

DISCHARGE SUMMARY

Name	B/O SREE VIDYADHARI NARAYANA BHATLA	UHID	FDH-00046102
Father/Guardian	Mr PRADEEP KOUTHU	Age/Gender	0 Y 0 M 6 D/ Female
Address	..., Hyderabad, Hyderabad, Telangana, INDIA, 500001		
IP No	IP25-00020664	Admission Date	27-05-2026
Ref Doctor			
Discharge Date	28-05-2026		

Consultant:

Dr. Kondam Pradeep Reddy

MBBS, MD, DNB (Pediatrics), DM (Neonatology)

Consultant Pediatrician & Neonatologist

Reg.No : 76060

DIAGNOSIS	ICD CODE
UNCONJUGATED HYPERBILIRUBINEMIA	P 59.9

History: B/O SREE VIDYADHARI NARAYANA BHATLA, is a 6 Days, old baby girl presented with history of yellowish discolouration of skin and eyes since 1 day prior to admission. For the above complaints, she was investigated on OPD basis (Serum bilirubin was 18.78 mg/dl). In view of hyperbilirubinemia, she was admitted to Rainbow Children's Hospital, Financial district for further management.

Birth history:



Name	B/O SREE VIDYADHARI NARAYANA BHATLA	UHID	PH-00046102
IP No	IP25-00020664	Admission Date	27-05-2026

TERM / AGA / ASSISTED VAGINAL DELIVERY (KIWI) / LBW: 2.470 kg / BABY GIRL / CIAB

INFANT OF DIABETIC / HYPOTHYROID MOTHER

Mother's Blood group is "A" positive. Baby's blood group is "A1" positive.

Examination: She was euthermic. Maintaining saturations at room air (98%). Heart Rate- 140/min, Blood pressure was 80/48mmHg and Respiratory Rate - 40/min. Icterus was present. Chest was clear with normal heart sounds. Abdomen was soft without organomegaly. Cry, tone, activity and newborn reflexes were normal. There were no obvious external congenital anomalies.

Weight on admission : 2.324 kilo grams.

Weight at discharge : 2.358 kilo grams.

Investigations: Enclosed.

Management: She was admitted in ward. Her serum bilirubin on admission (done on OP basis) was 18.68 mg/dl. She was started on double surface phototherapy. Baby was continued on demand breast feeds. Her serum bilirubin levels were regularly monitored which showed decreasing trend. Her last serum bilirubin on 7 day of life was 9.81 mg/dl with indirect fraction of 9.71 mg/dl. This does not come under phototherapy range, hence phototherapy stopped.

Baby remained hemodynamically stable and is being discharged with the following advice.

At the time of discharge : Baby was active, afebrile, hemodynamically stable, maintaining temperature, accepting & tolerating feeds well.

Advice:

Keep the baby clean & warm



Name	B/O SREE VIDYADHARI NARAYANA BHATLA	UHID	RDH-00046102
IP No	IP25-00020664	Admission Date	27-05-2026

Exclusive breast feeding every 2nd hourly followed by burping.

Monitor urine output.

Immunization as per schedule

Vitamin D3 Drops (1ml/800IU) 0.5ml once daily till further advice.

Nasoclear Nasal drops 2 drops in each nostril SOS for nose block.

Plan:

1. Serum bilirubin to be decided on follow up.

Review consultation with Dr. KONDAM PRADEEP REDDY, on Monday (01.06.2026) in OPD at Financial District with prior appointment (**Review consultation will be charged**).

Review back to Hospital: If baby is not feeding continuously for > 6 hours, If breathing fast, Fever or poor activity or lethargy, Bluish discolouration of lips, Increase in jaundice, Abnormal movements occurs.

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 doctor in a language that I can understand and I acknowledge.


Parent/ Attender

In case of emergency contact number 8121039503 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Financial District/ Banjara Hills / Rainbow Clinic Madhapur / Kukatpally / Vikrampuri / LB Nagar** dial just one toll free number **18002122**.



Name	B/O SREE VIDYADHARI NARAYANA BHATLA	UHID	UH-00046102
IP No	IP25-00020664	Admission Date	27-05-2026

You can also take appointments at any time by going **online** to our website
www.rainbowhospitals.in

Registrar/Resident/C.M.O

Consultant:

Dr. Kondam Pradeep Reddy

MBBS, MD, DNB (Pediatrics), DM (Neonatology)

Consultant Pediatrician & Neonatologist

Reg.No : 76060





ADMISSION SHEET

Registration Details :



Admission No : IP25-00020664

Admit Date : 27-May-2026

Admit Time : 12:56 PM UHID : FDH-00046102

Patient Details :

