

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ Consultant: _____ Dept : _____

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

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

IP5-00176148
BAH-00421700
Master SAYEED BIN OMER
04-11-2019 6 Y 8 M 5 D (M)
Dr. NALLA ANURAG REDDY



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
9/7/26	1:50pm	ER	ONCO	Abhishek

Cross Consultation Visit

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

[illegible][illegible][illegible][illegible][illegible]

9/7/26	CBP, LFT [Op basis]	-	Abhishek
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9/7/26	CBP, LFT [Op basis]	-	Abhishek
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9/7/26	CBP, LFT [Op basis]	-	Abhishek
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9/7/26	CBP, LFT [Op basis]	-	Abhishek
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10/7/26	COP, LFT, RBC		<u>Ucens</u>
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10/7/26	COP, LFT, RBC		<u>Ucens</u>
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10/7/26	COP, LFT, RBC		<u>Ucens</u>
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MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
9/7	Lumber Puncher.	3	0695004	Q
	conscious sedation.			
	Chemotherapy			

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : 10/7/26

Time : 12 pm

Prepared By : *clerk*

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Veena	Day. Oncology		

BAH-00421700 IP5-00176148
Master SAYEED BIN OMER
04-11-2019 6 Y 8 M 5 D (M)
Dr. NALLA ANURAAG REDDY



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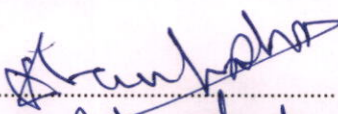
ADMISSION CRITERIA – ONCOLOGY

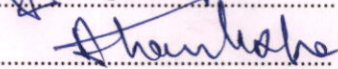
Admission / Transfer from:

☒ Emergency ☐ Outpatient (OPD) ☐ Ward ☐ Operation Theater ☐ Others:

Tick (✓) any of the following criteria requiring admission / transfer to ONCOLOGY

- ☐ For Chemotherapy-Day Care or IP Admission as per the Type of Chemotherapy
- ☐ Febrile Neutropenias (ANC <500 cells / mm³)
- ☐ Netropenic Enterocolitis
- ☐ Mucositis Induced Significant Diarrohea or Pain
- ☐ Neurological Complications (like Seizures, Bleeding, Thrombosis) that can arise while on Chemotherapy Treatment or at the Time of Presentation and also for other Systemic Problems like Pancreatitis during Chemotherapy
- ☐ Management of Oncological Emergencies
- ☐ Bleeding Problems (where it is indicated)
- ☐ Evaluation and Management of Severe Anemias
- ☐ Day Care Admissions for PRBC Transfusions
- ☐ Evaluation and Management of Sick Children who come with Hematological Problems like Severe Anemia like Autoimmune Hemolytic Anemia/ Bleeding/ Others
- ☐ Primary Immunodeficiency Disorders with Infections that Warrants Hospitalisation
- ☐ Management and Evaluation of Hemophagocytic LymphoHisticytosis
- ☐ Any Systemic Disorders with Significant Hematological issues like JRA / SLE with Secondary HLH

Signature of the Doctor: 

Name of the Doctor: 

Date & Time: 9/7/26 @ 1:35pm

BAH-00421700 IP5-00176148
Master SAYEED BIN OMER
04-11-2019 6 Y 8 M 6 D (M)
Dr. NALLA ANURAAG REDDY



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DISCHARGE CRITERIA – ONCOLOGY

Discharge to:

☐ HDU / Step down ICU

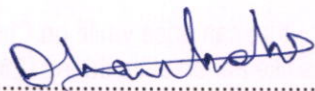
☐ Ward

☐ Outside Facility

☒ Others: Home

Tick (✓) any of the following criteria requiring discharge / transfer from ONCOLOGY

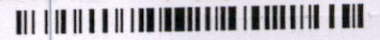
- ☒ Completion of chemotherapy, with no debilitating side effects.
- ☐ Resolution of febrile episode, with no fever > 24hrs and Absolute Neutrophil count (ANC) > 500cells/mm³.
- ☐ Admitted patients - Once the admitting problem gets resolved or made a plan to manage further on out-patient basis.

Signature of the Doctor: 

Name of the Doctor: Dr. Nalla Anuraag Reddy

Date & Time: 10/6/20 @ 12pm

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176148 Admit Date : 09-Jul-2026 Admit Time : 01:10 PM UHID : BAH-00421700

Patient Details :

Patient Name	: Master SAYEED BIN OMER	Age	: 6 Y 8 M 5 D
Guardian	: Mr OMER BIN SHAKEEL	DOB	: 04-11-2019
Gender	: Male	Religion	: Muslim
Occupation	:	Marital Status	: Single
Address (H)	: H.NO-21-3-589, MOOSA BOWLI Charminar Hyderabad Telangana INDIA 500002	Phone No	: 9573355662 / 9381733839
		E-mail	: na123@gmail.com

Admission Details :

Bed Type	: SEMI PRIVATE	Bed No	: SPVT 134	Ward Name	: 1F-HEMATO-ONCOLOGY
Room No	: SPVT 134	Admission Type	: First Visit		

Contact Details :

Name	: Mr OMER BIN SHAKEEL	Relationship	: Father
Contact Address	: H.NO-21-3-589, MOOSA BOWLI Charminar Hyderabad Telangana INDIA 500002	Phone No	: 9573355662 / 9381733839


Signature

Doctor Details :

