. Diet as advised.
2. Tablet Cefixime (200mg), 1 tablet, 12th hourly (after food) for 3 days.
3. Tablet Lansoprazole (40mg) 1 tablet once daily (1/2 hour before breakfast) for 3 days.
4. Kindly consult Dr. Preetham Kumar, Senior Consultant Pediatrics, after 3 days in OPD with prior appointment (This consultation will be charged).

In case of Fever:

Tablet Paracetamol (500mg), 1 tablet (if needed) if fever more than 99.6*F (maximum 4-6 hourly).

Tablet Ibuprofen (400mg), 1 tablet (if needed) (after food) for fever more than 101*F (maximum 8 hourly).

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

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

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

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

Registrar/Resident/C.M.O

Dr. PREETHAM KUMAR
MBBS,DNB(PEDS),DCH,FELLOW NEONATOLOGY
SENIOR CONSULTANT PEDIATRICS
39859

PatientName	: Master VISHWANATHA DHEERAJ	**Inpatient No.**	: IP-00060432
Age/Gender	: 11 Y 11 M 4 D/ Male	**Admit Date**	: 21-06-2026
Ward/Bed	: N 0 GF-EMERGENCY/ ER 101	**Discharge Date**	:

Investigation	Result	Unit		Biological Reference Interval
COMPLETE URINE EXAMINATION (Specimen : URINE)				TEST RESULT STATUS : REPORT AUTHORISED Order Date :21-06-2026 23:27
PHYSICAL				
COLOUR (Visual Examination)	PALE YELLOW			
APPEARANCE (Gross Examination)	CLEAR			
pH (Double pH indicator)	6.0			5 - 8.5
SPECIFIC GRAVITY (PKA Reaction)	1.030			1.005 - 1.030
SEDIMENT (Gross Examination)	NIL			NIL
CHEMICAL				
PROTEIN (Protein error of pH indicator)	Trace			NIL
GLUCOSE (GOD POD method)	NIL			NIL
KETONE BODIES (Acetoacetic acid reaction)	POSITIVE(+)			NEGATIVE
BILE SALTS (Hay's Sulfur Test)	ABSENT			ABSENT
BILE PIGMENTS (Diazo reaction)	ABSENT			ABSENT
NITRITE (Reflectance Photometry)	NEGATIVE			NEGATIVE
BLOOD (Peroxidase reaction)	ABSENT			ABSENT
LEUCOCYTES (Esterase reaction)	NEGATIVE			NEGATIVE
MICROSCOPY				
PUS CELLS	**4 - 6**	**HPF**	L	0 - 5
EPITHELIAL CELLS	**2 - 3**	**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 :23-06-2026 05:58
HEMOGLOBIN (Colorimetry)	12.1	g/dL		11.5 - 15.5
RBC COUNT (DC detection method)	4.03	10^12/L		4 - 5.2
PCV/HCT (Calculated)	**33.2**	**VOL%**	L	35 - 45
MCV (Calculated)	82.4	fL		77 - 95
MCH (Calculated)	30.1	pg/cells		25 - 33
MCHC (Calculated)	**36.6**	**g/dL**	H	32 - 36
RDW-CV (Calculated)	11.8	%		11.5 - 15
PLATELET COUNT (DC Detection Method)	252	10^9/L		150 - 450
MPV (Calculated)	7.2	fL		6.5 - 10
WBC COUNT (DC Detection Method)	**4.45**	**10^9/L**	L	4.5 - 13.5

PatientName	: Master VISHWANATHA DHEERAJ	Inpatient No.	: IP-00060432
Age/Gender	: 11 Y 11 M 5 D/ Male	Admit Date	: 21-06-2026
Ward/Bed	: N 0 GF-EMERGENCY/ ER 101	Discharge Date	:

Investigation	Result	Unit	Biological Reference Interval
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	43	%	33 - 61
LYMPHOCYTES (Microscopy, Leishman stain)	46	%	28 - 48
MONOCYTES (Microscopy, Leishman stain)	07	%	4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	04	%	1 - 4
PERIPHERAL SMEAR (Microscopy, Leishman stain)	**RBC - NORMOCYTIC / NORMOCHROMIC** **WBC - MORPHOLOGY NORMAL** **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 :23-06-2026 05:58
CRP (Immunoturbidimetry)	**22**	**mg/L**	H	<10

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Laboratory Report

9542233872

Master VISHWANATHA DHEERAJ

11 Y 11 M 5 D

VI26021104

Male

21-06-2026 08:53 PM

IP-00060432

21-06-2026 09:21 PM

VIH-00096429

Dr. PREETHAM KUMAR

N 0 GF-EMERGENCY / ER 101

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 .....

