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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00174453 **Admit Date** : 28-May-2026 **Admit Time** : 01:49 PM **UHID** : BAH-00644219

Patient Details :

Patient Name	: Baby Of ANUSHA	**Age**	: 0 Y 5 M 15 D
Guardian	: Mr KRISHNA C	**DOB**	: 13-12-2025 01:00 AM
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H NO 8-2-293/19, ROAD NO 14, Banjara Hills Hyderabad Telangana INDIA 500034	**Phone No**	: 9550681655/ 7032030904
		E-mail	: KRISHNACHAVAN892@GMAIL.COM

Admission Details :

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

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

Contact Details :

Name : Mr KRISHNA C **Relationship** : Father

Contact Address : H NO 8-2-293/19, ROAD NO 14, Banjara Hills Hyderabad Telangana INDIA 500034 **Phone No** : 9550681655 / 7032030904

Signature

Doctor Details :

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

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

BAH-00644219 IP5-00174453
Baby Of ANUSHA
13-12-2025 0 Y 5 M 15 D (F)
Dr. SIRISHA RANI

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BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 28/5/26 Time: 4pm

Blood Group of the Patient: O+ve Blood Group on the Blood Bag: O+ve.

Blood Bank Issue No: 26-01226 Date of Collection: 27/5/26 Date of Expiry: 3/7/26

Date & Time of Starting Transfusion: 28/5/26 @ 4:10pm Planned duration of Transfusion: 5 hours

Check for Correct Unit: ☑ Correct Patient: ☑

Blood products cross checked by: Nurse 1: NR. Israel Nurse 2: NR. Anji

Before starting transfusion vitals: Temp: 98.1°F HR 124/m RR: 26/m BP: 95/62 mm Hg SpO_2 99%.

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO_2	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
28/5	~~15 Min~~ 4:10pm	124/m	98.4°F	95/62 mm Hg	99%	–	–	–	–
28/5	~~15 Min~~ 4:25pm	118/m	98.1°F	95/62 mm Hg	99%	–	–	–	–
28/5	~~30 Min~~ 4:55pm	120/m	98.4°F	96/76 mm Hg	100%	–	–	–	–
28/5	~~30 Min~~ 5:25pm	116/m	98.2°F	104/76 mm Hg	100%	–	–	–	–
28/5	~~30 Min~~ 5:55pm	120/m	98.4°F	95/68 mm Hg	99%	–	–	–	–
	~~1 Hr~~ 6:55pm								
	~~1 Hr~~ 7:55pm								

Comments: .....

.....

Name of the Incharge-Nurse: NR. Venkat Name of the Nurse: NR. Anji.

Signature of the Incharge-Nurse: Venkat Signature of the Nurse: Anji.

Date & Time: 28/5/26 @ 6pm Date & Time: 28/5/26 @ 6pm

Issue Label / CrossMatching Report

Patient : **Baby Of ANUSHA .**
Patient's Blood Group :O Rh Positive
Hosp/Dr :Rainbow Childrens Hospital,DR. SIRISHA RANI
UHID No.: BAH-00644219 Wd-Bed No.:

Product : LR-PRBC Pedia-1
Blood Group : O Rh Positive
Unit No.: **BAH26-01226**
XMatching Report:Compatible
X-matched by: MONOJ

Issue Dt : 28/May/2026
Colln. Dt :22/May/2026
Exp. Dt :03/Jul/2026
Issued By : MONOJ

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P. Road No.2, Banjara Hills, Hyderabad, Telangana State
Lic No. 46/HD/TS/2018/BB/G

BAH-00644219 IP5-00174453
Baby Of ANUSHA
13-12-2025 0 Y 5 M 15 D (F)
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CONSENT FOR BLOOD TRANSFUSION

Name: B/o Anusha. Age: 5m Gender: Male ☐ Female ☑

UHID.No : BAH-00644219. Date: 28/5/26

Type of Blood Product:

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

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

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

.....

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

Patient (Or Patient Relative / Guardian):

Signature: .....

Name: .....

Date & Time .....

Doctor (Who is talking the consent)

Signature: .....

Name: Dr. Sahithi

Date & Time 28/5/26 3:30 PM.

Witness

Signature: .....

Name: Anusha.

Date & Time 28/5/26 3:30 PM

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

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ BAH-00644219 IP5-00174453 Baby Of ANUSHA 13-12-2025 0 Y 5 M 15 D (F) Dr. SIRISHA RANI

ıltant: _____ Dept : _____

Date of Admission: _____ of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/5	—	ER	—	Anq.