Doctor Name	: Dr. NALLA ANURAAG REDDY	Specialisation	: HEMATO ONCOLOGY
Referral Doctor	: Self	Phone No	:
Co-Consultant	: Dr. SIRISHA RANI		

Payment Details :

Payment Mode	: Cash	Deposit Amount	: 0.16
		Payor Name	: SELF PAY



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PEDIATRIC IN-PATIENT MEDICAL RECORD



BAH-00421700 IP5-00176148
Master SAYEED BIN OMER
04-11-2019 6 Y 8 M 6 D (M)
Dr. NALLA ANURAG REDDY



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : Sayed Bin Omer Age/Sex 6y / M
Information given by: Relationship Mother

Chief Presenting Complaints & Duration (Chronologically)

B-cell ALL
↓

Now came for LP + ITA - BMA rhd

History of present illness :

No fresh issues
↓

K/C/O B-cell ALL / CALCA positive /
CNS negative / poor prednisolone response

14/0 Pseudomonas sepsis / febrile neutropenia
Lower lip gangrene - debridement done on
05/06/20

16/0 abscess on right thigh on
20/6/2020

BAH-00421700 IP5-00176148
Master SAYEED BIN OMER
04-11-2019 6 Y 8 M 6 D
Dr. NALLA ANURAAG REDDY (M)

Pediatric Multiorgan history, & Physical Examination

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

Kfcl O B-cell ALL

Birth & Neonatal History:

Not significant.

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

} upper middle class

Developmental History :

Achieved at per age

Immunization History :

As per schedule



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) ~~38.2 kg~~ (Centile _____)

38.3 kg

On Examination :

Temperature : 98.6° Pulse Rate : 93 bpm B.P. 104/66 mmHg SPO2 100% RA

Resp. rate and type of breathing : 24 br/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): NKDA

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L A/E, clear

Any addles sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S1, S2

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : _____

Auscultation : S0, Non distended

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : 2 2

Motor System:

Nutriton : 2

Tone: 2 Power 2

Co-ordinator : 2

Posture : 2

Involuntary Movements : 2

Reflexes :

DTR

Plantars

Superficials: 3

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

N/C/O B-cell ALL

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Sepsis
shock

Desired goals of the treatment : Hemodynamic stability

Planned Labs:

CFT } done on
 CBP } op basis

N-B
 sent to

Planned Management

- LP + BANA MRD + IT
- Levothor
- Posaconazole
- Odiliv
- Septoran
- Montel
- Methotrexate
- Prevali
- NA

Signature of the Doctor: [Signature]

Name of the Doctor: Dr. Nanda

Date & Time: 09/07/2020, 1:35 PM

Signature of the Consultant: [Signature]

Name of the Consultant:

Date & Time:

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Master SAYEED BIN OMER
04-11-2019 8 Y 8 M 6 D (M)
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RESULT SHEET

Date	9/7					
Time						
Hb	12.3					
PCV	38.7					
RBC	4.24					
WBC	6.80.					
N/L	66/26.					
Platelets	314					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP	220					
SGPT	42					
SGOT	77					
T.Bill/Conj	1.0/0.4					
T.Protein	7.0					
S.Albumin	4.1					
S.Globulin	2.9					
A/G Ratio	1.4					
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Chd B Res. Sec	
9/17/26 9:00pm.	<u>Procedure Notes</u> Procedure done under Child-Alert precautions. BMA + LP - done clear CSF + int. No post procedure complications. No c/o Bleeding.	
	Child Alert & Stable.	<u>Adv</u> - Continue chest therapy. - Monitor vitals - Inpt (w/). Dr. Prallank.
		N/B poor @ 5:30pm 9/17/26.



10107126	
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W/B
Uccers
606374
10/7/26 @ 11am

BAH-00421700 IP5-00176148
Master SAYEED BIN OMER
04-11-2019 6 Y 8 M 6 D (M)
Dr. NALLA ANURAAG REDDY



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Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : <u>SYP. MONTEL</u>				Date Time	<u>9/7</u>														
Dose <u>5ml</u>	Route <u>PO</u>	Frequency <u>OD</u>	Start Dt. <u>09/07</u>																
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nanda.</u>																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG : <u>SYP. PREVALL</u>				Date Time	<u>9/7</u>														
Dose <u>3.5ml</u>	Route <u>PO</u>	Frequency <u>OD</u>	Start Dt. <u>09/07</u>																
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nanda.</u>																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG : <u>TAB. NAC</u>				Date Time	<u>9/7</u>	<u>10/7</u>													
Dose <u>300mg</u>	Route <u>PO</u>	Frequency <u>BD</u>	Start Dt. <u>09/07</u>																
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nanda.</u>																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG : <u>TAB. METHOTREXATE</u>				Date Time															
Dose	Route	Frequency	Start Dt.																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

Signature

VERIFIED BY : Name

Sheet No: **REGULAR PRESCRIPTIONS** Weight Ward

DRUG : TAB. PANTOPRAZOL				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																				

DRUG CHART

Date of Admission: 09/07/26 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 :				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:				

Weight. 38.3 kg Ward.

Page: 2/4

Dr. NALLA ANURAG REDDY



Date
Time

Nurse Sig.

Nurse Sig.

Nurse Sig.

Nurse Sig.

DRUG :

Route

Start Date

Name & Signature of the Doctor

Additional Instructions:

	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

Date Time								
		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

[illegible]

Signature _____

Weight. Ward.

