Rainbow Children's Hospitals - Visakhapatnam

Plot No.15, Health City layout,Sy. No. 21 & 27,Part of Chinagadili,GVMC Limits. Govt General Hospital Kda ,Vishakhapatnam ,Andhra Pradesh, INDIA ,530040.
TEL NO :891-3501601
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP22-00023482 **Admit Date** : 03-Jul-2026 **Admit Time** : 08:05 AM **UHID** : HCV-00036853

Patient Details :

Patient Name	: Master MD ZAHID UR RAHAMAN	**Age**	: 11 Y 6 M 24 D
Guardian	: Mr MD F RAHAMAN	**DOB**	: 09-12-2014
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: Avn College Road Vishakhapatnam Andhra Pradesh INDIA 530001	**Phone No**	: 9959843333/ 7893716666
		E-mail	: no@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : DC 211 **Ward Name** : 2F-SECOND FLOOR

Room No : DC 211 **Admission Type** : First Visit

Contact Details :

Name : Mr MD F RAHAMAN **Relationship** : S/O

Contact Address : Avn College Road Vishakhapatnam Andhra Pradesh INDIA 530001 **Phone No** :

Signature

Doctor Details :

Doctor Name : Dr. Kandula RadhaKrishna / Dr. Raju Kakarlapudi **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : Dr. Radha Krishna **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name:----------

HCV-00036853 IP22-00023482
Master MD ZAHID UR RAHAMAN
09-12-2014 11 Y 6 M 24 D (M)
Dr. Kandula RadhaKrishna / Dr. Raju

UHID No :.....IP No :.....:.....Dept.:.....

Date of Admission :.....Discharge:.....Time:.....

Room / Bed No :.....Ward .....ted Billable bed type:.....

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
03/07/26	8:30Am	ER	PICU	Akhil

Cross Consultation Visit

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

MEDICAL EQUIPMENT (WARD & ICU

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
3/7/26	Cardiac monitor	8:30	9:30	93336	[signature]
	Syringe pump	Am	Am 3/7/26		

INVESTIGATIONS

Date	Investigations	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

Date: Time: Prepared By:

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref. No. : F/PICU / ADMR / 08

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PEDIATRIC INTENSIVE CARE ADMISSION RECORD

Name: master MD ZAHID UR RAHAMAN Age: 11Y Gender: M

I.P. No: 00023982 UHID No. : 00036853

Father's / Mother's Name : Mr MD F RAHAMAN Age: 11y/m

Address : AUN College Road Vishakhapatnam Andhrapradesh INDIA 530001

Tel : 9959843333/7983716666 E-mail: no@gmail.com

Date of PICU admission : 03/07/2026 Time 8:05 ☑ am ☐ pm

Reffered Patient ☑ - Self Referral ☐ - Rainbow Patient ☐

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

Referring Consultant : Dr. Radhakrishna

Admitting Consultant : Dr. Radhakrishna / Dr. Raju

Indication for PICU referral :

Prism III score at 24 hors of admission : Worse SOFA Score :

Date of : Discharge : Transfer : Death:

Duration of ICU Stay:

Final Diagnosis :

Presenting Complaints / Chief Complaints :

K/C/O Duchenne Muscular Dystrophy

↓

came with ~~Hypertension~~ Etoplirsen Infusion

Past History (Including Previous treatment and investigations) :

K/C/O Duchenne Muscular Dystrophy

Birth and Developmental History :

H / O Allergy :

Family History :

immunization History :

INITIAL ASSESSMENT

RBS:.....Temperature :.....(N)..... Weight (kg) :.....42 kg.....

RESPIRATORY SYSTEM FINDINGS :

Air Way : ☐ Open ☐ Maintainable ☐ Not Maintainable ☐ Intubated, If Intubated, Size & position of ETT :.....

Respiratory Examination Finding : (Air entry, breath sounds, S/o distress etc.) : Respiratory Rate

:.....B/L AE (+).....

SPO_2 :..... O_2 by NC / FM / NRB mask / Oxyhood, at..... .....L / min

Ventilatory Support : ☐ Yes ☐ No - Day # of Vent :.....Respiratory Efforts :.....

