Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00175012 **Admit Date** : 11-Jun-2026 **Admit Time** : 08:30 AM **UHID** : BAH-00633048

Patient Details :

Patient Name	: Baby JUVERIA FATIMA	**Age**	: 3 Y 5 M 11 D
Guardian	: Mr MOHD WASIF UDDIN	**DOB**	: 31-12-2022
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H NO - 18-13-8/J/285, JAHANGIRABAD , BANDLAGUDA JAGIR Hyderabad Telangana INDIA 500086	**Phone No**	: 8801963673/ 7013862651
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : ER 01 **Ward Name** : 1B-EMERGENCY

Room No : ER 01 **Admission Type** : First Visit

Contact Details :

Name : Mr MOHD WASIF UDDIN **Relationship** : Father

Contact Address : H NO - 18-13-8/J/285, JAHANGIRABAD , BANDLAGUDA JAGIR Hyderabad Telangana INDIA 500086 **Phone No** : 8801963673 / 7013862651

Signature

Doctor Details :

Doctor Name : Dr. SIRISHA RANI **Specialisation** : HEMATO ONCOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant : Dr. JAPA AVINASH

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : SELFPAY

BAH-00633048 IP5-00175012
Baby JUVERIA FATIMA
31-12-2022 3 Y 5 M 11 D (F)
Dr. SIRISHA RANI

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 11/06/26 Time of arrival : 8:04 Am

Chief Complaints: Come for IVIG transfusion RBS: NA

Height : 101cms Weight : 15-22kgs BMI : Head Circumference (<2 years) NA

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

If yes , identify NO

Pain Screening: ☐ Yes ☑ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☑ FLACC ☐ Wong Baker

☐ Character NA ☐ Location NA ☐ Frequency NA ☐ Duration NA

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With family

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

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

Time of Initial assessment completed by ER Nurse : 8:06 Am

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

Time	Nursing Notes
	Assess the child condition
	→ seeing Dr - prathibha.
	→ vitals checked and recorded.
	→ IV placement done
	→ started IVIG transfusion

Samples collected by: /

Time:

Samples sent by : / NA

Time: / NA.

Medication given in ER:

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

Nill

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 111 b/m BP: 104/63 (73) CFT: <2sec	Shift - out from ER to: /
RR: 24 b/m SPO_2 : 96%	Time of Shift - out: ER
GCS: 15/15 Temperature : 98.0°F	Handover given to: /
Pain Score: 0/10	(Nurse's Name)
Repeat RBS (if applicable): NA	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): .....

— IV placement done —

Name of the Nurse : Renuka Signature of the Nurse : R

Date & Time : 11/06/24 @ 3pm

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Juveria Fatima Age : 3yrs Gender: ☐ Male ☑ Female

Date : 11/06/2026 Time of Arrival : 8:00Am Triage Completion Time : 8:02Am

Allergies: ☑ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): NKA ☐ Not known any drug Allergies

Source of Information : ☑ Parents ☐ Others (Specify) NA

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing
☑ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS
☑ Stable
☐ Unstable :
☐ Not – Life - Threatening
☐ Life – Threatening

Initial Vital Signs: Temp: 98.0F PR: 111bpm BP: 104/63 (73) RR: 24bpm SpO2: 96% CRA

Chief Complaints: came for IVIg Transfusion

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

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

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

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

☐ Both patient and triage staff should perform hand hygiene.

☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Keerthana

Signature of Triage Nurse : .....

Date & Time : 11/06/26 @ 8:02Am

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU / 2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

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ACTIVITY RECORD FOR BILLING

Name :_____

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Baby JUVERIA FATIMA
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Dr. SIRISHA RANI

UHID No. : _____ nsultant: _____ Dept : _____

Date of Admission: ____ te of Discharge : _____ Time: _____

Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/6/26	2:40pm	ER	~~oncology~~	pooja

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
11/06	Infusion Pump Cardiac Monitor	9 Am		525fo	Sammhy

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
	~~Infusion Pump~~			
11/06	IV placement	(1)	2568	Samphy
	IV IV Transfusion			

ANY OTHER INFORMATION

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.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Sirisha Rani Date : 11/06/26

Type of Admission: ☐ OPD ☑ ER ☐ Referral (if referral, Doctor's Name: .....

