ACTIVITY RECORD FOR BILLING

Name: --

UHID No : --------------- IP No : ------- VIH-00205932 Baby Of POOJA 12-06-2026 0 Y 0 M 3 D (F) Dr. SURENDER RAO DUSA IP-00060355 ------------------ Dept : -----------------

Date of Admission : ---------------- Ti[...] :harge : ---------------- Time: -----------

Room / Bed No : --------------- Ward . [...] illable bed type : ------------------------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
19/6/26	1pm	NICU	215	[signature]

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. Murtaza Kamal	16/6/26	3090739 ✓	Maria
2.	Dr. MOHD. ABDUL KHALID	16/6/26	3090818 ✓	Asif
3.	Cross checked by Maria. 19/6/26 2Am			
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Sign
15/6/26	VBG, ~~RBS~~ (1)	26020500	Asif
	CBP, CRP, urea, creatinine, SBR, S/E, calcium	26020498	
	CXR (1)	26009609	
	Blood culture	26020498	
15/6/26	ABG, RBS (2)	26020507	Mario
16/6/26	Magnesium, calcium, PT/APTT	26020513	
	ABG, RBS (3)	26020514	Mario
	CXR (2)	260-009615	
16/6/26	2D ECHO	26-009624	[illegible]
16/6/26	S/E	26020532	Asif
16/6/26	ABG, RBS (4)	26020536	Asif
16/6/26	NSG	26009647	Asif
16/6/26	ABG, RBS (5)	26020580	Asif
16/6/26	CXR (3)	26-009668	[illegible]
16/6/26	ABG, RBS (6)	26020587	Mario
17/6/26	CBP, CRP, SBR, S/E, urea, Creatinine, calcium	26020592	Mario
	ABG, RBS (7)	26020593	Mario
	CXR (4)	26-009673	Mario
	RBS	26020661	Asif
	CSF culture	26020660	
	CSF Analysis	26020659	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
15/6/26	Monitor	7PM		30906138	Asef
	Infussion Pump		18/6/26 12pm		
	Oxygen		18/6/26 10Am		
	ventilator		16/6/26 4pm		
	Syringe Pump (Dobutamine)		17/6/26 @ 11Am		
	Syringe Pump (Sildenafil)		16/6/26 @ 10Am	30906 39	
	Syringe Pump (Adrenaline)		15/6/26 9pM	30906 40	
	Syringe pump (Hep-NS)		17/6/26 @ 12PM	3090667	Maris
	Syringe pump (Fentany)		16/6/26 @ 10Am	3090669	
16/6	CPAP	10pm	17/6/26 @ 10Am	3090996	
	Cross Checked by Maria 19/6/26 2Am				
19/6/26	oxygen	4Am		3092080	[signature]
	Cross checked by Raja 20/6 6 1:49M				

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
15/6/26	I.V Placement	1	3090641	Asy.
15/6/26	Arterial line	1	3090670	Maria
16/6/26	Nebulisation	2	3090980	Maria
17/6/26	Lumbar Puncture	1	3091289	Asy
17/6/26	Nebulisation	4	3091426	[illegible]
17/6/26	IV placement	1	3091427	[illegible]
18/6/26	Nebulisation	1	3091948	[illegible]
	cross checked by		Maria	
	19/6/26	2Am		

ANY OTHER INFORMATION

Date : 20/6/26 Time : @ 1:43 PM Prepared By : [illegible]

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

Ref. No. : F / HW / INVS / INPR / 02

DAILY INVESTIGATION SHEET

Patient Name: VIH-00205932 IP-00060355 Baby Of POOJA 12-06-2026 0 Y 0 M 7 D (F) Dr. SURENDER RAO DUSA

Age : ....

No. : ....

Date	Investigation	Ward	Nurse Signature	Bill No.	Received Date & Signature
18/6/26	SBR, TFT	NICU	Maria	26020724	
18/6/26	ABG, RBS	NICU	Maria	26020725	
	X-Ray	NICU		26-009740	
19/6/26	RBS	NICU		26020823	
	cross checked		by	maria 19/6/26 9Am	
19/6/26	CBP, CRP, S/E	NICU		26020822	
20/6	GRBS @ 6Am 68mg/dl				

Name	Baby Of POOJA	**UHID**	VIH-00205932
Father/Guardian	Mr BUSA SRINU	**Age/Gender**	0 Y 0 M 8 D/Female
Address	H.NO:1-1/1,BUS STAND,LINGAMPALLY, MANDAL,CHILPOOR ,LINGAMPALLY,JANGOAN,TELANGANA., Malkapur, Warangal, Telangana, INDIA, 506145		
IP No	IP-00060355	**Admission Date**	15-06-2026
Ref Doctor	Anupama C	**Discharge Date**	20-06-2023

DISCHARGE SUMMARY

Consultant:
Dr. SURENDER RAO DUSA
MD (Pediatrics), Fellowship in Neonatology
SENIOR CONSULTANT PEDIATRICS

Diagnosis:
Term/AGA/Baby girl
Meconium Aspiration Syndrome - Severe PPHN - MV - 2x Surfactant - HFOV (Outside) - MV - CPAP- Low flow oxygen
Culture Positive Sepsis - E.Coli (Outside)
Asymptomatic Hypocalcemia

Chronological age: 8 days

History: Baby Of POOJA is a term (37 weeks) / AGA / baby girl of birth weight 3.4 kgs, born to primi mother delivered by Elective Lower Segment Cesarean Section (Indication : MSL) on 12.06.2026 at 03:09 pm at Ramya Hospital. Baby said to have cried immediately after birth. Apgar scores and resuscitation details were not known. Baby developed respiratory distress after birth for which baby was started on CPAP and was shifted to Shuraksha Hospital where baby was continued on CPAP, Chest x-ray done was suggestive of MAS. In view of impending respiratory failure baby was intubated and surfactant was given and connected to mechanical ventilator, but in view of persistence of

respiratory distress requiring higher pressure ventilatory settings another dose of surfactant was given and was continued on mechanical ventilator. At 20 hours of life as there was failure of conventional ventilation, HFOV was started and baby was monitored. On day 2 of life there was poor perfusion for which Injection Dobutamine was started. On day 2 of life, 2D Echo was done which was suggestive of severe PAH for which, Injection Milrinone was added along with Injection Adrenaline and Injection Sildenafil. In view of coagulopathy 2 FFP transfusions were given. In view of persistence of respiratory distress and probable requirement of iNO, baby was referred and transported to NICU, Rainbow Children's Hospital, Karkhana, for further management.

Maternal History : Mrs. POOJA is a 24 years old primi mother with marital life of 5 years. Non Consanguineous marriage. Mother's blood group is "A" Positive. Expected delivery date: 19.06.2026.

G1 : Present pregnancy, spontaneous conception.

She had regular antenatal checkups and antenatal scans were normal. There was no history of Urinary tract infection / Abortions / Hydramnios / Premature Rupture of Membranes/ diabetes / Hypertension / Thyroid / Cardiac / Renal abnormalities. She received calcium, iron supplementation and TT prophylaxis.

On examination: At the time of admission, baby was euthermic and maintaining saturations on mechanical ventilator. Her heart rate was 164/min, blood pressure was 55/31 (42) mmHg. On auscultation of chest, air entry was bilaterally equal with normal heart sounds. Abdomen was soft without organomegaly. There were no obvious external congenital anomalies.

Weight on Admission : 3.40 kgs
Weight on Discharge : 2.940 kgs
Head circumference : 31 cms
Length :46 cms

Baby blood group : "A' Positive (Blood group to be repeated after 4 months).

Investigations: Enclosed.

Management: Meconium Aspiration Syndrome - Severe PPHN - MV - 2x Surfactant - HFOV (Outside) - MV - CPAP - Low flow oxygen: Baby was nursed in thermoneutral environment. Her initial VBG showed pH 7.49, pCO2 32.7 mmHg, pO2 31 mmHg, HCO3 25.2 mmol/L, BE -1.7 mmol/L. Her initial chest x-ray showed bilateral haziness. In view of respiratory distress baby was continued on mechanical ventilator. Her ventilatory settings were optimized according to serial ABGs and chest x-rays. In suspicion of PPHN, Injection Sildenafil, Injection Dobutamine was continued. 2D Echo showed situs, solitus , Levocardia, PPHN, mild TR / Mild PAH, PFO left tor right shunt, good Biventricular Function, Left Arch , No CoA, so Injection Sildenafil and Injection Dobutamine were stopped. As baby had good spontaneous breathing efforts, baby was extubated after 20 hours of admission. As baby had significant stridor, baby was connected to CPAP. As stridor and work of breathing improved, baby was weaned off to low flow oxygen after 12 hours and then to room air after 24 hours. At present, baby is maintaining saturations on room air.

Probable sepsis: She was screened for sepsis and was started on intravenous fluids, intravenous antibiotics after sending blood culture. Her complete hemogram showed hemoglobin 12.6 gm%, white blood cells count 9,820 cells/cumm, platelet count 1.85 lakhs/cumm. C. Reactive protein 52.0 mg/L. Serum electrolytes showed serum sodium - 146 mmol/L, serum potassium - 4.4 mmol/L, serum chloride - 107 mmol/L, serum calcium 6.9 mg/dl, blood urea 33.4 mg/dl, serum creatinine 0.7 mg/dl. Coagulation profile showed PT 17.4 sec, INR 1.24, APTT 33.5 sec. Blood culture sent at the time of admission was sterile after 48 hours of incubation. Repeat hemogram done on 17.06.2026 showed hemoglobin 16.1 gm%, white blood cells count 8,250 cells/cumm, platelet count 1.54 lakhs/cumm, C. Reactive protein 40 mg/L. In view of high

CRP levels, lumbar puncture was done and CSF analysis showed showed 4 cells (100% lymphocytes), occasional RBCs+ with protein of 116 mg/dl, sugar of 71 mg/dl. CSF culture was sent, report awaited. IV antibiotics stopped after 5 days.

Serum bilirubin done on 19.06.2026 was 10.8 mg/dl with direct fraction of 0.1 mg/dl and indirect fraction of 10.7 mg/dl. Her serum bilirubin was regularly monitored. Her last serum bilirubin done on 18.06.2026 was 12.5 mg/dl with direct fraction of 0.1 mg/dl and indirect fraction of 12.4 mg/dl which does not come under phototherapy range.

Asymptomatic Hypocalcemia: Baby had low serum calcium levels (6.9mg/dl) on the day of admission which was managed with serum calcium correction and IV fluids. Repeat serum calcium after 24 hours was 8.6 mg/dl.

Feeding : Once hemodynamically stable, she was started on OG feeds on day 2 of admission (day 4 of life), which were increased gradually. Baby reached on full OG feeds on day- 6 of life. Oral feeds were started on day- 6 of life, which she accepted and tolerated well. At present, baby is on demand oral feeds, which she is accepting and tolerating well.

2D Echo

Date	Day of life	Impression:
16.06.2026	4	Situs solitus, levocardia, PPHN, Mild TR / Mild PAH, PFO left tor right Shunt, Good Biventricular Function, Left Arch , No CoA

Neurosonogram

Date	Day of life	Impression:
16.06.2026	4	No focal brain lesions. ACA RI - 0.65

Name	Baby Of POOJA	UHID	VIH-00205932

Thyroid Function Test			
Date	**T3 (80-275)**	**T4 (5.41-17)**	**TSH (0.72-11)**
18.06.2026	80.53	8.78	4.39

At the time of discharge: Baby was active, hemodynamically stable and maintaining saturations at room air, accepting feeds well.

Advice :

1. Warmth care.
2. Continue demand oral feeding.
3. Encourage breast feeding.
4. Immunization as per schedule (To be given on follow up).
5. Vitamin D3 drops (1ml/800IU), 0.5 ml once daily till one year of age.
6. NBS (Advanced) & Hearing test (OAE) to be done on follow up.
7. Kindly consult Dr. Surender Rao Dusa, Consultant Pediatrician & Neonatologist, on Monday (22.06.2026) in OPD with prior appointment (This consultation will be charged).

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

In Case of Emergency Contact 040-42462200 Extn: 2010 (or) 9963766633 for lethargy, respiratory distress, refusal of feeds, decreased activity, seizures, jaundice, feeding difficulty.

The discharge advice and details on how to obtain emergency care has been explained to me in the language that I understand.