Patient Name : Baby B/O SREE VIDYADHARI NARAYANA BHATLA Age : 0 Y 0 M 6 D
Guardian : Mr PRADEEP KOUTHAN DOB : 21-05-2026 12:00 PM
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : Hyderabad Hyderabad Telangana INDIA 500001 Phone No : 9618407550/ 9618407550
E-mail : vidyadhari93@gmail.com

Admission Details :

Bed Type : TWIN SHARING

Bed No : TS 323 A

Ward Name : 3F -TWIN SHARING

Room No : TS 323 A

Admission Type : First Visit

Contact Details :

Name : Mr PRADEEP KOUTHAN Relationship : Father
Contact Address : Phone No :

Praadeep
Signature

Doctor Details :

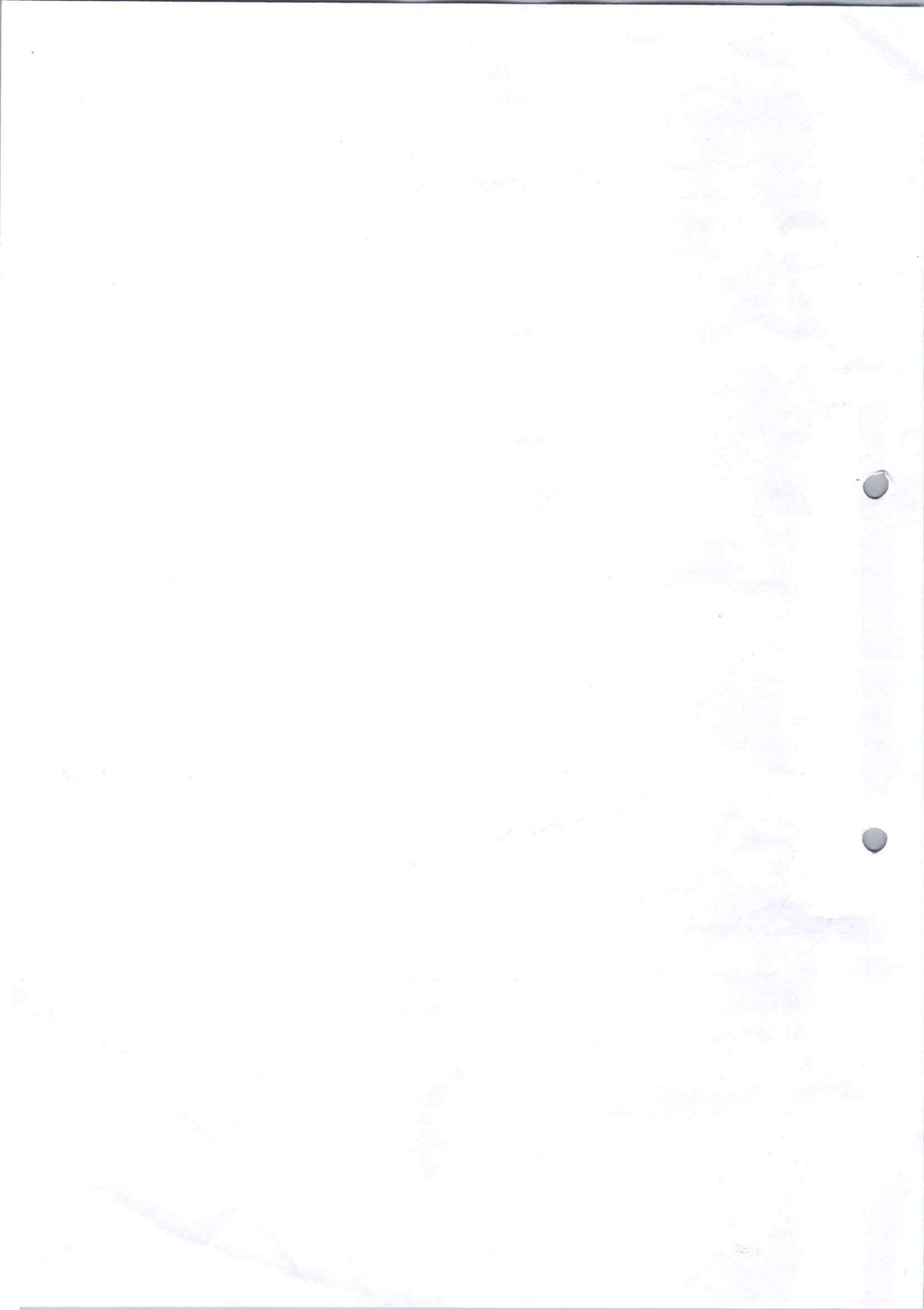
Doctor Name : Dr. KONDAM PRADEEP REDDY Specialisation : GENERAL PEDIATRICS
Referral Doctor : Phone No :
Co-Consultant :

Payment Details :

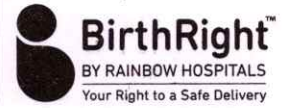
Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD



FDH-00046102 IP25-00020664
 Baby B/O SREE VIDYADHARI (F)
 21-05-2026 0 Y 0 M 6 D
 Dr. KONDAM PRADEEP REDDY



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>MNI.</u>	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	<u>28/05/26</u>						
	Shift	<u>M</u>						
	Medical Condition (Any special condition to be noted):	<u>-</u>						
	Diet:	<u>DBM</u>						
ASSESSMENT	Allergy:	<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	<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):	<u>RA</u>						
	Tubes/Drains/Catheter:	<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	<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:	<u>98.4°F</u>					
		Res:	<u>42</u>					
		SpO ₂ :	<u>99%</u>					
		Pulse:	<u>142</u>					
		BP:	<u>-</u>					
		LOC:	<u>C.</u>					
	Fall Risk Score:	<u>0/10</u>						
Pain Score:	<u>0/10</u>							
Skin Integrity	<u>Good</u>							
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:	<u>-</u>						
	Others Specify:	<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	<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:	<u>DBM</u>						
	Critical Lab Test / Values:							
	Other Special Orders / Medications:	<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	<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 checked="" 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 checked="" 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):	<u>Dependent</u>							
Post Operative Procedure Special Orders:		<u>-</u>						
Handed Over By Name :		<u>P9m</u>						
Signature / ID :		<u>017137</u>						
Date:		<u>28/05/26</u>						
Time:		<u>03PM</u>						
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								

Patient Sticker

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 checked="" 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:								

ACTIVITY RECORD FOR BILLING

Name: ----- FDH-00046102 IP25-00020664
 Baby B/O SREE VIDYADHARI
 21-05-2026 0 Y 0 M 6 D (F)
 UHID No : ----- Dr. KONDAM PRADEEP REDDY
 Date of Admission : ----- Date of Discharge : ----- Time: -----
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
27-5-26	1:00 PM	ER	323A	YASEEW
28/05/26	12:00 PM	ward	Billing	Sung

Cross Consultation Visit

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



EMERGENCY ROOM TRIAGE FORM

Patient's Name : B/O SREE VIDYADHARI NARAYANA BHATLA Age : 6 days Gender: Male Female
 Date : 27-5-26 Time of Arrival : 12:40 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: 98F PR: 140/min BP: 80/48 RR: 40/min SpO₂: 98% SBR: 18.68

Chief Complaints: 1/0 yellow discoloration on body & eyes

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS	
Appearance	Work of Breathing	<input checked="" type="checkbox"/> Stable	
<input checked="" type="checkbox"/> Normal	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased	<input type="checkbox"/> Unstable :	
<input type="checkbox"/> Sick Looking	<input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea	<input type="checkbox"/> Not - Life - Threatening	
Circulation / Colour		<input type="checkbox"/> Life -Threatening	
<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding			

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: [Signature]
 Triage Completion Time : _____

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 two 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 : YASEEN Signature of Triage Nurse : [Signature]

Date & Time : 27-5-26 @ 12:42 PM

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 27-5-26 Time of arrival : 12:40 PM

Chief Complaints: 1/0 Yellow discoloration on the body

Height : Weight : 2.32⁴kg Head Circumference (<2 years)

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

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

Character Location Frequency Duration

<p>RISK FOR FALL: If patient is < 6 years <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No Ambulatory Aids: • Wheelchair <input type="checkbox"/> Yes <input type="checkbox"/> No • Uses furniture for support <input type="checkbox"/> Yes <input type="checkbox"/> No Gait/Transferring: • Bedrest / immobile <input type="checkbox"/> Yes <input type="checkbox"/> No • Weak <input type="checkbox"/> Yes <input type="checkbox"/> No • Impaired <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Status: Forgets limitations <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IF YES FOR ANY CATEGORY = RISK FOR FALLING Fall Risk Intervention: <input checked="" type="checkbox"/> Escort while ambulating <input checked="" type="checkbox"/> Assist Patient <input checked="" type="checkbox"/> Educate patient and family on fall precautions/prevention</p>	<p>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</p> <p>Inform consultant for positive criteria</p> <p>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</p> <p>Inform consultant for positive criteria</p>
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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 Parent

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

Time of Initial assessment completed by ER Nurse : 12:43 PM

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

Time	Nursing Notes
12:42 ^{PM}	Assessed the condition checked the vital sign And Inform to doctor

Samples collected by:

Time:

Samples sent by:

Time:

Nil

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: 150 b/m BP: 89/45 CFT: 2 sec RR: 40 b/m SPO2 at FiO2: 99% GCS: 15 Temperature: 98.8 F Pain Score: _____ Repeat RBS (if applicable): _____	Shift - out from ER to: 323A Time of Shift - out: 2:05 PM Handover given to: _____ (Nurse's Name)