Composition of I.V. Fluid
(Don't mention ml/hr = Mcg/kg/min. etc)

BAH-00421700 IP5-00176148
Master SAYEED BIN OMER
04-11-2019 8 Y 8 M 6 D (M)
Dr. NALLA ANURAG REDDY

Patient



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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: DNLD

	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	SYP. LEVOFLOX	10ml	PO	BD	09/07 9 AM	☒ C ☐ DC
2	Tab. POSOCOCONAZOLE	100mg	PO	BD	09/07 8 AM	☒ C ☐ DC
3	SYP. ODIDIV	10ml	PO	TID	09/07 8 AM	☒ C ☐ DC
4	SYP. SEPTTRAN-DS	7.5ml	PO	BD	09/07 8 PM	☒ C ☐ DC
5	SYP. MORFEL	5ml	PO	OD	09/07 10 AM	☒ 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 : Dr. Narely

Date & Time : 9/7/26 Alc

Nurse Name & Signature : Nr. Abhishek

Date & Time : 9/7/26

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Dr. NALLA ANURAAG REDDY



CHEMOTHERAPY PRESCRIPTION

All the chemotherapy medications are high risk / high alert drugs.
While administering chemotherapy drugs watch for nausea, vomiting, rashes,
urine output and any local extravasation of the drug.

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Sheet No. :	Weight (kg) :	Body Surface Area :	Diagnosis :	Protocol :						
①	38kg	1.2	B-ALL	consolidation						
DATE	TIME	Composition of Chemotherapy (if infusion, mention ml / hr = Mcg / kg / min. etc.)	DOSE	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
9/12/26	2:30pm	iv METHOTREXATE iv CYTARABINE iv HYDROCORTISONE	12mg 30mg 15mg	IT	STAT	A	Aneradha	9/7		Aneradha
							Susmita			Susmita
9/12/26	5:30pm	iv MESNA in 100ml NS	200mg	IV	100ml/hr	A	pooja	9/7		pooja
							Aneradha			Aneradha
9/12/26	6:50pm	iv CYCLOPHOSPHAMIDE in 200ml NS	1.2gm	IV	100ml/hr	A	pooja	9/7		Savitri
							Aneradha			
9/12/26	9pm	iv MESNA in 500ml 1/2 NS	800mg	IV	100ml/hr	A	Savitri	10/7		Subham
							Subhakar			Savitri
9/12/26	2AM	iv MESNA in 500ml 1/2 NS	400mg	IV	100ml/hr	A	Subham	10/7		Subham
							Savitri			Savitri



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
9/17/26	1:30pm	0/10	NEI	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	- NA -	ABH/SL
10/7	9am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Swif
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

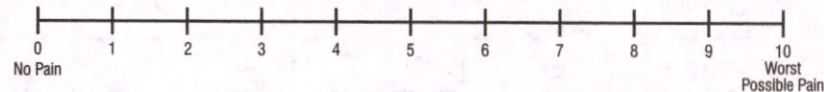
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



BAH-00421700 IP5-00176148
Master SAYEED BIN OMER
04-11-2019 6 Y 8 M 5 D (M)
Dr. NALLA ANURAAG REDDY



Doc. No. : RCHBH/ FRM / CLINICAL / 126



SCHOOL AGE (5-12 years)
**Children's Observation &
Early Warning Scoring Chart**

**Rainbow
Children's
Hospital**
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/7 Time: 9AM

Doctor / Nurse / Family Concern?

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94

99.6
98

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

100
90
80
70
60
50

Heart Rate (Number)

106bpm

Resp. Rate (bpm)
(Over 1 Minute) *

70
60
50
40
30
20
10

Resp Rate (Number)

