

ACTIVITY RECORD FOR BILLING

VIH-00178414 IP-00060313
Baby MUDE SATHIANANDA SRI
29-08-2018 7 Y 9 M 13 D (F)
Dr. SURENDER RAO DUSA

Nam _____

UHIC  _____ Consultant : _____ Dept : _____

Date of Admission : 1st floor Time : _____ Date of Discharge : _____ Time: _____

Room / Bed No : 114 Ward : 1st floor Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/6/1	12:50pm	GR	114	OK

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
11/61	CBP CRP	26019994	
	X-ray Erect abdomen	26009363	Jr
	USG abdomen		
Cross checked by <i>[Signature]</i> 12/6/26			
 			
 			
 			
 			
 			
 			
 			
 			
 			
 			
 			
 			
 			
 			
 			
 			
 			

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
11/6/1	W Placement	1	3089406.	J
<i>Cross checked by [Signature] 12/6/26</i>				

ANY OTHER INFORMATION

.....
.....
.....
.....
.....
.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward <i>[Signature]</i> 12/6 @ 11AM	Billing Assistant	Billing Supervisor
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Name	Baby MUDE SATHANANDA SRI	UHID	VIH-00178414
Father/Guardian	Mr MR. SEVE NAIK	Age/Gender	7 Y 9 M 14 D/Female
Address	PLOT NO: 99 100 PHASE 3, T P S KRISHNA NAGAR, RAMPALLY, Keesara, Hyderabad, Telangana, INDIA, 501301		
IP No	IP-00060313	Admission Date	11-06-2026
Ref Doctor	DR. M B PRASAD	Discharge Date	12-06-2026

DISCHARGE SUMMARY

Consultant: Dr. SURENDER RAO DUSA

MD (Pediatrics), Fellowship in Neonatology
SENIOR CONSULTANT PEDIATRICS
47776

Diagnosis: Acute gastritis with dehydration with constipation

History: Baby MUDE SATHANANDA SRI is a 7 Y 9 M 14 D old girl brought with complaints of stomach pain since 3 days, 3-4 episodes of nonbilious nonprojectile vomitings one day back, decreased oral intake, not passed stools since 2 days prior to admission. For the above complaints, she was referred to Rainbow Children's Hospital for further management.

Examination: She was afebrile, maintaining saturations at room air. Her heart rate was 83/min, blood pressure was 110/70 mmHg and RR 22/min. On auscultation of chest, air entry was bilaterally equal with normal heart sounds and there was no murmur. Abdomen was soft, non tender without organomegaly. She was conscious and oriented. There was no focal neurological deficits or meningeal signs. Examination of other systems including spine was normal.

Weight on admission : 32.6 kgs.

Investigations: Enclosed.

Name

Baby MUDE
SATHANANDA SRI

UHID

VIH-00178414

Management: She was admitted in ward and started on intravenous antibiotics and intravenous fluids. She was treated symptomatically with antiemetics and antacids. In view of constipation, proctoclysis enema was given and started on laxatives.

Her hemogram showed Hb 12.6 gm%, WBC count of 9,990 cells/cumm, platelets of 3.2 lakhs/cumm and CRP 10 mg/L. X-ray erect abdomen showed significant fetal loading. Ultrasound abdomen showed few prominent lymphnodes in RIF.

Her vitals were regularly monitored. Her symptoms gradually reduced. Parents were counselled about course of illness and continuation of gastrodiet for few more days. She remained hemodynamically stable throughout the hospital stay without any complication. She is being discharged with the following advice.

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

Advice:

1. Gastrodiet as advised.
2. Syrup Metronidazole (5ml=200mg) 7.5ml, 8th hourly for 3 days.
3. Tablet Lansoprazole (30mg) 1 tablet once daily (30 minutes before breakfast) for 3 days.
4. Syrup Smuth 10ml once daily for 5 days.
5. MuOut powder, 1 scoop in 100ml of water, 12th hourly for 2 weeks.
6. Syrup Buscopan 7.5ml, 8th hourly if pain abdomen.
7. Follow up with Dr. M B Prasad, Consultant Pediatrician.

In case of vomiting:

Syrup Ondansetron (5ml=2mg), 10ml (maximum 8th hourly) 30 minutes before food.

Name

Baby MUDE
SATHANANDA SRI

UHID



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

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

In Case of high fever, vomitings and decreased activity or decreased urine output, Contact Emergency 040-42462200 Extn: 2010 (or) 7337357870.

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

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctorin the language that I understand and I have understood the same.

Name :

Signature :

Relationship with patient :

This summary has been explained by :

Summary prepared by: Dr. B. Prashanthi
DEO : MD Younus Pasha

Registrar/Resident/C.M.O

Dr. SURENDER RAO DUSA

MD (Pediatrics), Fellowship in Neonatology
SENIOR CONSULTANT PEDIATRICS
47776

PatientName : Baby MUDE SATHANANDA SRI

Inpatient No. : IP-00060313

Age/Gender : 7 Y 9 M 13 D/ Female

Admit Date : 11-06-2026

Ward/Bed : N 0 GF-EMERGENCY/ ER 102

Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)		TEST RESULT STATUS : REPORT AUTHORISED	
Order Date :11-06-2026 12:07			
HEMOGLOBIN (Colorimetry)	12.6	g/dL	11.5 - 15.5
RBC COUNT (DC detection method)	5.02	10 ¹² /L	4 - 5.2
PCV/HCT (Calculated)	35.0	VOL%	35 - 45
MCV (Calculated)	69.7	fL	L 77 - 95
MCH (Calculated)	25.2	pg/cells	25 - 33
MCHC (Calculated)	36.2	g/dL	H 32 - 36
RDW-CV (Calculated)	13.1	%	11.5 - 15
PLATELET COUNT (DC Detection Method)	320	10 ⁹ /L	150 - 450
MPV (Calculated)	7.9	fL	6.5 - 10
WBC COUNT (DC Detection Method)	9.99	10 ⁹ /L	5 - 14.5
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	60	%	H 32 - 54
LYMPHOCYTES (Microscopy, Leishman stain)	28	%	28 - 48
MONOCYTES (Microscopy, Leishman stain)	04	%	4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	08	%	H 1 - 6
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC - NORMOCYTIC / NORMOCHROMIC WBC - MORPHOLOGY NORMAL WITH RELATIVE EOSINOPHILIA 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 :11-06-2026 12:07			
CRP (Immunoturbidimetry)	10.0	mg/L	<10