Ventilatory Setting : Leak around ETT :.....Delivered Vt :.....

ABG :.....$EtCO_2$.....P/F ratio:.....O.I :.....

Any Nebs :.....ICD ? ☐ Yes ☐ No, if Yes details :.....

CXR :.....

CARDIO VASCULAR SYSTEM CLINICAL EXAM : Heart Rate :.....Cardiac Rhytho :.....

(Heart sounds, murmur etc.) :.....

Quality of Pulses :.....Good..... cap refill Time :.....Liver Edge :.....cm below Rt costal Margin

Blood Pressures : NIBP :.....IBP :.....CVP :.....

Infusion of any Inotropes? : ☐ Yes ☐ No - If yes, then details :.....

.....

Any Other Infusions :.....

Last 2D Echo Findings : .....

Size of the heart and lung fields in latest CXR :.....

Arterial line in Situ : ☐ Yes ☐ No Place of art, line & its condition:.....

Central line in Situ : ☐ Yes ☐ No Place of central line & its condition :.....

INFECTION and ANTIBIOTICS :

☐ Febrile ☐ Afebrile Current Antibiotics Details (Antibiotic name and day #):.....

Cultures Done outside ? ☐ Yes ☐ No - If Yes, details :.....

Describe c/s Reports :.....

Other Labs (Latex, Serology, etc):.....

Ongoing Antibiotics :.....

.....

Adbominal Exam:.....Soft.....

.....

.....

ENT Exam : .....

Central Nervous System:

Level of Consciousness : AVPU / GCS score :.....Active.....

Neurological Findings :.....

.....

.....

.....

.....

Relevant data from outside (Neuro imaging any ongoing medications etc) :.....

.....

.....

.....

Clinical Summary and Provisional Diagnosis: K/C/O Duchenne Muscular Dystrophy

PLAN OF CARE

Preventive aspects of the treatment:

Desired goals of the treatment:

PLANNED INVESTIGATIONS	PLANNED MANAGEMENT
- CUE - OPD visit	- Infusion of 1200 mg of Eteplirsen

Doctor's Signature: [signature]

Name: Dr. [illegible]

Consultant's Signature:

Name:

PLEASE FILL UP THE FOLLOWING DETAILS

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

Ref. No. : F / HW / PGN / INPR / 15

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PROGRESS NOTES
(USE BALL POINT PEN ONLY)

Patient N HCV-00036853 IP22-00023482
Master MD ZAHID UR RAHAMAN
09-12-2014 11 Y 6 M 24 D (M)
Dr. Kandula RadhaKrishna / Dr. Raju
Age : .....
I.P. No. :

DATE	TIME	(SIGN ALL ENTRIES, DATE & TIME OF EACH ENTRY IS COMPULSORY)
3/7/26		S/B Dr Raju / Dr Yash
	8 Am	
		→ 11 year old boy Zahid with Duchenne Muscular Dystrophy on Exon dys 51 (Eteplirsen)
		→ As of Now admitted for 37th Post trial infusion of Eteplirsen
		Vitals
		HR - 110 BPM o/E Afebrile,
		SPO₂ - 98% Pallor ⊖
		RR - 32/min Edema ⊖
		Tem (N)
		Today's Weight - 42 kg
		Today Urine Routine (N)
		NIB

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Plan

- TO infuse 1200 mg of
  Etanercept infusion over 40 mins
  @ 150 ml/hr (30 mg/kg) (2 vials of
  each of 100 mg/2 ml x2
  and
  500 mg/10 ml x2)
  (In 100 ml NS)
- Monitor vitals

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RESULT SHEET

HCV-00036853 IP22-00023482
Master MD ZAHID UR RAHAMAN
09-12-2014 11 Y 6 M 24 D (M)
Dr. Kandula RadhaKrishna / Dr. Raju

Patient Name : ....
Age : .... Ge ....
I.D. No. : ....

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						
Doctor's Signature						

op-basic

Date	03/07/26					
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells	2-4					
CUE - RBC Cells	nil					
CUE						
Epithlial cells	1-2					
CASTS	Absent					
Bacteria	Absent					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Doctor's Signature						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

Ref. No. : F / HW / DC / INPR / 05

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Patient Name : .... Age : ....

Gender ☐ M ☐ F - Hospital No ....

Consultant : ....

Date of Admission : ....

HCV-00036853 IP22-00023482
Master MD ZAHID UR RAHAMAN
09-12-2014 11 Y 6 M 24 D (M)
Dr. Kandula RadhaKrishna / Dr. Raju

DRUG ALLERGIES :

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. **ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.**

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).

- Use approved pharmaceutical names, **BLOCK LETTERS**, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line / through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the **FIVE RIGHTS** before administration of medication.

1) Right Patient **2)** Right Drug **3)** Right Dosage **4)** Right Route **5)** Right Time

- **AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR).** Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

HCV-00036853 IP22-00023482
Master MD ZAHID UR RAHAMAN
09-12-2014 11 Y 6 M 24 D (M)
Dr. Kandula RadhaKrishna / Dr. Raju

	I.P. No.	Sheet No.	Wards	Weight (kg)

REGULAR PRESCRIPTIONS

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date / Time

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
3/7/26	8 AM	ETEPLIRSEN	1200 mg over 40min	Chemo Port	D	

HCV-00036853 IP22-00023482
Master MD ZAHID UR RAHAMAN
09-12-2014 11 Y 6 M 24 D (M)
Dr. Kandula RadhaKrishna / Dr. Raju

	I.P. No.	Sheet No.	Wards	Weight (kg)

I.V. FLUIDS CHART

DATE	TIME	Composition of I.V. FLUID (if infusion, mention ml / hr = Mcg / kg / min. etc.)	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.

Inj. Elosphies

Ref. No. : F / HW / BTM / NSG / 03

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~~BLOOD PRODUCTS~~ TRANSFUSION MONITORING FORM

Name of the patient : MD. ZAID Rahman UHID : 36853 I.P. No. : 23482

Age : 4Y Gender : M Department : PICU Ward : PICU

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 : 8/7/24 @ 8:30 Am Planned duration of transfusion : 1 hr

PLEASE MONITOR THE FOLLOWING EVERY 30 MINUTES

Time	HR	Temperature	Blood pressure	SpO_2	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
8:30Am	96	97.6°F	103/55 (70)	98%	–	–	–	–
9Am	94	97.5°F	103/55 (70)	98%.	–	–	–	–
9:15am	98	97.6°F	103/55(70)	99%				
9:30 Am	96	97.7°F	100/57 (71)	100%	–	–	–	–

Comments : NO reaction during transfusion

Nurse Name : Ajeent Nurse Signature : Ajeent

CIN : U85110 TG1998 PTC029914

HCV-00036853 IP22-00023482
Master MD ZAHID UR RAHAMAN
09-12-2014 11 Y 6 M 24 D (M)
Dr. Kandula RadhaKrishna / Dr. Raju

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NURSING INITIAL ASSESSMENT FOR PICU

Date of Admission: 3/7/26

Source of Admission: ☐ OPD ☐ Ward ☑ Other: PICU

Reason for Admission: c/o fever c/o ...

Admission Diagnosis: Muscular dystrophy

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

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

Do you require an interpreter? ☐ Yes ☑ No

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

If yes, identify —

Source of Information : ☐ Family ☐ Patient ☐ Others, Specify			
SIGNIFICANT HISTORY	Past Medical History	Past Surgical History	Last Hospital Admission
	Muscular dystrophy	/	Last week
	Family History: —		
	Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☑ No If yes please list, Was the child's birth normal? ☐ Yes ☑ No If No, please describe problems: Are the child's immunization up to date? ☑ Yes ☐ No		
CURRENT MEDICATIONS	Taking Medications? ☐ Yes ☑ No If yes, Fill the reconciliation form Medicine brought to the hospital? ☐ Yes ☑ No		

Observations: Weight: 42kgs Length: — Head Circumference (< 2 years): —

Temp.: 97.1°F HR: 96 RR: 20 BP: 103/... (70)