26bpm

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

100%

Conscious Normal
Level Altered

GCS *

15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

Score 1 : Continue normal observation by staff nurse

Score 2 : Shift in charge nurse to be informed and continue hourly observations

Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see

Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

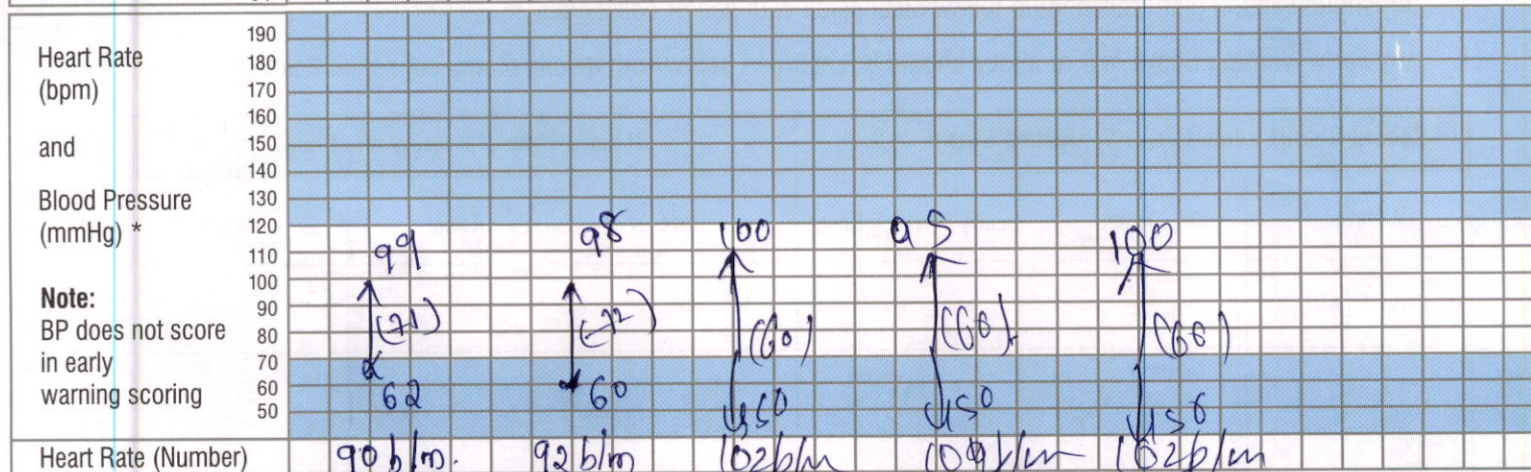
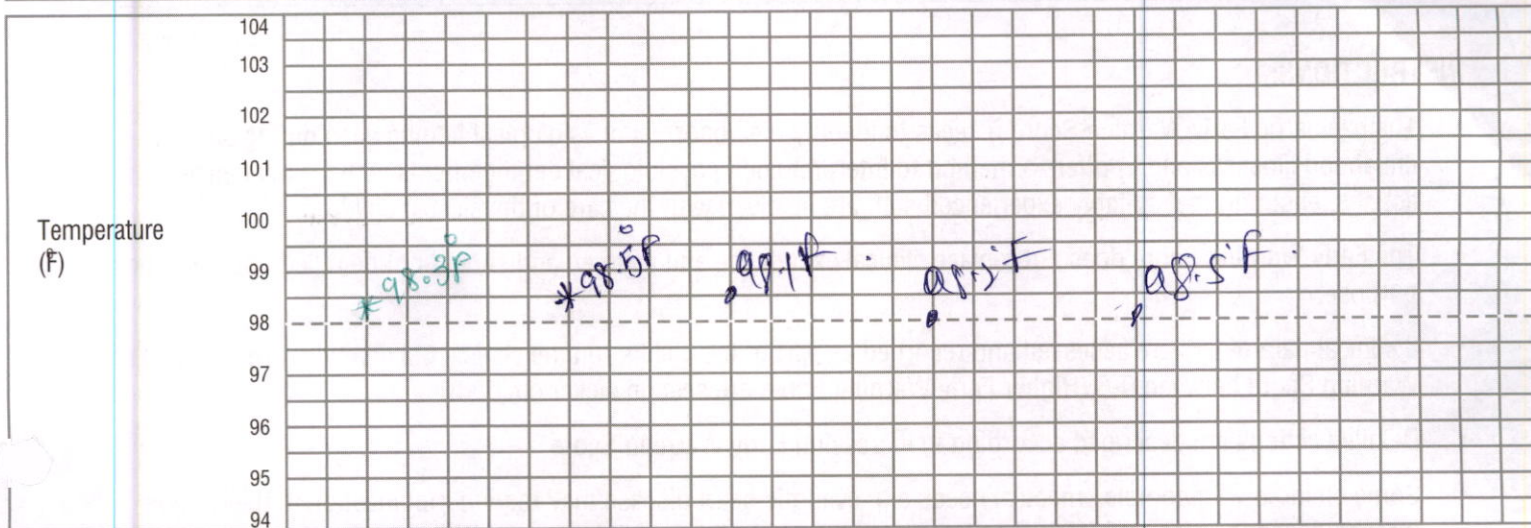
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION: I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND: Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT: I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION: I need you to ... come to see the child in the next (XX mins) AND Is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9/12 Time: 4pm 4pm 10pm 3Am 6Am
Doctor / Nurse / Family Concern?



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

TOTAL SCORE	
Number of shaded boxes	0
Pain Score	0
Observer's Initials	Q

ACTIONS

NB: Scores 3 should be recorded overleaf

Score 1	: Continue normal observation by staff nurse
Score 2	: Shift in charge nurse to be informed and continue hourly observations
Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

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Master SAYEED BIN OMER
04-11-2019 6 Y 6 M 6 D (M)
Dr. NALLA ANURAG REDDY



FLUID CHART

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Sheet No. : 2

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
12/2	08:00 am	120	100ml								200ml	T J a	
	09:00 am	80ml											
	10:00 am												
	11:00 am												
	12:00 pm	120	100ml										
	01:00 pm												
Total Intake : 200 ml						Total Output : 200ml							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake													
Total 24 hrs. Output													

Patient

BAH-00421700 IP5-00176148
 Master SAYEED BIN OMER
 04-11-2019 8 Y 8 M 5 D (M)
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FLUID CHART

Sheet No. : 1

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm									100ml		
	05:00 pm											
	06:00 pm	H ₂ O	100ml	100ml						80ml		
	07:00 pm			100ml								
Total Intake : 400 ml						Total Output : 180 ml						
	08:00 pm			100ml						200ml		
	09:00 pm	chicken	100ml	100ml								
	10:00 pm	chicken		100ml								
	11:00 pm			100ml								
	12:00 am	H ₂ O		100ml						50ml		
	01:00 am			100ml								
Total Intake : 700ml						Total Output : 250ml						
	02:00 am			100ml						200ml		
	03:00 am			100ml								
	04:00 am			100ml								
	05:00 am			100ml								
	06:00 am			100ml								
	07:00 am			100ml						200ml		
Total Intake : 600ml						Total Output : 400ml						