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Baby MUDE SATHANANDA SRI

7 Y 9 M 13 D

Female

IP-00060313

VIH-00178414

SURENDER RAO DUSA

R26-009363

11-06-2026 12:12 PM

12-06-2026 10:44 AM

DRAFT

ULTRASOUND ABDOMEN

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

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

SPLEEN :Normal in size and echotexture.

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

KIDNEYS :

Right kidney : 80x32 mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

Left kidney : 84x40 mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

URINARY BLADDER : Distended well and appears normal.

No ascites / lymphadenopathy. No evidence bowel wall thickening /edema.

Appendix measures 2.7mm and normal.

Print Date/Time : 12-06-2026 10:44 AM

Printed By : YOUNUS PASHA
MOHAMMAD

Page: 1 of 2

Baby MUDE SATHANANDA SRI

9949662318

7 Y 9 M 13 D

R26-009363

Female

11-06-2026 12:12 PM

IP-00060313

12-06-2026 10:44 AM

VIH-00178414

SURENDER RAO DUSA

Impression

- 1. Few prominent lymphnodes in RIF.**
- 2. Rest unremarkable.**

Suggested clinical correlation.

ERROR LOG

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

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

ADMISSION SHEET

Registration Details :



Admission No : IP-00060313

Admit Date : 11-Jun-2026

Admit Time : 11:43 AM UHID : VIH-00178414

Patient Details :

Patient Name : Baby MUDE SATHANANDA SRI

Age : 7 Y 9 M 13 D

Guardian : Mr MR. SEVE NAIK

DOB : 29-08-2018

Gender : Female

Religion :

Occupation :

Martial Status :

Address (H) : PLOT NO: 99 100 PHASE 3, T P S KRISHNA
NAGAR, RAMPALLY Keesara Hyderabad
Telangana INDIA 501301

Phone No : 9949662318

E-mail : na@gmail.com

Admission Details :

Bed Type : SHARED WARD

Bed No : ER 102

Ward Name : N 0 GF-EMERGENCY

Room No : ER 102

Admission Type : First Visit

Contact Details :

Name : Mr MR. SEVE NAIK

Relationship : Father

Contact Address : PLOT NO: 99 100 PHASE 3, T P S KRISHNA
NAGAR, RAMPALLY Keesara Hyderabad
Telangana INDIA 501301

Phone No : 9949662318

Signature

Doctor Details :

Doctor Name : Dr. SURENDER RAO DUSA

Specialisation : GENERAL PEDIATRICS

Referral Doctor : DR. M B PRASAD

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : CARE HEALTH INSURANCE LIMITED

Patient Name : Baby. MUDE SATHANANDA SRI UHID : VIH-00178414 IPD : IP-00060313 Gender : Female
 Age : 7 Y 9 M 13 D

VIH-00178414 IP-00060313
 Baby MUDE SATHANANDA SRI
 29-08-2018 7 Y 9 M 13 D (F)
 Dr. SURENDER RAO DUSA



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Baby. Sathananda Sri Age : 94 Gender: Male Female

Date : 11/6/26 Time of Arrival : 11:32 AM

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

Source of Information: Parents Others (Specify) _____

Mode of Arrival : Ambulatory Wheelchair Ambulance

Initial Vital Signs: Temp: 99°F PR: 83b/m BP: 102/67 (85) RR: 28b/m SpO₂: 99%

Chief Complaints: cb: Stomach pain x 2 days, vomiting (3 episode), not eating

INITIAL PHYSIOLOGICAL CATEGORIZATION Appearance <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sick Looking Circulation / Colour <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding		Work of Breathing <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea		INITIAL PHYSIOLOGICAL STATUS <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Unstable : <input type="checkbox"/> Not - Life - Threatening <input type="checkbox"/> Life - Threatening
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Triage Classification	CTAS
<input type="checkbox"/> Level 1 : Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2 : EMERGENT : Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	<input checked="" type="checkbox"/> 30 min
<input type="checkbox"/> Level 4 : LESS URGENT : Significant illness but not life threatening	<input type="checkbox"/> 60 min
<input type="checkbox"/> Level 5 : NON - URGENT : May receive care when convenient	<input type="checkbox"/> 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 : A. S. Sathananda
 Triage Completion Time : 11:36 AM

Communicable Disease Triage Screening

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

- Have you had fever (elevated temperature) in the past 2 weeks? Yes No
- Have you had cough or a rash in the past 2 weeks? Yes No
- 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

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past 2 weeks? Yes No
 If yes, State Location: _____
- Are your parents / close contacts at home is/a healthcare worker? (please encircle the choices) (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? Yes No

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

- Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

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

- Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- The patient should be given a surgical mask immediately, if not already wearing one.
- Both patient and triage staff should perform hand hygiene.
- The staff should use PPE (as appropriate).