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

1800 2122 www.rainbowhospitals.in

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

Master VISHWANATHA DHEERAJ

11 Y 11 M 4 D

Male

IP-00060432

VIH-00096429

PREETHAM KUMAR

R26-009963

22-06-2026 11:43 AM

22-06-2026 02:30 PM

DISCHARGE SUMMARY

DRAFT

ULTRASOUND ABDOMEN

LIVER : Normal in size 10.5 cm and echotexture. No intra hepatic biliary duct dilatation. Portal vein is normal. No focal lesions.

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

SPLEEN: 10.7 cm

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

KIDNEYS :

Right kidney : 100 mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

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

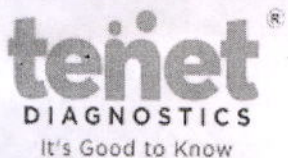
URINARY BLADDER : Distended well and appears normal.

HIMAYATHNAGAR | BANJARA HILLS (JCI, NABH & NABL Accredited) | HYDERNAGAR (NABH Accredited) | KONDAPUR OUTPATIENT CLINIC (JCI Accredited-IVF) | SECUNDERABAD (NABH Accredited) | KONDAPUR | L B NAGAR (NABH Accredited) | NANAKRAMGUDA
1800 2122 www.rainbowhospitals.in

Impression

1. **Mild splenomegaly**
   - No focal lesions
2. **Mild increase in wall thickness of caecum and terminal ileum**
   - To rule out ileitis
3. **Mild ascites**
4. **Appendix is normal.**

Suggested clinical correlation.



PLEASE SCAN QR CODE
TO VERIFY THE REPORT ONLINE

Name	: **MASTER.VISHWANATHA DHEERAJ VIH-00096429**	TID/SID	:UMR4747880/ 32098378
Age / Gender	: 11Y(s) / Male	Registered on	: 22-Jun-2026 / 12:09 PM
Ref.By	: DR PREETHAM KUMAR	Collected on	: 22-Jun-2026 / 11:20 AM
Req.No	: 26NRLH0230842	Reported on	: 22-Jun-2026 / 16:10 PM
Sample Type	: Serum	Client Name	: RAINBOW CHILDREN HOSPITAL -SECUNDERABAD

TEST REPORT

DEPARTMENT OF IMMUNOLOGY I

Typhi IgM Antibody

Investigation	Result	
Typhi. IgM Antibody	**Weak Positive**	Negative

Method: Immunochromatography

Interpretation: This test qualitatively detects the prescence of IgM class of Lipopolysaccharide specific to S.typhi in human serum.

Samples with positive results should be confirmed with alternative testing method and clinical findings before a positive determination is made.

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

--- End Of Report ---

Dr.Safaa Muneer Ahmed
Consultant Microbiologist
Reg.No - APMC/FMR/77996

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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

Registration Details :

Admission No : IP-00060432 **Admit Date** : 21-Jun-2026 **Admit Time** : 08:20 PM **UHID** : VIH-00096429

Patient Details :

Patient Name	: Master VISHWANATHA DHEERAJ	**Age**	: 11 Y 11 M 3 D
Guardian	: Mr PRAVEEN KUMAR	**DOB**	: 18-07-2014
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: FLAT NO 101, 1ST FLOOR SREE DHATRI RESIDENCY SADANA VIHAR KAPRA Bhadas B. O Hyderabad Telangana INDIA 500094	**Phone No**	: 9542233872
		E-mail	: na@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD **Bed No** : ER 101 **Ward Name** : N 0 GF-EMERGENCY

Room No : ER 101 **Admission Type** : First Visit

Contact Details :

Name	: Mr PRAVEEN KUMAR	**Relationship**	: S/O
Contact Address	: FLAT NO 101, 1ST FLOOR SREE DHATRI RESIDENCY SADANA VIHAR KAPRA Bhadas B.O Hyderabad Telangana INDIA 500094	**Phone No**	: 9542233872 / 9515118132

Signature

Doctor Details :

Doctor Name	: Dr. PREETHAM KUMAR	**Specialisation**	: GENERAL PEDIATRICS
Referral Doctor	: SELF	**Phone No**	:
Co-Consultant	:		

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : VIDAL HEALTH INSURANCE TPAPVT LTD

ar No. Issued: 10/05/2018

Government of India

आधार

విశ్వనాథ ధీరజ్
Vishwanatha Dheeraj
పుట్టిన తేదీ / DOB : 18/07/2014
పురుషుడు / Male

ఆధార్ అనేది గుర్తింపు రుజువు మాత్రమే, పౌరసత్వం లేదా పుట్టిన తేదీ కి కాదు. ఇది ధృవీకరణతో మాత్రమే ఉపయోగించాలి (ఆన్‌లైన్ ప్రమాణీకరణ

