

### ACTIVITY RECORD FOR BILLING

*(Handwritten circle with '1')*

Name : \_\_\_\_\_

BAH-00635170 IP5-00173782  
Mrs SANGEETHA BANDARI  
02-09-1991 34 Y 8 M 11 D (F)  
Dr. SIRISHA RANI

UHID No. : \_\_\_\_\_ Consultant: \_\_\_\_\_ Dept : \_\_\_\_\_



Date of Admission: \_\_\_\_\_ Date of Discharge : \_\_\_\_\_ Time: \_\_\_\_\_

Room / Bed No : \_\_\_\_\_ Ward : \_\_\_\_\_ Suggested Billable bed type : \_\_\_\_\_

### WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
13/05	3.20 pm	ER	0710	Ramya

### Cross Consultation Visit

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

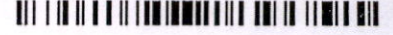






**ADMISSION SHEET**

**Registration Details :**



**Admission No :** IP5-00173782      **Admit Date :** 13-May-2026      **Admit Time :** 02:52 PM      **UHID :** BAH-00635170

**Patient Details :**

**Patient Name :** Mrs SANGEETHA BANDARI      **Age :** 34 Y 8 M 11 D  
**Guardian :** Mrs B LAXMI      **DOB :** 02-09-1991  
**Gender :** Female      **Religion :**  
**Occupation :**      **Martial Status :** Married  
**Address (H) :** H NO 6-1-197, P S M L COLONY, Sadashivpet      **Phone No :** 9010982286  
Medak Telangana INDIA 502291      **E-mail :** NOMAIL@GMAIL.COM

**Admission Details :**

**Bed Type :** BASINET      **Bed No :** CRDL HO DC 1-1      **Ward Name :** 1F-HEMATO-ONCOLOGY  
**Room No :** CRDL HO DC 1-1      **Admission Type :** First Visit

**Contact Details :**

**Name :** Mrs B LAXMI      **Relationship :** MOTHER  
**Contact Address :** H NO 6-1-197, P S M L COLONY, Sadashivpet      **Phone No :** 9010982286  
Medak Telangana INDIA 502291

*B. Sangeetha*  
Signature

**Doctor Details :**

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

**Payment Details :**

**Payment Mode :** Cash      **Deposit Amount :** 0.00  
**Payor Name :** SELFPAY

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 Mrs SANGEETHA BANDARI  
 02-09-1991 34 Y 8 M 11 D (F)  
 Dr. SIRISHA RANI

## EFFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	3			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record				
6	Doctors progress sheets	1			
7	Nursing plan of care and handover sheets	2			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia & post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Extra	5			
	<b>Total No. of Pages</b>	<b>22</b>			

*Sirisha Rani*  
 Signature and Date :  
 13/5/26

## ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /  
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

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Pati



Rainbow<sup>®</sup>  
 Children's  
 Hospital  
 It takes a lot to treat the little.

BirthRight<sup>™</sup>  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/05/26	<u>Day Care Notes</u>	
2pm	child - c/o AML - May 2024 relapsed May 2025 GUT GVHD stage 4 - On Treatment now mother - for Donor Workup	
	o/e - vitals stable	<u>Plan</u>
	Resp } P/A } ⊕ CVS }	1) IV cannula - CBP 2) IV fluids 3) Donor workup
		<u>Dr Jayashri</u>
	Dr. B Banerjee 13/05/26	



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# DRUG CHART

Date of Admission: 13/05/26 Drug Allergies:  Not known any Drug Allergies

## FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).  
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.  
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.  
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.  
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.  
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.  
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time  
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

## SOS / PRN (As Required Medication)

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

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

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

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



**REGULAR PRESCRIPTIONS**

Weight. 57kg Ward. ....

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

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

<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Date																		
Name & Signature of the Doctor Starting the Drugs:																					
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<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Date																		
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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: ..... Onw .....

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

\* C- Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: *Sirisha* .....

Date & Time: 13/5/20 @ 3:30 PM .....

Nurse Name & Signature: *Ramya* .....

Date & Time: 13/05/20 @ 03:46 PM .....



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# FLUID CHART

Sheet No. : 1

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

*13/5/26*

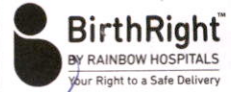
Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**



# 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.
3. 24 hrs. total to be entered in the kardex in RED.

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													
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	02:00 am													
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	04:00 am													
	05:00 am													
	06:00 am													
	07:00 am													
<b>Total Intake :</b>						<b>Total Output :</b>								

<b>Total 24 hrs. Intake</b>	
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<b>Total 24 hrs. Output</b>	
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