Pain Score: 0/10 Specify Site: — (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☐ Yes ☑ No Score: — (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 20) (Document in the Braden Q Assessment Sheet)

HCV-00036853 IP22-00023482
Master MD ZAHID UR RAHAMAN
09-12-2014 11 Y 6 M 24 D (M)
Dr. Kandula RadhaKrishna / Dr. Raju

Behavioural Status on Admission :

☐ Sleeping ☐ Crying ☑ Calm ☐ Distressed/Consolate ☐ Drowsy

FUNCTIONAL SCREENING: If a patient needs assistance with any of the following inform consultant

☐ Mobility problem ☐ Walking Problem ☐ No Abnormality Detected

☐ Developmental Delay ☑ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

☐ 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?) ....

Orientation has been given regarding the following aspects:

☑ ID Band in situ

☑ Bedside safety explained

☑ PICU Routine: Doctor's rounds/Medication time

☐ Visiting policy explained

Orientation given to: ☑ Family ☐ Others specify ....Mother....

Name of Person Orientation was given to: ....Kalfia....

Orientation not given Reason: ....

Nurse Name: ....[illegible].... Nurse Signature : ....[signature]....

Date & Time: ....3/7/20 P.10P....

DISCHARGE PLAN

Source of Information: ☑ Family ☐ Friend

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

Will Physiotherapy require at home: ☐ Yes ☑ No

Is home medical equipment anticipated: ☐ Yes ☑ No

Is home oxygen therapy anticipated: ☐ Yes ☑ No

Are dressing needs at home anticipated: ☐ Yes ☑ No

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

Discharge Medications: ☐ Yes ☑ No

Details: ....

Final Diagnosis: ....K/C/O Duchenne Muscular dystrophy....

Nurse Name: ....[illegible].... Nurse Signature : ....[signature]....

Date & Time: ....3/7/20 P.10pm....

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IP22-00023482
HCV-00036853 (M)
Master MD ZAHID UR RAHAMAN
09-12-2014 11 Y 6 M 24 D
Dr. Kandula RadhaKrishna / Dr. Raju

Ref. No. : F/HW/PTF/INPR/14

PATIENT TRANSFER FORM

P... / I.P. No	Date & Time of Admission	Date & Time of Transfer Order
MD ZAHID UR RAHAMAN Ip. No - 00023482	03/07/2026 @ 8:05 AM	03/07/2026 @ 8:10 AM
Treating Consultant	**Transfer ordered by**	**Reason for Transfer**
Dr. Kandula Radhakrishna / Dr. Raju	Dr.	Admission
From Bed / Ward / Hospital	**To Bed / Ward / Hospital**	**Information to attendant** Yes ☑ No ☐
ER	PICU	
Number of Sheets in clinical file	**Number of Imaging films**	**Personal belongings including clinical documents. If any handed over to attendant** Yes ☐ No ☐ If yes, What ?
18		

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes written by Doctor:

Name and Signature of Person filling this part	Name of person ordering transfer	Name & Signature of Nurse Supervisor	Referral note & referral Doctor Name:
Akhil		Bhavana Akhil [signature]	

Patient & Clinical records received by: [signature]

Signature with Date & Time 3/7/26 ...

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

Ref. No. : F / PICU / CON / ADM / 15

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CONSENT FOR ADMISSION IN PEDIATRIC INTENSIVE CARE UNIT (PICU)

I ....M. Kashifa........ S/o Mr./ Ms ....Relaam........ hereby declare that our patient Mr. / Ms .... who is related to me as .... is getting admitted in the Pediatric Intensive Care Unit (PICU) of Rainbow Children's Hospital on ....3/7/26.... with UHID No. : ....36853....

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

........K/C/O Dumbeun........

........Needles allergy........

The doctors have clearly explained to me that my patient Mr./ Ms. .... during his / her stay in the PICU may undergo various medical and surgical procedures like airway management, mechanical ventilation, central line insertion, PICC Line and arterial line placements, chest drain, or peritoneal drain insertion etc.

