Rainbow Children's Hospital

BirthRight by Rainbow

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 : IP5-00176073 **Admit Date** : 07-Jul-2026 **Admit Time** : 01:27 PM **UHID** : BAH-00659108

Patient Details :

Patient Name	: Master VASPULA ROHAN	**Age**	: 11 Y 6 M 19 D
Guardian	: Mr V KIRAN KUMAR	**DOB**	: 18-12-2014
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H NO 17-1-382/V/2/3, VYSHALI NAGAR, BESIDE HMWS Champapet Hyderabad Telangana INDIA 500079	**Phone No**	: 8019444933/ 9290640480
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : SEMI PRIVATE **Bed No** : SPVT 109 **Ward Name** : 1F-VIBGYOR

Room No : SPVT 109 **Admission Type** : First Visit

Contact Details :

Name : Mr V KIRAN KUMAR **Relationship** : Father

Contact Address : H NO 17-1-382/V/2/3, VYSHALI NAGAR, BESIDE HMWS Champapet Hyderabad Telangana INDIA 500079 **Phone No** : 8019444933 / 9290640480

Signature

Doctor Details :

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

Referral Doctor : SELF **Phone No** :

Co-Consultant : Dr. NALLA ANURAAG REDDY

Payment Details :

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

Payor Name : STAR HEALTH AND ALLIED INSURANCE CO LTD

BAH-00659108 IP5-00176073
Master VASPULA ROHAN
18-12-2014 11 Y 6 M 19 D (M)
Dr. SIRISHA RANI

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ IP No : _____Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
7/7/26	2:50pm	ER	Onco	

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
7/7	Fibrinogen	26068040	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
7/7	blood transfusion	(1)	969220	
8/7	chemo therapy	(1)	969221	

ANY OTHER INFORMATION

Nill

Date : 8/7/26 Time : @11am Prepared By : Ankitha

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Ankitha	SPU		

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PEDIATRIC IN-PATIENT MEDICAL RECORD

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Dr. SIRISHA RANI

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

BAH-00659108 IP5-00176073
Master VASPULA ROHAN
18-12-2014 11 Y 6 M 19 D (M)
Dr. SIRISHA RANI

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Icteric. B-cell ALL/ CNS3.
Low grade fever
Decreased appetite

History of present illness :

Admitted for PRBC transfusion
LP.

CBP- 7.5/ 2370/ N-65%, Pt-2 lakh.

No Ho cough/cold.

No Decreased appetite
No weight loss.

BAH-000...
Master VASPULA ROHAN
18-12-2014 11 Y 6 M 19 D (M)
Dr. SIRISHA RANI

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History : Normal for age.

Immunization History : Immunized till date.

(P.T.O.)

(P.T.O.)

18-12-2014 11 Y 6 M 19 D (M)
Dr. SIRISHA RANI

Pediatric Multiorgan History & Physical Exam

Anthrop

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Master VASPULA ROHAN
18-12-2014 11 Y 6 M 19 D (M)
Dr. SIRISHA RANI

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: cubicles

Desired goals of the treatment : Hemodynamic stability

Planned Labs:

Blood group opposition

NB
Dlawani
9/12/26

Planned Management

- PRBC transfusion - 1 unit.
- chemo.
- Inj. ondem IV BD
- Depo. T 1 - X2 BD.
- Continue ODIV.
- inj. PEG ASPARGINASE T/m.

Signature of the Doctor: N. PM
Name of the Doctor: N. Praveen
Date & Time: 07/1/26 11:30 pm

Signature of the Consultant: [signature]
Name of the Consultant: D. [illegible]
Date & Time: 7/1/26 10:0 AM

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/s/B Resident	
7/5/24 4:02pm.	K/c/o BCell ALL/CALLA+/CNS①. Admitted for PRBC+chemotherapy.	
	No new issues.	
	O/E	
	Cmd Alert & Active.	
	Vitals stable.	Plan
		- Start PRBC transfusion.
		- Continue chemotherapy.
		-

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26 8:00 AM	c/s/B Resident	
	Hello B cell ALL | CALLA + | CALS ⊖ |	
	No new issues.	
	O/E	
	Child Alert & Active.	
	Vitals stable.	
	CVS: S1S2 ⊕	
	RS: BLAE ⊕	
	P/A: Soft	
	CNS: WNL.	Plan.
	Dr. Prasanthi	- Continue chemotherapy.
		- D/c today.
		- monitor vitals
		Inform(SO) :
		- Get dressing done Before discharge
		R/A 1 week

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RESULT SHEET

Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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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: 109 .....

