Rainbow Children's Hospital | BirthRight by Rainbow

Rainbow Children's Hospitals - Financial District

Survey No 74, Nanakramaguda village, Serilingampally(M) ,Hyderabad ,Telangana, INDIA ,500032.
TEL NO :040-44665555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP25-00020475 **Admit Date** : 16-May-2026 **Admit Time** : 10:44 PM **UHID** : FDH-00045947

Patient Details :

Patient Name	: Baby ABHIGNA REDDY	**Age**	: 5 Y 3 M 15 D
Guardian	: Mr HARISHWAR REDDY	**DOB**	: 01-02-2021
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 6-24, REDDY COLONY , CHEVALLA Chevela Ranga Reddy Telangana INDIA 501503	**Phone No**	: 9676254695/ 9705275755
		E-mail	:

Admission Details :

Bed Type : PICU **Bed No** : PICU-01 **Ward Name** : 4F -PICU

Room No : PICU-01 **Admission Type** : First Visit

Contact Details :

Name : Mr HARISHWAR REDDY **Relationship** : Uncle

Contact Address : 6-24, REDDY COLONY , CHEVALLA Chevela Ranga Reddy Telangana INDIA 501503 **Phone No** : / 9705275755

AH Reddy
Signature

Doctor Details :

Doctor Name : Dr. REENA MATHEW **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 10000.00

Payor Name : ICICI LOMBARD GENERAL INSURANCE CO LTD

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ACTIVITY RECORD FOR BILLING

:DH-00045947 IP25-00020475
Name: ----------Baby ABHIGNA REDDY ----------
)1-02-2021 5 Y 3 M 15 D (F)
Dr. REENA MATHEW
UHID No : ---------- IP No t : ---------- Dept : ----------

Date of Admission : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
16/5/26.	11:30 PM	ER.	PICU.	A-Roy.
17/5/26	12p~.	PICU	309	

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
16/5/26	CBP, CRP, Urea, Creat, S/E, Cal, mag, PT/APTT, LFT,	17470	Suvarya
	VBG, GRBS - 106mg/dl	17471	
16/5/26	CT Brain (plain)	5946	
	CT-spine (plain)		
16/5/26	Chest X Ray	5951	
~~17/05/26~~	~~NHA~~	~~6330~~	~~Sk~~

Cross Checked
by Tuhina
18-05-26

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
17/5/26	Inv monitor	1 AM	17/05/26 12pm		
	Infusion pump	1 AM	18/5 @ 6AM	6293	Bmd1.

Cross checked by Tuhin 18-05-26 @

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
16/5/26.	IU Placement	①	76265.	A. Roy.
7/5	NHA	①	6330	

Cross checked Timing 16-05-26

ANY OTHER INFORMATION

Date : 16-5-26 Time : 12:59 PM Prepared By : YASEEN

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Ankush.	PICU.		

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PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
DH-00045947 IP25-00020475 Baby ABHIGNA REDDY 01-02-2021 5 Y 3 M 15 D (F) Dr. REENA MATHEW	16/6/26 @ 10.44 p.m.	16/06/26 @ 11:45 PM
	Transfer Ordered by	**Reason for Transfer**
	DR. Sajid.	Admission.
From Unit	**To Unit**	**Information to Attendant**
ER.	PICU	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
16.	–	Yes ☑ No ☐ - OP If yes, what ? File

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	SOCC & HighPressure	①
2.	PCM & Intrafix	
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Ankush.	DR. Sajid.