Patient Name : Mast. VISHWANATHA DHEERAJ UHID : VIH-00096429 IPD : IP-00060432 Gender : Male

VIH-00096429 IP-00060432
Master VISHWANATHA DHEERAJ
18-07-2014 11 Y 11 M 3 D (M)
Dr. PREETHAM KUMAR

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Mast. Vishwanatha Age : 11 yrs Gender: ☑ Male ☐ Female

Date : 21/6/26 Time of Arrival : 8:5 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: 99.0°F PR: 105 b/m BP: 117/80 (90) RR: 26 b/m SpO_2: 99 %

Chief Complaints: C/o fever since 3 days

INITIAL PHYSIOLOGICAL CATEGORIZATION	INITIAL PHYSIOLOGICAL STATUS
Appearance: ☑ Normal ☐ Sick Looking Work of Breathing: ☑ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding	☑ 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

Praveen
Signature of Parent / Guardian

Triage Completion Time : 8:10 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.

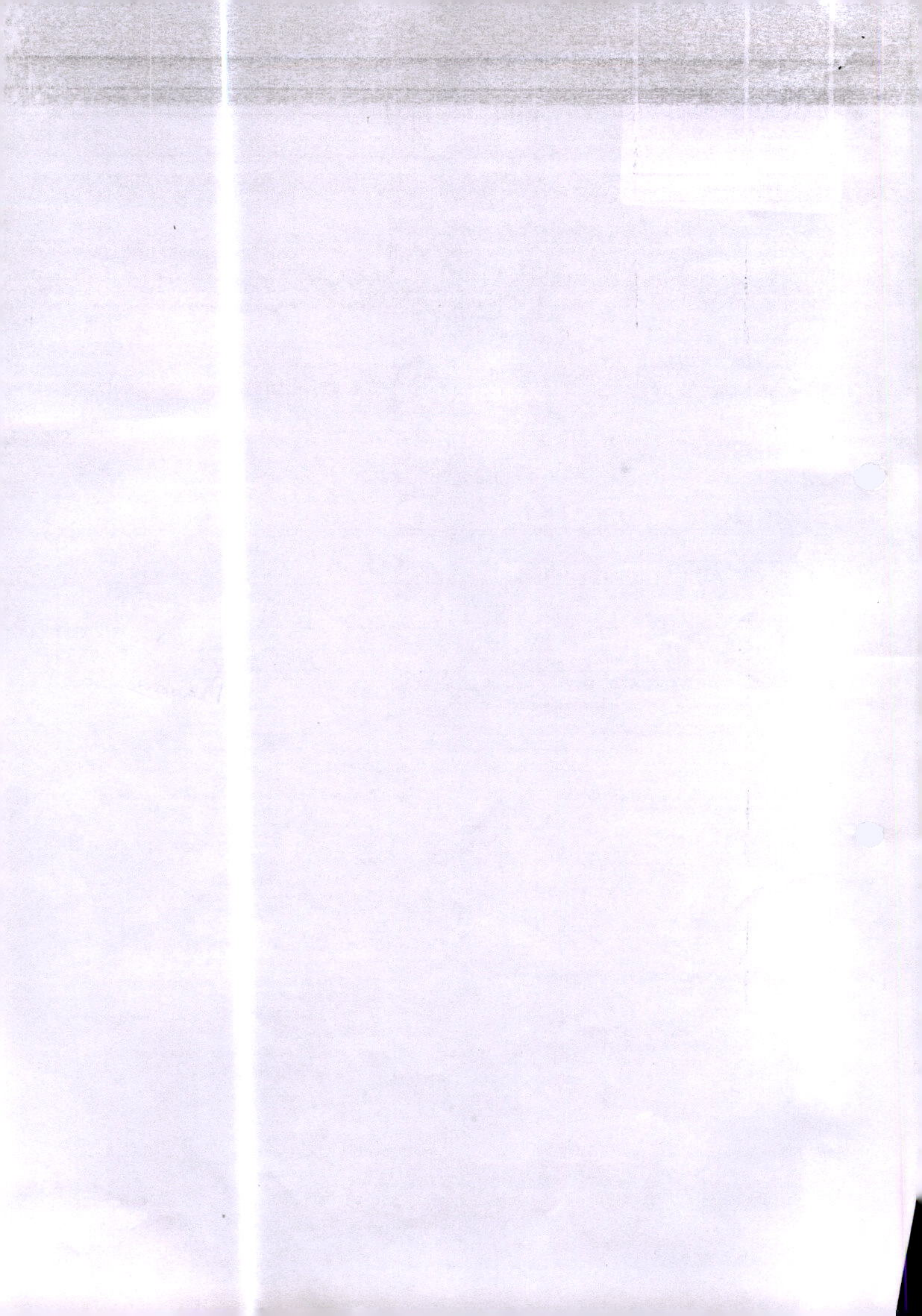
☐ Both patient and triage staff should perform hand hygiene.

☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Kezia Signature of Triage Nurse : [signature]

Date & Time : 21/6/26 @ 8:10 pm

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



Patient Name : Mast. VISHWANATHA DHEERAJ UHID : VIH-00096429 IPD : IP-00060432 Gender : Male Age : 11 Y 11 M 3 D

VIH-00096429 IP-00060432
Master VISHWANATHA DHEERAJ
18-07-2014 11 Y 11 M 3 D (M)
Dr. PREETHAM KUMAR

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 21/6/26 Time of arrival : 8:11 pm

Chief Complaints: C/o fever x 3 days RBS: —

Height : 141 cm Weight : 41.32 kg 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:			Functional Screening: ☐ No Abnormalities Detected
☐ If patient is < 6 years tick below fall risk intervention directly			☐ Mobility Problem
☐ If Patient is > 6 years Assess the below parameters			☐ Walking Problem
			☐ Developmental Delay
History of Falling: within past 3 months	☐ Yes	☐ No	☐ Musculoskeletal Congenital Abnormality
Ambulatory Aids:			**Inform consultant for positive criteria**
• Wheelchair	☐ Yes	☐ No	
• Uses furniture for support	☐ Yes	☐ No	
Gait/Transferring:			
• Bedrest / immobile	☐ Yes	☐ No	**Nutritional Screening:** ☐ No Abnormalities Detected
• Weak	☐ Yes	☐ No	☐ Underweight
• Impaired	☐ Yes	☐ No	☐ Overweight
Mental Status: Forgets limitations	☐ Yes	☐ No	☐ Feeding Problem
IF YES FOR ANY CATEGORY = RISK FOR FALLING			☐ Special diet
Fall Risk Intervention:			☐ Special feeding method
☐ Escort while ambulating			**Inform consultant for positive criteria**
☐ Assist Patient			
☐ Educate patient and family on fall precautions/prevention			

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 : 21/6/26 @ 8:16 pm

Patient Name : Mast. VISHWANATHA DHEERAJ UHID : VIH-00096429 IPD : IP-00060432 Gender : Male
Age : 11 Y 11 M 3 D

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

Time	Nursing Notes
8:5pm => patient come to the ER.	
8:10pm -> vitals checked and. Recorded.	
8:15pm => Dr Ganesh has seen to the pt.	
8:26pm => Dr Advice Admission	
8:20 PM* Admission Done	
8:40PM* IV placement Done	
8:53PM* samples collected & sent to lab	
*pt shifted to ward	

Samples collected by: Sr. Heena — Time: 8:40PM

Samples sent by : Sr. Heena — Time: 8:50PM

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
			Nil		

Condition of patient at time of shift - out : mm#S	Details of Shift - out
HR: 102b/m BP: 102/69(74) CRT: <3sec	Shift - out from ER to: 130
RR: 22b/m SPO$_2$: 99%	Time of Shift - out: 21/6/26 @ 9:30PM
GCS: 4,5,6 Temperature : 98°F	Handover given to: (Nurse's Name) Sr. Manisha
Pain Score: 0	
Repeat RBS (if applicable):	Br Sabin

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV placement

Name of the Nurse : TSr. Sabin

Signature of the Nurse : [signature]

Date & Time : 21/6/26 @ 9:30PM

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-00096429 IP-00060432 Master VISHWANATHA DHEERAJ 18-07-2014 11 Y 11 M 3 D (M) Dr. PREETHAM KUMAR	21/6/26 @ 9:20 PM	21/6/2026 at 9:32 PM
	Transfer Ordered by Dr. Ganesh	Reason for Transfer admission
From Unit ER	To Unit 1st Floor ( )	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 21	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.	— Nill	
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Shanthi [signature]	DR. Ganesh.

Patient & Clinical Records Received by : Manisha

Date & Time of Patient Received : 21/6/26 @ 9:32 pm

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

VIH-00096429 IP-00060432
Master VISHWANATHA DHEERAJ
18-07-2014 11 Y 11 M 4 D (M)
Dr. PREETHAM KUMAR

Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 8:15pm Mode of Arrival: By walk Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: Nil

Body Weight: 41.32 Kg

Height: 141 cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
yes	NO	NO

Family History: Nil

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

If yes please list, Nil

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

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

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

Observations: Weight: 41.32kg Length: 141cm Head Circumference (< 2 years): —

Temp.: 98.4°F HR: 112b/m RR: 27b/m BP: 108/73(69)

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

Fall Risk Assessment: ☐ Yes ☑ No Score: 0' (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: Nil 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: .... (Date/Time): ....