Total 24 hrs. Intake

1,700 - 44.34kg

Total 24 hrs. Output

830 - 1,444kg



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 1:50pm Mode of Arrival: wheel chair Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction

Body Weight: 38.31 Kg

No Allergy reactions

Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>NA</u>	<u>NA</u>	<u>NA</u>

Family History:

Healthy family

Has the child or close family member had recent contact with a communicable disease? ☒ Yes ☐ No

If yes please list,

Was the child's birth normal? ☒ Yes ☐ No If No, please describe problems:

Are the child's immunization up to date? ☒ Yes ☐ No

Current Medication: ☐ None ☒ Yes, If Yes, fill reconciliation form

Observations: Weight: 38.31kg Length: Head Circumference (< 2 years):

mp: 98.4F HR: 80b/m RR: 24b/m BP: 93/54 (61)

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

Fall Risk Assessment: ☐ Yes ☐ No Score: 19 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

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

Character of Pain 0 Location Frequency Duration

FUNCTIONAL SCREENING: ☒ No Abnormalities Detected

☐ Mobility Problem

☐ Walking Problem

☐ Developmental Delay

☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormalities Detected

☐ Underweight

☐ Overweight

☐ Special Feeding Method

☐ Feeding Problem

☐ Special diet

☐ No Abnormality Detected

Inform consultant for positive criteria



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Date:

Assessment:

- ☐ Maintain Skin Integrity
- ☐ Patient & Family Education

[illegible]

Re-Assessment:

Special Notes:

Nurse Signature: _____ Nurse Name: _____ Date & Time: _____



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date:

Assessment: patient hearing weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the pt general condition	8:30am	→ Assessed the pt general condition	pt feels better
9am	monitor vitals	9:30am	→ monitored the vital signs	
10am	maintain personal hygiene	10:30am	→ maintained the personal hygiene	
11am	Ensure safety.	11:30am	→ monitored the safety	
12pm	Administer medications	12:30pm	→ Administered the medications	
1pm	maintain I/O chart	1:30pm	→ maintained the I/O chart	

Re-Assessment: pt feels better

Special Notes:

Nurse Signature: *Ch*

Nurse Name: *Cheng*

Date & Time: 10/2/20 @ 139



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/3/23

Assessment: patient having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the patient	8:30pm	→ Assessed the patient	Patient feel Better
9am	→ General condition		→ General condition	
11am	→ maintain personal hygiene	12:30pm	→ maintained personal hygiene	
4am	→ Ensure Safety	4:30am	→ provided Siderails	
6am	→ Monitor Dp chart	6:30am	→ monitored Dp chart	

Re-Assessment:

Special Notes: Patient is active

Nurse Signature: [Signature]

Nurse Name: Sawitri

Date & Time:

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/7/26

Assessment: patient hearing lp of BMA

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the patient general condition	2:30pm	Assessed the patient general condition	patient is now improved.
4pm	monitor vitals	4:30pm	monitored vitals	
5pm	maintain fluid balance	5:30pm	maintained fluid balance	
6pm	maintain personal hygiene		maintained personal hygiene	
7pm	Administer medications	7:30	Administered medications	

Re-Assessment: patient feels better

Special Notes:

Nurse Signature: [Signature]

Nurse Name: pooja

Date & Time: 9/7/26 @ 8pm

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: ER Date of Admission: 9/7/26

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known		If Yes Specify:		
		<u>K/C/O B-cell #11</u>						
BACKGROUND	Area	ER 1:50pm	once 8pm	once 8am	once 12pm			
	Shift Time							
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>			
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	<u>98.7</u>	<u>98.4</u>	<u>98.6</u>	<u>98.4</u>		
		Res:	<u>24b/m</u>	<u>24b/m</u>	<u>25b/m</u>	<u>26b/m</u>		
		SpO ₂ :	<u>98%</u>	<u>99%</u>	<u>100%</u>	<u>99%</u>		
		Pulse:	<u>118b/m</u>	<u>116b/m</u>	<u>112b/m</u>	<u>112b/m</u>		
		BP:	<u>98/61</u>	<u>99/60</u>	<u>100/66(72)</u>	<u>90/61</u>		
		Fall Risk Score:	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>		
	Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0</u>	<u>0</u>			
	Recommendations	Safety Needs:	<u>Yes</u>	<u>side rails</u>	<u>Side rails</u>	<u>side rails</u>		
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>			
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>			
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>			
Handed Over By Name :		<u>Abhishek</u>	<u>pooja</u>	<u>Savitree</u>	<u>veena</u>			
Signature :		<u>Abhi</u>	<u>Pt</u>	<u>Savitree</u>	<u>veena</u>			
Date:		<u>9/7/26</u>	<u>9/7</u>	<u>10/7</u>	<u>10/7</u>			
Time:		<u>1:50pm</u>	<u>8pm</u>	<u>8am</u>	<u>12pm</u>			
Taken Over By Name :		<u>pooja</u>	<u>Savitree</u>	<u>veena</u>	<u>D/C</u>			
Signature :		<u>Pt</u>	<u>Savitree</u>	<u>veena</u>	<u>D/C</u>			
Date:		<u>9/7/26</u>	<u>9/7</u>	<u>10/6/26</u>	<u>D/C</u>			
Time:		<u>7:55pm</u>	<u>8pm</u>	<u>8:05pm</u>	<u>D/C</u>			