Patient & Clinical Records Received by : Bzwij

Date & Time of Patient Received : 16/05/26 @ 11:50

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

FDH-00045947 IP25-00020475
Baby ABHIGNA REDDY
01-02-2021 5 Y 3 M 16 D (F)
Dr. REENA MATHEW

PICU

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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 17/05/26 Time: 9:15AM

Weight: 17kgs Centile: 25th Centile

Height: — Centile: —

Inference: Well Nourished Child

RDA: 1660KCAL - 1700KCAL Calories: 1700KCAL Protein: 19.0gms

Diet Recommendations: Advised moderate Carbohydrates & Adequate protein & Balanced meal

Re-Assesment: —

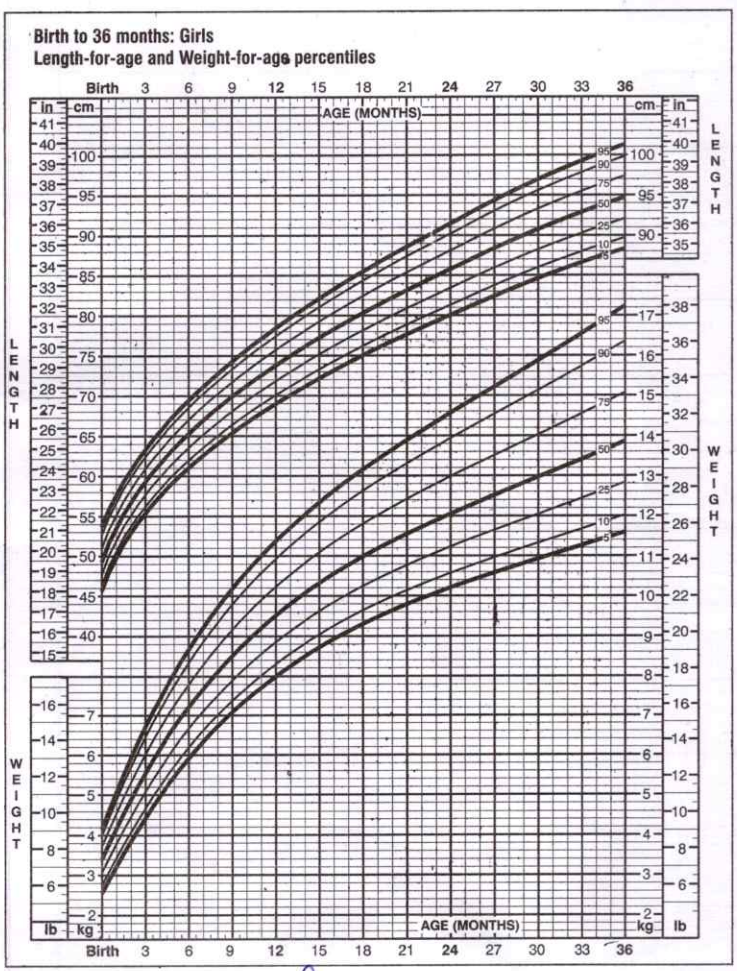
Food Allergies: Nil Veg/Non-veg

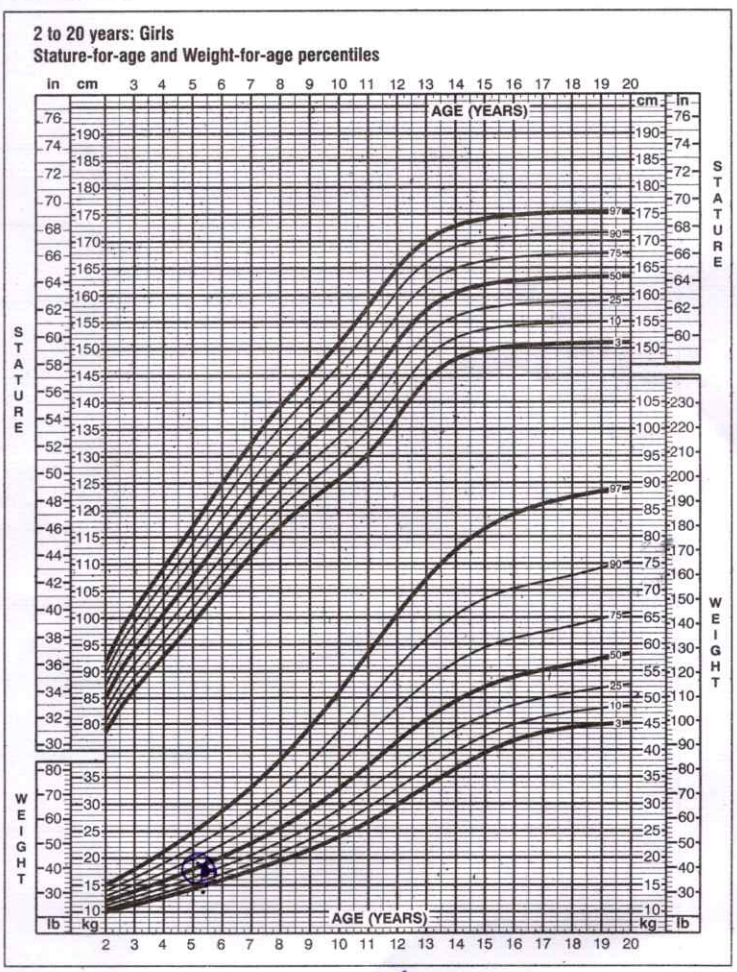
Diagnosis: TBI Chead Injury

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Vanashi