Start Time of Assessment: 9:30 AM Weight: 15.2 kg

Allergic History: .....

Chief Complaints:
β thalassemia major
Post MSD HSCT
with Herpes zoster in perineum
& Daycare admission ER.
for IVIG

Pediatric Assessment Triangle

A Appearance - TICLS ☑

B Breathing
- ☐ ↑ WOB
- ☐ ↓ WOB
- ☑ Normal
- ☐ Gasping / Apnea

C Circulation
- ☑ Normal
- ☐ Abnormal
  - Pallor ☐
  - Cyanosis ☐
  - Mottling ☐
  - Bleeding ☐

Initial Physiological Status: ☑ Stable ☐ Unstable
- Life Threatening ☐
- Non Life Threatening ☐

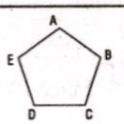
Any urgent interventions needed: ☐ Yes ☐ No
If Yes .....

Significant Past History: .....

Medication History: .....

Relevant Investigations: .....

Primary Assessment



Airway
- ☐ Open
- ☐ Maintainable
- ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Breathing
Rate: 24/min SpO₂ on ~~FiO₂~~ 96% on CR/A
Rhythm: .....
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: .....
Palpation Findings (If necessary) .....

Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Circulation

HR: 114/min

CFT — Central .... Peripheral <2sec.

Any urgent interventions needed: ☐ Yes ☑ No

If Yes* ....

BP: 104/63 (73) mmHg

Pulse Volume: — Central .... Peripheral .... good

If in Shock: — Compensated .... Hypotensive ....

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: ....

ECG: ....

Any Signs of Heart Failure: ☐ Yes ☐ No

Disability

GCS: .... AVPU: ....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

Pupils: — Responsive ☐ Non-Responsive ☐

Size — Right .... Left ....

Active Seizures: ☐ Yes ☐ No Sugars: ....

Signs of Neurological compromise ....

Exposure

Temp.: 98°F.

Any Rash: ☐ Yes ☐ No,

If yes describe the rash ....

Active bleed ....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: ....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes ....

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings: B thalassemia major / post MSD HSCT. Herpes zoster.

Labs Planned: ....

Treatment Planned:
- Daycare admission - FR.
- IVIg 10 gm.
- T. Acyclovir 400mg - 1/2 TID
Syp. Cyclosporine 0.1ml SD × 4 weeks
Acivir Ointment TID × 1 week

N.B. [illegible] 11/3/2

Need for Oxygen: ☐ Yes ☑ No if yes Low Flow ☐ High Flow ☐ PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): ....

Assessment done by

Name of the Doctor: N. Prathiksha

Signature: N.PS

Date & Time: 1/08/26

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: ....

Signature: ....

Date & Time: ....

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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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: CR Shifted to: CR

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						☐ C ☐ DC
2						☐ 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. RAMYA

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

Nurse Name & Signature: Renuka

Date & Time : 11/6/26 1:30pm

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Juveria fatima.