Social History: Lives With ....parent..

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

All Information Obtained From ☐ Patient ☑ Mother ☐ Father ☐ Other Family Member

Orientation has been given regarding the following aspects:

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

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

Patient Rights & Responsibilities: ☑ Yes ☐ No

Information given to ...parents..

Nurse's Name: ......Manisha...................... Date: ..21/6/26............ Time: 10pm....... Manisha Signature

PEDIATRIC IN-PATIENT MEDICAL RECORD

VIH-00096429 IP-00060432
Master VISHWANATHA DHEERAJ
18-07-2014 11 Y 11 M 3 D (M)
Dr. PREETHAM KUMAR

Patient Name: ______

UHID ID: ______

Department: ______

Consultant: ______

Pediatric Multiorgan History & Physical Examination

Name : ______ Age/Sex ______

Information given by: ______ Relationship ______

Chief Presenting Complaints & Duration (Chronologically)

GI symptoms
< 2 days ago
→ Fever × 3 days
No localizing signs
other

History of present illness :

- Fever × 3 days.
  < moderate grade. (101°F)
  < Intermittinent, ↓ medication
  Not A/W cold & cough..
  [loose motions, vomitings 2 days ago
  ↓
  now subsided.]

intake - (N)
U.O - (N)

No other localizing signs
(Throat pain, Burning micturation
Snoring, Rash, headache)
Admitted on 19/6/26
taken IV Ceftriaxone for 2 day
i/v/o Persistent symptoms

19/6/2026
Hb - 11.6.
Plt - 2.61
RBC - 4.2.
TLC - 10,700.
N/L - 90/7.
CRP - (56)

21/6/2026
Hb - 10.3
RBC - 3.77
TLC - 3,400
Plt - 1.85
Sr. electrolytes - (N)
Sr. Creatine - (N).
N/L - 75/21.
CRP - (122)

Widal - 1:160 Typhi 'O'
On Day 1 - 1:160 'H'
urate (N)

VIH-00096429 IP-00060432
Master VISHWANATHA DHEERAJ
18-07-2014 11 Y 11 M 3 D (M)
Dr. PREETHAM KUMAR

Pediatric Multiorgan History & Physical Examination

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

1st – 5-6 yrs, AFI

2nd admission – NOW

Birth & Neonatal History:

No perinatal insult.

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information : Cl (5)

Developmental History :

(N) in all 4 domains.

Immunization History :

upto date.

(P.T.O.)

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 91kg (Centile ________)

On Examination :

Temperature : 98°F Pulse Rate : 105/min B.P. 117/80 SPO2 99%

Resp.rate and type of breathing : 21/min

Rash________

Lymphadenopathy________

Oedema :________

Allergies (if any): ________

Respiratory System :

Inspection (any s/o distress) : ________

Air entry & breath sounds : Clear

Any addes sounds : ________

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

Cardiovascular System :

Inspection of procordium : ________

Heart Sounds : S1 S2

Any murmur :________

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

Per Abdomen :

Inspection________

Palpation : Soft

Ausculation :________

Spine :________ External Genitelia : ________

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

VIH-00096429 IP-00060432
Master VISHWANATHA DHEERAJ
16-07-2014 11 Y 11 M 3 D (M)
Dr. PREETHAM KUMAR

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score :

Cranial Nerves : Intact

Motor System:

Nutriton :

Tone: Power

Co-ordinator : (N)

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials:**

Plantars

Sensory System :

(N)

Bladder / Bowel :

Clinical Summary & Diagnostic:

AFI (D3 ↓ evaluation) ? Typhoid

(P.T.O.)

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBP
CRP - ↑Ca++] outside opd basis
Sr. electrolytes.
Sr. Creatinine.
- B/C/S.
- CUE
- Typhoid IgM.
- extra plain. (1).

Planned Management

IVF
- Inj. Piptaz.
- Inj Esomeprazole.
- Antipyretics (SOS)
- vitals 4th hly
- Inform SR.

Noted by - Sabin
21/6/26 @ 9 pm

Signature of the Doctor: [signature]

Name of the Doctor: CH. GANESH

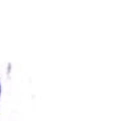
Date & Time: 21/6/2026.

Signature of the Consultant: [signature]

Name of the Consultant: [signature]

Date & Time: 21/6/26 4pm

VIH-00096429 IP-00060432
Master VISHWANATHA DHEERAJ
18-07-2014 11 Y 11 M 3 D (M)
Dr. PREETHAM KUMAR



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/6/2026 8:00 AM		AFI (D3 ↓Evaluation)
		- No fevers ∵ admission
		- vitals stable.
		(N) intake
		NO concerns
		(N) U.O.
		CVS - S1S2
		CNS - NAD
		RS - B/L AE (+)
CUE (N)		P/A - soft
	CBP, CRP - T/W	Plan
		- Trace Typhoid IgM.
		- vitals 6th hrly
		- Continue Piptaz D,
		- Inform SOS
		cl - Cus
		- Trace B/C.
	Dr Lavanya A 22/6/26 9AM	USG Abdomen.