Name of Triage Nurse : Suvarna
 Date & Time : 11/6/26 @ 11:36 AM

Signature of Triage Nurse : [Signature]

Patient Name : Baby. MUDE SATHANANDA SRI UHID : VIH-00178414 IPD : IP-00060313 Gender : Female
Age : 7 Y 9 M 13 D

VIH-00178414 IP-00060313
Baby MUDE SATHANANDA SRI
29-08-2018 7 Y 9 M 13 D (F)
Dr. SURENDER RAO DUSA



NUROLOGIC INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 11/6/26 Time of arrival : 11:37 AM
Chief Complaints : Stomach pain, not passing stool, vomiting 2 days (3 episodes) RBS : -
Height : 138 cm Weight : 32.6 kg BMI : - Head Circumference (<2 years) : -
Allergies: Yes No Medications Blood Transfusion Food Other: -
If yes, identify

Pain Screening: Yes No If Yes, Pain Score: 1 Pain Tool Used: N Pass FLACC Wong Baker
 Character Abbing Location Abdomen Frequency Intermittent Duration 2 days

RISK FOR FALL: <input type="checkbox"/> If patient is < 6 years tick below fall risk intervention directly <input checked="" type="checkbox"/> If Patient is > 6 years Assess the below parameters History of Falling: within past 3 months <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Ambulatory Aids: • Wheelchair <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Uses furniture for support <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Gait/Transferring: • Bedrest / immobile <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Weak <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Impaired <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Mental Status: Forgets limitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No IF YES FOR ANY CATEGORY = RISK FOR FALLING Fall Risk Intervention: <input type="checkbox"/> Escort while ambulating <input type="checkbox"/> Assist Patient <input checked="" type="checkbox"/> Educate patient and family on fall precautions/prevention	Functional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected <input type="checkbox"/> Mobility Problem <input type="checkbox"/> Walking Problem <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Musculoskeletal Congenital Abnormality Inform consultant for positive criteria Nutritional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected <input type="checkbox"/> Underweight <input type="checkbox"/> Overweight <input type="checkbox"/> Feeding Problem <input type="checkbox"/> Special diet <input type="checkbox"/> Special feeding method Inform consultant for positive criteria
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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?)
Time of Initial assessment completed by ER Nurse : 11:40 AM

Patient Name : Baby. MUDE SATHANANDA SRI UHID : VIH-00178414 IPD : IP-00060313 Gender : Female
 Age : 7 Y 9 M 13 D

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

Time	Nursing Notes
11:32 AM	*PT Came to ER from Dr. Sreendhar OPD
11:53 AM	*vitals checked and Recorded
11:35 AM	*ER Doctor seen the pt & gave intimation for Admission
11:43 AM	*Admission Done
12:40 PM	*IV Placement Done
12:50 PM	*Samples Collected & sent to lab
12:50 PM	*PT shifted to ward

Samples collected by: *J. Sr. Lema*
 Samples sent by: *J. Sr. Lema*

Time: @ 12:40 PM
 Time: @ 12:50 PM

Medication given in ER:

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

Condition of patient at time of shift - out:	Details of Shift - out
HR: 106b/m BP: 102/69(70) FT: 23sec RR: 22b/m SPO ₂ : 99% GCS: 4.5.6 Temperature: 97.8°F Pain Score: Repeat RBS (if applicable):	Shift - out from ER to: 114 Time of Shift - out: 11/6/26 @ 12:50 PM Handover given to: <i>Dr. Srikant</i> (Nurse's Name)


Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any): *IV Cannulation*

Name of the Nurse: *Sr. Suvama* Signature of the Nurse: *[Signature]*

Date & Time: *11/6/26 @ 12:50 PM*

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00178414 IP-00060313 Baby MUDE SATIANANDA SRI 29-08-2018 7 Y 9 M 13 D (F) Dr. SURENDER RAO DJSA 		Date & Time of Admission 11/6/26 @ 11:43 AM	Date & Time of Transfer Order 11/6/26 @ 12:50 PM
		Transfer Ordered by Dr. Vishwaja	Reason for Transfer Admission
From Unit G2	To Unit 114	Information to Attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Number of Sheets in Clinical File 26	Number of Imaging Films 1	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what? OP file sheet	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
Name & Signature of Person who is Transferring Suvarna		Name of Person Ordered Transfer Dr. Vishwaja	
Patient & Clinical Records Received by : sreelath			
Date & Time of Patient Received : 11/6/2026 @ 12:50 PM			

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

- Unavailable Bed Nurse not Available Available Bed not ready

Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 12:50pm Mode of Arrival: walking Admitting From: ER OPD Direct

Allergy / Adverse Reaction Body Weight: 32.6 Kg
 Nil Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>yes</u>	<u>nil</u>	<u>yes</u>

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 Medication: None Yes, If Yes, fill reconciliation form

Observations: Weight: 32.6kg Length: Head Circumference (< 2 years):

Temp.: 98.6 HR: 112b/m RR: 32b/m BP:

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

Fall Risk Assessment: Yes No Score: 12 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 24) (Document in the Braden Q Assessment Sheet)

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

Character of Pain Location Frequency Duration

FUNCTIONAL SCREENING: No Abnormalities Detected
 Mobility Problem Walking Problem
 Developmental Delay Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: No Abnormalities Detected
 Underweight Overweight Special Feeding Method
 Feeding Problem Special diet No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With *family*

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:

Call Bell in Reach : Yes No

Waste Disposal Explained: Yes No

Infusion Pump : Yes No

Hand hygiene Explained: Yes No Others

Patient Rights & Responsibilities: Yes No

Information given to *nil*

Nurse's Name: *Sukanya* Date: *11/6/22* Time: *1pm*

[Signature]
Signature



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

VIH-00178414 IP-00060313
Baby MUDE SATHIANANDA SRI
29-08-2018 7 Y 9 M 13 D (F)
Dr. SURENDER RAO DUSA





Pediatric Multiorgan History & Physical Examination

Name : Mude Sathananda Sri Age/Sex 7y / Female
Information given by: Mother Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Abd Stomach pain since 3 days.
10 vomits 2 days back
also ↓ oral intake } Since 2 days.
Not passed stool }

History of present illness :

child presented with the
Abd - stomach pain since 3 days
↳ diffuse abdominal pain, no tenderness.
Intermittent
dull aching type.
also 10 vomits since yesterday - 3-4 episodes/day
content - food/water
yellowish-green colour - 1 episode
also ↓ oral intake
Not passed stool since yesterday
↳
consulted outside hospital
used Symp - cyclopam
Syp. Moten DS
Syp. OFM DS
probiotics } 2 days.
↓
Due to persistence of symptoms
referred to PCH.

NO H/O Fever, cold, cough, loose stools.



Pediatric Multiorgan History & Physical Examination

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

H/O & admissions 2 year back for fever
(2 days each time)

Birth & Neonatal History:

Term / 1000g / 2.8kg / NO NICU stays



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

} class III

Developmental History :

Appropriate for age in all domains

Immunization History :

Received vaccination upto date

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 32.6 kg (Centile _____)

On Examination :

Temperature : 97°F Pulse Rate : 83/min B.P. 107/67 SPO2 99%

Resp. rate and type of breathing : 22/min

Rash ⊖

Lymphadenopathy ⊖

Oedema : ⊖

Allergies (if any): ⊖

Respiratory System :

Inspection (any s/o distress) : Bil symmetrical chest movements

Air entry & breath sounds : R/LAE ⊕

Any addes sounds : NO

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

Cardiovascular System :

Inspection of precordium : ⊖

Heart Sounds : L/S ⊕

Any murmur : NO

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

Per Abdomen :

Inspection ⊖

Palpation : soft, nontender Bloaty ⊕

Ausculation : Bs ⊕

Spine : ⊖ External Gehitelia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Awake 15/15

Cranial Nerves : Intact

Motor System:

Nutriton : _____

Tone: _____ Power 4/5 all limbs

Co-ordinator : _____

Posture : _____

Involuntary Movements : NO

Reflexes : +

DTR +

Superficials: +

Plantars flexor

Sensory System : +

Bladder / Bowel : NO incontinence

Clinical Summary & Diagnostic:

Acute gastroenteritis & dehydration

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: To prevent complication.

Desired goals of the treatment: To treat current condition

Planned Labs:

- CBP ✓
- CRP ✓
- Abd Xray (erect) ✓
- USG abdomen ✓

By Dr. Sunder Rao Sr
Planned Management

- 1) IV fluids
- 2) Tab metronidazole
- 3) Tab tramoprazole
- 4) Tab Zofran - 8mg

Noted by
Sunder
12:50 PM

Signature of the Doctor: [Signature]

Signature of the Consultant: [Signature]

Name of the Doctor: Dr. Vishwaja

Name of the Consultant: [Signature]

Date & Time: 11/6/26

Date & Time: _____



①

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11.6.26 3:00PM	S/B Registrar	
	acute Gastric with delay duodenum	
	Intermittent abdominal pain of child usually	
	CRT < 3s	
	afebrile	
	US - 95%	
	RS - RAG(I), clear	Plan
	P/- soft	→ P/G enema stat
	no tenderness	→ Tilted 4 th tube
	Luj. Melenoidajek : D1	
	Sameer	
	(Dr. Sameer)	
	wket by steel bands on abdomen @ 5:00pm	

Dr. Sameer
 11/6/26
 10:30 AM



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: AGE		Any Infection: <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify:				
	Surgery / Procedure: _____		Post OP Day: _____				
BACKGROUND	Date	11/6/2016 Morning	11/6/2016 Evening	11/6/2016 N	12/6/2016 N		
	Shift						
	Medical Condition (Any special condition to be noted):	Nil	Nil	NPL	Nil		
	Diet:	Gastro diet	Gastro diet	Gastro diet	G diet		
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA		
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	97.6°F		98.4°F	98.6°F	
		Res:	24b/m		26b/m	24b/m	
		SpO ₂ :	99%		98%	99%	
		Pulse:	101b/m		116b/m	110b/m	
		BP:	96/78(80)		91/72(69)	100/72(62)	
		LOC:	conscious	conscious	conscious	conscious	
		Fall Risk Score:	10	10	10	10	
	Pain Score:	0	0	0	0		
	Skin Integrity	Intact	Intact	Intact	Intact		
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	Nil	Nil	NPL	Nil		
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	Gastro diet	Gastro diet	Gastro diet	G diet		
	Critical Lab Test / Values:	Nil	Nil	NPL	Nil		
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		
ADL (Dependent / Non Dependent):	Dependent	Dependent	dependent	dependent			
Post Operative Procedure Special Orders:		Nil	Nil	NPL	Nil		
Handed Over By Name :		Surender	Surender	Subham	manish		
Signature / ID :		[Signature]	[Signature]	[Signature]	[Signature]		
Date:		11/6/2016	11/6/2016	11/6/2016	12/6/2016		
Time:		@12:50 PM	@8 PM	@8 AM	@2 PM		
Taken Over By Name :		Surender	Subham	manish			
Signature / ID :		[Signature]	[Signature]	[Signature]			
Date:		11/6/2016	11/6/2016	12/6/2016			
Time:		@12:50 PM	@8 PM	@8 AM			