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

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

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

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

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

Patient Attendant :

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

Name : ....M. KASHIFA....

Relationship with Patient: ....Mother....

Date & Time : ....3/7/26....

Witness :

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

Name : ....Rajeev....

Date & Time : ....3/7/26 @ 9A....

Doctor (who is taking the consent) :

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

Name : ....Dr YASH....

Date & Time : ....3/7/26 9A....

Inj. Ceftriaxone Ref. No. F/HW/CON/BT/03

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CONSENT FOR BLOOD TRANSFUSION

Patient Name: MD ZAID s/o Rafique Age: 11Y

Gender : ☒ M ☐ F - IP No. : 23482

Ward / Bed NO. : PICU Date : 3/7/26

Type of Blood Product:

I M. Kashifa 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 HIV antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections can very rarely 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 component 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 he alternative for this procedure that.....

.....

All the above-mentioned risks 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 (PRBC, Platelets, FFP, Cryoprecepitate etc) to me /my Patient during he present hospital stay and treatment.

Patient(Or Patient relative / Guardian):

Signature : .....

Name : M. KASHIFA

Date & Time : 3/7/26

Witness:

Signature : Agreed

Name : Agreed

Address : .....

.....

Contact No. : .....

Date & Time : 3/7/26 9 AM

Doctor(Who is taking the consent):

Signature : .....

Name : Dr YASIN

Date & Time : 3/7/26 9 AM

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Your Right to a Safe Delive

రక్త మార్పిడి కొరకు అంగీకార పత్రము

రోగిపేరు ..... వయస్సు.....పు ☐ స్త్రీ ☐

ఐ.పి. నెంబరు ..... వార్డు/ బెడ్ నెం .....

రక్త మార్పిడి రకం .....

నేను ..... ఇందు మూలముగా రెయిన్‌బో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నపుడు పూర్తి చికిత్సలో భాగంగా (నాకు గాని/ నా రోగికి గాని రక్తమార్పిడిక్రై/ రక్త భాగాల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడీస్, హైపటైటీస్ బి సర్ఫేస్ యాంటిజన్, హైపటైటీస్ యాంటిబడీస్, మలేరియా మరియు సిఫ్లిస్ లక్షణాలు లేవని పరీక్షించబడినదనియు వివరించడమైనది. రక్త పరీక్ష విండో పీరియడ్ లో జరిగినప్పటికి మరియు పరీక్షలో కనబడని అనేక ఇతర ఇన్‌ఫెక్షన్ ద్వారా అతి అరుదుగా రక్తమారిపడి చేసినప్పుడు మార్పిడి ఇన్‌ఫెక్షన్‌లు సోకి వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త భాగ మార్పిడికి సంబంధించిన రియాక్షన్‌లు సోకే ప్రమాదం వుందని, ద్రవం ఓవర్ లోడ్ మొదలగు సాధారణంగా అరుదైనది అని నేను అర్థం చేసుకున్నాను.

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డాక్టర్లు ఈ ప్రక్రియలో ప్రత్యామ్నాయం గురించి నాకు/ నా రోగికి ఏమని వివరించారనగా పైన పేర్కొన్న అన్ని రకాల సమస్యలను నా రోగికి చికిత్స చేసే డాక్టరు నాకు / మాకు పూర్తిగా అర్థమయ్యే బాషలో వివరించినారు, దానికి నేను అంగీకరింస్తూ, నా రోగికి పూర్తి రక్తమార్పిడికి (మొత్తం రక్తం) / రక్త భాగాల మార్పిడికి (పి.ఆర్.బి.సి., ప్లేట్‌లెట్స్, ఎఫ్.ఎఫ్.పి.,) క్రయోప్రెస్సిపిటేట్ మొదలగునవి. మా సమ్మతిని ఇస్తున్నాను.

సహాయకుడు(అటెండెంట్)

సంతకము .....

పేరు.....

తేది మరియు సమయము .....

సాక్షి

సంతకము .....

పేరు.....

తేది మరియు సమయము .....

డాక్టర్

సంతకము .....

పేరు.....

తేది మరియు సమయము .....