HIGH RISK FOLLOW UP
Note: Register for Neurodevelopmental assessment with developmental specialist

Name : BUSA. SRINU Signature : B. Srinu

Relationship with patient : Father

This summary has been explained by : Roja Rei 20660 @ 1:51 PM

Summary prepared by: Dr.Barasha/Dr.Vishal
Typist : Kalyan

for Dr Vishal

Registrar/Resident/C.M.O

Dr. SURENDER RAO DUSA
MD (Pediatrics), Fellowship in Neonatology
SENIOR CONSULTANT PEDIATRICS
47776

INSURANCE COPY

PatientName	: Baby Of POOJA	Inpatient No.	: IP-00060355
Age/Gender	: 0 Y 0 M 3 D/ Female	Admit Date	: 15-06-2026
Ward/Bed	: N 2F-NICU I/ NICU 249	Discharge Date	:

Investigation	Result	Unit		Biological Reference Interval
BILIRUBIN (INDIRECT / DIRECT) (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED		Order Date :15-06-2026 20:01
TOTAL BILIRUBIN (Azobilirubin)	10.8	mg/dl		<11.7
CONJUGATED BILIRUBIN (Spectrophotometric)	0.1	mg/dl		<0.6
UNCONJUGATED BILIRUBIN (Spectrophotometric)	**10.7**	**mg/dl**	H	0.6 - 10.5

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit		Biological Reference Interval
CALCIUM (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED		Order Date :15-06-2026 20:01
CALCIUM (Arsenazo dye)	**6.9**	**mg/dl**	L	7.5 - 11.9

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Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit		Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)		TEST RESULT STATUS : REPORT AUTHORISED		Order Date :15-06-2026 20:01
HEMOGLOBIN (Colorimetry)	**12.6**	**g/dL**	L	14.25 - 22.5
RBC COUNT (DC detection method)	**3.35**	**10^12/L**	L	4 - 6.6
PCV/HCT (Calculated)	**33.5**	**VOL%**	L	45 - 67
MCV (Calculated)	100.1	fL		95 - 121
MCH (Calculated)	**37.6**	**pg/cells**	H	31 - 37
MCHC (Calculated)	**37.5**	**g/dL**	H	29 - 37
RDW-CV (Calculated)	14.1	%		13 - 18
PLATELET COUNT (DC Detection Method)	185	10^9/L		150 - 450
MPV (Calculated)	8.0	fL		6.5 - 10
WBC COUNT (DC Detection Method)	9.82	10^9/L		5 - 21
Differential Count				
NEUTROPHILS (Microscopy, Leishman stain)	**71**	%	H	19 - 49
LYMPHOCYTES (Microscopy, Leishman stain)	**25**	%	L	26 - 36
MONOCYTES (Microscopy, Leishman stain)	**3**	%	L	7 - 18

PatientName	: Baby Of POOJA	Inpatient No.	: IP-00060355
Age/Gender	: 0 Y 0 M 3 D/ Female	Admit Date	: 15-06-2026
Ward/Bed	: N 2F-NICU I/ NICU 249	Discharge Date	:

Investigation	Result	Unit	Biological Reference Interval
EOSINOPHILS (Microscopy, Leishman stain)	1	%	1 - 4
PERIPHERAL SMEAR (Microscopy, Leishman stain)	**RBC : ANISOCYTOSIS WITH NORMOCYTIC / HYPOCHROMIC, TARGET CELLS(++)** **WBC : MORPHOLOGY NORMAL** **PLATELETS : ADEQUATE**		

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Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit		Biological Reference Interval
C REACTIVE PROTEIN (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED		Order Date :15-06-2026 20:01
CRP (Immunoturbidimetry)	**52.0**	**mg/L**	H	<10

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Investigation	Result	Unit		Biological Reference Interval
CREATININE (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED		Order Date :15-06-2026 20:01
CREATININE (Enzymatic)	**0.7**	**mg/dl**	H	0.03 - 0.5

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Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED	Order Date :15-06-2026 20:01
SODIUM (Direct ISE)	146	mmol/L	133 - 146
POTASSIUM (Direct ISE)	4.4	mmol/L	3.2 - 6
CHLORIDE (Direct ISE)	107	mmol/L	96 - 110

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Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval

PatientName	: Baby Of POOJA	Inpatient No.	: IP-00060355
Age/Gender	: 0 Y 0 M 3 D/ Female	Admit Date	: 15-06-2026
Ward/Bed	: N 2F-NICU I/ NICU 249	Discharge Date	:

Investigation	Result	Unit	Biological Reference Interval
UREA (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :15-06-2026 20:01
UREA (Kinetic, Urease)	33.4	mg/dl	6 - 36

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Investigation	Result	Unit		Biological Reference Interval
VENOUS BLOOD GAS (POCT) (Specimen : BLOOD)				TEST RESULT STATUS : REPORT ENTERED Order Date :15-06-2026 20:25
PH (Reagent Strip/Double PH Indicator)	**7.49**	**unit**	H	7.35 - 7.45
pCO2	**32.7**	**mm Hg**	L	35 - 48
pO2	**31**	**mm Hg**	L	83 - 108
HCO3	25.2	mmol/L		
BE	1.7	mmol/L		
O2 Sat	66.8	mmol/L		

Investigation	Result	Unit	Biological Reference Interval
ARTERIAL BLOOD GAS (POCT) (Specimen : BLOOD)			TEST RESULT STATUS : REPORT ENTERED Order Date :15-06-2026 23:24
PH (Reagent Strip/Double PH Indicator)	7.45	unit	7.35 - 7.45
pCO2	38.6		
pO2	83	mm Hg	83 - 108
HCO3	26.4		
BE	2.4	mmol/L	
O2 Sat	96.3	mmol/L	

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)			TEST RESULT STATUS : REPORT ENTERED Order Date :15-06-2026 23:24
RANDOM BLOOD GLUCOSE (GOD/POD)	99	mg/dl	70 - 140

Investigation	Result	Unit	Biological Reference Interval
CALCIUM (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :16-06-2026 04:41
CALCIUM (Arsenazo dye)	8.6	mg/dl	7.5 - 11.9

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Investigation	Result	Unit	Biological Reference Interval

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040-42462200, Ext 2000,2001,2002,

PatientName	: Baby Of POOJA	Inpatient No.	: IP-00060355
Age/Gender	: 0 Y 0 M 4 D/ Female	Admit Date	: 15-06-2026
Ward/Bed	: N 2F-NICU I/ NICU 249	Discharge Date	:

Investigation	Result	Unit	Biological Reference Interval
MAGNESIUM (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :16-06-2026 04:41
MAGNESIUM (Formazon dye)	2.0	mg/dl	1.2 - 2.4

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Investigation	Result	Unit	Biological Reference Interval
PT/APTT (PROTHROMBIN TIME / ACTIVATED PARTIAL THROMBOPLASTIN TIME) (Specimen : PLASMA)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :16-06-2026 04:41
PT (Optical Clot Detection)	17.4	Seconds	
PT Calcuiated Biological Reference Interval	12.5 - 14.5 secs		
INR	1.24		
APTT (Optical Clot Detection)	33.5	Seconds	
APTT Calculated Biological Reference Interval	28.5 - 35.1 secs		

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Investigation	Result	Unit		Biological Reference Interval
ARTERIAL BLOOD GAS (POCT) (Specimen : BLOOD)				TEST RESULT STATUS : REPORT ENTERED Order Date :16-06-2026 04:41
PH (Reagent Strip/Double PH Indicator)	**7.48**	**unit**	H	7.35 - 7.45
pCO2	38.1			
pO2	100	mm Hg		83 - 108
HCO3	28.2			
BE	4.5	mmol/L		
O2 Sat	97.9	mmol/L		

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)			TEST RESULT STATUS : REPORT ENTERED Order Date :16-06-2026 04:41
RANDOM BLOOD GLUCOSE (GOD/POD)	94	mg/dl	70 - 140

Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :16-06-2026 10:37

PatientName	: Baby Of POOJA	**Inpatient No.**	: IP-00060355
Age/Gender	: 0 Y 0 M 4 D/ Female	**Admit Date**	: 15-06-2026
Ward/Bed	: N 2F-NICU I/ NICU 249	**Discharge Date**	:

Investigation	Result	Unit		Biological Reference Interval
SODIUM (Direct ISE)	146	mmol/L		133 - 146
POTASSIUM (Direct ISE)	4.8	mmol/L		3.2 - 6
CHLORIDE (Direct ISE)	101	mmol/L		96 - 110

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit		Biological Reference Interval
ARTERIAL BLOOD GAS (POCT) (Specimen : BLOOD)				TEST RESULT STATUS : REPORT ENTERED Order Date :16-06-2026 11:28
PH (Reagent Strip/Double PH Indicator)	7.42	unit		7.35 - 7.45
pCO2	43.3			
pO2	**76**	**mm Hg**	L	83 - 108
HCO3	27.0			
BE	3.4	mmol/L		
O2 Sat	95.1	mmol/L		
HCT (Pulse Height Detection)	48	%		10 - 75

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)			TEST RESULT STATUS : REPORT ENTERED Order Date :16-06-2026 11:28
RANDOM BLOOD GLUCOSE (GOD/POD)	125	mg/dl	70 - 140

Investigation	Result	Unit		Biological Reference Interval
ARTERIAL BLOOD GAS (POCT) (Specimen : BLOOD)				TEST RESULT STATUS : REPORT ENTERED Order Date :16-06-2026 18:13
PH (Reagent Strip/Double PH Indicator)	7.44	unit		7.35 - 7.45
pCO2	45.2			
pO2	**58**	**mm Hg**	L	83 - 108
HCO3	29.4			
BE	6.7	mmol/L		
O2 Sat	90.4	mmol/L		
HCT (Pulse Height Detection)	61	%		10 - 75

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)			TEST RESULT STATUS : REPORT ENTERED Order Date :16-06-2026 18:13
RANDOM BLOOD GLUCOSE (GOD/POD)	113	mg/dl	70 - 140

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040-42462200, Ext 2000,2001,2002,

PatientName	: Baby Of POOJA	**Inpatient No.**	: IP-00060355
Age/Gender	: 0 Y 0 M 4 D/ Female	**Admit Date**	: 15-06-2026
Ward/Bed	: N 2F-NICU I/ NICU 249	**Discharge Date**	:

Investigation	Result	Unit		Biological Reference Interval
Investigation	Result	Unit		Biological Reference Interval
ARTERIAL BLOOD GAS (POCT) (Specimen : BLOOD)				TEST RESULT STATUS : REPORT ENTERED Order Date :16-06-2026 22:56
PH (Reagent Strip/Double PH Indicator)	7.39	unit		7.35 - 7.45
pCO2	54.4			
pO2	**52**	**mm Hg**	L	83 - 108
HCO3	30.3			
BE	6.5	mmol/L		
O2 Sat	85.6	mmol/L		

Investigation	Result	Unit		Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)				TEST RESULT STATUS : REPORT ENTERED Order Date :16-06-2026 22:56
RANDOM BLOOD GLUCOSE (GOD/POD)	106	mg/dl		70 - 140

Investigation	Result	Unit		Biological Reference Interval
BILIRUBIN (INDIRECT / DIRECT) (Specimen : SERUM)				TEST RESULT STATUS : REPORT AUTHORISED Order Date :17-06-2026 04:07
TOTAL BILIRUBIN (Azobilirubin)	**13.1**	**mg/dl**	H	<11.7
CONJUGATED BILIRUBIN (Spectrophotometric)	0.1	mg/dl		<0.6
UNCONJUGATED BILIRUBIN (Spectrophotometric)	**13.0**	**mg/dl**	H	0.6 - 10.5

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
CALCIUM (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :17-06-2026 04:07
CALCIUM (Arsenazo dye)	9.8	mg/dl	7.5 - 11.9

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 :17-06-2026 04:07
HEMOGLOBIN (Colorimetry)	16.1	g/dL	14.25 - 22.5

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

Rainbow Children's Hospital - Secunderabad

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040-42462200, Ext 2000,2001,2002,

PatientName	: Baby Of POOJA	**Inpatient No.**	: IP-00060355
Age/Gender	: 0 Y 0 M 5 D/ Female	**Admit Date**	: 15-06-2026
Ward/Bed	: N 2F-NICU I/ NICU 249	**Discharge Date**	:

Investigation	Result	Unit		Biological Reference Interval
RBC COUNT (DC detection method)	4.23	10^12/L		4 - 6.6
PCV/HCT (Calculated)	**42.7**	**VOL%**	L	45 - 67
MCV (Calculated)	100.8	fL		95 - 121
MCH (Calculated)	**38.1**	**pg/cells**	H	31 - 37
MCHC (Calculated)	**37.8**	**g/dL**	H	29 - 37
RDW-CV (Calculated)	14.4	%		13 - 18
PLATELET COUNT (DC Detection Method)	154	10^9/L		150 - 450
MPV (Calculated)	7.9	fL		6.5 - 10
WBC COUNT (DC Detection Method)	8.25	10^9/L		5 - 21
Differential Count				
NEUTROPHILS (Microscopy, Leishman stain)	**87**	%	H	19 - 49
LYMPHOCYTES (Microscopy, Leishman stain)	**08**	%	L	26 - 36
MONOCYTES (Microscopy, Leishman stain)	**04**	%	L	7 - 18
EOSINOPHILS (Microscopy, Leishman stain)	01	%		1 - 4
PERIPHERAL SMEAR (Microscopy, Leishman stain)	**RBC - NORMOCYTIC / NORMOCHROMIC** **WBC - MORPHOLOGY NORMAL WITH RELATED NEUTROPHILIA** **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 :17-06-2026 04:07
CRP (Immunoturbidimetry)	**40.0**	**mg/L**	H	<10

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit		Biological Reference Interval
CREATININE (Specimen : SERUM)		**TEST RESULT STATUS : REPORT AUTHORISED**		Order Date :17-06-2026 04:07
CREATININE (Enzymatic)	0.4	mg/dl		0.03 - 0.5

Dr. SRUJANA SHYAMALA, MD, DNB

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PatientName	: Baby Of POOJA	Inpatient No.	: IP-00060355
Age/Gender	: 0 Y 0 M 5 D/ Female	Admit Date	: 15-06-2026
Ward/Bed	: N 2F-NICU I/ NICU 249	Discharge Date	:

Investigation	Result	Unit	Biological Reference Interval

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit		Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)				TEST RESULT STATUS : REPORT AUTHORISED Order Date :17-06-2026 04:07
SODIUM (Direct ISE)	142	mmol/L		133 - 146
POTASSIUM (Direct ISE)	5.3	mmol/L		3.2 - 6
CHLORIDE (Direct ISE)	98	mmol/L		96 - 110

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit		Biological Reference Interval
UREA (Specimen : SERUM)				TEST RESULT STATUS : REPORT AUTHORISED Order Date :17-06-2026 04:07
UREA (Kinetic, Urease)	12.4	mg/dl		6 - 36

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit		Biological Reference Interval
ARTERIAL BLOOD GAS (POCT) (Specimen : BLOOD)				TEST RESULT STATUS : REPORT ENTERED Order Date :17-06-2026 04:08
PH (Reagent Strip/Double PH Indicator)	7.36	unit		7.35 - 7.45
pCO2	57.4			
pO2	**52**	**mm Hg**	L	83 - 108
HCO3	28.6			
BE	6.8	mmol/L		
O2 Sat	84.3	mmol/L		

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)			TEST RESULT STATUS : REPORT ENTERED Order Date :17-06-2026 04:08
RANDOM BLOOD GLUCOSE (GOD/POD)	80	mg/dl	70 - 140

Investigation	Result	Unit	Biological Reference Interval
CSF ANALYSIS (Specimen : CSF)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :17-06-2026 15:20
COLOUR (Visual Examination)	COLOURLESS		
APPEARANCE (Gross Examination)	CLEAR		

PatientName	: Baby Of POOJA	**Inpatient No.**	: IP-00060355
Age/Gender	: 0 Y 0 M 5 D/ Female	**Admit Date**	: 15-06-2026
Ward/Bed	: N 2F-NICU I/ NICU 249	**Discharge Date**	:

Investigation	Result	Unit		Biological Reference Interval
PH (Reagent Strip/Double PH Indicator)	**8.0**	unit	H	7.35 - 7.45
CLOT FORMATION	ABSENT			
CSF PROTEIN	**116**	**mg/dl**	H	15 - 45
CSF GLUCOSE (Trinder)	71	mg/dl		60 - 90
CELL COUNT	**TLC :- 4 CELLS**			
CELL TYPE	**100 % LYMPHOCYTES OCCASIONAL RBC(+)**			

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit		Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)		TEST RESULT STATUS : REPORT ENTERED		Order Date :17-06-2026 15:24
RANDOM BLOOD GLUCOSE (GOD/POD)	113	mg/dl		70 - 140

Investigation	Result	Unit		Biological Reference Interval
BILIRUBIN (INDIRECT / DIRECT) (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED		Order Date :18-06-2026 04:40
TOTAL BILIRUBIN (Azobilirubin)	**12.5**	**mg/dl**	H	<11.7
CONJUGATED BILIRUBIN (Spectrophotometric)	0.1	mg/dl		<0.6
UNCONJUGATED BILIRUBIN (Spectrophotometric)	**12.4**	**mg/dl**	H	0.6 - 10.5

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

DISCHARGE SUMMARY

MC-7373

Rainbow Children's Hospital - Secunderabad
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040-42462200, Ext 2000,2001,2002,

PatientName	: Baby Of POOJA	Inpatient No.	: IP-00060355
Age/Gender	: 0 Y 0 M 6 D/ Female	Admit Date	: 15-06-2026
Ward/Bed	: N 2F-NICU I/ NICU 249	Discharge Date	:

Investigation	Result	Unit	Biological Reference Interval
THYROID FUNCTION TEST (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :18-06-2026 04:40
TRIIODOTHYRONINE (T3) (Eclia)	80.53	ng/dL	80 - 275
THYROXINE (T4) (Eclia)	8.78	µg/dl	5.41 - 17
THYROID STIMULATING HORMONE (TSH) (Eclia)	4.39	µIU/ml	0.72 - 11

Dr. HAFSA AHMAD, MBBS,DCP

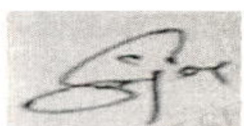
CONSULTANT CLINICAL PATHOLOGY, Reg No : 36473

PatientName	: Baby Of POOJA	Inpatient No.	: IP-00060355
Age/Gender	: 0 Y 0 M 6 D/ Female	Admit Date	: 15-06-2026
Ward/Bed	: N 2F-NICU I/ NICU 249	Discharge Date	:

Investigation	Result	Unit		Biological Reference Interval
ARTERIAL BLOOD GAS (POCT) (Specimen : BLOOD)				TEST RESULT STATUS : REPORT ENTERED Order Date :18-06-2026 04:41
PH (Reagent Strip/Double PH Indicator)	7.43	unit		7.35 - 7.45
pCO2	41.2			
pO2	**49**	**mm Hg**	L	83 - 108
HCO3	26.4			
BE	2.9	mmol/L		
O2 Sat	85.5	mmol/L		

Investigation	Result	Unit		Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)				TEST RESULT STATUS : REPORT ENTERED Order Date :18-06-2026 04:41
RANDOM BLOOD GLUCOSE (GOD/POD)	90	mg/dl		70 - 140

Investigation	Result	Unit		Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)				TEST RESULT STATUS : REPORT AUTHORISED Order Date :19-06-2026 05:32
HEMOGLOBIN (Colorimetry)	14.6	g/dL		13.5 - 19.5
RBC COUNT (DC detection method)	**3.85**	**10^12/L**	L	3.9 - 6.3
PCV/HCT (Calculated)	**38.7**	**VOL%**	L	42 - 66
MCV (Calculated)	100.6	fL		88 - 126
MCH (Calculated)	37.9	pg/cells		28 - 40
MCHC (Calculated)	37.7	g/dL		28 - 38
RDW-CV (Calculated)	14.7	%		13 - 18
PLATELET COUNT (DC Detection Method)	314	10^9/L		150 - 450
MPV (Calculated)	8.4	fL		6.5 - 10
WBC COUNT (DC Detection Method)	14.67	10^9/L		5 - 21
Differential Count				
NEUTROPHILS (Microscopy, Leishman stain)	46	%		19 - 49
LYMPHOCYTES (Microscopy, Leishman stain)	**43**	**%**	H	26 - 36
MONOCYTES (Microscopy, Leishman stain)	10	%		7 - 18
EOSINOPHILS (Microscopy, Leishman stain)	01	%		1 - 4
PERIPHERAL SMEAR (Microscopy, Leishman stain)	**RBC : NORMOCYTIC / HYPOCHROMIC WBC : MORPHOLOGY NORMAL PLATELETS : ADEQUATE**			



Dr. SRUJANA SHYAMALA, MD, DNB
Consultant Pathologist, Reg.No : 39356

Interim Report
DISCHARGE SUMMARY
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PatientName	: Baby Of POOJA	Inpatient No.	: IP-00060355
Age/Gender	: 0 Y 0 M 7 D/ Female	Admit Date	: 15-06-2026
Ward/Bed	: N 2F-NICU I/ NICU 249	Discharge Date	:

Investigation	Result	Unit		Biological Reference Interval
C REACTIVE PROTEIN (Specimen : SERUM)				TEST RESULT STATUS : REPORT AUTHORISED Order Date :19-06-2026 05:32
CRP (Immunoturbidimetry)	9.0	mg/L		<10

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit		Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)				TEST RESULT STATUS : REPORT AUTHORISED Order Date :19-06-2026 05:32
SODIUM (Direct ISE)	142	mmol/L		133 - 146
POTASSIUM (Direct ISE)	5.7	mmol/L		3.2 - 6
CHLORIDE (Direct ISE)	105	mmol/L		96 - 110

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit		Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)				TEST RESULT STATUS : REPORT ENTERED Order Date :19-06-2026 06:32
RANDOM BLOOD GLUCOSE (GOD/POD)	99	mg/dl		70 - 140
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)				TEST RESULT STATUS : REPORT ENTERED Order Date :20-06-2026 01:14
RANDOM BLOOD GLUCOSE (GOD/POD)	**68**	**mg/dl**	L	70 - 140

Baby Of POOJA

0 Y 0 M 3 D

Female

IP-00060355

VIH-00205932

SURENDER RAO DUSA

7702764478

R26-009609

15-06-2026 08:24 PM

17-06-2026 05:02 PM

DRAFT

X-RAY CHEST AP VIEW

Cardiothoracic ratio within normal limits.

No evidence of fracture of the ribs.

Clavicle and shoulder girdle normal.

No pneumothorax / pleural effusion.

Prominent bilateral bronchovascular markings.

ET tube, UV line, NG tube insitu.

Multiple air distended bowel loops in the abdomen.

CP angles are clear.

Domes of diaphragm are normal.

Print Date/Time : 17-06-2026 05:02 PM Printed By : A HARISH CHANDRA KALYAN

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

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Baby Of POOJA | 7702764478
0 Y 0 M 4 D | R26-009615
Female | 16-06-2026 04:42 AM
IP-00060355 | 19-06-2026 04:29 PM
VIH-00205932
SURENDER RAO DUSA

DRAFT

X RAY - CHEST PA

Cardiothoracic ratio within normal limits.

Ventricular configuration and aortic arch normal.

Mild haziness in bilateral lung fields.

ET tube, NG tube, UV line insitu.

Air distended stomach.

Domes of diaphragm are normal.

CP angles are clear.

Bones and soft tissues normal.

No subdiaphramatic pathology.

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 040-69513233
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Baby Of POOJA	7702764478
0 Y 0 M 4 D	R26-009624
Female	16-06-2026 08:27 AM
IP-00060355	16-06-2026 09:08 AM
VIH-00205932	16-06-2026 09:09 AM
SURENDER RAO DUSA	

PEDIATRIC ECHOCARDIOGRAM REPORT

Situs & Cardiac Looping	Situs Solitus Levocardia
Systemic Veins	To RA
Pulmonary Veins	To LA
Atrio ventricular connection	Concordance
Ventricular arterial connection	Concordance
Great artery relationship	NRGA
Right atrium	Normal
Left atrium	Normal
Inter atrial septum	PFO L-->R SHUNT
Mitral Valve	Normal
Tricuspid Valve	MILD TR , RVSP=33mmHg
Right ventricle	Normal
Left ventricle	Normal
Inter ventricular septum	Intact
Aorta and aortic arch	Left Arch / No COA
Pulmonary artery and branch PA	Normal
Aortic Valve	Normal
Pulmonary valve	Normal
Coronaries	Normal
PDA	NO PDA
Pericardium	Nil
Others	Nil

MEASUREMENTS:

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
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DISCHARGE SUMMARY

Baby Of POOJA

0 Y 0 M 4 D

Female

IP-00060355

VIH-00205932

SURENDER RAO DUSA

7702764478

R26-009624

16-06-2026 08:27 AM

16-06-2026 09:08 AM

16-06-2026 09:09 AM

PARAMETER	ABSOLUTE cm)	Z score	PARAMETER	ABSOLUTE cm)	Z score
AO	0.7		Tricuspid Annulus		
LA	0.9		Mitral Annulus		
IVSd	0.3		Aortic Annulus		
LVIDd	1.4		PA Annulus		
LVPWd	0.2		RPA		
IVSs	0.5		LPA		
LVIDS	0.9		MPA		
LVPWs	0.3		AO Isthmus		
EF	71%		LV Mass		
FS	36%		Others		

Impression

SITUS , SOLITUS , LEVOCARDIA

PPHN

MILD TR / MILD PAH

PFO L-->R SHUNT

GOOD BIVENTRICULAR FUNCTION

LEFT ARCH , NO COA

Baby Of POOJA	7702764478
0 Y 0 M 4 D	R26-009624
Female	16-06-2026 08:27 AM
IP-00060355	16-06-2026 09:08 AM
VIH-00205932	16-06-2026 09:09 AM
SURENDER RAO DUSA	

Dr. MURTAZA KAMAL
MBBS, MD, DNB, DrNB
Reg No: TSMC/FMR/26664

DISCHARGE SUMMARY

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
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Baby Of POOJA | 7702764478
0 Y 0 M 4 D | R26-009647
Female | 16-06-2026 01:06 PM
IP-00060355 | 16-06-2026 04:29 PM
VIH-00205932
SURENDER RAO DUSA

DRAFT

Neurosonogram

FINDINGS:

Both the lateral and third ventricles are normal. No hydrocephalus.

Atrium of right lateral ventricle-7.5mm

Atrium of left lateral ventricle-7.8mm

Fourth ventricle is normal.

Posterior fossa structures are grossly normal.

No e/o intraventricular echoes.

Visualized cerebral parenchyma is normal.

Both thalami are normal.

No evidence of lenticulostriate artery calcification.

Impression

No focal brain lesions.
ACA RI - 0.65

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 040-69513233

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Baby Of POOJA	7702764478
0 Y 0 M 4 D	R26-009668
Female	16-06-2026 08:39 PM
IP-00060355	19-06-2026 04:33 PM
VIH-00205932	
SURENDER RAO DUSA	

DRAFT

X RAY - CHEST PA

Cardiothoracic ratio within normal limits.

Ventricular configuration and aortic arch normal.

Mild haziness in right upper zone.

NG tube, UV line in situ.

Few air distended bowel loops in the abdomen.

Domes of diaphragm are normal.

CP angles are clear.

Bones and soft tissues normal.

No subdiaphramatic pathology.

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
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Baby Of POOJA | 7702764478
0 Y 0 M 5 D | R26-009673
Female | 17-06-2026 04:09 AM
IP-00060355 | 19-06-2026 04:34 PM
VIH-00205932
SURENDER RAO DUSA

DRAFT

X RAY - CHEST PA

Cardiothoracic ratio within normal limits.

Ventricular configuration and aortic arch normal.

Mild haziness in right upper zone.

NG tube, UV line insitu.

Few air distended bowel loops in the abdomen.

Domes of diaphragm are normal.

CP angles are clear.

Bones and soft tissues normal.

No subdiaphramatic pathology.

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

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DEFICIENCY CHECK LIST OF MEDICAL CASE SHEET

Patient Name VIH-00205932 IP-00060355 Baby Of POOJA 12-06-2026 0 Y 0 M 7 D (F) Dr. SURENDER RAO DUSA

IP.No: 60355

Ward:

DOA: 15/6/20

Sl.No	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	1	✓	✓	
2	Discharge Summary	3	✓	✓	
3	Nursing Initial assessment form	2	✓	✓	
4	Patient Trasfer Forms	1	✓	✓	
5	In-patient Medical Record	4	✓	✓	
6	Doctors Progress Sheets	6	✓	✓	
7	Nurses Progress notes				
8	Consultation Sheets				
9	General Consent for Treatment	1	✓	✓	
10	Conset for Surgery				
11	Consent for Blood Transfusion				
12	Consent forChemotherapy				
13	Consent for High Risk formula	1	✓	✓	
14	Consent for Restraint	1	✓	✓	
15	DAMA Consent				
16	Consent for Special Procedure	2	✓	✓	
17	Consent for Radiological Investigations				
18	Consent for HIV Test				
19	Anaesthesia consent form				
20	Anaesthesia notes(Pre Anaesthesia & Post)				
21	Pre Operative checklist				
22	Surgical safety Checklist				
23	Operation Theatre notes				
24	Nurses Clinical Presentation				
25	TPR & BP chart	3	✓	✓	
26	Intake and Output chart (fluid Chart)	2	✓	✓	
27	Drug Chart (Regular prescription)	2	✓	✓	
28	Daily Investigation sheet				
29	Investigation Values (Result Sheet)	1	✓	✓	
30	Nebulization Chart				
31	Diabetic chart				
32	Nutritional Review chart				
33	MLC form (in case of MLC)				
34	Patient Education Form				
35	the Humpty Dumpty scale	2	✓	✓	
36	thrombophlebitis	2	✓	✓	
37	pain Assessment	2	✓		
38	Neonatal weight	1	✓	✓	
39	other	9	✓	✓	
	Total No. of Pages	46 pages			

Signature and Date : [signature] 20/6/26 11 AM

ERROR LOG

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

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Secunderabad

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

ADMISSION SHEET

Registration Details :

Admission No : IP-00060355 **Admit Date** : 15-Jun-2026 **Admit Time** : 06:53 PM **UHID** : VIH-00205932

Patient Details :

Patient Name	: Baby Of POOJA	**Age**	: 0 Y 0 M 3 D
Guardian	: Mr BUSA SRINU	**DOB**	: 12-06-2026 01:00 AM
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: H.NO:1-1/1,BUS STAND,LINGAMPALLY, MANDAL,CHILPOOR ,LINGAMPALLY,JANGOAN, TELANGANA. Malkapur Warangal Telangana INDIA 506145	**Phone No**	: 7702764478/ 9000086361
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type	: NICU	**Bed No**	: NICU 259	**Ward Name**	: N 2F-NICU III
Room No	: NICU 259	**Admission Type**	: First Visit		

Contact Details :

Name	: Mr BUSA SRINU	**Relationship**	: Father
Contact Address	: H.NO:1-1/1,BUS STAND,LINGAMPALLY, MANDAL,CHILPOOR ,LINGAMPALLY,JANGOAN,TELANGANA. Malkapur Warangal Telangana INDIA 506145	**Phone No**	: 7702764478

Signature

Doctor Details :

Doctor Name	: Dr. SURENDER RAO DUSA	**Specialisation**	: GENERAL PEDIATRICS
Referral Doctor	: Anupama C	**Phone No**	: 9701111906
Co-Consultant	:		

Payment Details :

		Deposit Amount	: 20000.00
Payment Mode	: DC/CC Card	**Payor Name**	: MEDI ASSIST INSURANCE TPA PVT LTD

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 5 D (F)
Dr. SURENDER RAO DUSA

NURSING INITIAL ASSESSMENT FOR NICU

Date of Admission: 15/06/26

Source of Admission: ☐ OPD ☐ Ward ☐ Labor Ward ☑ Other: local transport

Reason for Admission: Term / PPHN

Admission Diagnosis: Term / PPHN

Accompanied By: ☑ Parent ☐ Guardian ☐ Other Name: ....