Noted by
 manish
 12/6/2016
 @ 10:45 AM

VH-00178414 IP-00060313
 Baby MUDE SATHANANDA SRI
 29-08-2018 7 Y 9 M 13 D (F)
 Dr. SURENDER RAO DUSA



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date						
	Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:	Temp:					
		Res:					
		SpO ₂ :					
		Pulse:					
		BP:					
		LOC:					
		Fall Risk Score:					
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physiotherapy:						
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	PU Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	DVT Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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:							



NURSING CARE RECORD



Date: 11/6/2016

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon	3pm	→ maintain fluid balance		Administered IVF DMS 45ml/hr	To maintain hydration	Patient is stable	Sulbham 11/6/2016 @ 3pm
Night	10pm	Maintain fluid balance		Administered IVF DMS (45ml/hr)	To maintain hydration.	Patient is stable	Sulbham 11/6/2016 @ 8pm

VIH-00178414 IP-00060313
 Baby MUDE SATHANANDA SRI
 29-08-2018 7 Y 9 M 13 D (F)
 Dr. SURENDER RAO DUSA



NURSING CARE RECORD



Date: 12/16/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning				Discharge note			
Afternoon				doctor come for round advise for discharge			
Night							

Noted By
 Manisha
 12/16/26
 @10:40AM



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	11/6/26	11/6	12/6		
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	2		
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1		
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1		
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	1		
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2		
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1		
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1		
Total			9	9	9		

Intervention:

-Fall Risk: Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	✓	✓	✓	
Call device within reach	x	x	x	
Wheels Locked	✓	✓	✓	
Room free of clutter	✓	✓	✓	
Adequate lighting	✓	✓	✓	
Wheel chair up	✓	✓	✓	
Other Intervention(s) Specify	✓	✓	✓	
Nurse's Name:	Hema	Sudha	manu	
Signature:	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
Date:	11/6/26	11/6	12/6	
Time:	12 PM	1 PM	10:40 PM	

Noted by Manu for 12/6/26 @ 10:40 PM

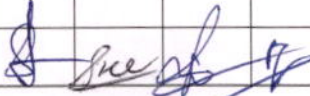
VIH-00178414 IP-00060313
 Baby MUDE SATHANANDA SRI
 29-08-2018 7 Y 9 M 13 D (F)
 Dr. SURENDER RAO DUSA



CHECKLIST FOR THROMBOPHLEBITIS

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-	-						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-						
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-	-						
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-	-						
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-						
Signature of the Nurse				 Noted by manish 12/6/26 @10:40am									

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

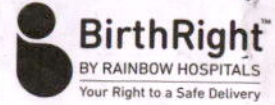
Signature : Syath Name : Syath

Signature of Ward In Charge :

Signature : Elizabeth Name : Elizabeth



PAIN ASSESSMENT FORM



Date	Time	Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/6/20	12:10 PM	0	—	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	—	[Signature]
11/6/20	3 PM	0	—	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	—	[Signature]
11/6	11 AM	0	—	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	←	[Signature]
12/6/20	10 AM	0	—	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mil	manjha
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Noted by
 manjha
 12/6/20
 @10:40 AM

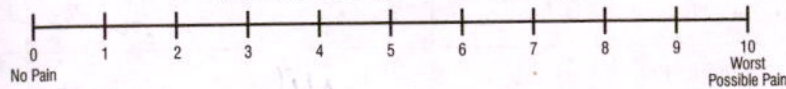
Re-assessment Frequency:
 1. Every eight hours for all hospitalized patients.
 2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 a) At least every 2 hours for the first 24 hours b) Then every 4 hours.
 c) Prior to pain pain-relieving intervention. d) Within 30 – 60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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

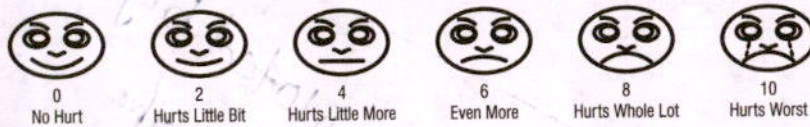
Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





BRADEN 'Q' SCALE

					Date :	11/6/20	11/6/20	11/6/20	11/6/20
					Time :	12:20 PM	1:15 PM	1:00 PM	1:00 PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4	4
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	4
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	28	28
Docu. No. : RCH /FRM / CLINICAL / 119					Evaluator's Name	[Signature]	[Signature]	[Signature]	[Signature]

Noted by Manisha 11/6/20 @ 10:00 AM

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> • Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> • Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> • Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> • Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

ULTRA SOUND ABDOMEN REQUEST FORM

1st FLOOR

AFTERNOON

11/06/2026

PATIENT NAME :

VIH-00178414 IP-00060313
Baby MUDE SATHANANDA SRI
29-08-2018 7 Y 9 M 13 D (F)
Dr. SURENDER RAO DUSA

DATE:



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

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

SPLEEN : Normal in size and echotexture.

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

KIDNEYS : Right kidney : ^{80x32} mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

Left kidney : ^{84x40} mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

URINARY BLADDER : Distended well and appears normal. No ascites / Lymphadenopathy. No evidence bowel wall thickening / edema.

→ *Appendix measures 2.7mm & normal.*

IMPRESSION: ~~No obvious sonological abnormality in abdomen.~~

~~Rest unremarkable~~

- 1) Few prominent lymphnodes in RIF
- 2) Rest Unremarkable

Suggested clinical correlation.

DR MOHD ABDUL KHALID MD, DNB.