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	T- Dolo	4mg	Po	12H	07/7 8am	☑ C ☐ DC
2	T. UDILIV	300mg	Po	8H	2/7/7 8am.	☑ C ☐ DC
3	T- BACTRIM DS	1tab	Po	12H Monday wednesday fridays	6/7	☑ C ☐ DC
4	T- STAMLO 2.5mg	1tab	Po	24H	6/7 2pm	☑ C ☐ DC
5	T- Lincosit	1tab	Po	24H	6/7 4pm	☑ C ☐ DC
6	T- Shelcal	1tab	Po	24H	6/7 2pm	☑ C ☐ DC
7	TD.					☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : N. Praveen. M.P.S

Date & Time : 07/7/26, 1:30pm.

Nurse Name & Signature: Bhavani

Date & Time : 7/7/26 @ 1:30 pm

Docu. No. : RCHBH /FRM / GENERAL / 090

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DRUG CHART

Date of Admission: 7/7/20 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:				

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

BAH-000599108 IPS-0017/5073
Master VASPULA ROHAN
18-12-2014 11 Y 6 M 19 D (M)
Dr. SIRISHA RANI

REGULAR PRESCRIPTIONS

Weight. 50.5kg Ward. .....

DRUG : Inj. ONDANSETRON

Dose	Route	Frequency	Start Date
8mg	IV	12H	07/12

Name & Signature of the Doctor Starting the Drugs: N. Pearlitha

Additional Instructions:

Date/Time: 7/12 8/12

10AM Prawin 10pm Prawin Ankitha

10:30 8pm

10pm Sourabh prawin

Daily Doctor's Endorsement by a Sign

DRUG : T-DEXAMETHASONE 4mg

Dose	Route	Frequency	Start Date
	PO	12H	7/12

Name & Signature of the Doctor Starting the Drugs: N. Pearlitha

Additional Instructions:
→ 4mg in morning
2mg in night

Date/Time: 7/12 8/12

10AM Home Prawin Ankitha

10pm Sourabh

Daily Doctor's Endorsement by a Sign

DRUG : T- UDILIV 300mg

Dose	Route	Frequency	Start Date
1tab	PO	8H	7/12

Name & Signature of the Doctor Starting the Drugs: N. Pearlitha.

Additional Instructions:

Date/Time: 7/12 8/12

6AM Home Sourabh

8pm

2pm prawin

10pm Sourabh

Daily Doctor's Endorsement by a Sign

DRUG : T- STAMLO 2.5mg

Dose	Route	Frequency	Start Date
1tab	PO	24H	7/12

Name & Signature of the Doctor Starting the Drugs: N. Pearlitha

Additional Instructions:

Date/Time: 7/12

4pm

2 6pm prawin

Daily Doctor's Endorsement by a Sign

Dr. SIRISHA RANI

Weight. 50-5kg. Ward. .....

VARIABLE DOSE	Date▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route / Start Date		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

VARIABLE DOSE	Date▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route / Start Date		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
07/7/26	4:42pm	PRBC	1unit over 4 hours	IV	N.P.W	Sourav Praneela
~~7/7/26~~		Inj. Lasix	~~2nd midway and 2nd at the~~ end way.	IV	~~N.P.W~~	
7/7/26		Inj. Ansl	~~2nd.~~ End Int	~~IV~~	~~N.P.W~~	
~~8/7/26~~		~~Inj. PEGASPARGINASE~~	Stop			
7/7/26	4:40pm	Inj AVIL	1 ml	IV	d	Praneela Sourav
7/7/26	10:30pm ~~4:40pm~~	Inj LASIX	20 mg	IV endway	d	Sourav Praneela

18-12-2014 11 Y 6 M 19 D (M)

Dr. SIRISHA RANI

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I.V. FLUIDS CHART

Weight. 50-55 Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign

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

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Master VASPULA ROHAN
18-12-2014 11 Y 6 M 20 D (M)
Dr. SIRISHA RANI

oc. No. : RCH/ FRM / CLINICAL / 126

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 7/7/26 Time:	5PM	10PM	8/7/26. 2AM	6AM
Doctor / Nurse / Family Concern?				

