

ADMISSION SHEET

Registration Details :



Admission No : IP5-00174684 Admit Date : 03-Jun-2026 Admit Time : 09:32 AM UHID : BAH-00654648

Patient Details :

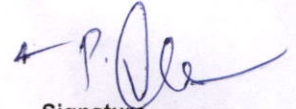
Patient Name : Baby SRI HARINI RAO Age : 2 Y 6 M 30 D
Guardian : Mr VENKAT RAO DOB : 04-11-2023
Gender : Female Religion :
Occupation : Martial Status : Single
Address (H) : H.NO-9-4-636 SAPATHAGIRI COLONY Phone No : 7816055044/ 9000807678
Karimnagar Karimnagar Telangana INDIA E-mail : 7816055044@d
505001

Admission Details :

Bed Type : DAY CARE Bed No : HO DC 3 Ward Name : 1F-HEMATO-ONCOLOGY
Room No : HO DC 3 Admission Type : First Visit

Contact Details :

Name : Mr VENKAT RAO Relationship : Father
Contact Address : H.NO-9-4-636 SAPATHAGIRI COLONY Phone No : 7816055044 / 9000807678
Karimnagar Karimnagar Telangana INDIA
505001


Signature

Doctor Details :

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

Payment Details :

Payment Mode : Cash Deposit Amount : 2377.71
Payor Name : SELFPAY

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ Consultant: _____ Dept : _____

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

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

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Baby SRI HARINI RAO
04-11-2023 2 Y 6 M 30 D (F)
Dr. BIRISHA RANI



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/6/26	10:00 am	ER	ONCO	Abhishek

Cross Consultation Visit

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

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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

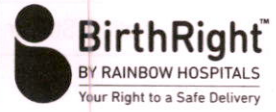
- For Chemotherapy-Day Care or IP Admission as per the Type of Chemotherapy
- Febrile Neutropenias (ANC <500 cells / mm³)
- Netropenic Enterocolitis
- Mucositis Induced Significant Diarrohea or Pain
- Neurological Complications (like Seizures, Bleeding, Thrombosis) that can arise while on Chemotherapy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

Name of the Doctor: *Sirishi*

Date & Time: *3.16/26 @ 12pm*

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Dr. SIRISHA RANI



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: [Signature]

Name of the Doctor: Dr. Soorani

Date & Time: 3/6 @ 3 PM

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 Dr. SIRISHA RANI

Patient



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6/26	Ball for Inclusion	(P)
	Hb: 9.3 WBC: 900 PLF: 1.4L	 AFP today wk-3 Vinc & Daunorubicin today (wk-2) ct Dexam
		Noted by Dr. [Signature] 1/6/26 3/6 @ 3PM
		[Signature] 3/6

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 Dr. SIRISHA RANI

①

RESULT SHEET

Date	3/6/26			
Time	9pm			
Hb	9.3			
PCV	28.0			
RBC	3.28			
WBC	0.91			
N/L	159			
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				

op casts

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 Dr. SIRISHA RANI



DRUG CHART

Date of Admission: 2/6/26 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:																					

VERIFIED BY : Name Sign



REGULAR PRESCRIPTIONS

Weight. 15-86 kg Ward.

DRUG : <i>ly. ONDANSETRON</i>				Date Time	<i>3/6</i>															
Dose	Route	Frequency	Start Date																	
<i>3mg</i>	<i>IV</i>	<i>8H</i>	<i>03/6</i>	<i>GA X</i>																
Name & Signature of the Doctor Starting the Drugs:				<i>N. Prathima</i>																
Additional Instructions:				<i>for pain</i>																
Daily Doctor's Endorsement by a Sign				<i>for</i>																
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																				

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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: *ICU* Shifted to: *ONCO*

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	Syp. Ziprax	3ml	PO	12H		<input type="checkbox"/> C <input type="checkbox"/> DC
2	T. Voriconazole	1/2 tablet	PO	24H		<input type="checkbox"/> C <input type="checkbox"/> DC
3	T. Amlodipine 2.5mg	1/2	PO	24H		<input type="checkbox"/> C <input type="checkbox"/> DC
4	Syp. Bactrim	2.5ml	PO	12H Monday, Wednesday, Friday		<input type="checkbox"/> C <input type="checkbox"/> DC
5	Syp. Cloxacillin ph	3ml	PO	24H		<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: *N. Pratikshu* - *N. Pratikshu*

Date & Time: *03/06/26, 10 am.*

Nurse Name & Signature: *Pooja*

Date & Time: *3/6/26 @ 10:00*

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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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 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											
	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 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												
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

CONSENT FOR CHEMOTHERAPY



Patient Name : Sri harini Rao Age : 2y Gender : Male Female
UHID No : BAH - 00654698 Department : Oncology Date : 3/6/26
Type of Chemotherapy : DANORUBICINS

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
..... Explained

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 : P. Venkat
Name : Venkat
Relationship with Patient : Father
Date & Time : 3/6/26 @ 1pm

Witness :
Signature : P. Venkat
Name : Venkat
Date & Time : 3/6/26 @ 1pm

Doctor (who is taking the consent):
Signature : [Signature]
Name : Dr. Sandhya
Date & Time : 3/6/26 @ 1pm

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Dr. SIRISHA RANI



CONSENT FOR BLOOD TRANSFUSION

Name: SRI harini Rao. Age: 2y Gender: Male , Female
UHID No: BAH-00654648 Date: 3/6/26.

