

BAH-00654245 IP5-00174683
Master OMAR AHMED YASIN
01-08-2024 1 Y 10 M 2 D (M)
Dr. NALLA ANURAAAG REDDY



ADMISSION CRITERIA – ONCOLOGY

Admission / Transfer from:

- Emergency Outpatient (OPD) Ward Operation Theater Others:


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

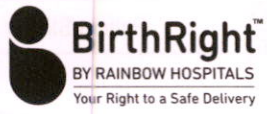
- For Chemotherapy-Day Care or IP Admission as per the Type of Chemotherapy
- Febrile Neutropenias (ANC <500 cells / mm3)
- Netropenic Enterocolitis
- Mucositis Induced Significant Diarrohea or Pain
- Neurological Complications (like Seizures, Bleeding, Thrombosis) that can arise while on Chemotherapy 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: *[Handwritten Signature]*

Name of the Doctor: *N. Anurag Reddy*

Date & Time: *3/6/26 @ 10:4AM*

BAH-00654245 IP5-00174683
Master OMAR AHMED YASIN
01-08-2024 1 Y 10 M 2 D (M)
Dr. NALLA ANURAAG REDDY




DISCHARGE CRITERIA – ONCOLOGY

Discharge to:
 HDU / Step down ICU Ward Outside Facility Others:

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: *[Handwritten Signature]*

Name of the Doctor : *A. J. Reddy*

Date & Time: *3/6/2024, 4pm*

BAH-00654245 IP5-00174683
Master OMAR AHMED YASIN
01-08-2024 1 Y 10 M 2 D (M)
Dr. NALLA ANURAG REDDY



RESULT SHEET

Date	3/6				
Time	1 PM				
Hb	8.5				
PCV	27.1				
RBC	2.64				
WBC	3.14				
N/L	20/70				
Platelets	172				
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					

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: ICU Shifted to: oncology

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	Syr. Rautar	1.5ml	PO	12H		<input type="checkbox"/> C <input type="checkbox"/> DC
2	T. AmloDipine (2.5ml) 1/2 tablet		PO	24H		<input type="checkbox"/> C <input type="checkbox"/> DC
3	Vitamin-D3 drops	0.5ml	PO	24H		<input type="checkbox"/> C <input type="checkbox"/> DC
4	Syr sephran	2.5ml	PO	12H		<input type="checkbox"/> C <input type="checkbox"/> DC
5	Syr. Zincvit	2.5ml	PO	24H		<input type="checkbox"/> C <input type="checkbox"/> DC
6	Syr Cellimax plus.	2.5ml	PO	24H		<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: N. Pratikshu. N.R.

Date & Time: 3/6/26, 9:30am

Nurse Name & Signature: Jayanya & D

Date & Time: 3/6/26 @ 9:50AM



REGULAR PRESCRIPTIONS

Weight 11kg Ward

DRUG : <u>Wj. ONDANSETRON</u>				Date Time	<u>3/6</u>															
Dose	Route	Frequency	Start Date																	
<u>2 mg</u>	<u>W</u>	<u>BH</u>	<u>03/6</u>																	
Name & Signature of the Doctor Starting the Drugs:																				
<u>N. Prathibha</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				



Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
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.	

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
		2g MIDA 201401				
3/6/26	1PM	2g MIDA 201401	1mg	iv	<u>Abhishek</u>	<u>Narshree</u> <u>Uday</u>

VERIFIED BY : Name Signature

I.V. FLUIDS CHART

Weight: 11 kg Ward:



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

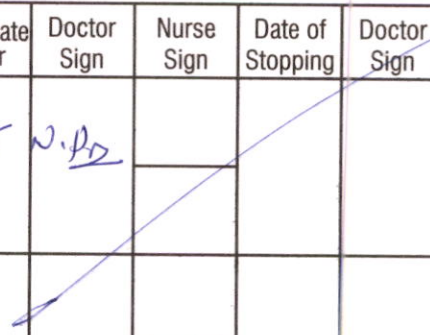
Nurse
Sign

03/6/28 .