Temperature (F) — 104 / 103 / 102 / 101 / 100 / 99 / 98 / 97 / 96 / 95 / 94

- 5PM: 97.9°F
- 10PM: 98.1°F
- 2AM: 97.8°F
- 6AM: 98.0°F

Heart Rate (bpm) and Blood Pressure (mmHg) * — 190 / 180 / 170 / 160 / 150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50

Note: BP does not score in early warning scoring

- 5PM: 116 / (79) / 60
- 10PM: 120 / (85) / 70
- 2AM: 109 / (85) / 69
- 6AM: 112 / (89) / 79

Heart Rate (Number)	112 b/m	98 b/m	108 b/m	89 b/m

Resp. Rate (bpm) (Over 1 Minute) * — 70 / 60 / 50 / 40 / 30 / 20 / 10

Resp Rate (Number)	25 b/m	28 b/m	25 b/m	26 b/m
Resp Distress (Mod/ Severe / None / Mild)				
Receiving O_2 (l/min) O_2 Saturations (%)	98.1%	100%	99%	100%
Conscious Level (Normal / Altered)				
GCS *	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	1	0	1	0
Pain Score	0	0	0	0
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.

Patient Sticker

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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 I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

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Master VASPULA ROHAN
18-12-2014 11 Y 6 M 19 D (M)
Dr. SIRISHA RANI

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FLUID CHART

Sheet No. : .....

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	Intake: Nature of Fluid	Intake: Route: Mouth	Intake: Route: I.V	Intake: Route: N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
7/7	02:00 pm											
	03:00 pm											Sirisha
	04:00 pm	PRBC Utpatti		67.5							Line	
	05:00 pm			67.5			✓			✓		Sirisha
	06:00 pm			67.5								
	07:00 pm											
Total Intake :						**Total Output :**						
8/7	08:00 pm			—								
	09:00 pm	Urine Albumin		—						✓		Sirisha
	10:00 pm			60ml			NP				line	
	11:00 pm			60ml						✓		Sirisha
	12:00 am			60ml								
	01:00 am			60ml								Sirisha
Total Intake :						**Total Output :**						
8/7	02:00 am			60ml								Sirisha
	03:00 am	Albumin		60ml						✓		
	04:00 am			—			NP				line.	Sirisha
	05:00 am	Urine		—						✓		
	06:00 am			—								Sirisha
	07:00 am			—								
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

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Sheet No. : .....

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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	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											
	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**	

BAH-00659108 IP5-00176073
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NURSING CARE RECORD

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Shift: ☐ Morning ☑ Afternoon ☐ Night

Date: 7/7/26

Assessment: .....

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
2Pm ⇒ Assess Pt general condition 4Pm ⇒ maintain IO chart 6Pm ⇒ PRBC transfusion start going on 8Pm ⇒ Administer medications as Per doctors orders		2:10Pm ⇒ Assessed Pt general condition 4:10Pm ⇒ maintained IO chart 6:10Pm ⇒ PRBC transfusion is going on 8:10Pm ⇒ Administered IV fluids as Per doctors orders		Pt condition is normal

Re-Assessment: Monitor vitals

Special Notes: PRBC transfusion is going on

Nurse Signature: Shirisha Nurse Name: Shirisha Date & Time: 7/7/26 @ 2Pm

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NURSING CARE RECORD

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Shift: ☐ Morning ☑ Afternoon ☐ Night

Date: 7/7/26

Assessment: Pt having dull Activity.

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 Pt General condition	8PM	→Assessed Pt General condition	Pt condition is Normal
10PM	→ monitor Vital signs	10PM	→ monitored Vital signs	
2AM	→ maintain I/O chart.	2AM	→maintained I/O chard	
8AM	→Administer the medicat ions as per doctors Order	8AM	→Administered the medicat ions as per doctors order.	