GROWTH CHART (GIRLS)





Dietician's Name Ashiya

Dietician's Signature Ashi

Docu. No. : RCH / FRM / CLINICAL / 161

(P.T.O.)

Daily Notes:

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PATIENT TRANSFER FORM

FDH-00045947 IP25-00020475
Baby ABHIGNA REDDY
01-02-2021 5 Y 3 M 16 D (F)
Dr. REENA MATHEW

	Date & Time of Admission	Date & Time of Transfer Order
	16/05/26 @ 10:44pm	17/05/26 2 p.m.
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
DR. Reena	DR. Reena	TBI ? observation.
From Unit	**To Unit**	**Information to Attendant**
PICU		Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
33	CT- Flim. Brain CT.- Spine	Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

DR. Reena

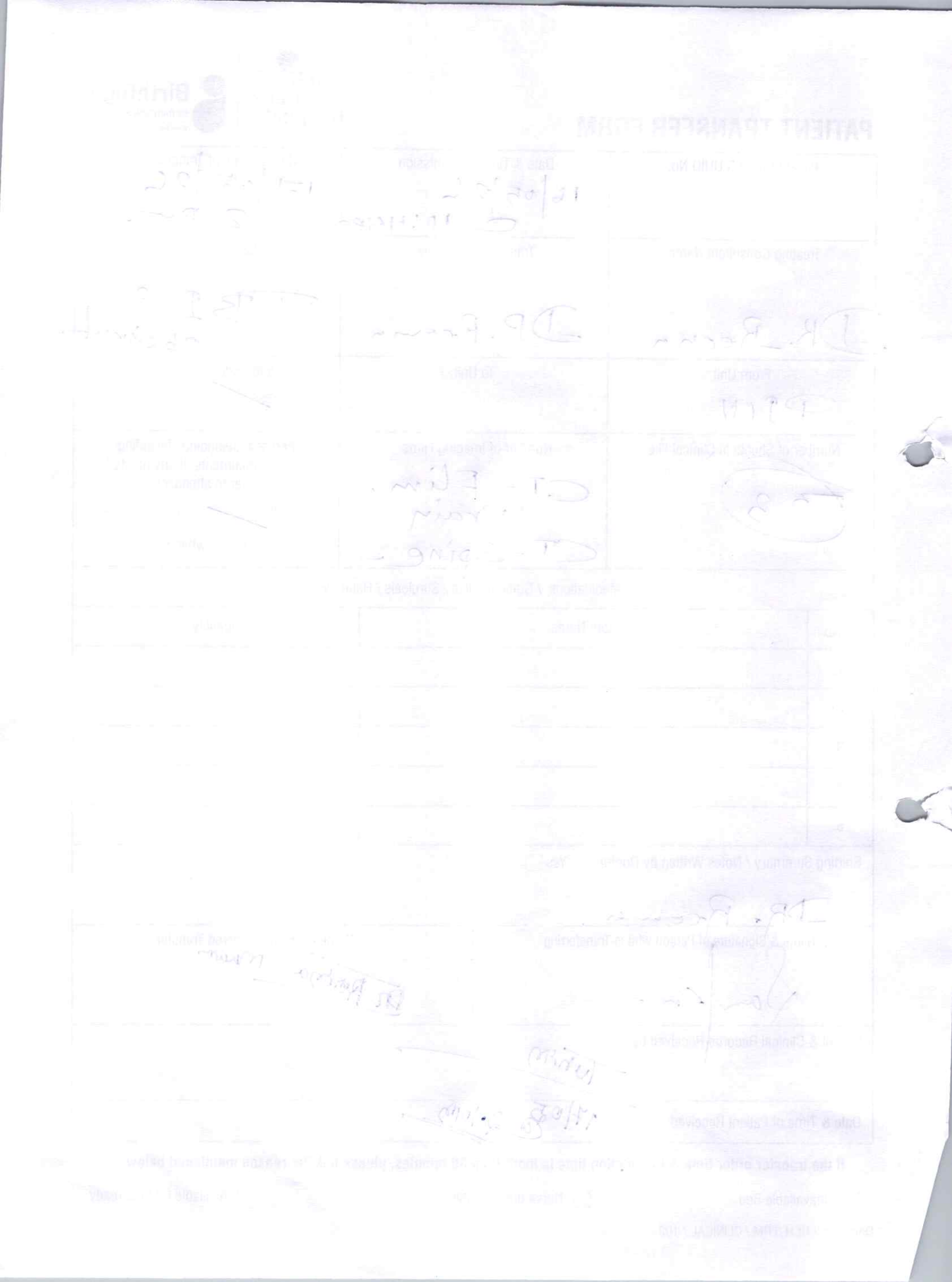
Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
	Dr. Reena Mathew