Primary Language: ☑ Telugu ☑ English ☐ Hindi ☐ Other Specify ....

Do you require an interpreter? ☐ Yes ☑ No

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

If yes, identify: Nil

Source of Information: ☐ Family ☐ Others, Specify: Nil

Past Medical History	Past Surgical History	Last Hospital Admission
	Nil	

Significant History	Family History: Nil

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

If yes please list, ...

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

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

Current Medications	Taking Medications? ☐ Yes ☑ No If yes, Fill the reconciliation form Medicine brought to the hospital? ☐ Yes ☑ No

Observations:

Birth Weight: 3.3 kgs Head Circumference: 35 cm Length: 48 cm

☐ Term ☐ Pre-Term ☐ Post-Term

Blood Group: Mother: .... Baby: ....

Feeding: ☐ Breast Feeding ☑ Formula ☐ Both

Maternal Details: Age: .... years, **PARA:** .... **Gestation:** 37 Weeks, ... Days

Risk Factors: ☐ PROM ☐ Fetal Distress ☐ Diabetes Mellitus / Gestational Diabetes

☐ PH / Pre Eclampsia ☑ Others, Specify: ....

Mode of Delivery: ☑ Normal ☐ LSCS - Emergency / Elective ☐ Instrumental ☐ AVD

Indication: Nil

Doc. No. : RCH / FRM / CLINICAL / 096

Newborn Assessment:

Temp: 98.6F HR 164 b/Min RR 66 b/Min BP 55/31(42) SpO²: 98%

Pain Score 0 (Follow N Pass and Document)

Fall Risk Intervention Done: ☐ Yes

Risk of Pressure Sore: ☐ Yes ☑ No (Fill Braden Q Sheet)

General Appearance: ☐ Posture ☐ Well-Fixed ☐ Asymmetry

Behavioural Status on Admission:

☐ Sleeping Crying ☑ Calm ☐ Drowsy

Skin: ☑ Pink ☐ Meconium Stain ☐ Others, Specify

Functional Screening: If a patient needs assistance with any of the following inform consultant

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality ☐ No Abnormalities Detected

Inform Consultant for Positive Criteria

Nutritional Screening:

☐ Underweight ☐ Overweight ☐ Special Feeding Method

☐ Feeding Problem ☐ Special Diet ☐ No Abnormalities Detected

Inform Consultant for Positive Criteria

Social History: Lives With Parents

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

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

Orientation has been given regarding the following aspects:

☑ ID Band in situ

☑ Bedside safety explained

☑ NICU Routine: Doctor's rounds/Medication time

☑ Visiting policy explained

Orientation given to: ☑ Family ☐ Others

Name of Person Orientation was given to: Father

Orientation not given Reason:

DISCHARGE PLAN

Source of Information: ☑ Family ☐ Friend

Will patient require transportation arrangements to go home: ☐ Yes ☑ No

Will Physiotherapy require at home: ☐ Yes ☑ No

Is home medical equipment anticipated: ☐ Yes ☑ No

Is home oxygen therapy anticipated: ☐ Yes ☑ No

Breastfeeding ☑ Yes ☐ No

Formula Feed ☑ Yes ☐ No

Are dressing needs at home anticipated: ☐ Yes ☑ No

Any other needs anticipated: ☐ Yes ☑ No If Yes Specify

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 4 D (F)
Dr. SURENDER RAO DUSA

Discharge Medications: ☐ Yes ☐ No

Details:

Final Diagnosis: Tam/ PPHN

Nurse Signature: Mani's

Nurse Name:

Date & Time: 15/06/26 8pm

Discharge Details: (To be completed by discharging Nurse)

Neonatal Condition at Discharge:

baby condition is a stable

Feeding: ☐ Breastfeeding Exclusively ☑ Breastfeeding and Formula Feeding ☐ Formula Feeding

Vitamin K given: ☑ Yes ☐ No

Vaccinations given ☐ BCG ☐ Hepatitis B ☑ Others: ....

Neonatal Screen Taken: ☐ Yes ☑ No, parents advised to have Neonatal Screen at National screening program center on: ....../....../......

Hearing Test: ☐ Yes ☑ No

Jaundice: ☑ NIL ☐ Slight ☐ Moderate

Passed Urine: ☑ Yes ☐ No

Passed Meconium: ☑ Yes ☐ No

Weight at discharge: 2.940

Appointment was given for follow-up at OPD: ☑ Yes ☐ No

Date of Discharge: 20 / 06 / 26

Discharge to ☑ Home ☐ Other: ....

Against Medical Advice: ☑ Yes ☐ No

Referred to another hospital: ☐ Yes ☑ No

Nurse Signature:

Nurse Name: Raja

Date & Time: 20/6/26 @ 11 AM

PATIENT TRANSFER FORM

Patient Name / I.P. No.	Date & Time of Admission	Date & Time of Transfer Order
IH-00205932 IP-00060355 Baby Of POOJA 2-06-2026 0Y0M6D (F) Dr. SURENDER RAO DUSA	15/6/26 @ 6:53pm	19/6/26 @ 1pm
	Transfer ordered by Dr. Surender Rao	**Reason for Transfer** Stable
From Unit NICU	**To Unit** 215	**Information to attendant** Yes ☑ No ☐
Number of Sheets in clinical file 49	**Number of Imaging films** x-ray - 5 ABG - 8 ICU charts - 3	**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.	Baby wipes	2
2.	Kooches	3
3.	Aptamil Gold	1
4.	D/w 10ml	40
5.	Inj. meropenum 500mg	2

Shifting Summary / notes written by Doctor : Dr. Shriker

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sandhya	Dr. Surender Rao

Patient & Clinical records received by : Padma

Date & Time of Patient Received: 19/6/26 @ 1:20pm

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

☐ Unavailable bed ☐ Nurse not available ☐ Available bed not ready

Docu. No. RCHBH/FRM/CLINICAL/102

Ref No : F / NICU / IPMR / 03

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : POOJA Age : 24. Father's Name : .... Age : ....

Date of Birth : 2/2/2001 Date of Admission : .... I.P. No.: ....

NICU Consultant : .... Referring Consultant : ....

Transferring Unit : ☐ OT ☐ Labour Room ☐ ER ☐ Ward

Transported ? ☐ Yes ☐ No - If yes : ☐ Long (> 30 kms) ☐ Short (< 30 kms)

BIRTH INFORMATION

Name : B/o POOJA

Gender : ☐ M ☑ F Blood Group : ....

Date of Birth : 12/6/26 Time of Birth : ....

Place of Birth : Ramya. Hospital

Mother's Blood Group : A Positive

Birth Weight (gms) : 3.4 kgs Length (cms) : ....

OFC (cms) : ....

Estimated Gesth Age : 37 wks.

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : ✓ .... Ht : .... Wt : .... BMI : .... Married Life : 5yrs LMP : .... EDD : 19/6/2026

Conception : Spontaneous or with Rx. : ....

Booked at what GA. : .... AN Steroids Drugs / Doses : ....

Last Scans Details : ....

.... TT Immunization and Iron / Folic Acid : ....

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs

Consanguinity : ☐ Yes ☐ No

If yes, degree of consanguinity : ☐ 1 ☐ 2 ☐ 3

✓ **H/o PIH (after 20 weeks) / PE**

How many Drugs / Doses / Since how long : ....

....

H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) : .... Ⓝ

....

IUGR - when detected : ....

Doppler (Increased Resistence / ADEF / REDF / Redistrbution in MCA) / Ductus Venosus : .... Ⓝ

AFI : .... Ⓝ

H/o GDM/ pre GDM/ on diet or insulin ⊖

Controlled or not, recent values, HbA1 values : ....

....

Compliance with Rx : ....

Scans : LGA, TIFFA , Fetal Echo : ....

✓ **H/o Hypothyriodism :** when diagnosed ? Medication?

....

Any other Chronic Medical Problems, when detected drugs ? .... Ⓝ

(Anemia, SLE, Jaundice, CHD, Heart Disease)

Infection : H/O, Fever

(☐ Malaria ☐ UTI ☐ TORCH ☐ TB ☐ HIV ☐ HBV)

UTI : when : .... Any culture : ....

PPROM : Duration : .... ☐ Uterine Tenderness ☐ Foul Smelling Liquor ☐ HVS (if taken) - Results : ....

Medication during Pregnancy : .... Duration : ....

PAST OBSTETRIC HISTORY

G : .... P : .... A : .... L : ....

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
	Primi					

PERINATAL HISTORY

Treating Obstetrician : .... Hospital : Ramya .... ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☑ Elective ☒ Emergency Indication : ....

Specify the reason : MSL (F) ....

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL : (F) ....

Resuscitaion : ☐ Yes ☐ No

Cord ABG : ....

Placenta : (weight, surface, No. of cotyledons, calcifications,

malformations, clots etc : ....

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : .... Weeks : ....

SIGN	0	1	2
COLOUR	Blue or Pale	Acrocyanotic	Completely Pink
HEART RATE	Absent	< 100 Minutes	> Minutes
REFLEX IRRITABILITY	No Response	Grimace	Cry or Active Withdrawal
MUSCLE TONE	Limp	Some Flexion	Active Motion
RESPIRATION	Absent	Weak Cry; Hypoventilation	Good, Crying

	1 Minute	5 Minutes	10 Minutes
TOTAL	N/A	N/A	

Resuscitation			
Minutes	1	5	10
Oxygen			
PPV / NCPAP			
ETT			
Chest Compressions			
Epinephrine			

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

HOPI :

Baby said to have CLAB
↓
delivered in Ramya hospital
↓
dev RD soon after birth
↓
connected to CPAP
↓
Referred to Swarsha at ~2 hrs of life

Swarsha : ~~[illegible]~~ - 2 doses. 24 hrs of life.

CPR s/o MAS — CKP - 35
O_2 labilty (+)
↓
Intubated → SIMV + 1 dose of surfactant
↓
10 hrs of life :- O_2 labilty (+), PaO_2 ↓. → 2nd dose of surfactant
↓
Day 20h of life :- HFOV

D2 - Dobuta + Adrenaline i/v/o shock.

↓
Day 2 & Day 3 :- 2D echo → progressively ↑ in PA pressure.
↓
started on milrinone, sildenafil
Adrenaline

Investigation details in previous Hospital :
Received 2FFP i/v/o - coagulopathy
INR - 1.3 & 1.8.
↓
Referred i/v/o - sev. PPHN

Feeding History :

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.5°C HR : 164/m RR : .... NIBP : 55/31 (42) CFT : <3sec

Color of the extremities : pink.

Jaundice : ⊝ Pallor : ⊝ SpO2 : 98% ↓ mv.

Anthropometry : Birth Weight : 3.4 kg Length : .... HC : .... Present Weight : ....

Ponderal Index : .... AGA : ✓ SGA : .... LGA : ....

HEAD TO TOE EXAMINATION

HEAD :
- Fontanelles : (N)
- Sutures (N)
- Shape / Moulding : (-)
- Edema / Bruising : (-)
- Size - (H.C.) :

Facies : (Any Facial Dysmorphism) no dysmorphism

NECK and CLAVICLES :
- Range of Motion : (N)
- Asymmetry :
- Masses : (-)

EYES :
- Symmetry : (N)
- Red Reflex :
- Discharge : (-)

EARS, NOSE MOUTH and THROAT :
- Ear set / Shape : (N)
- Periauricular Pits / Tags : (-)
- Nasal shape / Patency : (+)
- Palate : no cleft
- Gums :
- Lips : } (N)
- Tongue :

THORAX and BREASTS :
- Shape of Thorax : (N)
- Position of Nipples and Number : 2 in no, normal posit

ABDOMEN and UMBILICUS :
- Shape : (N)
- Organomegaly : (-)
- Bowel Sounds : (+)
- Umbilical Stump : [illegible]
- Discharge : (-)

GENITILIA :
- Labia / Hymen : (N)
- ~~Testicles/penis :~~
- Anus : patent

HERNIAL ORIFICES free

TRUNK and SPINE : (N)

SKIN LESIONS : (-)

EXTREMETIES :
- Fingers / Toes :
- Arms / Legs :
- Deformities : } (N)
- Mobility :
- Hip Joint Examination :

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : ☑ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress : RR : [illegible] SCR / ICR / See - Saw breating :

Scoring of respiratory distress if present (Silverman or Downe's) :

Mention if baby is on : ☐ Hood box ☐ CPAP ☐ Ventilator

Settings :

Spo2 : 98% I/Aw Auscultation : BAE ⊕ Breath Sounds : NVBS ⊕ Added Sounds :

Cardiovascular System :

HR : 164/m BP : 55/34

Precordial Activity : Ⓝ

Femoral Pulses : felt

Murmurs : ⊖

Other Peripheral Pulses : felt

Signs of Cardiac Failure : ⊖

Abdomen :

Hernia orifice : free

Shape : Ⓝ

Anal Patency : ⊕

Palpation : soft

Umbilical Cord : [illegible]

Palpable masses : ⊖

First urine passed : Yes

Abdominal girth : Ⓝ

Meconium passed : Yes

Nervous System : Higher intellectual functions (Sensorium) : on sedation Midazolam. | Intermittently active

State of wakefulness : ē good tone

Prechtle Score :

Nerves :

Motor System :

Passive Tone : ↓ sedation.