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

(P.T.O)

VIH-00096429 IP-00000432
Master VISHWANATHA DHEERAJ
18-07-2014 11 Y 11 M 4 D (M)
Dr. PREETHAM KUMAR

22/6/26
3:30pm

S/B Resident.

Adv — AFI (D3)

No fever spikes.

O/E

Child alert

Euthermic

Vitals stable

CVS S1S2 (+)

P/A – BAE (+)

P/A – soft

Plan

1) CBP, CRP tlm

2) Inj pip-taz

3) Monitor vitals

informed sos

22/6/26

Noted by Indu
@ 8pm
22/6/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/6/26 8:30AM	S/B Resident	
	DSG - AFI (D4)	
	No fever spikes	
	O/E	
	Child alert	
	Euthermic	
	Vitals stable	
	CVS - S1S2 (+)	
	RS - BAE (+)	
	P/A - soft	
		plan
		1) Inj piptaz
		2) Trace B/c/s Typhoid IgM
	CRP (↓)	3) plan for d/c Today
		4) Supp. [illegible]
Vishwanatha [illegible]	Dr. KUNAHNA 23/6/26 9AM.	
		noted by Manasa 23/6 @ 10AM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

VIH-00096429 IP-00060432
Master VISHWANATHA DHEERAJ
18-07-2014 11 Y 11 M 3 D (M)
Dr. PREETHAM KUMAR

NURSING SHIFT HAND OVER FORM

SITUATION		
Diagnosis: AFI ? Typhoid	Any Infection: ☐ Yes ☑ No ☐ Not Known If Yes Specify: Nil
Surgery / Procedure:	Post OP Day:

Section	Item	21/6/26 N	21/6/26 N	22/6/26 M	22/6 E	22/6 N	23/6/26 M
BACKGROUND	Medical Condition (Any special condition to be noted):	Nil	Nil	Nil	Nil	Nill	Nil
	Diet:	normal	N diet	N. diet	N. diet	N diet	N 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	98.6F	98.3F	98.4°F	97.4°F
	Res:	29 b/m	22b/m	20 b/m	22b/m	23b/mint	23 b/m
	SpO_2:	98%	99%	99%	98%	98%	99%
	Pulse:	96b/m	103b/m	95 b/m	98b/m	96b/mint	97 b/min
	BP:	115/75	107/79	91/80(85)	104/63(80)	106/70(82)	107/80(8)
	LOC:	conscious	conscious	Conscious	conscious	conscious	Conscious
	Fall Risk Score:	11	11	11	11	11	11
	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	Nil	Nil	Nill	Nil
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Special Diet:	normal	N.diet	N diet	N. diet	N Diet	N Diet
	Critical Lab Test / Values:	Nil	nil	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	Nil	Nil	Nill	Nil
Handed Over By Name :		Sabina	Manisha	Anitha	Indu	Manisha	Subham
Signature / ID :		[illegible]	M/9050145	A/9050140	8661108	M/9050145	[illegible]
Date:		21/6/26	22/6/26	22/6/26	22/6/26	23/6/26	23/6/26
Time:		@9:30	@8Am	@2pm	@8pm	@8AM	@1:30pm
Taken Over By Name :		Manisha	Anitha	Indu	Manisha	Subha	
Signature / ID :		M/9050145	A/9050140	8661108	9050145	1914	
Date:		21/6/26	22/6	22/6/26	22/6/26	23/6	
Time:		@9:30pm	@8am	@2pm	8P	@8am	

Noted by Maheswari 23/6 01pm

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

VIH-00096429 IP-00060432
Master VISHWANATHA DHEERAJ
18-07-2014 11 Y 11 M 4 D (M)
Dr. PREETHAM KUMAR

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify: ....
	Surgery / Procedure:	Post OP Day:

BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	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):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

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

Rainbow Children's Hospital
BirthRight by Rainbow

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:	**Master VISHWANATHA DHEERAJ**	**Age :**	**11 Y 11 M 3 D**
IP No:	**IP-00060432**	**Sex:**	**Male**
Consultant:	**Dr. PREETHAM KUMAR**	**Ward/Bed No:**	**N 0 GF-EMERGENCY/ER 101**

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 [illegible]o consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for [illegible]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 [illegible]rance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.................) [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: [signature]