Patient & Clinical Records Received by : Tuhin

Date & Time of Patient Received : 17/05 @ 2.10pm

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



:DH-00045947 IP25-00020475
Baby ABHIGNA REDDY
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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Baby Abhigna Age : 5 y. **Gender:** ☐ Male ☐ Female

Date : 16/5/26. Time of Arrival : 10:10 pm

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

Source of Information : ☐ Parents ☐ Others (Specify) .....

Mode of Arrival : ☐ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 98 F PR: 90 b/m BP: 84/74/79 RR: 21 b/m SpO_2: ..... got Hit over Forehead

Chief Complaints: C/O - Fall Down During Cycling, Vomiting 4 episodes.

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☐ Normal
☐ Sick Looking

Circulation / Colour
☐ Normal ☐ Abnormal ☐ Bleeding

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

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

Unconscious for 30 sec.

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

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

Vamshi
Signature of Parent / Guardian

* CTAS - Canadian Triage and Acuity Scale

Triage Completion Time : 10:14 pm

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Samyal

Signature of Triage Nurse : .....

Date & Time : 16/5/26 @ 10:12 pm

:DH-00045947 IP25-00020475
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Dr. REENA MATHEW
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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 16/5/26 Time of arrival : 10:10pm Unconsciousness For 30 Sec.

Chief Complaints: Fall Down while Cycling, Vomiting 4 Episodes

Height : ..... Weight : 17 Kg Head Circumference (<2 years) .....

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

If yes , identify .....

Pain Screening: ☐ Yes ☐ No If Yes, Pain Score: 03/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker

☐ Character ... Moderate ☐ Location ..... Over Forehead ☐ Frequency ..... Continuous ☐ Duration .... 30 min +

RISK FOR FALL:

If patient is < 6 years	☐ Yes	☐ No
If **'Yes'** tick below fall risk intervention directly		
If Patient is > 6 years		
If **'Yes'** Assess the below parameters		
History of Falling: within past 3 months	☐ Yes	☐ No
Ambulatory Aids:		
• Wheelchair	☐ Yes	☐ No
• Uses furniture for support	☐ Yes	☐ No
Gait/Transferring:		
• Bedrest / immobile	☐ Yes	☐ No
• Weak	☐ Yes	☐ No
• Impaired	☐ Yes	☐ No
Mental Status: Forgets limitations	☐ Yes	☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

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

Social History: Lives With ..... Parents .....