Active Tone : ↓ sedation.

Neonatal Reflexes :

Grasp : ☐ Palmar ☐ Plantar ☐ Sucking ☐ Rooting ☐ Crossed adductor :

Moro's : not checked. DTR :

ATNR : Skull and Spine :

Any Congenital Anomalies : none.

Diagnosis : Single | Term 37 wks | female | 3.4 kgs | AGA | Emes CS | MAS | PPHN | MV - HFO
↳ 2° surfactant

FOOT PRINTS

Left Side :

Right Side :

Resident Doctor :

Signature : [signature]

Name : Barasha.

Date & Time : 15/6/26 7pm

Consultant :

Signature : [signature]

Name : Dr. Surendra Rao

Date & Time : 15/6/26 7pm

PLEASE FILL UP THE FOLLOWING DETAILS

1. Name of the referring Doctor :
2. Name of te referring Hospital :
   Address :
   Contact Numbers :
3. Contact Details of the referring Doctor :
   Mobile No. : .... E-mail ID :
4. Name of the Doctor in Rainbow Team :
   .... on whose name the patient is being referred.

AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis : ....

....

....

Present Issues : ....

....

....

Vital : ☐ HR : .... ☐ RR : .... ☐ BP : .... ☐ SPO2 : .... Weight : ....

Any Oxygen requirement : ....

Systemic : ....

....

Medications : ....

① TV @ 120 ml/kg/day - 10% 150-P.

② Inj ~~[illegible]~~ Mero, Amikacin

③ B/c/s, ~~[illegible]~~, CXR, NPI, ABG, ~~[illegible]~~
↳ OD. ↳ TID.

④ 2D echo (t/m).

⑤ PT, APTT, INR (t/m).

Noted by
Dr. [illegible]
15/6/26
7pm

Plan during ward follow up :

....

....

....

....

....

....

Feeding Plan at the time of shifting : ....

....

....

Screenings done during NICU Stay :

NSG : ....

Hearing Screen : ....

ROP : ....

TFT : ....

NP2 : ....

VIH-00205932 IP-00060355
Baby Of POOJA
12-05-2026 0 Y 0 M 3 D (F)
Dr. SURENDER RAO DUSA

...OGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/26 11pm	Baby seen Sedated well. PV-good, CRT<3sec BP - Maintained ABG done. Milrinone, Sildenafil, Dobutamine Mero, Amikacin.	Adv Taper ventilator settings PSIMV FiO2 - 70→50. PIP - 16 Peep - 6. Rate - 40. D. Vishal Noted by Maria 15/6/26 11pm
16/6/26 12Am	Sr Ca - 6.9 Asymptomatic. 8 ml/kg of inj Calcium gluconate Repeat Sr Ca 4/m.	Noted by Maria 16/6/26 12Am

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 3 D (F)
Dr. SURENDER RAO DUSA

..OGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/6/26 8 Am	Day 4 / Term / AGA / Baby girl / 3.4 Kg / MAS – MV – HFOV / RD – 2x surfactant / severe PPHN – Sildanefil, Dobutamine / gram negative culture positive sepsis / DIC – 1xFFP / Hypocalcemia.	
	Issues :- PPHN – mild, High Elevated, 2D Echo done., Polyuria.	
	T – wt	Normothermic.
	I/O – 220/305	PSIMV – FiO2 – 40
	U/O – 6.9 ml/Kg/hr.	PIP – 16/6.
	S/O – 1 time.	Rate – 35.
	GRBS – 94 mg/dl.	CVS – S1S2 (+), Hyperdynamic Precordium
		C/T/A – Sedated
	Plan :-	RS – BAE (+).
	Target SpO2 · 90–96%.	P/A – soft.
	Target MAP > 39.	
	IV – [illegible] ml/Kg/day – 10% D50 P + MVI + 5 ml/Kg Ca++	120 ml/kg –
	NPO, A/f Start feeds.	
	NSG today, 2D Echo done.	
	Trace Blood C/S.	
	Sildanefil, Dobutamine – Ionotropes.	
	Fentanyl.	
	Inj Meropenem, Inj Amikacin (D2).	
	CXR OD, ABG TID, GRBS 6th hrly.	
	Taper Ventilator settings.	After extubation
D. Vishal	Monitor vitals, I/O charting	O4 → 5 ml Q3H
	Sildanefil → stop	↑3 ml all feeds,
	Stop fentanyl	

Plan to extubate SPE – No more sample,

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 3 D (F)
Dr. SURENDER RAO DUSA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/6/26 8 Am	Arterial line	
	- 24 G Intracath is used.	
	- (L) Lower limb posterior tibial artery is felt.	
	- area cleaned. ē swab.	
	- Intracath Inserted & checked for Backflow.	
	- Push given f/b. backflow.	
	- Fixed with - Tegaderm.	
		Dr. Vishal.
	Noted By Br. Abey 16/6/26.	Dr. Surendar Rao Dusa 16/6/26. 10:30 AM

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 4 D (F)
Dr. SURENDER RAO DUSA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/6/26 5PM	Extubation note	
	-> Baby Extubated and kept on RA	
	-> As baby was not maintaining saturations connected to LFO2 @ 0.5L	
	O/E	
	GC - Stable	
	T - Euthermic	
	HR - 156/min	ADV
	RR - 54/min	- CST
	TV - Good	- W/F distress, Desaturation
	CRT - <3sec	- ABG - 6PM
	BP - 69/49 (50)	- Cx ray @ 10PM
		- plan to start feeds after x ray & 5ml x 3hrly (↑ 3ml alt feeds)
		- NP, - T/m
9:30PM	Baby is having tachypnea c̄ mild retractions - ↓ saturations - borderline - 90-91% - inspiratory stridor (+) Expiratory wheeze (+)	
		- Start CPAP - 5 21-30%
		- Budecort Nebs.

Noted by Mario

476
344

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Baby Of POOJA
12-06-2026 0 Y 0 M 5 D (F)
Dr. SURENDER RAO DUSA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/6/26 9AM	D5 / term / AGA / Girl / 3.4kg / MAS - MV - NPOV / RD - 2x surfactant / severe PPHN / Gram negative culture positive sepsis / DIC - 1xPRP / hypocalcemia	
	T. wt -	O/E - Normothermic
	I/O - 470/377ml	On LFO$_2$
	U/O - 4.6 cc/kg/hr	Removed CPAP at 7AM
	S/O - 3 times	CFT/A - Good
	GRBS - 88 mg/dl	CVS - S1S2 (+)
		R/S - NAE (+)
		P/A - soft
	Plan	
	- Target SPO$_2$ 90-96%	
	- Target MAP >39	
	- ABG - OD, GRBS OD	
	- TF - 140 ml/kg/day - 10% 150 P after 3pm	
	- OG feeds - 5ml Q3H (↑5ml each feed) (TF - 60ml Q6H)	
	- Trace blood c/s	
	- inj Meropenem - D3, inj Amikacin - D3	
	- inj [illegible] - given (yesterday & morning)	
	- I/O charting, vitals monitoring	
	- Remove UVC - plan - today.	
	- Nebs - adren, budecort	
	- SBR, TFT - T/M	

Noted By Dr. Asy 17/6/26

Dr. [signature] 17/6/26 10:15AM
Reg. No. 47776

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 5 D (F)
Dr. SURENDER RAO DUSA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/6/26	Lumbar puncture notes	
	=> Informed & written consent taken	
	- Pre RBS - 113 mg/dl	
	- Knee chest position given to pt c̄ SPO2 monitor attached.	
	- Area exposed & located b/w L4-L5, 26	
	- Sterilization done	
	- CSF taken.	
	- Needle removed	
	- Pressing ~~done~~ c̄ - Fin	
	- Uneventful.	
		Noted by Aseef 17/6/26
17/6/26		
STN	→ Baby seen	
	→ CRT - < 3sec	
	- CTA - Good	
	- CRPR - Good	
	- SPO2 - 96 % on low flow	
		Adv
		- CSF
		- Trace CSF analysis
		- Trace CSF C/S
		- SBR, TFT T/M
Dr. (Chandra)		- Feed - 15ml (↑ 5ml each feed)
		Noted by Aseef 17/6/26

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 5 D (F)
Dr. SURENDER RAO DUSA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/6/26 8AM	Day 6 / Term / AGA / girl / 3.4 kgs / MAS - MV - HFOV / RDx 2 surfactant / sev. PPHN / gram negative culture positive sepsis / DIC - 1xFFP / asymp hypoCa.	
	Issues -	
	Intermittent tachypnea (+).	
	Wt - 3.10 (+60g)	Normothermic
	TFI - 470/290	LFO₂ → RA
	UO - 3.5	CCO CRO₂
	SO - 3	C/T/A good CRT < 3 sec
	GRBS - 90 mg/dL	Chest - BAE (+), CVS - T/A/R AGA
		CNS - S1S2 (+)
		P/A - soft, BS (+).
Adv -	Target SpO₂ 90-96%, MAP > 39.	
	ABG, CXR - now	
	IV @ 150 ml/kg/day - 10% 180-P	after 3PM.
	OG feeds - 43 ml q3H 1 5ml each feed	(T/F - 40 ml q3H) (hold) → 42 ml q24
B/C/S. 48hrs no growth	Try oral feeds.	
	Inj meropenem - D4/7 amikacin D4/7	
	Stop budecort neb.	
	Trace SBR, TFT.	Dr. Surender 18/6/26. 10.50 AM.
	CBP, CRP, S/E (T/m).	Noted by [signature] 18/6/26

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

(P.T.O)

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 4 D (F)
Dr. SURENDER RAO DUSA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/6/26 4pm	Baby sm.	
	taking & tolerating feeds well	
	Passing urine & stool.	
	Child Active.	
	Neb c Budecort :- stop	
	CSF analysis (N) TC - (4)	
	CSF glu - 71.	} partially treated Bact meningitis.
	PROTIEN = 116.	
		Adv
		- trace CSF · culture
		- CBP, CRP, Sr E t/m.
		Noted by [signature] 18/6/26

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 4 D (F)
Dr. SURENDER RAO DUSA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/6/26 8AM	Day 7 / Term / AGA / Fem / 3.4 kg / MAN - MV - HFOV / RP - 2x surfactant / Sev. PPHN / Gram-ve Ceftriaxone positive Sepsis / DIC - 1x FFP / Asymp. Hypocalcemia / Probably Rx meningitis.	
	Issues: - on low flow O2 - restarted d/t Desat.	
	TWT = 3.03 (↓70g)	Normothermic
	I/O = 412/245	On LFO2 - 0.1L
	U/O = 3.3cc/kg/day	GA - good CRT<3 sec
	S/O = 7 times	Chest - BAE ⊕ /
	GRBS.	CVS - T/A / R AGA
		CVS - S1S2 ⊕
		P/A - soft BS ⊕
	Adv: Target SpO2 90-96%. MAP > 39	
	ABG + CRP - SOS	
	TV - 150cc/kg/day - ~~100 ...~~	
	Oral Demand feeds.	
	Inj. Meropenem D5/7.	~~Total (5) days~~ Stop after 5 days.
	Inj. Amikacin - D5/7	
	- I/O charting, vitals monitoring	
& Dr Shekar	- Oral demand feeds (+1/4 - 63 ml x 2 hrly)	
	- W/F desaturation	
	- Shift to room with LFO2 - 0.1 L/min	
		Dr. Surender 19/6/26 10:40 AM
	Noted by [signature] 19/6/26	

IH-00205932 IP-00060355
Baby Of POOJA
2-06-2026 0 Y 0 M 6 D (F)
Dr. SURENDER RAO DUSA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10:40 AM	Shifting notes	
	B/o Pooja, fch, 37wk / Bwt 3.4 kg AGA delivered by Em LSCS i/v/o MSL at outside hospital, developed severe RDS after birth, initially managed outside and Referred to NICU for further management	
	NICU course was significant for MAS c PPHN and requiring intubation and SIMV/PSIMV; Baby Recieved 2 doses of surfactant.	
	2D Echo - progressive elevated pulmonary artery pressure managed with sildenafil and ionotropic support. (Dobutamine)	
	Blood culture was +ve outside for Gm -ve sepsis and started on IV Meropenem, Amikacin.	
	Associated Coagulopathy/DIC managed with FFP transfusion. Baby also had asymptomatic hypocalcemia; corrected c IV Ca Gluconate; CSF findings s/o partially Rx meningitis	
	Gradually Respiratory status improved - extubated - CPAP/LFO2. Feeds were gradually escalated and baby is currently on oral Demand feeds, tolerating well.	

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

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 7 D (F)
Dr. SURENDER RAO DUSA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	plan	
	- Low flow O_2 - 0.1L	
	- continous monitoring.	
	- continue IV Meropenem, Amikacin total 5 days.	
	- w/f Desaturation episode.	
	- trace CSF culture & other pending Reports	
Dr [illegible]		Noted by Sr. [illegible] 19/6/26

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 7 D (F)
Dr. SURENDER RAO DUSA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/26 10 AM	CS/B Resident	
	Dg / Term / AGA / FCH / 3.4 kg / MAS - MV-HFOV/RD - 2x surfactant / Sec PPHN / Gram -ve culture positive sepsis / DR-1 HFF / Asymp. Hypocalcemia /	
	Issues - on low flow O2	
	T. Wt - 2.940 kg (↓ 90 gm)	
		Plan
	O/E - Normothermic	- Stop meropenem after 11 am dose
	CFT / A good	
	CRT < 3 sec	
	CVS - S1S2 (N)	- [illegible]
	RS - B/L AE (+)	
	PA - soft	- Oral demand feeds 60 ml Q3H
	wf [illegible]	
		- W/ [illegible]
		- Vaccination at follow up
		- Discharge Flup on Monday
Noted by Akanksha 20/6/26 @ 11 AM		Dr. Surender Rao 20/6/26 10:30 AM [signature]

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: RD. (Respiratory Distress)			Any Infection: ☐ Yes ☑ No ☐ Not Known If Yes Specify: ...Nil...			
	Surgery / Procedure: –			Post OP Day: –			
BACKGROUND	Date / Shift	19/6/26 E	19/6/26 N	20/6/26 M			
	Medical Condition (Any special condition to be noted):	Nill	Nil	Nil			
	Diet:	EBM	EBM	DBM			
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	NP	NP(0.1)				
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.0F	98.2F	98.0F			
	Res:	39b/m	38b/m	39b/m			
	SpO_2:	99%	98%	99%			
	Pulse:	148b/m	140b/m	140b/m			
	BP:	–	–	–			
	LOC:	conscious	conscious	conscious			
	Fall Risk Score:	16	16	16			
	Pain Score:	0	0	0			
	Skin Integrity	Intact	Intact	Intact			
Recommendations	Safety Needs:	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	Nill	Nil	Nil			
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	EBM	EBM	DBM			
	Critical Lab Test / Values:	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			
Post Operative Procedure Special Orders:			Nil	–			
Handed Over By Name :		Padma	Nagmani	Roja			
Signature / ID :		606329	[illegible]	[illegible]			
Date:		19/6/26	20/6/26	20/6/26			
Time:		@8pm	@8am	@4pm			
Taken Over By Name :		Nagmani	Roja / Akhila				
Signature / ID :		[illegible]	606607				
Date:		19/6/26	20/6/26				
Time:		@8pm	@8am				

Discharge note
Send for billing
process

Note by
Roja
20/6/26 4pm

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

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 7 D (F)
Dr. SURENDER RAO DUSA

NURSING SHIFT HAND OVER FORM

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

Section	Item						
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:						

VIH-00205932
Baby Of POOJA
12-06-2026 0 Y 0 M 4 D
Dr. SURENDER RAO DUSA
IP-00060355
(F)

Patient S

NURSING CARE RECORD

Date: ....

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am	Assessment	=>	Assessed the Baby condition	=> 2D ECHO Done	I/O chart maintained 6th hrly	
	12PM	vitals	=>	vitals are checked & recorded	=> ABG, RBS T/D Done	Baby Passed urine	Asif 16/6/26. @ 2PM
	2PM	Feeds	=>	NPO	=> cont Abx	& Motion	
Afternoon	3PM	Assessment	=>	Assessed the Baby condition	=> NSG Done	=> I/O chart maintained 6th hrly	
	6PM	vitals	=>	vitals are checked & recorded	=> ABG, RBS Done	=> Baby passed urine	Asif 16/6/26 @ 8PM.
	8PM	Feeds	=>	plan to start feeds after xray	=> cont Antibiotics	& Motion	
Night	8pm	assessment	8pm	assessed baby condition	baby is stable	watach for desaturation	13/6/26 8AM
	10pm	vital signs	10pm	monitored & Recorded			
	7AM	I/O charting	7AM	I/O charting 6th hourly			

Docu. No: RCH /FRM / CLINICAL / 148

VIH-00205932 IP-00060355
Baby Of POOJA
12-05-2026 0 Y 0 M 3 D (F)
Dr. SURENDER RAO DUSA

NURSING CARE RECORD

Date: ....

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	8pm 10pm 7AM	assessment vital signs IO charting	8pm 10pm 7AM	assessed baby condition monitored & recorded I/O charting 6th hourly	baby is stable	watch for desaturation	[signature] 16/5/26 8pm

Docu. No: RCH /FRM / CLINICAL / 148

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 5 D (F)
Dr. SURENDER RAO DUSA

NURSING CARE RECORD

Date: 17/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	9Am	Assessment	=>	Assessed the Baby Condition	Cont CPAP	I/o chart maintained	
	12Pm	vitals	=>	vitals are checked & recorded	Cont Antibiotics	6th hrly	[signature] 17/6/26 @ 2 PM
	2pm	Feeds	=>	OG Feeds 3rd hrly	cont Nebs	Baby Passed urine &	
Afternoon	3Pm	Assessment	=>	Assessed the Baby condition	Cont L/F	I/o chart maintained 6th hrly	
	6Pm	Vitals	=>	vitals are checked & recorded	cont Antibiotics	LP Done	[signature] 17/6/26 @ 8 PM.
	8pm	Feeds	=>	OG Feeds 3rd hrly T/F 60 ml	cont Nebs	Baby Passed urine &	
Night	8pm	assessment	8pm	assessed baby Condition	baby is stable	watch for desaturation	Mavis 18/6/26 8am
	10pm	vital signs	10pm	monitored & Recorded			
	7AM	Feeds	7AM	on Feeds continue			

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 5 D (F)
Dr. SURENDER RAO DUSA

NURSING CARE RECORD

Date: 18/6/26

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am 10Am	Assessment feeds	8Am 10Am	Assessed baby condition OG feeds 60ml 3rd hrly	→ Baby on Low flow	→ Vitals are normal → Baby is active	Sandy 18/6/26 2pm
Afternoon	3pm 7pm	Vitals I/O chart	3pm 7pm	monitored vitals every hourly maintained I/O chart	→ Tolerating feeds → Baby is stable	→ I/O chart maintained 6th hourly	Sandy 18/6/26 8pm
Night	8 pm | 8 am	Assessment vital signs feeds.	8 pm | 8 am	Assessed the baby condition monitored vital signs. given feeds 3rd hrly	baby is active	monitored Intake output chart.	Sherly 18/6/26 @8pm

Docu. No: RCH /FRM / CLINICAL / 148

H-00205932 IP-00060355
Baby Of POOJA
2-06-2026 0Y0M6D (F)
Dr. SURENDER RAO DUS

NURSING CARE RECORD

Date: 19/6/26.

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am 10Am 1Pm	Assessment Feeds Vitals	8Am 10Am 1pm	Assessed baby condition oral demand feeds monitored vitals	→ Baby is stable → Tolerating feeds	→ I/O chart maintained 6th hourly	Pandy 19/6/26 8pm
Afternoon	4pm	* maintain fluid Balance.	4pm	* Maintained the fluid Balanced. Nutritional status	* Prevent to the dehydration	* Re-Assesment every 2nd hourly Feeding.	Padma 19/6/26 @8pm
Night	9pm 11pm	Ensure Safety feeding	9Pm 11pm	Baby kept in crib. feeding given every second hourly.	Prevent from falls PO maintained nutritional Status	Patient is stable	20/6/26 Nag 9Am

Docu. No: RCH /FRM / CLINICAL / 148

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 7 D (F)
Dr. SURENDER RAO DUSA

NURSING CARE RECORD

Date: 20/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	1/1 8A	to maintain Good nutritional status	1/1 8A	Discharge Notes → Dr. come for rounds baby stable Dr. advice send. All billing progress			Regi Dr 20/6/26 @11:4
Afternoon							
Night							

Rainbow Children's Hospital - Secunderabad

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby Of POOJA**	**Age :**	**0 Y 0 M 3 D**
IP No:	**IP-00060355**	**Sex:**	**Female**
Consultant:	**Dr. SURENDER RAO DUSA**	**Ward/Bed No:**	**N 2F-NICU III/NICU 259**

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 also 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 e 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 clearance. In case of failing the submission, I will pay 200/- Rs.
ceivers 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: B. Srinu.
Relationship: Father
Date: 15/6/2026 Time: 6:53 pm.
Wittness Name:
Wittness Signature: [signature]

Patient Address:
H.NO:1-1/1,BUS STAND,LINGAMPALLY, MANDAL,CHILPOOR ,LINGAMPALLY, JANGOAN,TELANGANA. Malkapur Warangal Telangana INDIA 506145

CONSENT FOR SPECIAL PROCEDURES

Patient Name : B/o Pooja .... Gender: ☐ Male ~~☐ Female~~

UHID No : 205932 .... Department : NICU .... Date : 15/6/26

I BUSA - SRINU .... S / D / W / O komuRiave ....

Here by give consent for procedure of : Arterial Line ....

For my patient, Named : ....

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

....

....

....

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

....

....

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

Name of the Doctor performing the procedure: Dr. Kundana priya ....

Patient Attendant :

Signature : B. Srinu

Name : BUSA - SRINU

Relationship with Patient: Father

Date & Time : 15/6/26 9pm

Witness :

Signature : Marie

Name : ....

Date & Time : 15/6/26 9pm

Doctor (who is taking the consent) :

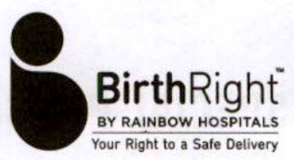
Signature : [signature]

Name : 15/06/26 D. Vishal

Date & Time : 15/6/26. 9pm

Docu. No. : RCH/FRM/CLINICAL/019

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు .... లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి .... విభాగం .... తేదీ ....

నేను .... S/D/W/O ....

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా ....

నా రోగికి, పేరు : ....

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

....

....

....

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు : ....

సహాయకుడు(అటెండెంట్)

సంతకము ....

పేరు ....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము ....

పేరు ....

సాక్షి

సంతకము ....

పేరు ....

తేదీ మరియు సమయము ....

Docu. No. : RCH/FRM/CLINICAL/019

CONSENT FOR SPECIAL PROCEDURES

Patient Name : B/o pooja Gender: ☐ Male ☑ Female

UHID No : 205932 Department : NICU Date : 17/6/26

I Srinu S/D/W/O Komaraih.

Here by give consent for procedure of : Lumbar puncture

For my patient, Named : B/o Pooja.

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

....

....

....

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

....

....

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

Name of the Doctor performing the procedure: Dr. Harish.

Patient Attendant :

Signature : B- Siy

Name : BUSA. Srinu

Relationship with Patient: Father

Date & Time : 17/6/26 2.30pm

Witness :

Signature : Asect

Name : Ben. Asect

Date & Time : 17/6/26 2.30 pm

Doctor (who is taking the consent) :

Signature : Marys

Name : Dr. Harish

Date & Time : 17/6/26. 2.30pm

ప్రత్యేక విధానాలకు సమ్మతి

రోగి పేరు .... లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి .... విభాగం .... తేదీ ....

నేను .... S/D/W/O ....

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా ....

నా రోగికి, పేరు : ....

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

....

....

....

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు : ....

సహాయకుడు(అటెండెంట్)

సంతకము ....

పేరు ....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము ....

పేరు ....

సాక్షి

సంతకము ....

పేరు ....

తేదీ మరియు సమయము ....

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 3 D (F)
Dr. SURENDER RAO DUSA

ANTIBIOTIC JUSTIFICATION FORM

Date of Admission: ....

Antibiotic Name	Date & Time	Reason	48 Hours Culture	Antibiotic Reviewed at 72 Hours (If No Please Justify)
INJ MEROPENEM	15/6/26	POSITIVE SEPTIC SCREEN.	–	–

A. Reasons for Starting Empirical Antibiotics:

1. Preterm's with risk factors:
   a. PPROM
   b. Positive Maternal Culture (HVS/Urine C/S
   c. Maternal Pyrexia / Chorioamnionitis
2. Term Babies
   a. PROM > 18 hours
   b. Sepsis Screen Positive at 12 hours
      i. High TLC/ High CRP / High PCT / Thrombocytopenia / Leukopenia
      ii. Shift to left / Bank forms / Neutrophilia on PS
3. Out born with suspected sepsis
4. Culture negative Sepsis
5. Clinical Sepsis
   a. Frequent Apnoea's attributed to suspected sepsis
   b. Hemodynamic instability
   c. Temperature instability
   d. Suspected NEC
   e. Lethargy
6. VAP
7. Congenital Pneumonia
8. Meningitis
9. Aspiration Pneumonia
10. Any sick newborn

B. Prophylactic Antifungals

B1 – Extreme PT (<28 Weeks) or ELBW (<1000 grams)
B2 – Central line in situ (PICC / UVC) in < 28 weeks & or < 1kg.
B3 – Septic Shock

C. Culture Positive Sepsis

Consultant Name & Signature : D. Vishal [signature]
Date & Time : 15/6/26. 7pm

Name & Signature of Infection Control Nurse : Swapna [signature]
Date & Time : 15/06/26 @ 07:30pm

Docu.No. : RCH /FRM / CLINICAL / 076

CONSENT FOR ADMISSION IN NEONATAL INTENSIVE CARE UNIT (NICU)

I ....BUSA. SRINU........ S/o Mr./ Ms ....komuraih........ hereby declare that our patient Mr. / Ms B/o Pooja........ who is related to me as .... is getting admitted in the Neonatal Intensive Care Unit (NICU) of Rainbow Children's Hospital on 15/6/26........ with UHID No. : ....205932........

The doctors have explained to me in a language understood by me that my child has following health related issues : ....

....

....

The doctors have clearly explained to me that my patient Mr./ Ms. B/o pooja........ during his / her stay in the NICU may undergo various medical and surgical procedures like airway management, mechanical ventilation, UAC, UVC (Umblical Vein and Arterial Lines) PICC Line and arterial line placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is implied that I give consent for various invasive procedure to save the life of my child.

I understand that a sick child in NICU has life threatening medical conditions.

I understand that when a child is sick in the NICU with multiple medical and surgical procedures performed upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of infections, bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child Mr. / Ms :..B/o pooja........ .... in the NICU fully understanding the associated risks involved from various procedures, high risk medications and infections in the NICU and treat him/her with all necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant :

Signature : ....[signature]....

Name : ....Busa. Srinu....

Relationship with Patient: ....Father....

Date & Time : 15/6/26 ....at.... 9pm....

Witness :

Signature : ....Navis....

Name : ....A....

Date & Time : ....15/6/26 .... 9pm....

Doctor (who is taking the consent) :

Signature : ....[signature]....

Name : ....D. Vishal.....

Date & Time : ....15/6/26 9pm....

Ref. No. : F / NICU / CON / ADM / 16

నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్ (ఎన్. ఐ. సి. యు) సమ్మతి పత్రం

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

యు.హెచ్. ఐ.డి ....

నేను .... చి ....