DNS

IV

45 N.P.D



Signature

VERIFIED BY : Name

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)

BAH-00654245 IP5-00174683
 Master OMAR AHMED YASIN
 01-08-2024 1 Y 10 M 2 D (M)
 Dr. NALLA ANURAAG REDDY

Patient :

3/6



FLUID CHART

Sheet No. :

- All measurements in ml.
- 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												
	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 Sticker

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												
	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-00654245 IP5-00174683
Master OMAR AHMED YASIN
01-08-2024 1 Y 10 M 2 D (M)
Dr. NALLA ANURAAG REDDY



CONSENT FOR SPECIAL PROCEDURES

Patient Name : Omar Ahmed Yasin Gender: Male Female

UHID No : 654245 Department : PHO Date : 3/4/25

I Ahmed yasin S/D/W/O Yasin

Here by give consent for procedure of : lumbar puncture

For my patient, Named : Omar Ahmed

The doctors have clearly explained to me that the procedure has following possible complications:
bleeding, infections, neurotoxicity

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

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. Nikhil

Patient Attendant :
Signature : [Signature]

Name : Ahmed yasin salad

Relationship with Patient: Father

Date & Time : 3/6/26 @ 12:35pm

Witness : [Signature]

Signature : [Signature]

Name : Ahmed yasin

Date & Time : 3/6/26 @ 12:35pm

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Nikhil

Date & Time : 3/6/25, 11am

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం పురుషుడు స్త్రీ

యు.హెచ్.ఐ.డి విభాగం 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-00654245 IP5-00174683
Master OMAR AHMED YASIN
01-08-2024 1 Y 10 M 2 D (M)
Dr. NALLA ANURAAG REDDY



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

lumbar puncture

- 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. Anuraag Reddy 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: AQ
Name: Ahmed Yasin
Relationship with patient: Father
Date & Time: 3/6/26 @ 12:35 pm

Witness:

Signature: Ahmed
Name: Ahmed Yasin Salad
Date & Time: Father 3/6/26 @ 12:35 pm

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Anuraag Reddy Date: 3/6/26 Time: 12:35

ప్రాసీజర్ల సెడేషన్కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: రోగి రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, క్రింది విషయాలను అంగీకరిస్తున్నాను:

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

- సెడేషన్ వల్ల సంభవించగల సాధ్యమైన క్రింది సమస్యలు/ప్రమాదాలు గురించి నాకు తెలిపారు: గుండె వేగం మారడం, రక్తపోటు మారడం, ఆక్సిజన్ అవసరం, అలర్జి ప్రతిచర్యలు, ఎగువ శ్వాసనాళ అడ్డంకి, లాలింజోస్టాసమ్, జనరల్ అనస్థీషియాగా మారాల్సిన అవకాశం.
- ప్రాసీజర్ సమయంలో నొప్పి, భయం, ఆందోళన తగ్గించేందుకు సెడేషన్ ఇవ్వడం అవసరం అని నాకు వివరించారు. ఇది ప్రాసీజర్ సజావుగా, సురక్షితంగా జరగడానికి సహాయపడుతుంది.
- సెడేషన్కు సంబంధించిన ప్రయోజనాలు, ప్రమాదాలు, ప్రత్యామ్నాయం (జనరల్ అనస్థీషియా) గురించి నాకు స్పష్టంగా వివరించారు.
- డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ ప్రాసీజర్ 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:



moderate Sedation Flow-Sheet

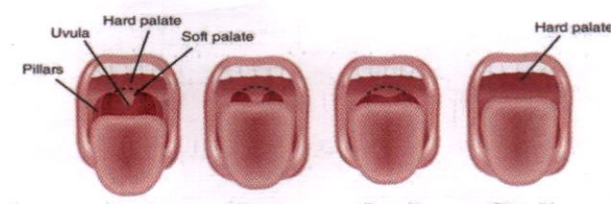
Immediate Pre-Sedation Assessment

B.P	PR	R.R	Temp	SPO ₂	Pain Score	Weight
78/50	99b/m	20b/m	98.5°F	99%	0	11 kg

Diagnosis: I-II

Procedure: lumbar puncture

Comorbidities: nil

<input checked="" type="checkbox"/> Risk, benefits & alternatives discussed; <input checked="" type="checkbox"/> Patient understand & elects to proceed <input checked="" type="checkbox"/> Consents for procedure and sedation signed and dated ASA Physical Status <input type="checkbox"/> ASA PS 1: Healthy Patient <input checked="" type="checkbox"/> ASA PS 2: Mild Systemic Disease, no functional limitations <input type="checkbox"/> ASA PS 3: Severe Systemic Disease, functional limitations <input type="checkbox"/> ASA PS 4: Severe Systemic Disease, constant threat to life <input type="checkbox"/> ASA PS 5: Moribund Patient unlikely to survive 24 hrs. <input type="checkbox"/> ASA PS 6: A declared braindead patient whose organs are being removed for donor purposes <input type="checkbox"/> E: Emergency procedure GCS: E ₄ M ₆ V ₅	AIRWAY EVALUATION Mouth: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Loose Teeth <input type="checkbox"/> Small Mouth <input type="checkbox"/> Protruding Incisors <input type="checkbox"/> Receding Lower Jaw <input type="checkbox"/> Dentures Neck: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Decreased ROM <input type="checkbox"/> Thyromental Distance Less Than 6 cm <input type="checkbox"/> Short Neck  <p>Mallampati Class: <input checked="" type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV</p>
<input checked="" type="checkbox"/> IV Site: Gauge:	
Sedation Plan: <u>W</u>	
Allergies: <u>nil</u>	

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

Observation to be documented every 15 mins

TIME	BP	PR	RR	O ₂ Sat%	O ₂ Supplementation	Comments / Initials
Baseline	99/50	90b/m	20b/m	99%	-	-

DRUG & IV Fluid: (including Nitrous Oxide)	ROUTE	DOSE	TIME GIVEN	SUBSEQUENT DOSES AND TIME
Dij. Midazolam	IV	1mg	12:50pm	

Doctor Notes:
 child tolerated procedure well

Time of transportation to post sedation care room: LOC:

Doctor Name: Signature:

Post Sedation Care Room

Time																			
Monitoring	180																		
ECG NBP Oximeter	160																		
Pain Score (0-10)	140																		
Sedation Score (0-4).....	120																		
	100																		
	80	180																	
	60	180																	
	40	180																	

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 oncalling=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: @ 6pm

Nurse Name: pooja

Signature: pooja

Date: 3/6/26 Time: 6pm

Consultant Name: Dr. Pooja

Signature: [Signature]

Stamp

ADMISSION SHEET

Registration Details :



Admission No : IP5-00174683 Admit Date : 03-Jun-2026 Admit Time : 09:24 AM UHID : BAH-00654245

Patient Details :

Patient Name : Master OMAR AHMED YASIN Age : 1 Y 10 M 2 D
Guardian : Mr AHMED YASIN DOB : 01-08-2024 10:03 PM
Gender : Male Religion :
Occupation : Martial Status : Single
Address (H) : PARAMOUNT COLONY Tolichowki Hyderabad Phone No : 9392377972
Telangana INDIA 500008 E-mail : NA@GMAIL.COM

Admission Details :

Bed Type : DAY CARE Bed No : HO DC 2 Ward Name : 1F-HEMATO-ONCOLOGY
Room No : HO DC 2 Admission Type : First Visit

Contact Details :

Name : Mr AHMED YASIN Relationship : Father
Contact Address : PARAMOUNT COLONY Tolichowki Hyderabad Phone No : 9392377972
Telangana INDIA 500008

Signature

Doctor Details :

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

Payment Details :

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

ACTIVITY RECORD FOR BILLING

1

Name : _____

UHID No. : _____ IP No _____ Dept : _____

BAH-00654245 IP5-00174683
Master OMAR AHMED YASIN
01-08-2024 1 Y 10 M 2 D (M)
Dr. NALLA ANURAAG REDDY

Date of Admission: _____ charge : _____ Time: _____



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/6	9:50AM	ER	oncology	[Signature]

Cross Consultation Visit

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