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

Time of Initial assessment completed by ER Nurse : 10:14pm

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

Time	Nursing Notes
10:12PM	→ Assessed the general condition
	→ Checked vital sign.
	→ Informed ER Doctor &
	Seen the Doctor

Samples collected by: YASEEN Time: 11:45PM

Samples sent by : Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
	~~Syp. Paracetamol~~	~~P/O~~	~~[illegible]~~		
11PM	IV 3% NS bolus	IV	50ml over 30min	[signature]	[signature]

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 90b/m BP: 90/72 CFT: 2sec	Shift - out from ER to: PICU
RR: 89b/m SPO2 at FiO2: 99%	Time of Shift - out: 11:45
GCS: 15 Temperature : 98F	Handover given to: (Nurse's Name) [signature]
Pain Score: —	
Repeat RBS (if applicable): —	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV Placement

Name of the Nurse : YASEEN Signature of the Nurse: [signature]

Date & Time : 16-5-25 @ 11:45PM

Ref. No: F/PICU/ADMR/08

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PEDIATRIC INTENSIVE CARE ADMISSION RECORD

FDH-00045947 IP25-00020475
Baby ABHIGNA REDDY
01-02-2021 5 Y 3 M 16 D (F)
Dr. REENA MATHEW

Name : ..... Age : ..... Gender : .....

I.P.No. : ..... UHID No. ; .....

Fathers' / Mother's Name : ..... Age : .....

Adress : .....

.....

Tel. : ..... E-mail : .....

Date of PICU admission : ..... Time : ..... ☐ 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 : .....

Admitting Consultant : .....

Indication for PICU referral : .....

Prism III score at 24 hrs of admission : .....

Date of : Discharge : ..... Transfer : ..... Death : .....

Duration of ICU Stay : .....

Final Diagnosis : .....

.....

.....

.....

.....

.....

Presenting Complaints / Chief Complaints :

c/o. fall down while playing with bicycle @ 8:30pm

F/b → LOC (30sec) ?seizure like activity tightening of limbs

& 4 episodes of vomiting

↓

swelling (+) over Rt frontal region

abrasion (+) over Rt elbow

Past History (Including previous treatment and investigations) :

Not significant

Birth and Developmental History :

(N)

H / O Allergy :

Family History :

(N)

Immunization History : upto date

INITIAL ASSESSMENT

RBS : 106 g/dl Temperature : .... Weight (kg) : 17 kg

RESPIRATORY SYSTEM FINDINGS :

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

Respiratory Examination Finding: (Air entry, breath sounds, S/o distress etc.) : Respiratory Rate : 21 /m

....

SPO_2 : 98% O_2 by NC / FM / NRB mask / Oxyhood, at .... L / min

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

Ventilatory Settings : 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 : 90 bpm Cardiac Rhytho : ....

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

Quality of Pulses : .... cap retill Time : .... Liver Edge : .... cm below Rt costal margin

Blood Pressures : NIBP : 86/74 (79) 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 : ....

Abdominal Exam : ....

ENT Exam : ....

Central Nervous System :

Level of Consciousness : AVPU / GCS score : 14/15 Concious

Neurological Findings : Irritable

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

Clinical Summary and Provisional Diagnosis : TBI ?

PLAN OF CARE

Preventive aspects of the treatment :

Desired goals of the treatment :

PLANNED INVESTIGATIONS	PLANNED MANAGEMENT
CT brain c̄ cervical spine	IV Bx:M bolus (3ml/kg) over 30m
VBG, GRBS – 106mg/dl	F/b
CBP	↓
CRP	maintenance
LFT	@ 15ml/hr
S creatinine, urea	
Sr. electrolytes	IV DNS
PT/INR, APTT	Inj PCM
Cut, Mg	Inj Pantop, Inj ondans
X-ray chest	Inj Ceftriaxone – std
Noted by Sowarya @ 11:30pm. 16/5/26	

Doctor's Signature : [signature]

Name :

Consultant's Signature : [signature]

Name : Dr Reena Mew

PLEASE FILL UP THE FOLLOWING DETAILS

1. Name of the referring Doctor :
2. Name of te referring Hospital :
   Address :
   Contact Numbers :
3. Contact Details of the referring Doctor :
   Mobile No. : E-mail ID :
4. Name of the Doctor in Rainbow Team :

.... on whose name the patient is being referred.

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Dr. REENA MATHEW

(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/5/26 8:30am	PSB Dr. Unnati	
	Head injury	
	(Acc to RCPCH guidelines) A/S :- Mild [struck] without (risk factors.)	
	mild headache (+) → No sleep disturbance	
	No c/o altered mental status / Abnormal neurology /	
	No palpable skull injury or fracture / No post traumatic	
	seizures / No further episodes of vomiting / LOC.	
	Vitals :- HR :- 110/min	
	RR :- 28/min	
	SpO2 :- 99% @ RA	
	CFT < 2sec	
	CT / xray → oral report (N)	
	(No evidence of bleeding / fractures).	
	O/E :- conscious, oriented to time / place / person.	
	Hydration fair.	
	Alert / Active / Afebrile.	
	minimal pain / swelling abrasion (+) over Rt elbow.	
	S/E :- CNS :- GCS 15/15	
	B/L pupils equally reactive to light	
	No focal neurological deficits / No ab(N) posturing	
	CVS :- S1 S2 (+). No murmur heard	
	RS :- B/L AE (+). No Added sounds. No WOB.	
	P/A :- Soft / BS (+).	
		Plan
		→ Can shift to ward after rounds
[signature]		→ ↓ IV fluids if taking orally well
		→ Continue rest as charted.

Margin note: Drowsy / lethargy post injury LOC [struck] Minimal swelling over forehead

Docu. No. : RCH /FRM / CLINICAL / 088 (P.T.O)

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...OGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/05/2026	C/S/B Dr. Lohan	
9.00 Am	Mild Traumatic Brain Injury [LOC ~ 30 sec]	
	No further episodes of Vomitings	
	No further Seizures	Advice
	O/E GCS - 15/15	Encourage orally
	active, alert	
	HR - 96 bpm	- CT symptomatic
	RR - 24/min	management
	PP - well felt	
	SpO2 - 98%	- Neuroobservation
	BP - 108/68 (80)	
		- plan to shift to
	S/E B/L pupils - equal & Reactive	ward @.
	CNS - alert	- IVF DNS @ 18ml/h
	CVS - S1S2 (+), MC	allow orally
	RS - B/L NVB	→ Monitor GCS & vitals
	P/Abd - Soft	
	N.B. [signature]	[signature] [signature]

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/05/2026		
	C/S/B Dr. Sneha.	
8pm	D: Mild Traumatic Brain Injury	
	CLOC (~30 sec).	
	- GC: stable	
	- No further Seizure / vomiting.	
	- No fresh complaints	
	Vitals: HR: 92/min, RR: 22/min, SPO2: 98% RA, BP: 100/70 mmHg	GCS: 15/15; B/L Pupils equal and reactive.
		Plan: - Continue same as per Charting; - monitor GCS
		Taken by Tuhina 17/05 @8pm

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/5/2026		
4:30am	9/S/BDs: Sruthi	
	S: Mild Traumatic Brain Injury	
	(~LOC 30secs).	
	· GC: stable	
	- taking orally well.	
	· No seizures or vomiting further	
	· No new issues.	
	Comula: Out	
	Vitals	Plan
	HR: 90/min	
	RR: 20/min	- Stop IV fluids
	temp: 98F	
	SPO2: 98% RA	- Allow oral diet
	BP: 100/70mmHg	
	S/E	- Syp. CROCINDS 5.5ml
	CNS: conscious, alert	P/O 6hourly.
	GCS 15/15, B/L PEARL	
	CVS: S1S2⊕	- Syp. ONDENSATRON
	R/S: B/L NVBS⊕ P/A: soft, non distended	(2mg/5ml) 5ml P/O TDS

- TAB LANZOL DT (15mg) 1tab P/O OD B/F

PTO

FDH-00045947 IP25-00020475
Baby ABHIGNA REDDY
01-02-2021 5 Y 3 M 16 D (F)
Dr. REENA MATHEW

Rainbow® Children's Hospital — It takes a lot to treat the little.
BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	- w/f Sensorium, vomitings.	
	NB	
	Intim	
	BIJ	
	@7:30AM	
18/5/2026 9:30am	C/R/B Dr. Aishwarya.	
	Δ Mild traumatic Brain Injury.	
	Child taken orally → No vomiting	
	No headache / loss of consciousness	
	Child active and alert.	
	O/E: HR – 88/min	
	RR – 20/min	
	BP – 97/64 mmHg	
	S/E: CNS :- Tone, Reflex } (N) GCS – 15/15	
	CVS: S1S2 (+), No Murmur	
	P/A: Soft, Non tender	
	RS: B/L AE (+), NVBS	
	F/u + Tree 1) Cross SOS 2) Under play + 1 week (Ibrutinib)	Plan
		- Continue oral medication as advised
		- w/f headache/vomiting
		D/S today.

FDH-00045947 IP25-0002047 5
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

STAR HOSPITALS

UNIMED Healthcare Pvt. Ltd
Survey No.74, Financial District, Nanakaramguda,
Telangana, India - 500008
For Appointments: 1800 102 7827
GSTRN: 36AAACU8638B1ZD
CIN: U85110TG2006PTC051751
(Subject to Jurisdiction of Hyderabad)

Ms.BABY ABHIGNA REDDY

5 FEMALE

REF BY.
REENA MATHEW

TREATING PHYSICIAN

DEPARTMENT

UHID
910000153182

ENCOUNTER NO
912605161175

BILL NO	BILL DATE	MOBILE NO
91262001778	16 MAY 2026 23:43	9154777380

Bill Of Supply

S.No	PARTICULARS	CODE	UNIT	TARIFF	AMOUNT (IN INR)
1	CT - BRAIN SCAN (PLAIN)	CTN009	1.0	5300.00	5300.00
2	CT - SPINE (PLAIN)	CTN024	1.0	9560.00	9560.00

GROSS TOTAL **14860.00**

NET TOTAL **14,860.00**

Fourteen Thousand Eight Hundred and Sixty Only

RECEIPT DETAILS

RECEIPT NUMBER	TRANSACTION NO	BANK	TYPE	AMOUNT
912611002852			Credit Voucher	14,860.00

On The Account Of :Rainbow Children Medicare Limited

THANK YOU

PRINTED ON: 16 MAY 2026 23:43
Remrks :

Star Hospitals ★ A Unit of Unimed Health Care Pvt. Ltd. ★ Sign

BILLED BY
CHINDAM SHIVA
info@starhospitals.in

E & OE

STAR HOSPITALS

UNIMED Healthcare Pvt. Ltd
Survey No.74, Financial District, Nanakaramguda,
Telangana, India - 500008

For Appointments: 1800 102 7827
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Ms.BABY ABHIGNA REDDY

5 FEMALE

REF BY.
REENA MATHEW

TREATING PHYSICIAN

DEPARTMENT

UHID
910000153182

ENCOUNTER NO
912605161175

BILL NO	BILL DATE	MOBILE NO
91262001777	16 MAY 2026 23:37	9154777380

Bill Of Supply

S.No	PARTICULARS	CODE	UNIT	TARIFF	AMOUNT (IN INR)
1	X-RAY BEDSIDE CHEST PA/AP	XRY049	1.0	880.00	880.00

GROSS TOTAL **880.00**

NET TOTAL **880.00**

Eight Hundred and Eighty Only

RECEIPT DETAILS

RECEIPT NUMBER	TRANSACTION NO	BANK	TYPE	AMOUNT
912611002851			Credit Voucher	880.00