Re-Assessment: Nil

Special Notes:

Nurse Signature: Sri Nurse Name: Sravanthi Date & Time: 8/7/26 8AM

Docu. No: RCHBH /FRM / CLINICAL / 148

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THE HUMPTY DUMPTY SCALE 7/7/26 8/7

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	2			
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	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	2			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	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	1			
	TOTAL		10	10			

Intervention : -Fall Risk : Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position		Yes	Yes			
	Call device within reach		Yes	Yes			
	Wheels Locked		Yes	Yes			
	Room free of clutter		Yes	Yes			
	Adequate Lighting		Yes	Yes			
	Wheel Chair Support		No.	No			
	Other Intervention(s) Specify		No	No			
	Nurse's Name :		Sreenivasa	Gayathri			
	Signature :						
	Date :		7/7/26	8/7/26			
	Time :		1:30 pm	8pm			

Docu. No. RCHBH / FRM / CLINICAL / 005

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Sirisha Rani Department: ER Date of Admission: 7/7/26

SITUATION	Diagnosis: B cell ALL			Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify:			
BACKGROUND	Area / Shift Time	ER 2:05pm	1st floor 8pm-8pm	1st floor 8pm-8am			
	Medical Condition (Any special condition to be noted):	Nil	NA	NA			
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:	99.1°F		98.1°F			
	Res:	20b/m	25b/m	28b/m			
	SpO_2:	99%	99%	100%			
	Pulse:	134b/m	125b/m	120b/m			
	BP:	123/62 (74)		100/59			
	Fall Risk Score:	10	10	10			
	Pain Score:	0	0	0			
Recommendations	Safety Needs:	Yes	Yes	Yes			
	Physiotherapy	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	Nil	NA	NA			
	Special Diet:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	Nil	NA	NA			
Post Operative Procedure Special Orders:		NA	NA	NA			
Handed Over By Name :		Bhavani	Sirisha	Saraswathi			
Signature :							
Date:		7/7	7/7	6/07/26			
Time:		2:05 pm	8pm	8am			
Taken Over By Name :		Sirisha	Saraswathi	Akhila			
Signature :							
Date:		7/7	7/8/26	8/7			
Time:		@2pm	8pm	8am			

Patient Sticker

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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:						
	Pain 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:							

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BRADEN 'Q' SCALE

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					Date : 9/7 8/8		
					Time : 2pm		
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 extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	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	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	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	4	
FRICTION-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	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 mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	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	4	
				TOTAL SCORE	24	24	
				Evaluator's Name	Bhavani		

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

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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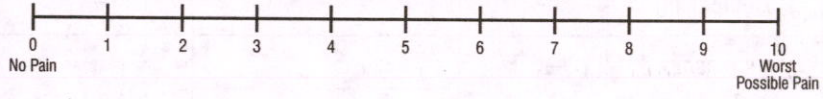
PAIN ASSESSMENT FORM

Date	Time	Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
7/2/26	2pm	0/10	/	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	Bhavani
7/7	4pm	0/10	←	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sravantho
				☐ 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:
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

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 brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

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, SaO_2	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

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DISCHARGE PLANNING FORM

Nationality: Indian

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: Advice doctor orders

2. Destination Post Discharge: ☑ Home
   Family Members Notified (Person Contacted)
   ☐ Transfer
   Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☐ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

			Remarks
☐ Medication	☑ Yes	☐ No	
☐ Bathing	☐ Yes	☑ No	
☐ Eating	☐ Yes	☑ No	
☐ Walking	☐ Yes	☑ No	Explain the Mother
☐ Dressing	☐ Yes	☑ No	
☐ Toileting	☐ Yes	☑ No	

4. Nutritional Plan:
   ☐ Dietary Instruction Discussed with the:
   ☐ Patient ☑ Family Member ☐ Others: .....

5. Discharge Planning Discussed with the:
   ☐ Patient ☑ Family Member ☐ Others: .....

6. Patient/Family Educational Plan:
   ☐ Educational Topic/s: personal Hygeine
   ☐ Patient's Educational Topic/s discussed with the:
   ☐ Patient ☐ Family Member ☐ Others: .....

Nurse Signature: .....

Nurse Name: .....

Date and Time: .....