DR V. MAHIDHAR (MD)

DR VAISHNAVI REDDY B (MD)

(Consultant Radiologist)

GENERAL CONSENT FOR TREATMENT

Patient Name: Baby MUDE SATHANANDA SRI Age : 7 Y 9 M 13 D
IP No: IP-00060313 Sex: Female
Consultant: Dr. SURENDER RAO DUSA Ward/Bed No: N 0 GF-EMERGENCY/ER 102

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

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

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:

1 We do not allow use of medication brought from outside by the patient.

2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.

(receivers Signature:.....)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.

4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name:

Sene neik.

Relationship:

Kathor

Date:

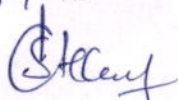
11/6/26

Time:

11:43 AM

Witness Name:

Witness Signature:



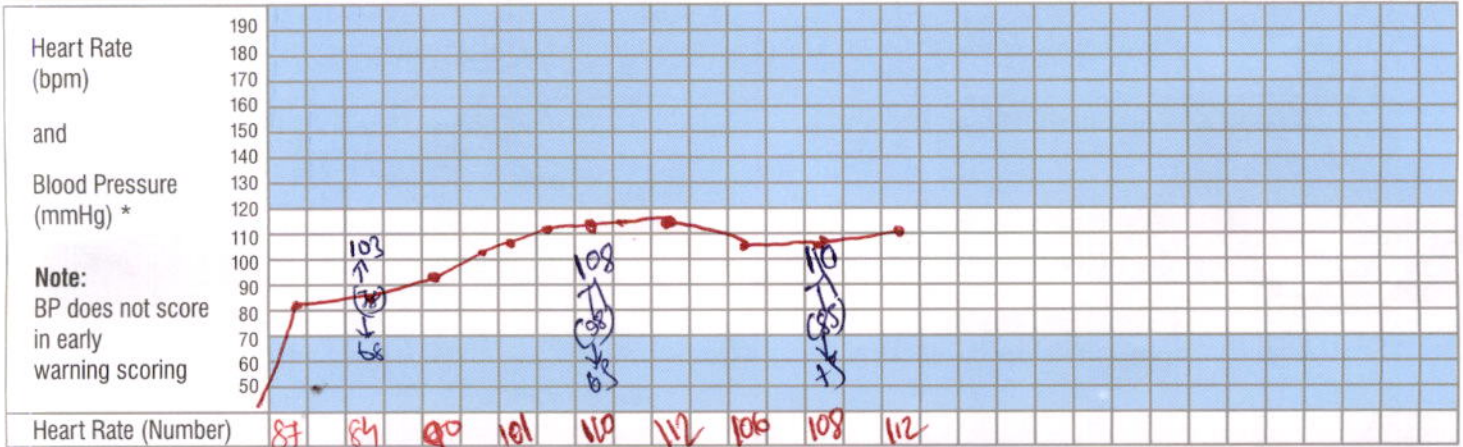
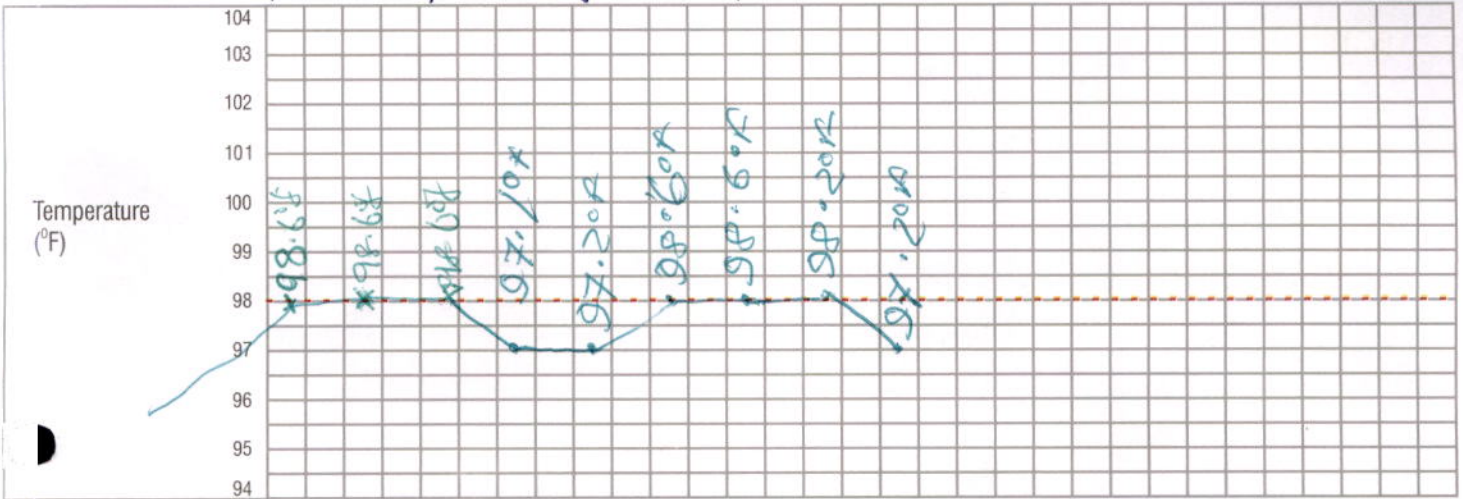
Patient Address:

PLOT NO: 99 100 PHASE 3, T P S
KRISHNA NAGAR, RAMPALLY Keesara
Hyderabad Telangana INDIA 501301



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 11/6/26	Time: 2	4	6	8	10	1	3	5	7
Doctor / Nurse / Family Concern?	pm	pm	pm	pm	pm	Am	Am	Am	Am



Resp Distress	Mod/ Severe None / Mild	N	N	P	N	N	N	N	N
Receiving O ₂ (l/min)	O ₂ Saturations (%)	99	98	99	100	98	100	98	100
Conscious Level	Normal / Altered	N	N	N	N	N	N	N	N
GCS *		15	15	15	15	15	15	15	15
TOTAL SCORE		0	0	0	0	0	0	0	0
Number of shaded boxes		0	0	0	0	0	0	0	0
Pain Score		2	2	2	2	2	2	2	2
Observer's Initials		S	S	S	P	P	P	P	P

ACTIONS	Score 1	: Continue normal observation by staff nurse
	Score 2	: Shift in charge nurse to be informed and continue hourly observations
	Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
	Score 4	: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
	Score 5 & 6	: Shift in charge AND PICU fellow or PICU consultant to be informed.