- 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

Venkatesh 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 Explained

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 / Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):
Signature: P. Venkatesh
Name: Venkatesh
Date & Time: 3/6/26 @ 12:30pm

Doctor (Who is talking the consent)
Signature: [Signature]
Name: DR. Sandhya
Date & Time: 3/6/26 @ 12:30pm

Witness
Signature: P. Venkatesh
Name: Venkatesh
Date & Time: 3/6/26 @ 12:30pm

రోగి పేరు: వయస్సు: లింగము పురుషుడు స్త్రీ

UHID. సంఖ్య: తేదీ:

రక్త ఉత్పత్తి రకాలు:

- | | | |
|---|---|---|
| <input type="checkbox"/> తాజా ఘనీభవించిన ప్లాస్మా | <input type="checkbox"/> ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు | <input type="checkbox"/> Random Donor Platelets |
| <input type="checkbox"/> క్రయో ప్రెసిపిటేట్ | <input type="checkbox"/> ఒకే ధాత ప్లేటిలెట్స్ | <input type="checkbox"/> Whole Blood |
| <input type="checkbox"/> మొత్తం రక్తం | <input type="checkbox"/> ఎర్ర రక్త కణం | <input type="checkbox"/> ఇతరులు..... |

నేను ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. ధాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడిస్, హైపటైటిస్ బి సర్వేస్ యాంటిజన్, హైపటైటిస్ యాంటిబడిస్, మలేరియా మరియు సిప్లిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణయ కాల పరిమితి లో జరిగినప్పటికీ 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 తెలిత్రవచ్చు 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 ఉత్పత్తులు ప్యాక్ చేయబడ / ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ప్లెప్ ఫ్రాజెన్ ప్లాస్మా, క్రయో ప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెండెంట్)	సాక్షి
సంతకము	సంతకం
పేరు	పేరు
తేదీ మరియు సమయము	తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)
సంతకము
పేరు

BAH-00654648 IP5-00174684
 Baby SRI HARINI RAO
 04-11-2023 2 Y 6 M 30 D (F)
 Dr. SIRISHA RANI



BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 3/6/26 Time: 12:30pm

Blood Group of the Patient: O Rh negative Blood Group on the Blood Bag: O negative

Blood Bank Issue No: BAH-26-00719 Date of Collection: 29/3/26 Date of Expiry: 29/3/24

Date & Time of Starting Transfusion: 3/6/26 Planned duration of Transfusion: 30 mins

Check for Correct Unit: Correct Patient:

Blood products cross checked by: Nurse 1: Veena Nurse 2: poja

Before starting transfusion vitals: Temp: 98.5° HR 96b/m RR: 26b/m BP: 98/50 SpO₂ 99%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
	15 Min	98b/m	98.5°	98/50	99%	NA	NA	NA	NA
	15 Min	96b/m	98.4°	99/62	98%	NA	NA	NA	NA
	30 Min								
	30 Min								
	30 Min								
	1 Hr								
	1 Hr								

Comments: NA

Name of the Incharge-Nurse: Nashana Name of the Nurse: Veena

Signature of the Incharge-Nurse: Nashana Signature of the Nurse: Veena

Date & Time: 3/6/26 @ 12:30pm Date & Time: 3/6/26 @ 1pm

BAH26-00719



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

170ml FRESH FROZEN PLASMA B.P

Qty: ~~200~~ ml. Prepared from Whole human blood collected in 49 ml. of C.P.D.A. Solution.

O

HIV I & II/ HBsAG/ HCV - Non reactive

VDRL - Non reactive

NAT(HIV-1 & 2) / HBsAG/ HCV)- Non reactive

Unit No.: BAH26-00719

Blood Group: O Rh Negative

Collection Date: 29/Mar/2026

Expiry Date: 29/Mar/2027

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Issue Label / CrossMatching Report

Patient : **Baby Sri Harini Rao -**

Patient's Blood Group : O Rh Positive

Hosp/Dr : Rainbow Childrens Hospital, DR. SIRISHA RANI

UHID No.: BAH-00654648 Wd-Bed No.:

Product : FFP

Blood Group : O Rh Negative

Issue Dt : 03/Jun/2026

Unit No.: **BAH26-00719**

Collm. Dt : 29/Mar/2026

XMatching Report: ABO Compatible

Exp. Dt : 29/Mar/2027

X-matched by: K.SAIKUMAR

Issued By :

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital

D.No.8-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road
No.2, Banjara Hills, Hyderabad, Telangana State
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