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DRUG CHART

Date of Admission: 11/6/22 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 *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES
- Nurses must follow strictly the FIVE RIGHTS before administration of medication.
  1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

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

Baby JUVERIA FATIMA
31-12-2022 3 Y 5 M 11 D (F)
Dr. SIRISHA RANI

REGULAR PRESCRIPTIONS

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

DRUG :

Date ▸ / Time ▾

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ / Time ▾

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ / Time ▾

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ▸ / Time ▾

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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Weight. 15-2kg Ward. .....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
11/06/26	9:35 am	IVIg	10 gm	IV	N.D	Renuka
			1ml/hr ↓ 15 minutes			
			~~2ml/hr~~ ↓ 15minutes			
			~~3ml/hr~~ Next 15 mins			
11/6/26	9:25AM	Inj. Avil	0.4ml	IV	N.	Renuka Shanthi
11/6/26	9:35am	IVIG injection	10gm (100ml)	IV		Pranay. Renuka
			1ml/hr in 15 mins 2ml/hr in next 15 mins			Pranay. Renuka
			3ml/hr in next 15 mins 4ml/hr in next 15 mins			Pranay. Renuka
			8ml/hr in next 5 hrs			

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

Baby JUVERIA FATIMA
31-12-2022 3 Y 5 M 11 D (F)
Dr. SIRISHA RANI

I.V. FLUIDS CHART

Weight. 15.2kg ..... Ward. .....

		position 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

Signature .....

VERIFIED BY : Name .....

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RESULT SHEET

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

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	

Patient Sticker

FLUID CHART

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Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	

BAH-00633048 IP5-00175012
Baby JUVERIA FATIMA
31-12-2022 3 Y 5 M 11 D (F)
Dr. SIRISHA RANI

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

~~BLOOD~~ IVIG PRODUCTS TRANSFUSION MONITORING FORM

Date: 11/06/26 Time: 9:35 Am

Blood Group of the Patient: — Blood Group on the Blood Bag: —

Blood Bank Issue No: — Date of Collection: — Date of Expiry: —

Date & Time of Starting Transfusion: 11/6/26 @ 9:35 am Planned duration of Transfusion: 5 hours

Check for Correct Unit: ☑ Correct Patient: ☑

Blood products cross checked by: Nurse 1: Pranavi Nurse 2:

Before starting transfusion vitals: Temp: 98.8°f HR 92b/m RR: 24b/m BP: 102/65(74) SpO_2 98-1

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO_2	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
11/6/26.	9:50am 15 Min	95b/m	98-7°f	102/66(78)	97-1.	—	—	—	—
11/6/26	10.05am 15 Min	98b/m	99-6°f	101/64(74)	98-1.	—	—	—	—
11/26/26	10.20 am 30 Min	103b/m	98-2°f	100/75(82)	99-1	—	—	—	—
11/6/26	10.50am 30 Min	108b/m	98-6°f	104/69(69)	99-1.	—	—	—	—
11/6/26	11.20 am 30 Min	112b/m	99-2°f	102/75(85)	98-1.	—	—	—	—
11/6/26	11.50am 1 Hr	116b/m	96-2°f	101/65(75)	99-1.	—	—	—	—
11/6/26	12.50 pm 1 Hr	114b/m	98-2°f	86/71(76)	100-1.	—	—	—	—

Comments: NIL

Name of the Incharge-Nurse: Saruba Name of the Nurse: Renuka

Signature of the Incharge-Nurse: Saruba Signature of the Nurse:

Date & Time: 11/6/26 @ 9:50am Date & Time: 11/06/26 @ 9:50am

IVIG

CONSENT FOR ~~BLOOD~~ TRANSFUSION

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BAH-00633048 IP5-00175012
Baby JUVERIA FATIMA
31-12-2022 3 Y 5 M 11 D (F)
Dr. SIRISHA RANI

Name: ..... Age: ..... Gender: Male ☐ Female ☑

UHID.No : ..... Date: 11/6/26.

Type of Blood Product:

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

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

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

.....

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

Patient (Or Patient Relative / Guardian):

Signature: .....

Name: ANJUM BEGUM

Date & Time ...11/6/26 & 9:05 Am.....

Doctor (Who is talking the consent)

Signature: .....

Name: .....

Date & Time 11/06/26., 9 am

Witness

Signature: .....

Name: Renuka

Date & Time ...11.06.26. & 9:10 Am.....

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