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

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)

VIH-00178414 IP-00060313
 Baby MUDE SATHANANDA SRI
 29-08-2018 7 Y 9 M 13 D (F)
 Dr. SURENDER RAO DUSA

oc. No. : RCH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation &
 Early Warning Scoring Chart

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

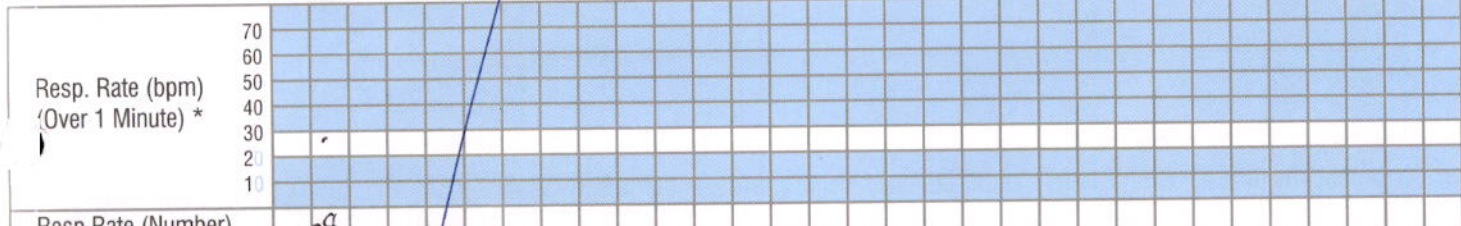
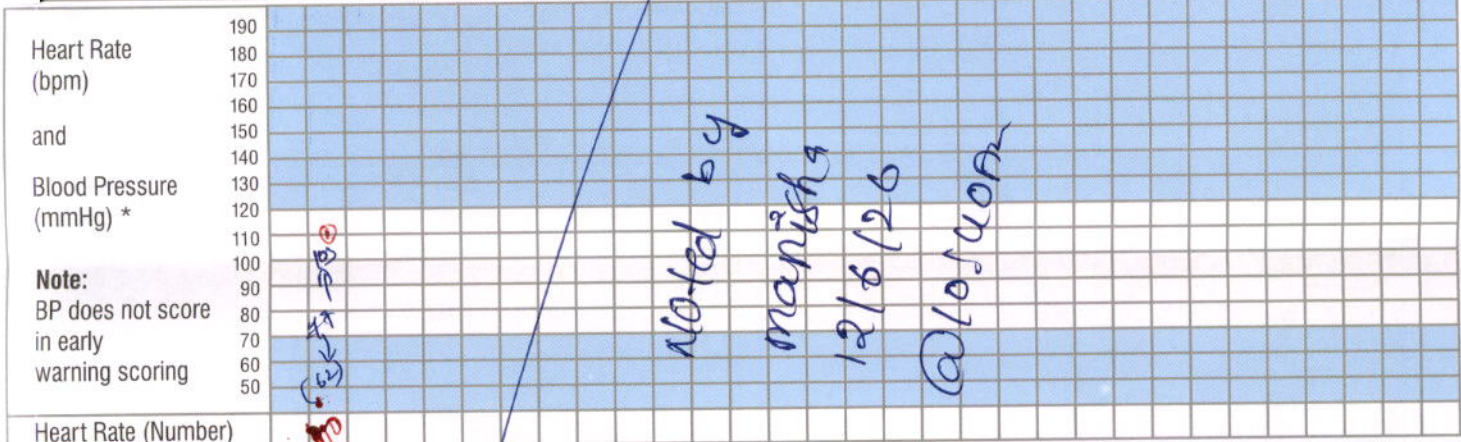
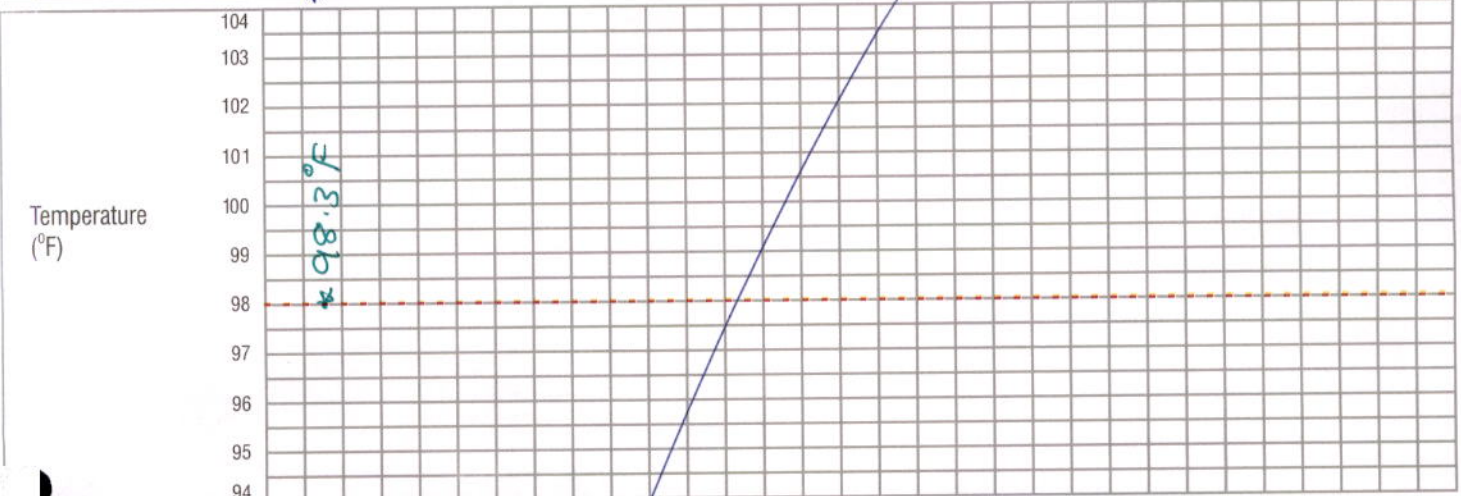
BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 12/6/26 Time: 9

Doctor / Nurse / Family Concern? *MS*



Resp Distress	None / Severe	2
Receiving O ₂ (l/min)		2
O ₂ Saturations (%)		99
Conscious Level	Normal / Altered	2
GCS *		5

TOTAL SCORE	
Number of shaded boxes	00
Pain Score	00
Observer's Initials	MS

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1	: Continue normal observation by staff nurse
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 Baby MUDE SATHIANANDA SRI
 29-08-2018 7 Y 9 M 13 D (F)
 Dr. SURENDER RAO DUSA

FLUID CHART

Sheet No. : 1

11/6/2026

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	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			45ml									} stool on 11/6/26 08pm
	03:00 pm			45ml									
	04:00 pm			45ml									
	05:00 pm			45ml									
	06:00 pm			45ml									
	07:00 pm			45ml									
	08:00 pm			45ml									
	09:00 pm			45ml									
	10:00 pm			45ml									
	11:00 pm			45ml									
	12:00 am			45ml									
	01:00 am			45ml									
Total Intake : <u>270ml</u>						Total Output : <u>2 times</u>							
	02:00 am			45ml									} 12/6/26 08AM
	03:00 am			45ml									
	04:00 am			45ml									
	05:00 am			45ml									
	06:00 am			45ml									
	07:00 am			45ml									
	08:00 am			45ml									
Total Intake : <u>270ml</u>						Total Output :							

Total 24 hrs. Intake 810 ml

Total 24 hrs. Output 6 times



FLUID CHART

Sheet No. :

12/6/26

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

		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am		<i>Orally</i>										
	09:00 am		<i>Water</i>										
	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 Manisha 12/6/26 @ 10:40 AM

Total 24 hrs. Intake

Total 24 hrs. Output

Patient Sticker

FLUID CHART

Sheet No. :

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

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

Total 24 hrs. Intake	
-----------------------------	--

Total 24 hrs. Output	
-----------------------------	--

MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
 (Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER Shifting to: 114

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	/					<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6		NG				<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Vishwaja

Date & Time: 11/06/26 @ 12pm

Nurse Name & Signature: Geeta J

Date & Time: 11/06/26 @ 12pm

REGULAR PRESCRIPTIONS

Weight: 32.6 kg Ward: 114



Dr. J. Shikha
Chitthur 11/6/26

DRUG : INJ. METRONIDAZOLE				Date Time	11/6	12/6
Dose	Route	Frequency	Start Date			
320mg	IV	8th hourly	11/6	6 am		
Name & Signature of the Doctor Starting the Drugs:				2 pm		
Additional Instructions:				10 pm		
Daily Doctor's Endorsement by a Sign						

Dr. D. Shikha
Chitthur 11/6/26

DRUG : INJ. ECOMETRAZOLE				Date Time	11/6	12/6
Dose	Route	Frequency	Start Date			
30mg	IV	once daily	11/6	6 am		
Name & Signature of the Doctor Starting the Drugs:				6 am		
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

As per doctor advice.
Dr. J. Shikha
Chitthur 11/6/26

DRUG : Scp. SMUT				Date Time	11/6	12/6
Dose	Route	Frequency	Start Date			
15ml	PO	12th hourly	11/6	10 am		
Name & Signature of the Doctor Starting the Drugs:				10 pm		
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

Dr. J. Shikha
Chitthur 11/6/26

DRUG : MOUT POWDER				Date Time		
Dose	Route	Frequency	Start Date			
2 scoops	PO	once daily	11/6	10 pm		
Name & Signature of the Doctor Starting the Drugs:						
Additional Instructions:						
Daily Doctor's Endorsement by a 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.

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
11.6.26	4:30 PM	INT. HYOSCINE BUTYLBROMIDE	15 mg	IV	<i>[Signature]</i>	Gayathri
11.6.26	4:00 AM	PROCTOCLYSIS ENEMA	1	P/R	<i>[Signature]</i>	Gayathri
11/6/26	10 PM	PROCTOCLYSIS ENEMA	100 ml	P/R	<i>[Signature]</i>	<i>[Signature]</i>
12/6/26	10:15 PM	PROCTOCLYSIS ADMP	200ml	P/R	<i>[Signature]</i>	<i>[Signature]</i>

[Handwritten notes and signatures on the right margin]

VERIFIED BY *[Signature]* Signature

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 Dr. SURENDER RAO DUSA



RESULT SHEET

Date	11.6.26				
Time	2.00 PM				
Hb	12.6				
PCV	35				
RBC	5.02				
WBC	9990				
N/L	59/27.9				
Platelets	3.2				
CRP	10				
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					