Name: V. Praveen kumar
Relationship: Father
Date: 21.06.2026 Time: 8:30
Wittness Name: [signature]
Wittness Signature: [signature]

Patient Address:
FLAT NO 101, 1ST FLOOR SREE DHATRI RESIDENCY SADANA VIHAR KAPRA Bhadas B.O Hyderabad Telangana INDIA 500094

VIH-00096429 IP-00060432
Master VISHWANATHA DHEERAJ
18-07-2014 11 Y 11 M 3 D (M)
Dr. PREETHAM KUMAR

Pat

/ CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

WARNING SCORE: CHILDREN'S UNIT

2/6/26

Date : .... Time:	11	1	3	5	7
Doctor / Nurse / Family Concern?	pm	AM	AM	AM	AM
Temperature (°F) (scale 94–104)	98.6°F	98.6°F	98.6°F	98.6°F	98.6°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190)	109 / 72 (63)				100 / 79 (60)
Heart Rate (Number)	110	100	105	107	104
Resp. Rate (bpm) Over 1 Minute) * (scale 10–70)					
Resp Rate (Number)	26	27	26	27	28
Resp Distress: Mod/ Severe / None / Mild	N	N	N	N	N
Receiving O_2 (l/min)					
O_2 Saturations (%)	98	99	98	99	99
Conscious Level: Normal / Altered	N	N	N	N	N
GCS *	15	15	15	15	15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0
Pain Score	0	0	0	0	0
Observer's Initials	M	M	M	M	M

Note: BP does not score in early warning scoring

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 02/ 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)

Doc. No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

22/6

Date : .... Time:	9 Am	11 AM	1 PM	3 pm	5 pm	7 pm	9 pm	11 pm	1 Am	3 Am	5 Am	7 Am
Doctor / Nurse / Family Concern?												
Temperature (F)	98.6F	98.6F	98.6F	98.6F	98.6F	98.6F	98.6F	98.6F	98.3°F	98.2°F	97.1°F	98.2°F
Heart Rate (bpm) and Blood Pressure (mmHg) *	91/80 (86)				102/61 (85)		100/78 (62)					
Heart Rate (Number)	100	98	102	98	95	101	103	109	110	100	104	107
Resp. Rate (bpm) (Over 1 Minute) *												
Resp Rate (Number)	18	19	19	21	22	21	24	22	20	25	25	24
Resp Distress: Mod/ Severe												
Resp Distress: None / Mild	N	N	N									
Receiving O_2(l/min)												
O_2Saturations (%)	98	99	97	98	98	98	98	99	97	100	99	99
Conscious Level: Normal	N	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	15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0	0	0	0	0
Observer's Initials	A	A	A	Ande	Ara	Ande	M	M	M	M	M	M

Note: BP does not score in early warning scoring

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
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Patient Sticker

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
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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-00096429 IP-00060432
Master VISHWANATHA DHEERAJ
18-07-2014 11 Y 11 M 4 D (M)
Dr. PREETHAM KUMAR

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

23/6/26

Parameter	Scale	Obs. 1
Date : .... Time:		9
Doctor / Nurse / Family Concern?		Aw
Temperature (F)	104, 103, 102, 101, 100, 99, 98, 97, 96, 95, 94	98.6°F
Heart Rate (bpm) and Blood Pressure (mmHg) *	190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50	120
Note: BP does not score in early warning scoring		
Heart Rate (Number)		112
Resp. Rate (bpm) (Over 1 Minute) *	70, 60, 50, 40, 30, 20, 10	
Resp Rate (Number)		
Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O_2(l/min)		
O_2Saturations (%)		99
Conscious Level	Normal	-
	Altered	
GCS *		15
TOTAL SCORE Number of shaded boxes		0
Pain Score		0
Observer's Initials		SV

Noted by
Subha
23/6/26
10am

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.

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A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

FLUID CHART

Sheet No. : 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.

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			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											
21/6	10:00 pm		Rice	40ml							1	manisha
	11:00 pm		water	40ml						✓		
	12:00 am			40ml							0	
	01:00 am			40ml							1	
Total Intake :	160ml					Total Output :						
	02:00 am			40ml							1	manisha 22/6/26 @ 8Am
	03:00 am			40ml						✓		
	04:00 am			40ml								
	05:00 am			40ml							0	
	06:00 am										1	
	07:00 am									✓		
Total Intake :	160ml					Total Output :						