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area							
	Shift Time							
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
		Fall Risk Score:						
Recommendations	Safety Needs:							
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:							
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:							
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature :								
Date:								
Time:								
Taken Over By Name :								
Signature :								
Date:								
Time:								

BAH-00421700 IP5-00176148
Master SAYEED BIN OMER
04-11-2019 6 Y 8 M 5 D (M)
Dr. NALLA ANURAAG REDDY



CONSENT FOR SPECIAL PROCEDURES

Patient Name : Sayed Bin omer Gender: ☒ Male ☐ Female

UHID No : BAH-00421700 Department : Neurology Date : 9/2/26

I Afia S/D/W/O Afia

Here by give consent for procedure of : L.P + BMA MRD + IT

For my patient, Named : Sayed Bin omer

The doctors have clearly explained to me that the procedure has following possible complications:

pain / bleed / headache

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

No Alternatives

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr. Aravani

Patient Attendant :

Signature : Afia

Name : Afia

Relationship with Patient: mother

Date & Time : 9/2/26 @ 2:30pm

Witness :

Signature : Afia

Name : Afia

Date & Time : 9/2/26 @ 2:30pm

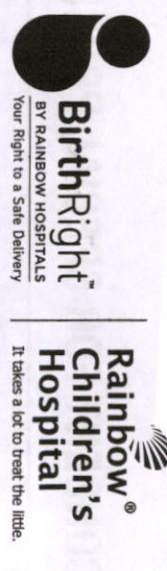
Doctor (who is taking the consent) :

Signature : B

Name : Dr. prashanth

Date & Time : 9/2/26

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం ☐ పురుషుడు ☐ స్త్రీ

యు. హెచ్.ఐ.డి. బిభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు (అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

BAH-00421700 IP5-00176148
Master SAYEED BIN OMER
04-11-2019 6 Y 8 M 5 D (M)
Dr. NALLA ANURAAG REDDY

Patient Sticker




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CONSENT FOR PROCEDURAL SEDATION

Authorization By: ☐ Patient ☒ Patient Attendant

I, the undersigned do hereby acknowledge the following:

- I have been made aware by the doctors in language known to me the details of sedation planned for the procedure
Chotsedation
- I have been made aware of the possible complications from the procedure of sedation as follows:
- Changes in heart rate, blood pressure, need for oxygen supplementation, allergic reactions, upper airway obstruction, laryngospasm, conversion to general anaesthesia
- I have been made aware that the sedation is being advised to relieve pain and anxiety during the procedure. It will help me remain calm, comfortable, and cooperative, allowing the procedure to be performed smoothly and safely.
- I have been clearly explained about the benefits, risk, and alternative of the sedation which is General Anaesthesia.
- I authorize Dr. Shravan and his / her team to perform the procedural sedation upon the patient / myself.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: [Signature]

me: Alia

Relationship with patient: mother

Date & Time: 9/7/26 @ 2:30pm

Witness:

Signature: [Signature]

Name: Alia

Date & Time: 9/7/26 @ 2:30pm

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. prabhakar Date 9/7/26 Time: 2:10pm

ప్రాసేజరల్ సెడేషన్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, క్రింది విషయాలను అంగీకరిస్తున్నాను:

నాకు తెలిసిన భాషలో, వైద్యులు ఈ క్రింది ప్రాసేజరల్ కు ఇచ్చే సెడేషన్ గురించి పూర్తి వివరాలు నాకు తెలిపారు:

- సెడేషన్ వల్ల సంభవించగల సాధ్యమైన క్రింది సమస్యలు/ప్రమాదాలు గురించి నాకు తెలిపారు: గుండె వేగం మారడం, రక్తపోటు మారడం, ఆక్సిజన్ అవసరం, అలర్జిక్ ప్రతిచర్యలు, ఎగువ శ్వాసనాళ అడ్డంకి, లాలింజోస్టాసమ్, జనరల్ అనస్థీషియాగా మారాల్సిన అవకాశం.
- ప్రాసేజరల్ సమయంలో నొప్పి, భయం, ఆందోళన తగ్గించేందుకు సెడేషన్ ఇవ్వడం అవసరం అని నాకు వివరించారు. ఇది ప్రాసేజరల్ సజావుగా, సురక్షితంగా జరగడానికి సహాయపడుతుంది.
- సెడేషన్కు సంబంధించిన ప్రయోజనాలు, ప్రమాదాలు, ప్రత్యామ్నాయం (జనరల్ అనస్థీషియా) గురించి నాకు స్పష్టంగా వివరించారు.
- డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ ప్రాసేజరల్ సెడేషన్ చేయడానికి నేను అనుమతిస్తున్నాను.
- పై సమాచారాన్ని నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ఉన్న ప్రశ్నలన్నీ, నాకు అర్థమయ్యే భాషలో సమాధానమిచ్చారు. ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

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Moderate Sedation Sheet

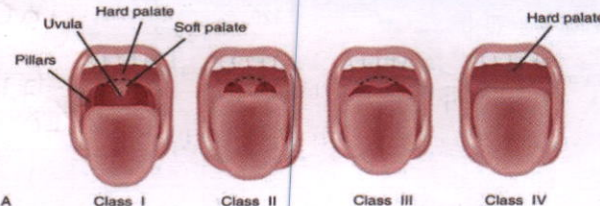
Immediate Pre-Sedation Assessment

B.P	PR	R.R	Temp	SPO ₂	Pain Score	Weight
104/66	94B/m		98.6°F		0	30.3 kg

Diagnosis: Child Bicuspid Aortic Valve / Aortic Regurgitation / Aortic Dissection

Procedure: LP + BM Aortic Endarterectomy

Comorbidities: None

☒ Risk, benefits & alternatives discussed; ☒ Patient understand & elects to proceed ☒ Consents for procedure and sedation signed and dated ASA Physical Status ☐ ASA PS 1: Healthy Patient ☒ ASA PS 2: Mild Systemic Disease, no functional limitations ☐ ASA PS 3: Severe Systemic Disease, functional limitations ☐ ASA PS 4: Severe Systemic Disease, constant threat to life ☐ ASA PS 5: Moribund Patient unlikely to survive 24 hrs. ☐ ASA PS 6: A declared braindead patient whose organs are being removed for donor purposes ☐ E: Emergency procedure GCS: E 4 M 6 V 5 ☒ IV Site: Gauge: Sedation Plan: <u>Pro Sedation</u> Allergies: <u>None</u>	AIRWAY EVALUATION Mouth: ☒ Normal ☐ Loose Teeth ☐ Small Mouth ☐ Protruding Incisors ☐ Receding Lower Jaw ☐ Dentures Neck: ☒ Normal ☐ Decreased ROM ☐ Thyromental Distance Less Than 6 cm ☐ Short Neck  Mallampati Class: ☒ I ☐ II ☐ III ☐ IV
---	--

Monitoring of Patient Intra – Procedure

Procedure Monitoring

Heart Rate (HR), Respiratory Rate (RR), Oxygen Saturation (O₂ Sat) continuously monitored, and Level of Consciousness (LoC) to be monitored and recorded minimally every 15 minutes until 15 minutes after the last administration of any sedation, then every 30 minutes, then every 1 hour until stable. Respiratory status to be monitored continuously.

Level of Consciousness (LoC):

- ☒ A - Alert
☐ V - Verbally Responsive
☐ P - Painfully Responsive
☐ U - Unresponsive

TIME	BP	PR	RR	O ₂ Sat%	O ₂ Supplementation	Comments / Initials
Baseline		90B/m	20B/m	100%	0.	

DRUG & IV Fluid: (including Nitrous Oxide)	ROUTE	DOSE	TIME GIVEN	SUBSEQUENT DOSES AND TIME
Inj. ketamine.	IV	2mg.	2:10pm	
Inj. midazolam.	IV	2mg	2:10pm	

Time of transportation to post sedation care room: 134 LOC: alert

Doctor Name: Dr. Prashant Signature: [Signature]

Post Sedation Care Room

[illegible]

TOTAL ALDRETTE SCORE AT DISCHARGE =
(If 9 and more patient can discharge from post Sedation care unit)

Activity :	Consciousness:	Respiration:	Oxygen Saturation:	Circulation:
Four extremities = 2	Fully awake = 2	Breathe Deep= 2	Sat O ₂ >92 % on room air = 2	BP +/- 20 mm hg of pre-op = 2
Two extremities = 1	Arousal on calling=1	Dyspnea, limited breathing = 1	Needs oxygen to maintain Sat O ₂ >90% = 1	BP +/- 20-50 mm hg of pre-op = 1
No extremities = 0	Unresponsive=0	Apnea = 0	Saturation <90% with oxygen = 0	Bp +/-50 mm hg of Pre-Op = 0

Patient Discharge Time: 2:30 pm

Nurse Name: 20019

Date: 9/7/26 Time: 2:30pm

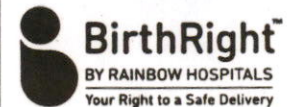
Consultant Name: Dr. Sandhya

Stamp

Signature: Pooja

Signature:

PROCEDURE SAFETY CHECK LIST (TIMEOUT OUTSIDE OT)



Patient Name: Omer Gender: ☒ Male ☐ Female UHID. No: 421700 Age: 2 years
 Date: 9/7/20 In-Time: 2 pm Out-Time: 2:30pm
 Doctor Performing Procedure: Up + Rm + IT Doctor Giving Sedation: _____ Assisting Nurse: Anuradha

SIGN IN		TIME OUT		SIGN OUT	
Time: <u>2:10pm</u>		Time: <u>2:20pm</u>		Time: <u>2:30pm</u>	
	Yes No NA		Yes No NA		Yes No NA
Patient is verified using two identifiers (Name & UHID)	☒ ☐ ☐	Correct Patient	☒ ☐ ☐	Name of the Surgical / Invasive Procedure is recorded	☒ ☐ ☐
All required documents, images, studies are available	☒ ☐ ☐	Correct Site	☒ ☐ ☐	Instrument, Sponge and Needle Count Completed	☒ ☐ ☐
NPO Status Checked from Patient / Patient Attendant	☒ ☐ ☐	Correct Procedure	☒ ☐ ☐	Specimens are labeled	☒ ☐ ☐
Consent is Signed	☐ ☐ ☐	All the team members introduced	☒ ☐ ☐	Any equipment problems are addressed	☐ ☐ ☐
Any need for blood products	☐ ☐ ☐				
If Yes Comment: _____					
Any Risk of Hemodynamic Compromise	☐ ☐ ☐				
If Yes Comment: _____					
Any drug or food allergy	☐ ☐ ☐				
If Yes Comment: _____					
Correct Site of Procedure Marked	☐ ☐ ☐				
All resources required are correct, available and functioning	☐ ☐ ☐				
Signature of the Doctor: <u>[Signature]</u>		Signature of the Nurse: <u>Anuradha</u>		Signature of the Nurse: <u>Anuradha</u>	
Name of the Doctor: <u>Dr. praveen</u>		Name of the Nurse: <u>Anuradha</u>		Name of the Nurse: <u>Anuradha</u>	