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CONSENT FOR CHEMOTHERAPY

Patient Name : V. Rohan - Age : 11 year Gender : Male ☑ Female ☐

UHID No : BAH- 00659108 Department : Oncology Date : 7/7/20

Type of Chemotherapy : Subcutaneous

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 .....

N/A.

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 : .....

Name : V. Kiran Kumar

Relationship with Patient: Father

Date & Time : .....

Witness :

Signature : .....

Name : .....

Date & Time : .....

Doctor (who is taking the consent):

Signature : .....

Name : Shanthisha

Date & Time : 7/7/20

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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. : (1)	Weight (kg) : 50.5kg	Body Surface Area:	Diagnosis: B-AL	Protocol: INDUCTION WK-3

INDUCTION

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.
7/7/26	10:30 pm	WEEK -3 Inj VINCRISTINE in 10ml NS	2mg	IV	once 10 min	d	A / B	7/7		S / A
7/7/26	10:45 pm	Inj DAUNORUBICIN. in 300 ml 1/2 DNS	30mg	IV.	60 ml/h	d	S / A	8/7		A / S

Docu. No. : RCHBH /FRM / CLINICAL / 082

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BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 7/7/26 Time: @4:42pm

Blood Group of the Patient: ..... Blood Group on the Blood Bag: .....

Blood Bank Issue No: ..... Date of Collection: ..... Date of Expiry: .....

Date & Time of Starting Transfusion: 7/7/26 @4:42 pm Planned duration of Transfusion: 4hours

Check for Correct Unit: ☑ Correct Patient: ☑

Blood products cross checked by: Nurse 1: Sourav Nurse 2: pramila

Before starting transfusion vitals: Temp: 98.8°F HR 112 RR: 28 BP: 116/59(77) SpO2 98

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO_2	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
7/7	15 Min	106bm	98.1F	106/82	99%	–	–	–	–
7/7	15 Min	110bm	97.3°F	112/68	98%	–	–	–	–
7/7	30 Min	111bm	98.6°F	116/70	99%	–	–	–	–
7/7	30 Min	115bm	97.3°F	117/72	97%	–	–	–	–
7/7	30 Min								
	1 Hr								
	1 Hr								

Comments: .....

.....

Name of the Incharge-Nurse: Neeraja Name of the Nurse: Sirisha

Signature of the Incharge-Nurse: ..... Signature of the Nurse: Sirisha

Date & Time: 7/7/26 @4:42pm Date & Time: 7/7/26 @4:42pm

CONSENT FOR BLOOD TRANSFUSION

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18-12-2014 11 Y 6 M 19 D (M)
Dr. SIRISHA RANI

Name: ..... Age: 11 Yr 6 M Gender: Male ☑ Female ☐

UHID.No : BAH-00659108 Date: 7/7/26.

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 Immuno-deficiency 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 0

.....

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. Sainath

Date & Time 7/7/26 3PM.

Witness

Signature: Sirisha, Sourav,

Name: Sirisha, Sourav

Date & Time 7/7 @ 4:42PM

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

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రక్త మార్పిడి కొరకు అంగీకార పత్రము

రోగి పేరు: ..... వయస్సు: ..... లింగము ☐ పురుషుడు ☐ స్త్రీ

UHID. సంఖ్య : ..... తేదీ: .....

రక్త ఉత్పత్తి రకాలు:

☐ తాజా ఘనీభవించిన ప్లాస్మా ☐ ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు ☐ Random Donor Platelets

☐ క్రయోప్రెసిపిటేట్ ☐ ఒకే ధాత ప్లేటిలెట్స్ ☐ Whole Blood

☐ మొత్తం రక్తం ☐ ఎర్ర రక్త కణం ☐ ఇతరులు.....

నేను ..... ఇందు మూలముగా రెయిన్బో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నపుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడీస్, హైపటైటీస్ బి సర్ఫేస్ యాంటిజన్, హైపటైటీస్ యాంటిబడీస్, మలేరియా మరియు సిఫ్లిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణిత కాల పరిమితి లో జరిగినప్పటికి పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలెత్తవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు .....

.....

పైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి చికిత్స చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. చికిత్స చేస్తున్న సమయంలో అన్ని రకముల రక్తమార్పిడులకు (మొత్తం రక్తం / లేదా రక్త ఉత్పతులు ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ఫ్రెష్ ఫ్రోజెన్ ప్లాస్మా, క్రయోప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెండెంట్)

సంతకము .....

పేరు .....

తేదీ మరియు సమయము .....

సాక్షి

సంతకం .....

పేరు .....

తేదీ మరియు సమయము .....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము .....

పేరు .....

BAH-00659108 IP5-00176073
Master VASPULA ROHAN
18-12-2014 11 Y 6 M 20 D (M)
Dr. SIRISHA RANI

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:
Arrival Time: 2.10PM Mode of Arrival: By walk Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction .....

Body Weight: 30.5kg Kg

Height: ..... cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
NA	NO	NO

Family History: NO

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: 30.5 Length: ..... Head Circumference (< 2 years): .....

Temp.: 98.5°F HR: 105 RR: 25 BP: 107/62

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

Fall Risk Assessment: ☐ Yes ☐ No Score: 10 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 23) (Document in the Braden Q Assessment Sheet)

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

Character of Pain ..... Location ..... Frequency ..... Duration .....

FUNCTIONAL SCREENING:
☑ No Abnormalities Detected
☐ Mobility Problem
☐ Developmental Delay
☐ Walking Problem
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:
☑ No Abnormalities Detected
☐ Underweight
☐ Feeding Problem
☐ Overweight
☐ Special diet
☐ Special Feeding Method
☐ No Abnormality Detected

Inform consultant for positive criteria

(P.T.O)

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With family

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

All Information Obtained From ☒ Patient ☑ Mother ☐ Father ☐ Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☑ Yes ☐ No Waste Disposal Explained: ☑ Yes ☐ No

Infusion Pump : ☑ Yes ☐ No Hand hygiene Explained: ☑ Yes ☐ No ☐ Others

Patient Rights & Responsibilities: ☑ Yes ☐ No

Information given to mother

Nurse's Name: [illegible] Date: 7/7 Time: 6:PM Signature

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
BAH-00659108 IP5-00176073 Master VASPULA ROHAN 18-12-2014 11 Y 6 M 19 D (M) Dr. SIRISHA RANI	7/7/26 @ 1:27 pm	7/7/26 @ 2:05 pm
	Transfer Ordered by Dr - prathiba	Reason for Transfer Admission
From Unit ER	To Unit Onco (109)	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 20	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant op file Yes ☑ No ☐ If yes, what ? Prabavathy

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
NR - Seesmita	Dr - prathiba