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any): *Nil*

Name of the Nurse: *YASEEN*

Signature of the Nurse: *[Signature]*

Date & Time: *2*



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

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

FDH-00046102 IP25-00020664
Baby B/O SREE VIDYADHARI
21-05-2026 0 Y 0 M 6 D (F)
Dr. KONDAM PRADEEP REDDY



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

cp yellowish discoloration
of skin ∴ 4 days

History of present illness :

A 6 day old female child
was brought with cp yellowish
discoloration of skin ∴ 4 days.

accepting feeds well

Recent admission

on 24-5-26

i/v/o TUBR - 19.0

T/t - DSPT

B.wt - 2.470 kg

Wt. d/s - -

T.wt - 2.324 kg

Wt. loss 5.91 %

MBG - A +ve

BBG - A +ve

@ DOL - 6

SBR - 18.78

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Term/AGA/AVD/Girl/CIAB/LBW-2.470kg
IDM

Birth & Socio Economic History:

About Father : _____
About Mother : DM
Any additional Information : _____

Developmental History :

Immunization History :

vaccinated at birth

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

On Examination :

Temperature : 98°F Pulse Rate : 140/m B.P. 80/48 SPO2 98%

Resp.rate and type of breathing : 40/m

Rash _____

Lymphadenopathy } ⊖ Icterus ⊕

Oedema : _____

Allergies (if any): _____

Respiratory System :

AEBE ⊕

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any addes sounds : _____

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

Cardiovascular System :

S₁S₂ ⊕

Inspection of procordium : _____

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen :

Inspection Soft, non tender

Palpation : _____

Auscultation : _____

Spine : _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____

Motor System:

Nutrition : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

C/T/A - Good

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

NNJ

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

 _____ to prevent Keratitis

Desired goals of the treatment : _____

 _____ resolution of symptoms

Planned Labs:

- SBR - to be decided
 after rounds tomorrow
 → GAFM tomorrow

10 AM
 Abru
 rounds

Planned Management

1) Start DSPT

2) Cover eyes & genitalia

3) DBF Q 2 HRLY

4) Monitor U/O

5) Vit D drops 0.5 ml OD

6) Tobramycin eye drops

7) Nasoclear drops

Signature of the Doctor: Kasmeera Az

Name of the Doctor: Dr. Kasmeera

Date & Time: 27-5-2026

Signature of the Consultant: any

Name of the Consultant: any

Date & Time: 27/5/26



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 Shifted to: 323-A

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						<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. Kameera Kameera A

Date & Time : 27-05-2026

Nurse Name & Signature: YASEEN

Date & Time : 27-5-26 1:00 PM



Patient Sticker



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

VERIFIED BY : Name Signature

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																				

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																				

Morning Shift

Clinical Diagnosis.....
Nursing Diagnosis.....

Plan of Care

Planned Investigations Procedures

Implementation

Handed Over by : Name & Signature

Received by : Name & Signature

Evening Shift

Clinical Diagnosis.....
Nursing Diagnosis.....

Plan of Care

Planned Investigations Procedures

Implementation

Handed Over by : Name & Signature

Received by : Name & Signature

Night Shift

Clinical Diagnosis... *MMJ*
Nursing Diagnosis... *yellow discoloration of the skin*

Plan of Care ** Attach the baby condition.
* maintain His chart.
* Don feed 2nd-3rd mly.*

Planned Investigations Procedures


Implementation ** Attached the baby condition.
* maintained His chart.
* Don feed given 2nd-3rd j.*

Pam 28/05/26 @ 8Am.
Handed Over by : Name & Signature

Received by : Name & Signature

PATIENT TRANSFER FORM



Patient Name & UHID No. FDH-00046102 IP25-00020664 Baby B/O SREE VIDYADHARI 21-05-2026 0 Y 0 M 6 D (F) Dr. KONDAM PRADEEP REDDY 		Date & Time of Admission 27-5-20 @ 12:56	Date & Time of Transfer Order 27-5-20 @ 2:05 PM
		Transfer Ordered by Dr. Mohit	Reason for Transfer Admission
From Unit ER	To Unit 323-A	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File - 11 -	Number of Imaging Films -	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what? <i>OT files given</i>	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	/	/	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring YASEEN		Name of Person Ordered Transfer Dr. Mohit	
Patient & Clinical Records Received by : <i>Ravish</i>			
Date & Time of Patient Received : 27/5/20 2 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

Handwritten notes in the top right corner, including a date and some illegible text.

Handwritten notes in the upper left quadrant, possibly a list or set of instructions.

Handwritten notes in the upper middle section, appearing as a series of short phrases.

Handwritten notes in the middle section, including a prominent horizontal line and several lines of text.

A single, long handwritten stroke or line in the lower middle area.

Handwritten notes in the bottom left corner, including a date and some illegible text.

Handwritten notes in the bottom right corner, including a date and some illegible text.