Any Adverse / Unexpected Events

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CONSENT FOR CHEMOTHERAPY


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Patient Name : Sayed Age : 6y Gender : Male ☒ Female ☐
UHID No : BAH-00421700 Department : PED Date : 9/7/26

Type of Chemotherapy : Intravenous

The type of reactions, nature of the major risks and complications arising from the treatment despite precautions has been explained to me. These can include Bone Marrow depression with subsequent infections, bleeding, nausea, vomiting, diarrhea, mouth ulcers, alopecia, fever, phlebitis, ulceration at the site of injection organ injuries etc.

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

I understand that no promise of cure or freedom from risk can be given. During the course of treatment I will report any symptoms if they become bothersome.

I have read the above and have no further questions about the treatment to be given.

Patient Attendant :

Signature : Afia

Name : Afia

Relationship with Patient : mother

Date & Time : 9/7/26 @ 5:30pm

Witness :

Signature : Afia

Name : Afia

Date & Time : 9/7/26 @ 5:30pm

Doctor (who is taking the consent):

Signature : d

Name : Dravain

Date & Time : 9/7/26

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THE HUMPTY DUMPTY SCALE

9/11/20

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2				
	13 years old and above	1					
Gender	Male	2	2				
	Female	1	2				
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1				
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1				
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1				
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1				
TOTAL			10				

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓					
Call device within reach		✓					
Wheels Locked		✓					
Room free of clutter		✓					
Adequate Lighting		✓					
Wheel Chair Support		✓					
Other Intervention(s) Specify		✓					
Nurse's Name :		Abhishek					
Signature :		Abhishek					
Date :		9/11					
Time :		1:30pm					

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BRADEN 'Q' SCALE

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					Date : 9/7/24			
					Time : 12:30P			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:xtremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4			
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4			
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4			
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4			
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4			
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4			
					TOTAL SCORE	28		
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					Evaluator's Name	Abhishek		

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

Type of Line: ☐ PICC Line ☐ UAC ☐ UVC ☐ Other Groshong Line Date of Initial Line Insertion: Duration of Central Line:

- Always perform hand hygiene before accessing central line
- Use Sterile gloves for handling central line
- Clean the hub with antiseptic solution every time before & after it is accessed
- Consider – antibiotic via central line before removal of the line
- Inspect Central line in each shift for the following

Parameters	Date	Shift Time	9/7 8pm	10/7 8am	10/7 2pm				
Can we remove Central Line today (Discuss in the clinical round)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Evidence of any inflammation at insertion site (Redness / Swelling (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Blood at insertion site (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any peeling of dressing? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is dressing clean and dry? (If no inform the doctor)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any leakage at insertion site? (If yes inform the doctor)			☒ Yes ☐ No	☐ Yes ☒ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there any obstruction to the infusion flow? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing intact and labelled properly			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Central line changed on									
Name of the Nurse			pooja	Smitha	Veen				
Signature of the Nurse									

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Master SAYEED BIN OMER
04-11-2019 6 Y 6 M 6 D (M)
Dr. NALLA ANURAAG REDDY



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Part - I.

Patient's / Learner Language: Hindi Patient / Learner Literacy: ☒ Read ☐ Write ☒ Speak Willingness to Learn: ☐ Yes ☐ No Healthcare Literacy: ☐ Yes ☐ No

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
9/7/26	1:30pm	8	procedure	M	1	0	1	1	NA	Abhishek
10/2	8am	3	pain management	M	1	0	1	1	NA	U

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)									
Learning Barriers:									
1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice					
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)					
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing						
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed									
Mechanism/s to overcome barrier/s:									
1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify						
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference							
Understanding:									
1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review							

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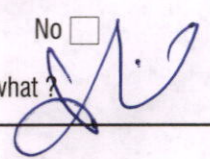
MULTI-DISCIPLINARY PLAN OF CARE FORM



Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
9/7/26 1:50pm	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	B-cell All	H-Stability	LP BMA	Dr. Nallu	☒ Nursing ☐ Others:
9/7/26 1:50pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	B-cell All	H-Stability	LP BMA	Abhishek	☒ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00421700 IP5-00176148 Master SAYEED BIN OMER 04-11-2019 6 Y 8 M 5 D (M) Dr. NALLA ANURAG REDDY 		Date & Time of Admission 9/7/26 at 1:10pm	Date & Time of Transfer Order 9/7/26 at 1:50pm
		Transfer Ordered by Dr. Nandan	Reason for Transfer Admission
From Unit ER	To Unit ONCO	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 25	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant 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 ☐			
Name & Signature of Person who is Transferring Dr. Abhishek		Name of Person Ordered Transfer Dr. Nandan	
Patient & Clinical Records Received by : pooja			
Date & Time of Patient Received : 9/7/26 @ 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