.... అనే బాలుడు / బాలిక యెక్క చికిత్స మేరకు రేయిన్బో చిల్డ్రన్ హాస్పిటల్ లోని నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్‌లో తేది .... నాడు పూర్తి సమ్మతితో చేర్పితిని. మా బాలుడి/బాలికలో ఈ క్రింద తెలిపిన ఆరోగ్య సమస్యల గురించి వైద్య నిపు ణుడు నాకు అర్థమగు భాషలో వివరించితిరి.

నవజాత శిశువుల ఇంటెన్సివ్‌కేర్ యూనిట్ లో మా పాప /బాబుకు వైద్య పరంగా అవసరమగు అన్ని రకాల చికిత్స విధానాలకు మరియు ప్రక్రియలను (ఉదా కృత్రిమ శ్వాస వెంటిలేటర్, ఆర్జీలియర్ లైన్, సింట్రల్ లైన్ క్రెస్ట్ డ్రైయిన్, పెరిటోనియల్ డ్రైయిన్ ఇంనర్శన్ వంటి ప్రక్రియలను డాక్టరు గారు నాకు ఆర్థమగు భాషలో(సవివరంగా) వివరించారు.

పైన తెలుపబడిన శస్త్ర ప్రక్రియలు చేసేముందు సమ్మతి తీసుకునే వీలు లేనిచో మా బాలుడ / బాలికను కాపాడుటకు అవసరమైన వైద్య శస్త్ర ప్రక్రియలు మా సమ్మతి లేకుండానే చేయవచ్చని నేను సమ్మతిస్తున్నాను.

ఆరోగ్య సమస్యలతో బాధపడుతున్న మా బాలుడికి/బాలికకు రుగ్మతలచే ప్రాణహాని కలుగవచ్చిన నాకు వైద్యుడు అర్థమగు భాషలో వివరించితిరి.

మా బాలుడు / బాలిక ఎన్.ఐ.సి. యు లో ఉన్నప్పడు ఎన్నో విధాల వైద్య మరియు శస్త్ర ప్రక్రియలు ఇంకా వివిధ చికిత్స విధానాలు అవసరం పడతాయని మరియు వాటివల్ల దుష్పరిణామాలు కలగవచ్చని అర్థం చేసుకున్నాను. ఆ పరిణామాలు ఎటువంటివి అనగా రక్తస్రావ ప్రమాదం కణజాలం దెబ్బతినడం మొదలగునవి.

మా బాలుడిని/బాలికను అడ్మిట్ చేయుటకు మరియు ఎన్. ఐ. సి.యు. లో ఉన్నప్పడు జరుగు చికిత్స విధానాలు మరియు శస్త్ర ప్రక్రియలు వలన కలిగే అపాయాలను నేను అంగీకరిస్తున్నాను. మా పేషంట్ ను తగినన విధంగా చికిత్స చేయడానికి వైద్యునికి నా పూర్తి అంగీకారం తెలియజేస్తున్నాను. వైద్యుడు నాకు అర్థమగు భాషలో అంతా వివరించారు.

మా బాలుడు / బాలిక .... ను ఇంటెన్సివ్ కేర్ యూనిట్ (ఎన్.ఐ.సి.యు) లో చేర్చుకొని అవసరమయ్యే వైద్యం చేయుటకు నేను వైద్య బృందానికి నా సమ్మతి ధృవపరుస్తున్నాను.

సహాయకుడు (అటెండెంట్)

సంతకము ....

పేరు ....

తేది మరియు సమయము ....

సాక్షి

సంతకము ....

పేరు ....

తేది మరియు సమయము ....

డాక్టర్

సంతకము ....

పేరు ....

తేది మరియు సమయము ....

APTAMIL GOLD

CONSENT FOR FORMULA FEEDS

Patient Name : B/o Pooja Age : 5 Days Gender : ☐ Male ☑ Female

UHID No : 205932 Reg. No. : 60355 Department : NICU - III Date : 17/6/26

I Mr / Mrs. : BUSA. SRINU aged 30 years, hereby declare that I have admitted my ☐ son / ☑ daughter in the Neonatal Intensive Care Unit of Rainbow Children's Hospital, Hyderabad on .... I hereby give consent for formula feed for my child. Doctors have explained me about the formula feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature : B. Sri

Name : BUSA. SRINU

Relationship with Patient: Father

Date & Time : 17/6/26 @ 11AM

Witness :

Signature : [signature]

Name : Dr. Asif

Date & Time : 17/6/26 @ 11AM

Doctor (who is taking the consent) :

Signature : [signature]

Name : Dr. Harish

Date & Time : 17/6/26 @ 11Am

డబ్బా పాలు పట్టించుటకు సమ్మతి పత్రం

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

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

తేదీ ....

నేను శ్రీ / శ్రీమతి .... వయస్సు .... సంవత్సరాలు

నా కుమార్తె / కుమారుడు రెయిన్బో ఆసుపత్రిలో నవజాత శిశువుల ఇంటెన్సివ్ కేర్ లో అడ్మిట్ చేసినాము మరియు (ఫార్ములా ఫీడ్) డబ్బా పాలు పట్టించుటకు నా పూర్తి అంగీకారం తెలుపుచున్నాను. డాక్టర్లు డబ్బా పాలు త్రాగించడం వల్ల కలుగు ఉపయోగాలు, ప్రత్యామ్నాయాలు, మరియు నష్టాలు గురించి నాకు అర్థమైన భాషలో వివరించారు.

సహాయకుడు(అటెండెంట్)

సంతకము ....

పేరు ....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము ....

పేరు ....

సాక్షి

సంతకము ....

పేరు ....

తేదీ మరియు సమయము ....

Doc. No. : RCH / FRM / CLINICAL / 016

CONSENT FORM FOR RESTRAINT

Patient Name : B/o Pooja UHID No : 205932

Gender: ☐ Male ☑ Female Age : 3 Days Date of Restraint : 15/06/26 Time of Restraint : 10pm

Type of Restraint:

Physical : —

Chemical : Inj: Fentanyl

Duration of Restraint :

Any likely complications: ☐ Hypotension ☐ Bradycardia ☐ Injury to skin

Any alternatives: ☐ Yes ☐ No if 'Yes' Specify: —

I have been explained the risk, benefits and alternatives of the same in the language that I know.

Patient Attendant :

Signature : BUSA. SRINU

Name : BUSA. SRINU

Relationship with Patient: Father

Date & Time : 15/6/26 10pm

Witness :

Signature : Mavis

Name : k

Address : Lingampally, telangana

Contact No: 7702764478

Date & Time: 15/6/26 10pm

Doctor (who is taking the consent) :

Signature :

Name : D. Vishal

Date & Time : 15/6/26. 9pm

Ref. No. : F / ICU / INO / VAS / 08.b

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It takes a lot to treat the little.

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IV INFUSION MEDICATION CHART (INOTROPES & VASOPRESSORS)

(All the drugs in this category belong to "High Risk / High Alert" medicines. Please watch for tachycardia / bradycardia, hypertension / hypotension any cardiac arrhythmia, patency of IV line, status of skin at IV site and color and perfusion of the fingers and toes while administering these drugs)

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 3 D (F)
Dr. SURENDER RAO DUSA

Patient Name : .... Age : .... Gender : ☐ M ☐ F

Weight .... IP No. : .... Sheet No. : ....

Date	Time	Name of Drugs	Composition	Dose Range	Dr's Sign.	Nurse Sign.		Stop Date	Dr's Sign.	Nurse Sign.
15/6	7pm	INJ. DOBUTAMINE	20 mg upto 50ml 5% Dextrose @ 0.2 - 1ml/hr	4-10 mcg/kg/min	[signature]	[signature]	[signature]	17/6/26		Aseef
15/6	7pm.	INJ ADRENALINE	10.2 mg upto 50ml 5% Dextrose (1-5ml/hr)	0.1 - 0.5 mcg/kg/min	[signature]	[signature]	[signature]	15/6/26		Maria

CALCULATIONS FOR SOME COMMONLY USED DRUGS:

Dopamine : Wt. x 30 mg in 50ml of 5% Dextrose ; 0.5 - 1ml/hr - 5-10mcg/kg/min
Dobutamine : Wt X 30mg in 50ml of 5 Percent Dextrose 0.5-1ml/hr; 5-10 mcg/kg/min
Epinephrine : Wt. x 0.3mg in 50ml of 5% Dextrose ; 0.1-0.5mcg/kg/min - 1-5ml/hr
Nor-epinephrine : Wt. x 0.3mg in 50ml of 5% Dextrose ; 1-5ml.hr - 0.1-0.5mcg/kg/min

Milrinone : Wt. X 1.5mg in 50ml of 5% Dextrose ; 1ml/hr - 1.5ml/hr - 0.5-0.75mcg/kg/min
Sodium Nitroprusside : 3mg/kg in 50ml D5 ; 0.5ml/hr - 4ml/hr (0.5-4mcg/kg/hr)
Nitroglycerine : 3ml/kg in 50ml D5 ; 0.5ml/hr - 5ml/hr (0.5-mcg/kg/min)
Labetalol : 0.25 - 3mg/kg/hr ; (1ml=5mg) ; take 2ml in 18ml NS(1ML-0.5 MG) 0.5- 1.5ml/kg/hr (0.25 – 3mg/kg/hr)

Ref. No. : F / ICU / SED / PAR / 08.a

IV INFUSION MEDICATION CHART (SEDATION & PARALYTICS)

(All the drugs in this category belong to "High Risk / High Alert" medicines.
Please watch for bradycardia, hypotension and respiratory depression while administering these drugs)

Patient Name : VIH-00205932 IP-00060355 Baby Of POOJA 12-06-2026 0 Y 0 M 3 D (F) Dr. SURENDER RAO DUSA .... Age : .... Gender : ☐ M ☐ F

Weight : .... Sheet No. : ....

Date	Time	Name of Drugs	Composition	Dose Range	Dr's Sign.	Nurse Sign.		Stop Date	Dr's Sign.	Nurse Sign.
15/6.	9pm	INJ FENTANYL.	4mL + 16mL NS, @ (0.1-0.4ml/kg/hr)	1-4mcg/kg/hr	[signature]	[signature]	[signature]	16/6/26 @ 10Am		[signature] Swetha

CALCULATIONS FOR SOME COMMONLY USED DRUGS:

Fentanyl : 1ml = 50mcg vial, take 4ml in 16 ml NS thus 1ml = 10mcg ; 0.1-0.4 ml/kg/hr (1-4mcg/kg/hr)

NOTE : In older children more than 20kg weight, take 8ml in 12ml of NS thus 1ml=20 mcg;0.2-0.8ml/kg/hr (1-4 mcg/kg/hr)

Midazolam : (Undiluted) 1ml = 1mg ; 0.1-0.5 ml/kg/hr (1.6-8 mcg/kg/min)

Ketamine : Weight x 30 mg/kg in 50ml NS ; 1-4ml/hr (10-40mcg/kg/min)

Dexmedetomedine : 1ml (100mcg) in 24 ml NS ; 1ml = 4mcg ;0.05 -0.2 ml/kg/hr (0.2 - 0.7 mcg/kg/hr)

Morphine : Weight x 1 mg/kg in 50ml 5% Dextrose 1-3 ml/hr - 20-60 mcg/kg/hr

Propofol : 1ml = 10mg ; 0.1-0.4 ml/kg/hr (1-4mg/kg/hr)

Vecuronium Powder : 4mg, diluted with 4ml NS (1ml-1mg), take 2ml in 8ml NS (1ml-0.2mg) 0.25 ml/kg/hr - 1.3 ml/kg/hr (0.05-0.15mg/kg/hr)

Pancuronium : (1ml -2mg) take 1ml in 9ml NS(1ml-0.2mg) 0.1ml/kg/hr-0.3ml/kg/hr (0.02-0.06mg/kg/hr)

Ref No. F/INPR/19

Patient Name :

I.P. No

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 5 D (F)
Dr. SURENDER RAO DUSA

NURSES ASSESSMENT CHART

Date : 18/6/26 Diagnosis : Term/ RDS Weight : 3.10 kg Chart No. : 1

Guide: COLOUR CODE — RED - PULSE; BLACK - RESP; GREEN - TEMP; BLUE - NIBP

AVPU: A- ALERT, V-VOICE, P-PAIN, U-UNRESPONSIVE

VERBAL: 5-ORIENTED, 4-CONFUSED, 3-IN APPROPRIATE WORDS, 2-INCOMPREHENSIBLE SOUND, 1-NONE

MOTOR: 6-OBEYS, 5-LOCALISES PAIN, 4-WITHDRAWS, 3-FLECTION, 2-EXTENSION, 1-NONE

Pupil size: 1 2 3 4 5 6 7 8

Time scale: Temp 105–95; 200, 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 35, 30, 28, 26, 24, 22, 20, 18, 16, 14, 12, 10

Time	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
Pulse	129	163	150	131	154	138	169	128	145	138	152	136	139	140	178	154	148	134	161	155	134	149	150	146
Temp	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5
Resp	64	39	41	32	27	37	39	55	39	33	50	42	47	42	40	33	42	58	60	46	52	51	40	49
NIBP (systolic)	64	84	71	75	80	73	56	69	59	81	78	73	75	68	55	78	74	76	72	69	86	80	69	64
NIBP (diastolic)	54	74	64	58	72	57	57	49	46	63	60	58	59	56	34	61	61	59	63	52	68	73	54	74
NIBP (mean)	50	67	59	49	68	48	51	43	42	54	52	50	50	49	20	51	55	52	59	44	59	70	41	49
O2	0.1	0.1	0.1																		0.2	0.2	0.2	0.2
SPO2	96	96	97	97	94	98	95	99	96	98	92	90	94	94	96	98	98	96	90	91	96	89	91	96
RBS	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
SUCTION	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
PHYSIOTHERAPY	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
AVPU	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A

Signature of the Nurse : [signature]

Morning Shift : [signature] 18/6/26 2pm

Evening Shift : [signature] 18/6/26 8pm

Night Shift : S. Leely 19/6/26 @ 8am

Patient Name : r. SURENDER RAO DUSA 2-06-2026 0 Y 0 M 6 D (F)