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
28/5	cardiac Moniter			31772	Rachel
28/5	Infusion pump				

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
28/5/26	Iv placement	OP D Basis		Rachel
28/5/26	Blood Transfusion	(1)	31773	Rachel

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00644219 IP5-00174453
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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr - Sirisha Rani Date : 28/05/26

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

Start Time of Assessment: ..... Weight: 6.03kg

Allergic History: .....

Chief Complaints:
- noticed to have pallor on regular visits.
- CBP shown s/o severe Anemia
- Now for PRBC Transfusion.

Pediatric Assessment Triangle

A Appearance - TICLS .....

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

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

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

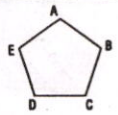
Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Significant Past History: Both parents - Thalassemia trait

Medication History: .....

Relevant Investigations: .....

Primary Assessment



Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

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

Breathing
Rate: 22/min SpO_2 on FiO_2 98%/RA
Rhythm: Regular
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: BAE (+)
Palpation Findings (If necessary).....

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

Circulation

HR: 112/min

CFT: Central <3sec; Peripheral .....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

BP: ..... mmHg

Pulse Volume: Central <3sec; Peripheral .....

If in Shock: Compensated .....; Hypotensive .....

Muffled Heart Sound: ☐ Yes ☑ No

Engorged Neck Veins: ☐ Yes ☑ No

Murmurs: ☐ Yes ☑ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☑ No

Disability

GCS: ..... AVPU: Alert

Pupils: Responsive ☑ Non-Responsive ☐

Size: Right .....; Left .....

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

Signs of Neurological compromise .....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Exposure

Temp.: 98.6°F

Any Rash: ☐ Yes ☑ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest ☐ Shock - Compensated ☐ Hypotensive ☐ ☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings: .....

Labs Planned: IV cannula – CBP ordered by

Treatment Planned: PRBC.

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

Final Diagnosis with possible Differential Diagnosis (If necessary): Severe Anemia now bcz PRBC transfusion

Assessment done by

Name of the Doctor: Tayabi

Signature: .....

Date & Time: 28/05/2020

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: .....

Signature: .....

Date & Time: .....

BAH-00644219 IP5-00174453
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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☑ Not known any Drug Allergies

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

Shifting From: ER Shifted to: —

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	VITCOFOL drops	2ml	PO	BD	28/5/26 9AM	☑C ☐DC
2	VITAMIN D3 Drops	0.5ml	PO	OD		☑C ☐DC
3	BEVON drops	0.5ml	PO	OD		☑C ☐DC
4	Syp RANTAC	1ml	PO	BD.		☑C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Sanithi

Date & Time : 28/5/26 11:30AM.

Nurse Name & Signature: Anji

Date & Time : 28/5/26 @ 5pm

BAH-00644219 IP5-00174453
Baby Of ANUSHA
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DRUG CHART

Date of Admission: 28/05/26 Drug Allergies: ..... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG : PARACETAMOL DROPS				Date / Time
Dose	Route	Frequency	Start Date	
0.9 ml	PO	6th hrly	28/5	
Doctor's Signature		Valid Period	Pharm.	
Jayalu		2 days		
Additional Instructions: (150mg/1ml) If T>100°F.				

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

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

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

Baby of ANUSHA
13-12-2025 0 Y 5 M 15 D (F)
Dr. SIRISHA RANI

REGULAR PRESCRIPTIONS

Weight. 6 kg Ward. .....

DRUG : VITCOFOL DROPS

Dose	Route	Frequency	Start Date
2 ml	PO	1-0-1	28/5

Name & Signature of the Doctor Starting the Drugs: Jayshri

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : VITAMIN D_3 drops

Dose	Route	Frequency	Start Date
0.5ml	PO	OD	28/5

Name & Signature of the Doctor Starting the Drugs: Jayshri

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : Syrup CALCIMAX PLUS

Dose	Route	Frequency	Start Date
2.5ml	PO	OD	28/5

Name & Signature of the Doctor Starting the Drugs: Jayshri

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

BAH-00644219 IP5-00174453
Baby Of ANUSHA
13-12-2025 0 Y 5 M 15 D (F)
Dr. SIRISHA RANI

Weight. ...6.kg..... Ward. .....

	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
28/5	3:50pm	Inj AVIL	3 mg	IV	Jayasri	Israel Rachel
28/5	3:45pm	Inj HYDROCORTISONE	12 mg	IV	Jayasri	Israel Rachel
28/5	4:10pm	PRBC	120ml over 5hours	IV	Jayasri	Israel Venkat

BAH-00644219 IP5-00174453
Baby Of ANUSHA
13-12-2025 0 Y 5 M 15 D (F)
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I.V. FLUIDS CHART

Weight. 6kg ..... Ward. .....

		sition of I.V. Fluid tion ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign

Signature .....

VERIFIED BY : Name .....