Total 24 hrs. Intake	320ml

Total 24 hrs. Output	8 times

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FLUID CHART

Sheet No. : 2

22/6

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							
22/6	08:00 am		Idly	40 ml						✓		
	09:00 am			40 ml								
	10:00 am		water	40 ml							0	Anitha
	11:00 am			40 ml						✓		22/6
	12:00 pm			40 ml								@2pm
	01:00 pm											
Total Intake : 200 ml						Total Output :						
22/6	02:00 pm											
	03:00 pm		Rice	40ml						✓		Indu
	04:00 pm		+	40ml							0	
	05:00 pm		water	40ml								@8pm
	06:00 pm			40ml						✓		22/6/26
	07:00 pm											
Total Intake : 160ml						Total Output :						
22/6	08:00 pm		Rice	40ml								
	09:00 pm		water	40ml								
	10:00 pm			40ml						✓		
	11:00 pm			40ml							0	manisha
	12:00 am			40ml								
	01:00 am									✓		
Total Intake : 120ml						Total Output :						
23/6/26	02:00 am			40ml								
	03:00 am			40ml								
	04:00 am			40ml						✓		manisha
	05:00 am			40ml							0	23/6/26
	06:00 am			40 ml								@8Am
	07:00 am			40ml								
Total Intake : 160 ml						Total Output :						

Total 24 hrs. Intake	640 ml

Total 24 hrs. Output	3times

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Dr. PREETHAM KUMAR

FLUID CHART

Sheet No. : (2)   23/6

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							
23/6	08:00 am											
	09:00 am		Idly						✓	R		
	10:00 am		water									
	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 :						

Noted by Subha 23/6 @10:00

Total 24 hrs. Intake		Total 24 hrs. Output	

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

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Dr. PREETHAM KUMAR

DRUG CHART

Date of Admission: .... 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: T. PARACETAMOL				Date / Time
Dose	Route	Frequency	Start Date	
500mg	PO	Q6H	21/6	
Doctor's Signature	Valid Period	Pharm.		
[signature]		[signature]		
Additional Instructions: 1 tab = 500mg 10-15mg/kg/dose				

DRUG: T. IBUPROFEN				Date / Time
Dose	Route	Frequency	Start Date	
400mg	PO	Q6H	21/6	
Doctor's Signature	Valid Period	Pharm.		
[signature]		[signature]		
Additional Instructions: 1 tab = 400mg. 10mg/kg/dose				

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

VERIFIED BY : Name .... Signature .... S. [signature] 21/6/2 (handwritten, twice)

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Dr. PREETHAM KUMAR

REGULAR PRESCRIPTIONS

Weight. 41kg Ward.

DRUG : INJ. PIPERACILLIN + TAZOBACTEM

Dose	Route	Frequency	Start Date
4g	IV	8th hrly	21/6

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: (After test dose) 100mg/kg/dose

Daily Doctor's Endorsement by a Sign

DRUG : INJ. ESOMEPRAZOLE

Date/Time: 21/6, 22/6, 23/6

Dose	Route	Frequency	Start Date
40mg	IV	24th hrly	21/6

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: 1mg/kg/dose

Daily Doctor's Endorsement by a Sign

S. maeykamal 21/6/26

DRUG : INJ. PIPERACILLIN TAZOBACTEM

Date/Time: 21/6, 22/6, 23/6

Dose	Route	Frequency	Start Date
4g	IV	8th hrly	21/6

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: (After test dose) 100mg/kg/dose

Daily Doctor's Endorsement by a Sign

S. maeykamal 21/6/26

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

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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

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Dr. PREETHAM KUMAR

I.V. FLUIDS CHART

Weight. 4 kg Ward. ....

		...mposition of I.V. Fluid (..., mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
21/6	9:45pm	IV DNS (1/2 main)	IV	40	[signature]	kalpa / mones	23/6	[signature]	[signature] / [signature]

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

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Master VISHWANATHA DHEERAJ
18-07-2014 11 Y 11 M 4 D (M)
Dr. PREETHAM KUMAR

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~~NEBULISATION~~ MEDICATION CHART

Date	Time	Drug	Nurse	Parents Signature
23/6/26	00.00	6AM		
	01.00	Inj ESOMEPRAZOLE 40mg (OD)	[signature]	[signature]
	02.00	Inj PIPTAZ 4gm (TID)		[signature]
	03.00			
	04.00			
	05.00	2pm		
	06.00	Inj PIPTAZ 4gm (TID)		
	07.00			
	08.00			
	09.00	10pm		
	10.00	Inj PIPTAZ 4gm (TID)		
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
22/6/26	00.00	6Am		
	01.00	Inj. Esmoprazole (40mg)(IV)(OD)		
	02.00	Inj. Piptaz (4gm)(IV)(TID)		
	03.00	2pm		
	04.00	Inj. Piptaz (4gm)(IV)(TID)		
	05.00	10pm		
	06.00	Inj. Piptaz (4gm)(IV)(TID)		
	07.00			
	08.00			
	09.00			
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
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	23.00			