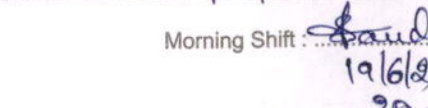
I.P. No

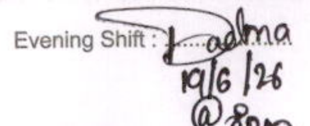
NURSES ASSESSMENT CHART

Date : 19/6/26 Diagnosis : ~~RDS~~ Term/PPHN Weight : 3.03 kg. Chart No. : (2)

Guide	Time	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
COLOUR CODE	200 / 210																								
RED - PULSE	200	173	144	173	162	156	145	148	147	150	152	160	170	159	140	145	142	138	135	140	142	150	128	136	135
BLACK - RESP	105 / 190																								
GREEN - TEMP	104 / 180	98.6	98.6	98.6	98.6	98.6	98.6			98.0F				98.3F		98.6F			98.6			98.4F			98.5F
BLUE - NIBP	103 / 170		73 / 58 / 50	61 / 46 / 39	45 / 37 / 33	69 / 55 / 49																			
	102 / 160																								
	101 / 150																								
A- ALERT	100 / 140																								
V-VOICE	99 / 130																								
P-PAIN	98 / 120																								
U-UNRESPONSIVE	97 / 110																								
	96 / 100																								
VERBAL	95 / 90	49	59	64	60	56	50	38	39	40	46	48	50	49	42	48	46	40	42	38	40	45	48	50	45
5-ORIENTED	80																								
4-CONFUSED	70																								
3-IN APPROPRIATE WORDS	60																								
2-INCOMPREHENSIBLE SOUND	50																								
1-NONE	40																								
	35																								
MOTOR	30																								
6-OBEYS	28																								
5-LOCALISES PAIN	26																								
4-WITHDRAWS	24																								
3-FLECTION	22																								
2-EXTENSION	20																								
1-NONE	18																								
• • • • • • • ● (1 2 3 4 5 6 7 8)	16 / 14 / 12 / 10																								
O2		0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
SPO2		97	91	92	99	93	98		99	98	97	98	99	99	98	98	97	–		–	–	–	–	–	–
RBS		–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
SUCTION		–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	
PHYSIOTHERAPY		–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
AVPU		A	A	A	A	A	A	A	P	P	A	A	A	A	a	a	a	a	a	a	a	a	a	a	a

Signature of the Nurse : [signature]


Morning Shift : Sandy 19/6/26 2pm


Evening Shift : Padma 19/6/26 @8pm

Night Shift : ....

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 7 D (F)
Dr. SURENDER RAO DUSA

Doc. No. : RCH/ FRM / CLINICAL / 124

INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 20/6/26 Time:

	8	9	10	11
Doctor/Nurse/Family Concern?	AM	AM	AM	AM
Temperature (°F) (104–94)		98.6F		98.6F
Heart Rate (bpm) and Blood Pressure (mmHg) * (190–50)				
Heart Rate (Number)	140	152	145	142
Resp. Rate (bpm) (Over 1 Minute) * (70–10)				
Resp Rate (Number)	40	42	45	50
Resp Distress Mod/ Severe				
Resp Distress None / Mild				
Receiving O_2 (l/min)	12	12	12	12
Saturations (%)	100	99	96	99
Conscious Level Normal	N	N	N	N
Conscious Level Altered				
*	15	15	15	15
TOTAL SCORE Number of shaded boxes	1	1	1	1
Score	0	0	0	0
Observer's Initials	S	S	S	S

Noted by sujala 20/6/26 at 10 Am

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 incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

...es 3 should be ... overleaf

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

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Baby Of POOJA
12-06-2026 0 Y 0 M 7 D (F)
Dr. SURENDER RAO DUSA

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)

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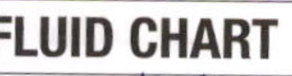
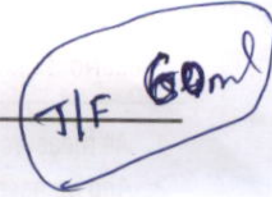
Baby Of POOJA
12-06-2026 0 Y 0 M 5 D (F)
Dr. SURENDER RAO DUSA



18/6/26



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: Nature of Fluid	Intake: Route (10% 150) Mouth	Intake: Route I.V	Intake: Route N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	08:00 am	Aptamil	10ml	14.7			✓			15ml	0	
	09:00 am	EBM		5.5	43ml		✓			15ml	0	
	10:00 am			5.5							0	
	11:00 am			5.5							0	
	12:00 pm	EBM	35ml	Stop			✓			20ml	0	
	01:00 pm										0	
Total Intake : 119.2ml									Total Output : 50ml			
	02:00 pm	EBM + Aptamil gold	40ml							35ml	0	
	03:00 pm										0	Bandy
	04:00 pm	Aptamil gold	35ml				✓			20ml	0	18/6/26
	05:00 pm										0	8pm
	06:00 pm	EBM	30ml								0	
	07:00 pm										0	
Total Intake : 105ml									Total Output : 55ml			
	08:00 pm	EBM	25ml							30ml	0	
	09:00 pm						✓				0	
	10:00 pm	Aptamil	45ml								0	
	11:00 pm										0	
	12:00 am	Aptamil	40ml				✓			60ml	0	
	01:00 am										0	
Total Intake : 110 ml.									Total Output : 90 ml.			
	02:00 am	Aptamil	30ml								0	Shirly
	03:00 am									20ml	0	19/6/26
	04:00 am	Aptamil	20ml				✓				0	@ 8am
	05:00 am										0	
	06:00 am	Aptamil	30ml.							30ml	0	
	07:00 am										0	
Total Intake : 80ml. (414.2ml)									Total Output : 50ml (245ml)			

Total 24 hrs. Intake	136.6 cc/kg/day	Total 24 hrs. Output	3.3 cc/kg/day.

MH-00205932 IP-00060355
Baby Of POOJA
2-06-2026 0 Y 0 M 6 D (F)
Dr. SURENDER RAO DUSA

FLUID CHART

Sheet No. : ②

19/6/26.

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

Date	Time	Intake				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	Aptamil	30ml				✓			15ml	0	
	09:00 am										0	
	10:00 am	EBM	40ml							25ml	0	
	11:00 am										0	Pandey
	12:00 pm	Aptamil gold	45ml				✓			80ml	0	19/6/26
	01:00 pm										0	2pm
Total Intake : 115 ml						Total Output : 60ml						
	02:00 pm		CBM (20ml)								0	
	03:00 pm											
	04:00 pm		CBM (25ml)				✓			✓	0	
19/6	05:00 pm											
	06:00 pm	Optamil gold	ff (30ml)							✓		padma
	07:00 pm						✓					19/6/26 @3pm
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm	Aptamil gold	AF 30ml									
	10:00 pm						✓			✓		20/6/26
19/6/26	11:00 pm	EBM (45ml)									0	[illegible]
	12:00 am											ESA
	01:00 am											
Total Intake :						Total Output :						
	02:00 am	EBM										
	03:00 am									✓		20/6/26
	04:00 am	EBM (45ml)									0	[illegible]
20/6/26	05:00 am											ESA
	06:00 am	EBM (30ml)										
	07:00 am						✓			✓		
Total Intake :						Total Output : 2 times						

Total 24 hrs. Intake		Total 24 hrs. Output	

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

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 7 D (F)
Dr. SURENDER RAO DUSA

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.

		Intake				Output					IV Site Thrombo-phlebitis Score	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		Sign. Nurse
			Mouth	I.V	N.G							
20/6/26	08:00 am		EPM (30ml)									Pooja 20/6/26 [illegible]
	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 :						

noted by Sushi [illegible] 20/6/26 [illegible]

Total 24 hrs. Intake		Total 24 hrs. Output	

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

00205932 IP-00060355
Baby Of POOJA
2-06-2026 0 Y 0 M 6 D (F)
Dr. SURENDER RAO DUSA

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: NICU Shifted to: 2nd Floor

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	INJ. MEROPENEM	136mg	IV	8th hrly	19/6 3AM	☑C ☐DC
2	INJ. AMIKACIN	5mg	IV	Once daily	18/6 7pm	☑C ☐DC
3						☐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 : Dr Surender [signature]

Date & Time : 19/6/26 1pm

Nurse Name & Signature: [signature]

Date & Time : 19/6/26 1pm

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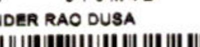
Baby Of POOJA
12-06-2026 0 Y 0 M 4 D (F)
Dr. SURENDER RAO DUSA



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 :				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 ....

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 3 D (F)
Dr. SURENDER RAO DUSA

REGULAR PRESCRIPTIONS

Weight. 3·4 kg Ward. NICU

DRUG: INJ MEROPENEM				Date/Time	15/6	16/6	17/6	18/6	19/6	20/6
Dose	Route	Frequency	Start Date							
136 MG	IV	8TH HOURLY	15/6	3AM	X	[signature]	[signature]	[signature]	Shaily	[signature]
Name & Signature of the Doctor Starting the Drugs: [signature]						[signature]	[signature]	[signature]	[signature]	[signature]
				11AM	X	[signature] Swetha	[signature] Jyothi	[signature] Jyothi	[signature] Jyothi	[signature]
Additional Instructions: 40 MG/KG/DAY				7PM	[signature]	[signature] Jyothi	[signature] Swetha	[signature] [signature]	[signature]	
Daily Doctor's Endorsement by a Sign										

DRUG: INJ AMIKACIN				Date/Time	15/6	16/6	17/6	18/6	19/6
Dose	Route	Frequency	Start Date						
51 MG	IV	ONCE DAILY	15/6						
Name & Signature of the Doctor Starting the Drugs: [signature]				7PM	[signature]	[signature] Jyothi	[signature] Swetha	[signature] [signature]	[signature]
Additional Instructions: 15 MG/KG/DAY									
Daily Doctor's Endorsement by a Sign									

DRUG: ADRENALINE NEBULISATION				Date/Time	16/6	17/6	
Dose	Route	Frequency	Start Date				
1·5 ML	NEBULISATION	thrice daily	16/6	12AM	X	[signature]	STOP
Name & Signature of the Doctor Starting the Drugs: [signature] (HOM'M)				8AM	X	[signature]	[signature]
Additional Instructions: 0·5 ML/KG. Take 1·5 ML + 2·5 ML NS via neb				4PM	[signature] Jyothi		
Daily Doctor's Endorsement by a Sign							

DRUG: BUDESONIDE NEBULISATION				Date/Time	16/6	17/6	18/6	
Dose	Route	Frequency	Start Date					
0·5 MG	P/N	TWICE DAILY	16/6	6AM	X	[signature]	[signature]	STOP.
Name & Signature of the Doctor Starting the Drugs: [signature]				6PM		[signature] Swetha		
Additional Instructions: 1 RESPULE + 0·5 MG								
Daily Doctor's Endorsement by a Sign								

As per doctor advice [signature] 15/6/26 VERIFIED Chitra
As per doctor advice [signature] 15/6/26 VERIFIED Chitra
Jyothi 16/6/26 VERIFIED
As per doctor advice VERIFIED Chitra

VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 3 D (F)
Dr. SURENDER RAO DUSA

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
16/6	10 PM.	INJ. DEXAMETHASONE	0.25 MG/KG	IV	[signature]	Mosic / [signature]
17/6	8 AM	INJ. DEXAMETHASONE	0.25 mg/kg	IV	[signature]	[signature] / Jyothi

Chsk 16/6 as per Surender Rao advice

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

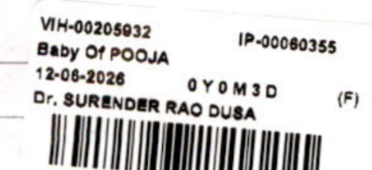
VIH-00205932 IP-00060355
Baby Of POOJA
12-06-2026 0 Y 0 M 3 D (F)
Dr. SURENDER RAO DUSA

I.V. FLUIDS CHART

Weight. 3.4 Ward. NICU

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
15/6	9pm	TV @ 120ml/kg/day 10% ISO-P + MVI + Ca.	IV	15.6ml	[signature]	Manic / [signature]	16/6 11Am	[signature]	[signature] / Jyothi
15/6	9pm	INJ SILDENAFIL. 5.5 mg (6.8 ml) + 5.2ml 5% D	IV	0.5ml	[signature]	[signature] / [signature]	16/6/26 @10 Am	[signature]	[signature] / Swetha
15/6	9pm	Inj HEP-NS. 250 in 50ml NS	IV	0.5ml	[signature]	[signature] / [signature]	17/6 @ 11AM	[signature]	[signature] / J
16/6	11Am	TV - 120cc/kg/day 10% ISOP + MVI + Ca+2	I.V.	20.4ml	[signature]	[signature] / Jyothi	17/6 11Am	[signature]	[signature] / Jyothi
17/6	11Am	TV - 160cc/kg/day 10% ISOP + MVI + Ca+2	I.V	15.5ml	[signature]	[signature] / Jyothi	18/6 12pm		[signature] / [signature]

VERIFIED BY : Name [signature] 16/6 [illegible]



RESULT SHEET

Date	15/6/26	16/6/26	17/6/26	18/6/26	19/6/26	
Time	8pm	5AM	6AM	6AM	6AM	
Hb	12.6		16.1		14.6	
PCV	33.5		42.7		38.7	
RBC	3.35		4.23		3.85	
WBC	9.82		8.25		14.67	
N/L	70.9/24.5		87.3/7.8		45.8/39.6	
Platelets	185		154		314	
CRP	52.0		40		9.0	
ESR						
PCT						
RBS						
Na	146	146	142		142	
K	4.4	4.8	5.3		5.7	
Cl	107	101	98		105	
Ca/Mg	6.9 Ca	8.6 / Mg 2.0	9.8			
Phosphate						
Urea	33.4		12.4			
Creatinine	0.7		0.4			
ALP						
SGPT						
SGOT						
T.Bill/Conj	10.8 – 0.1 – 10.7		13.1 < 0.1 13.0	12.5 – 0.1 – 12.4		
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR		17.4/1.24				
APTT		33.5				
CSF Protein / Sugar			[illegible]			
Cells			[illegible]			
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
	17/6/26					
CSF ANALYSIS						
PH	8.0		TFT			
CSF Protein	116					
CSF Glucose	71		TSH →	4.39		
Cell Count	TLC :- 4 cells		T4 →	8.78		
Cell Type	LYMPHOCYTES		T3 →	80.53		

Culture and Sensitivities : 48 hours no growth.

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI

Others (ECG, Contrast Studies etc.,) :