On The Account Of :Rainbow Children Medicare Limited

THANK YOU

PRINTED ON: 16 MAY 2026 23:37
Remrks :

Star Hospitals ★ A Unit of Unimed Health Care Pvt Ltd ★
Sign

BILLED BY
CHINDAM SHIVA
info@starhospitals.in

E & OE

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Sheet No: 2

REGULAR PRESCRIPTIONS

Weight 17kg Ward 3rd (A)

DRUG : T. LANZOL DT				Date/Time: 18/5
Dose	Route	Frequency	Start Dt.	
15mg	P/O	OD	18/5	8am — Nibedha Keka
Name & Signature of the Doctor Starting the Drugs: [signature]				
Additional Instructions: 30mins Before Breakfast				
Daily Doctor's Endorsement by a Sign				

DRUG : Syp. ONDANSETRON				Date/Time: 18/5
Dose	Route	Frequency	Start Dt.	
6ml	P/O	8 hourly	18/5	8am — 8:30 am, [signature] Tahir
Name & Signature of the Doctor Starting the Drugs: [signature]				2pm
Additional Instructions: (2mg/5ml) 30mins before food				10pm
Daily Doctor's Endorsement by a Sign				

DRUG :				Date/Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date/Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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

Patient Sticker

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG :

Dose	Route	Frequency	Start Dt.	Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.	Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.	Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.	Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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

:DH-00045947 IP25-00020475
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DRUG CHART

Date of Admission: 16/05/26 Drug Allergies: NA ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

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

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REGULAR PRESCRIPTIONS

Weight. 17 kg Ward. 3rd (II)

DRUG : Inj PARACETAMOL

Dose	Route	Frequency	Start Date
250 mg	IV	6 hrly	16/5

Name & Signature of the Doctor Starting the Drugs: Z

Additional Instructions:

Date / Time	16/5	17/5	18/3
12 AM	X		
6 AM	X		
12 PM	11:30 AM		
6 PM	X		

Stop.

Daily Doctor's Endorsement by a Sign

DRUG : Inj PANTOP

Dose	Route	Frequency	Start Date
2 mg	IV	OD	16/5

Name & Signature of the Doctor Starting the Drugs: Z

Additional Instructions:

Date / Time	16/5	17/5	18/5
6 AM			

Stop

Daily Doctor's Endorsement by a Sign

DRUG : Inj ONDENSETRON

Dose	Route	Frequency	Start Date
3 mg	IV	TID	16/5

Name & Signature of the Doctor Starting the Drugs: Z

Additional Instructions:

Date / Time	16/5	17/5	18/5
6 AM	X		
2 PM	X		
10 PM	11 PM		

Stop.

Daily Doctor's Endorsement by a Sign

DRUG : SYP. CROCIN DS

Dose	Route	Frequency	Start Date
5 ml	P/O	6 hrly	18/5

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: 2 D/5 ml

Date / Time	18/5
12 AM	X
6 AM	
12 PM	
6 PM	

Daily Doctor's Endorsement by a Sign

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Weight. 17 kg Ward. 3rd (A)

	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
26/5/2	11.00 P.M	IV 3% NS (3rd (A))	50 ml over 30 min	IV	[illegible]	Samsul. Yaseen.
14/5/24	1 AM	Inj CEFTRIAXONE	850 mg	IV	[illegible]	[illegible] Sushma

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I.V. FLUIDS CHART

Weight. 17 kg Ward. 3rd Ped

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
16/5	1AM	IV DNS	IV	56 ml/hr	J		17/5 @10PM		
16/5		~~IV 3rd DNS~~	~~IV~~	~~56 ml/hr~~					
17/5	10PM	DNS	IV	18 ml/hr			18/5 @ 7:30 AM		Ishita

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