Patient & Clinical Records Received by : Sirisha

Date & Time of Patient Received : 7/7/26

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

BAH-00659108 IP5-00176073
Master VASPULA ROHAN
18-12-2014 11 Y 6 M 19 D (M)
Dr. SIRISHA RANI

109

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 7/7/26 Time: 2:30 PM

Weight: 50.5 kgs Centile: 90th

Height: 156 cms Centile: 90th

Inference: Overweight child

RDA: — Calories: 1700 kcal/d Protein: 30 g/d

Diet Recommendations: Normal high protein diet

Re-Assesment: Avoid spicy, chilled & outside foods

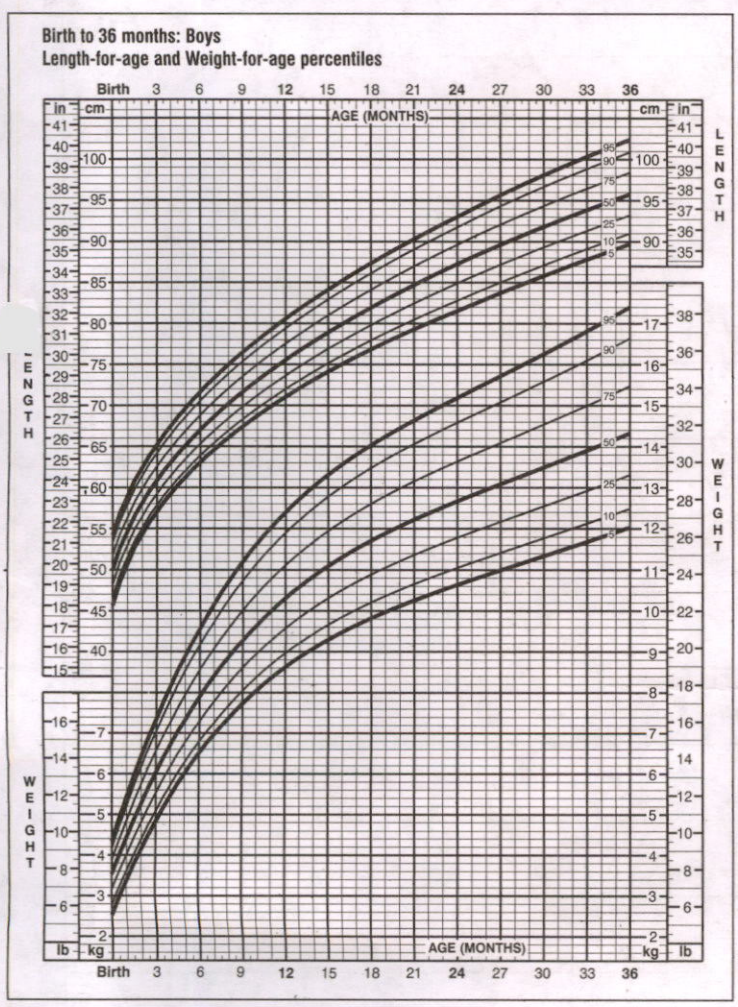
Food Allergies: NO Veg/Non-veg Non-veg

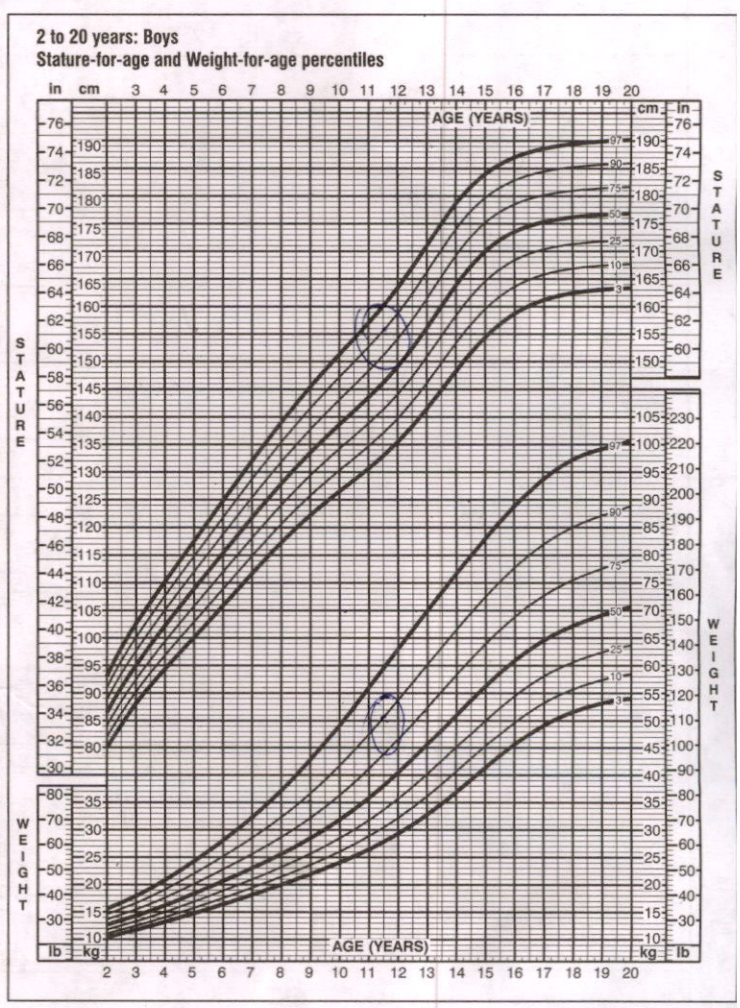
Diagnosis: R/c/o B cell ALL

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: parents don't need dietitian. Don't charge for NHA

GROWTH CHART (BOYS)





Dietician's Name Nikitha Dietician's Signature Nikitha

Daily Notes: