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

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Your Right to a Safe Delivery

ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ IP No : _____ Consultant: _____ Dept : _____

Date of Admission: ___ ate of Discharge : _____ Time: _____

BAH-00658924 IP5-00176150
Baby Of MARRIPUDI HIMAVARSHA (
09-08-2024 1 Y 11 M 0 D (M)
Dr. SANDHYA VADDADI

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
9/7/26	1:50pm	ER	ONCO 105	Abhishek

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
10/7	Bone Marrow Aspiration	26068950	
10/7/25	MRD panel.	26068954	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
10/7/20	Infussion pump	8:30pm		9685900	[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
10/07/16	Chemotherapy Dressing minor Bone Marrow conscious sedation lumbar puncture Blood transfusion	6	969587	

ANY OTHER INFORMATION

DO not Charge for NHA Nikitha

Date : Time : Prepared By : Saravanthi

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Saravanthi			

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 : IP5-00176150 **Admit Date** : 09-Jul-2026 **Admit Time** : 01:17 PM **UHID** : BAH-00658924

Patient Details :

Patient Name	: Baby Of MARRIPUDI HIMAVARSHA (M NAGA DHRUVA THARAK)	**Age**	: 1 Y 11 M 0 D
Guardian	: Mr MALLAVARAPU JEEVAN	**DOB**	: 09-08-2024 01:00 AM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H NO 1-61/3, NAGANPALLY, Bodhan Nizamabad Telangana INDIA 503185	**Phone No**	: 7093935797/ 7032586083
		E-mail	: JEEVANOID@GMAIL.COM

Admission Details :

Bed Type : FOUR SHARING **Bed No** : FSW 127 → 105 **Ward Name** : 1F-HEMATO-ONCOLOGY

Room No : FSW 127 **Admission Type** : First Visit

Contact Details :

Name : Mr MALLAVARAPU JEEVAN **Relationship** : Father

Contact Address : H NO 1-61/3, NAGANPALLY, Bodhan Nizamabad Telangana INDIA 503185 **Phone No** : 7093935797 / 7032586083

Signature

Doctor Details :

Doctor Name : Dr. SANDHYA VADDADI **Specialisation** : HEMATO ONCOLOGY

Referral Doctor : SELF **Phone No** :

Co-Consultant : Dr. SIRISHA RANI

Payment Details :

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

Payor Name : SELFPAY

105

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PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00658924 IP5-00176150
Baby Of MARRIPUDI HIMAVARSHA (
09-08-2024 1 Y 11 M 0 D (M)
Dr. SANDHYA VADDADI

Patient Name: B/o himavarsha

UHID ID: _____

Department: _____

Consultant: _____

BAH-00658924 IP5-00176150
Baby Of MARRIPUDI HIMAVARSHA ((M)
09-08-2024 1 Y 11 M 0 D
Dr. SANDHYA VADDADI

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: to prevent complication

Desired goals of the treatment : hemodynamic stability.

Planned Labs:

CBP.
RBS
~~Afow fibrinogen~~
N/B Abhishek

Planned Management

T. DEXA.
T. LANZOL
T. AMLODIPINE.
Syp SEPTRAN.
Syp CALCIMAR PLUS
Syp. ZINCOVIT

Signature of the Doctor: ....
Name of the Doctor: Sahithi
Date & Time: 9/7/26. 1:15PM.

Signature of the Consultant: ....
Name of the Consultant: Dr Sandhya
Date & Time: ....

BAH-00658924 IP5-00176150
Baby Of MARRIPUDI HIMAVARSHA (
09-08-2024 1 Y 11 M 1 D (M)
Dr. SANDHYA VADDADI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/8/26 9:00 Am.	Procedure Notes.	
	under strict Aseptic precautions	
	BMA + LP done.	
	short sedation given	
	No immediate complications.	
	No Bleeding.	
		[signature]
	Child Alert.	
	vitals stable.	
	c/o B Resident.	
10/8/26	Tcell ALL / mediastinal mass.	
	No new issues.	
	LP & BMA done.	
	O/E	
	Child Alert & Active.	
	vitals stable.	
	CVS: S1S2 (+)	Plan
	RS: B/L (A+E)	
	P/A: soft	- plan for d/c today.
	CNS: NAD.	- monitor vitals
		- Inform (SOS)
		[signature]

BAH-00658924 IP5-00176150
Baby Of MARRIPUDI HIMAVARSHA (
09-08-2024 1 Y 11 M 1 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

BAH-00658924 IP5-00176150
Baby Of MARRIPUDI HIMAVARSHA (
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RESULT SHEET

Date	9/7/26					
Time						
Hb	9.2					
PCV						
RBC						
WBC	4130					
N/L	44/43					
Platelets	3.17 lakhs					
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.,) : .....

BAH-00658924 IP5-00176150
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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: ward

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 SEPTRAN	2.5ml	PO	BD/A-D	9/7	☑C ☐DC
2	Syp CALCIMAX	5ml	PO	OD.		☑C ☐DC
3	Syp ~~ZINCOVIT~~ MOKTEL	2.5ml	PO	OD		☐C ☐DC
4						☐C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Sahithi $

Date & Time : 9/7/26

Nurse Name & Signature: Abhishek

Date & Time : 9/7/26 @ 1:50pm

BAH-00658924 IP5-00176150
Baby Of MARRIPUDI HIMAVARSHA (
09-08-2024 1 Y 11 M 0 D (M)
Dr. SANDHYA VADDADI

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight 15.7 kg Ward ....

DRUG	Dose	Route	Frequency	Start Dt.	Name & Signature of the Doctor Starting the Drugs	Additional Instructions	Date/Time entries	Daily Doctor's Endorsement by a Sign
Syp MOKTEL	2.5ml	PO	OD	9/7	Lahithi		9/7: 9PM Sons Arun	
Syp CALCIMAX PLUS	5ml	PO	OD	9/7	Sahithi		9/7: 9:30 PM Sons Arun	
Inj ONDENSETRON	4mg	IV	BD	9/07	T. Pavani		9/7: 6AM X Sons Arun; 6PM 7:30 PM Priyanka; 10/7	
Syp. DOMSTAL	3ml	oral	Q8HRLY	09/07	T. Pavani		9/7: 6AM X NPO; 2PM X; 10PM Sons Arun; 10/7	A A

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

Docu. No. : RCHBH /FRM / CLINICAL / 108

BAH-00658924 IP5-00176150
Baby Of MARRIPUDI HIMAVARSHA (
09-08-2024 1 Y 11 M 0 D (M)
Dr. SANDHYA VADDADI

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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

DRUG :

Dose	Route	Frequency	Start Dt.

Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

BAH-00658924 IP5-00176150
Baby Of MARRIPUDI HIMAVARSHA (
09-08-2024 1 Y 11 M 0 D (M)
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B1

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DRUG CHART

Date of Admission: 9/7/26 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 ..... nature .....

Baby Of MAKKIPUDI HIMAVARSHA (
09-08-2024 1 Y 11 M 0 D (M)
Dr. SANDHYA VADDADI

REGULAR PRESCRIPTIONS Weight. 15.7 kg Ward. .....

DRUG : T. LANZOL JR

Dose	Route	Frequency	Start Date
15mg	PO	OD	9/7

Name & Signature of the Doctor Starting the Drugs: Sahithi

Additional Instructions: 1tab = 15mg

Daily Doctor's Endorsement by a Sign

Date→ Time	9/7	10/7
	8AM X	NPO

DRUG : T. DEXAMETHASONE

Dose	Route	Frequency	Start Date
	PO	BD	9/7

Name & Signature of the Doctor Starting the Drugs: Sahithi

Additional Instructions: morning - 4Tab, evening - 3Tab, 1tab = 0.5mg

Daily Doctor's Endorsement by a Sign

Date→ Time	9/7
	8AM Hand
	8PM Soma Amma

DRUG : T. AMLODIPINE

Dose	Route	Frequency	Start Date
2.5mg	PO	OD	9/7

Name & Signature of the Doctor Starting the Drugs: Sahithi

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date→ Time	9/7
	6PM Priyanka

DRUG : Syp SEPTRAN

Dose	Route	Frequency	Start Date
2.5ml	PO	BD	9/7

Name & Signature of the Doctor Starting the Drugs: Sahithi

Additional Instructions: BD, Alternate day

Daily Doctor's Endorsement by a Sign

Date→ Time	9/7	10/7
	8AM X	Sushma Sravani
	8PM	X

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Baby Of MARRIPUDI HIMAVARSHA (
09-08-2024 1 Y 11 M 0 D (M)
Dr. SANDHYA VADDADI

Weight. ..... Ward. .....

	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.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
09/07/26	11:30 pm	FFP	150ml over 1 hour	IV		Sona Aruna
09/07	11:30 pm	Inj AVIL	0.2ml	IV		Sona Aruna

VERIFIED BY ..... Signature .....

09-08-2024 1 Y 11 M 0 D (M)
Dr. SANDHYA VADDADI

I.V. FLUIDS CHART

Weight. 15.7 kg 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 .....

BAH-00658924 IP5-00176150
Baby Of MARRIPUDI HIMAVARSHA (
09-08-2024 1 Y 11 M 1 D (M)
Dr. SANDHYA VADDADI

Doc. No. : RCH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9.12..........

Time:	3pm	6pm	10pm	10/12 2am	6am
Doctor / Nurse / Family Concern?					
Temperature (°F)	97.6°F	99°F	Refused	98.7°F	97.8°F
Heart Rate (bpm) and Blood Pressure (mmHg) *	124/63 (82)	109/67 (81)	Refused	102/59 (68)	101/57 (71)
Heart Rate (Number)	132b/m	124b/m		100b/m	90b/m
Resp. Rate (bpm) (Over 1 Minute) *				*	*
Resp Rate (Number)	28b/m	28b/m		28b/m	27b/m
Resp Distress: Mod/ Severe / None / Mild					
Receiving O_2(l/min) / O_2Saturations (%)	100%	100%		99.7%	99.1%
Conscious Level: Normal / Altered					
GCS *	15/15	15/15		15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0		1	1
Pain Score	0	0		0	0
Observer's Initials	M	M		8	0

Temperature scale: 104, 103, 102, 101, 100, 99, 98, 97, 96, 95, 94

Heart Rate / Blood Pressure scale: 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50

Note: BP does not score in early warning scoring

Resp. Rate scale: 70, 60, 50, 40, 30, 20, 10

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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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				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			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	

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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 :						
9/7	02:00 pm	↑	Rice								P	
	03:00 pm	NS		30ml							I	
	04:00 pm	BO long		30ml			NP				C	
	05:00 pm	↓		30ml							C line	Appr
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
9/7	08:00 pm		Rice	50ml							P	
	09:00 pm	Inj.		50ml							I	Appr
	10:00 pm	Dorubu		50ml		NA					C	
	11:00 pm	Cilon									C	
	12:00 am	1/2									line	Appr
	01:00 am	DNS 200ml										
Total Intake :						Total Output :						
10/7	02:00 am											
	03:00 am	[redacted]	oPO	30ml							P	Appr
	04:00 am	Dorb		30ml			NA				I	
	05:00 am			30ml		NA					C	Appr
	06:00 am	↓		30ml							line	
	07:00 am			30ml								
Total Intake :						Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

Docu. No. : RCHBH/FRM/CLINICAL/092

BAH-00658924 IP5-00176150
Baby Of MARRIPUDI HIMAVARSHA (
09-08-2024 1 Y 11 M 1 D (M)
Dr. SANDHYA VADDADI

NURSING CARE RECORD

Rainbow® Children's Hospital
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Shift: ☐ Morning ☑ Afternoon ☐ Night

Date: 9/7/26

Assessment: Baby Care for Chemotherapy

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 the general condition of the baby.	2.30pm	Assessed the general condition of the baby.	Implemented all the procedure.
3pm	Send CBP, RBS & fibrinogen	3.30pm	Sended CBP, RBS & fibrinogen	
4pm	Monitor vital signs.	4.30pm	Monitored vital signs.	
5pm	Administer medication as per doctor order.	5.30pm	Administered medication as per doctor order.	
7pm	start chemotherapy	7.30pm	Started chemotherapy.	

Re-Assessment:

Special Notes: Tm Lp + BMA (8.30 Am Oncology)

Nurse Signature: Meslin Nurse Name: Meslin. Date & Time: 9/7/26 @ 8 p.m

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Baby Of MARRIPUDI HIMAVARSHA (
09-08-2024 1 Y 11 M 1 D (M)
Dr. SANDHYA VADDADI

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NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☑ Night

Date: 9/7/26

Assessment: .....

.....

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
10pm	→ Assess the baby General condition, monitor vitals Record	11pm	→ Assessed the baby General condition, monitored vitals & recorded	By All the's done pt conditions improved
12am	→ plan to do FFP Today	1am	→ planned to do FFP Today	
2am	→ plan to do LP, BMA T/m NPO from 3am	4am	→planned to do LP, BMA T/m NPO from 3am	
6am	→ Administer medication as per Doctor order	8am	→ Administered medication as per Doctor order	

Re-Assessment: .....

FFP Done

.....

Special Notes: LP, BMA T/m NPO from 6a.m

.....

Nurse Signature: ..... Nurse Name: Aparanji Reg 021766 Date & Time: 10/7/26 @8pm

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION

Diagnosis: T. Cell ALL

Any Infection: ☐ Yes ☐ No ☑ ~~Not Known~~
If Yes Specify: .....

BACKGROUND

Area / Shift Time	ER 1:50pm	1st floor 2pm-8pm	1st floor 8pm-8a			
Medical Condition (Any special condition to be noted):	NA	NO	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:	98 °F	97 F	98.0 F			
Res:	24 b/m	28	27 b/m			
SpO_2:	99%	100%	100%			
Pulse:	118 bpm	129	113 b/m			
BP:	—	109/67	100/62			
Fall Risk Score:	12	12	12			
Pain Score:	0/10	0/10	0/10			

Recommendations

Safety Needs:	Yes	Yes	Yes			
Physiotherapy	☐ Yes ☑ ~~No~~	☐ Yes ☑ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Others Specify:	NA	NA	NA			
Special Diet:	☐ Yes ☑ ~~No~~	☐ Yes ☑ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Special Orders / Medications:	NA	NA	NA			
Post Operative Procedure Special Orders:	NA	NA	NA			
Handed Over By Name :	Nr Abdulla	Meelis	Aparajitha			
Signature :	~~Abdulla~~ 9/7/26	M	Apa			
Date:	9/7/26	9/7	10/7			
Time:	1:50pm	@8pm	8am			
Taken Over By Name :	Meelis	Aparajitha	Saraswathi.			
Signature :	M	Apa	S			
Date:	9/7	9/7	10/7/26			
Time:	@2.30pm	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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THE HUMPTY DUMPTY SCALE

9/7/26 10/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4			
	3 to less than 7 years old	3					
	7 to less than 13 years old	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		12	12			

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

	Bed in low position		↳	Yes			
	Call device within reach		↳	Yes			
	Wheels Locked		↳	Yes			
	Room free of clutter		↳	Yes			
	Adequate Lighting		↳	Yes			
	Wheel Chair Support		↳	NO			
	Other Intervention(s) Specify		↳	NO			
	Nurse's Name :		Abhishek	Appa			
	Signature :		Abhi	Rey			
	Date :		9/7/26	10/7			
	Time :		12:50pm	6am			

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BRADEN 'Q' SCALE

					Date : 9/8/24 10/8/24		
					Time : 12PM 6PM		
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	28	28	
				Evaluator's Name	Abhaya	Appu	

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

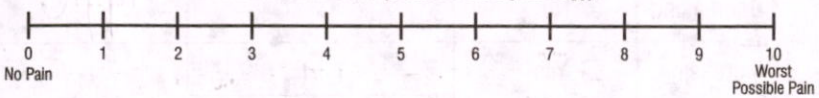
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
9/7/26	1:30pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	Ab Wsly
9/7	7pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Madhu
10/7	3am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Appy
10/7	11AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sravanthi
				☐ 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:

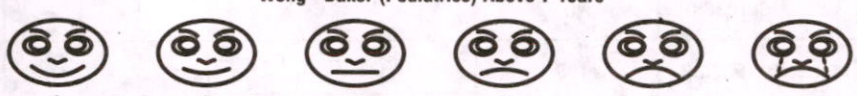
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within 30 – 60 minutes after pain 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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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
9/7/26	1:30pm	5	Medication	M	1	0	1	1	NIL	Abhishek
9/7/26	3pm	9	soft high protein diet	M	1	0	1	1	—	Nithin

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C Caregiver O: Other (Specify) .....

Learning Barriers:

1. No Learning Barriers
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify .....

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:

1. None
2. Obtain translator
3. Reassurance & Support
4. Teach Family / Others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify .....

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

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MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
9/7/26.	☑ Medical ☐ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	T- ALL	Hemodynamic stability	~~BA~~ BMA, LP, chemotherapy.	Sahithi	☑ Nursing ☐ Others:
9/7/26 1.50pm	☑ Medical ☐ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	T. All	Hemodynamic stability	BMA, LP chemotherapy	Abhishek	☑ Medical ☐ Others:
9/7/26 3pm	☐ Medical ☐ Nursing ☑ Others: Dietitian	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	T-All	soft high protein diet	RDA E - 1200 Kcal/d P 20g/d	Nithila	☐ Medical ☐ Nursing ☑ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

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ARRIPUDI HIMAVARSHA (
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CONSENT FOR SPECIAL PROCEDURES

Patient Name : Himavarsha. Gender: ☐ Male ☐ Female

UHID No : 658924 Department : Hematology Date : 10/7/26

I Jeevan. S/D/W/O parent of Himavarsha.

Here by give consent for procedure of : LP + BMA for MRD

For my patient, Named : .....

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

pain, bleeding, hematoma, headache

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: .....

Patient Attendant :

Signature : Jeevan M

Name : Jeevan. M

Relationship with Patient: Father

Date & Time : 10/7/26 8am

Witness :

Signature : Hima Vaesha. M

Name : Hima Vaesha M

Date & Time : 10/7/26 8am

Doctor (who is taking the consent) :

Signature : Ahambhas

Name : Ahambhas

Date & Time : 10/7/26 8am

ప్రత్యేక విధానాలకు సమ్మతి

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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-00658924 IP5-00176150
Baby Of MARRIPUDI HIMAVARSHA (
09-08-2024 1 Y 11 M 1 D (M)
Dr. SANDHYA VADDADI

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CONSENT FOR PROCEDURAL SEDATION

Authorization By: ☐ Patient ☑ Patient Attendant

I, the undersigned do hereby acknowledge the following:

- I have been made aware by the doctors in language known to me the details of sedation planned for the procedure
  short sedation for procedure
- 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. Simha. Rani 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: Jeevan M
Name: Jeevan M
Relationship with patient: Father
Date & Time: 10/7/26 8am

Witness:
Signature: Hima Vaeesha M
Name: Hima Vaeesha M
Date & Time: 10/7/26 8am

Doctor (who is taking consent):
Signature: Ahamkhan Name: Ahamkhan Date 10/7/26 Time: 8am

Patient Sticker

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ప్రాసీజరల్ 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, అలర్జీ ప్రతిచర్యలు, ఎగువ శ్వాసనాళ అడ్డంకి, లారింజోస్పాసమ్, 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: .....

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Baby Of MARRIPUDI HIMAVARSHA (
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Moderate Sedation Flow-Sheet

Immediate Pre-Sedation Assessment

B.P	P.R	R.R	Temp	SPO_2	Pain Score	Weight
100/60	104/m	26/m	98°F	100%	0	15.7kg.

Diagnosis: ALL

Procedure: for LP + BMA.

Comorbidities:

- ☑ Risk, benefits & alternatives discussed;
- ☑ Patient understand & elects to proceed
- ☑ Consents for procedure and sedation signed and dated

ASA Physical Status

- ☐ ASA PS 1: Healthy Patient
- ☑ ASA PS 2: Mild Systemic Disease, no functional limitations
- ☐ ASA PS 3: Severe Systemic Disease, functional limitations
- ☐ ASA PS 4: Severe Systemic Disease, constant threat to life
- ☐ ASA PS 5: Moribund Patient unlikely to survive 24 hrs.
- ☐ ASA PS 6: A declared braindead patient whose organs are being removed for donor purposes
- ☐ E: Emergency procedure

GCS: E M V

☑ IV Site: Gauge:

Sedation Plan: Short sedation.

Allergies:

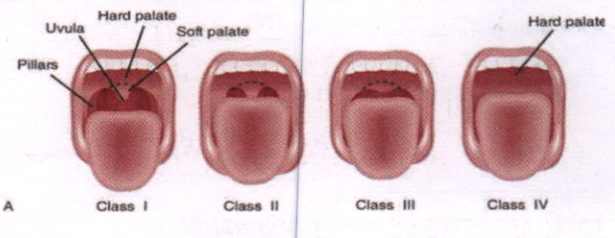
AIRWAY EVALUATION

Mouth:

- ☑ Normal
- ☐ Loose Teeth
- ☐ Small Mouth
- ☐ Protruding Incisors
- ☐ Receding Lower Jaw
- ☐ Dentures

Neck:

- ☑ Normal
- ☐ Decreased ROM
- ☐ Thyromental Distance Less Than 6 cm
- ☐ Short Neck



Mallampati Class: ☑ I ☐ II ☐ III ☐ IV

Monitoring of Patient Intra – Procedure

Procedure Monitoring

Heart Rate (HR), Respiratory Rate (RR), Oxygen Saturation (O_2 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	100/60	104b/m	26b/m	100%	-	-
	100/60	108b/m	26b/m	100%	-	-

DRUG & IV Fluid: (including Nitrous Oxide)	ROUTE	DOSE	TIME GIVEN	SUBSEQUENT DOSES AND TIME
Ketamine	IV	10mg	8:30am	-
Midazolam	IV	~~5mg~~ 1mg	8:50am	-

Doctor Notes: Uneventful.

Time of transportation to post sedation care room: 10.2 LOC: Alert

Doctor Name: Shanbhag Signature: Shanbhag

Post Sedation Care Room

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

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: 9:00am.

Nurse Name: Pooja Signature:

Date: 10/7/26 Time: 9am

Consultant Name: Dr. Sandhya Signature:

Stamp

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PROCEDURE SAFETY CHECK LIST (TIMEOUT OUTSIDE OT)

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Patient Name: Himavarsha Gender: ☐ Male ☑ Female UHID. No: 658924 Age: 1yrs

Date: 10/7/24 In-Time: 8:15am Out-Time: 9am

Doctor Performing Procedure: Dr. Sravani Doctor Giving Sedation: Dr. Sandhya Assisting Nurse: Pooja

SIGN IN Time: 8:20am	Yes	No	NA
Patient is verified using two identifires (Name & UHID)	☑	☐	☐
All required documents, images, studies are available	☑	☐	☐
NPO Status Checked from Patient / Patient Attendant	☑	☐	☐
Consent is Signed	☑	☐	☐
Any need for blood products	☐	☑	☐
If Yes Comment:			
Any Risk of Hemodynamic Compromise	☐	☑	☐
If Yes Comment:			
Any drug or food allergy	☐	☑	☐
If Yes Comment:			
Correct Site of Procedure Marked	☑	☐	☐
All resources required are correct, available and functioning	☑	☐	☐

Signature of the Doctor: Dhanlakshmi

Name of the Doctor: Dhanlakshmi

TIME OUT Time: 8:25am	Yes	No	NA
Correct Patient	☑	☐	☐
Correct Site	☑	☐	☐
Correct Procedure	☑	☐	☐
All the team members introduced	☑	☐	☐

Signature of the Nurse: Pooja

Name of the Nurse: Pooja

SIGN OUT Time: 8:40am	Yes	No	NA
Name of the Surgical / Invasive Procedure is recorded	☐	☐	☐
Instrument, Sponge and Needle Count Completed	☐	☐	☐
Specimens are labeled	☐	☐	☐
Any equipment problems are addressed	☐	☐	☐

Signature of the Nurse: Pooja

Name of the Nurse: Pooja

Any Adverse / Unexpected Events

Docu. No. : RCHBH /FRM / CLINICAL / 083

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CONSENT FOR CHEMOTHERAPY

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Patient Name : B/o Himavarsha Age : 1yr Gender : Male ☑ Female ☐

UHID No : BAH-00658924 Department : PHO Date : 9/7/26.

Type of Chemotherapy : Intravenous

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

The doctor have explained to me about the benefits and alternative for this procedure that 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 : [signature]

Name : Jeevan

Relationship with Patient: .....

Date & Time : .....

Witness :

Signature : Hima Vyshq

Name : Hima Vyshq

Date & Time : .....

Doctor (who is taking the consent):

Signature : [signature]

Name : SRAVANI.

Date & Time : 9/7/26. 4:30 pm.

CONSENT FOR BLOOD TRANSFUSION

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Name: Baby of marripudi himavarsha Age: 1y Gender: Male ☑ Female ☐

UHID.No : 658924 Date: 9/7/26

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 .....

.....

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: Tecvan. M

Date & Time 10/07/26 11:30PM

Doctor (Who is talking the consent)

Signature: .....

Name: T Pavan

Date & Time 10/07/26. 11:30PM

Witness

Signature: Aouna

Name: Aouna

Date & Time 10/7/26 11:30PM

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రక్త మార్పిడి కొరకు అంగీకార పత్రము

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

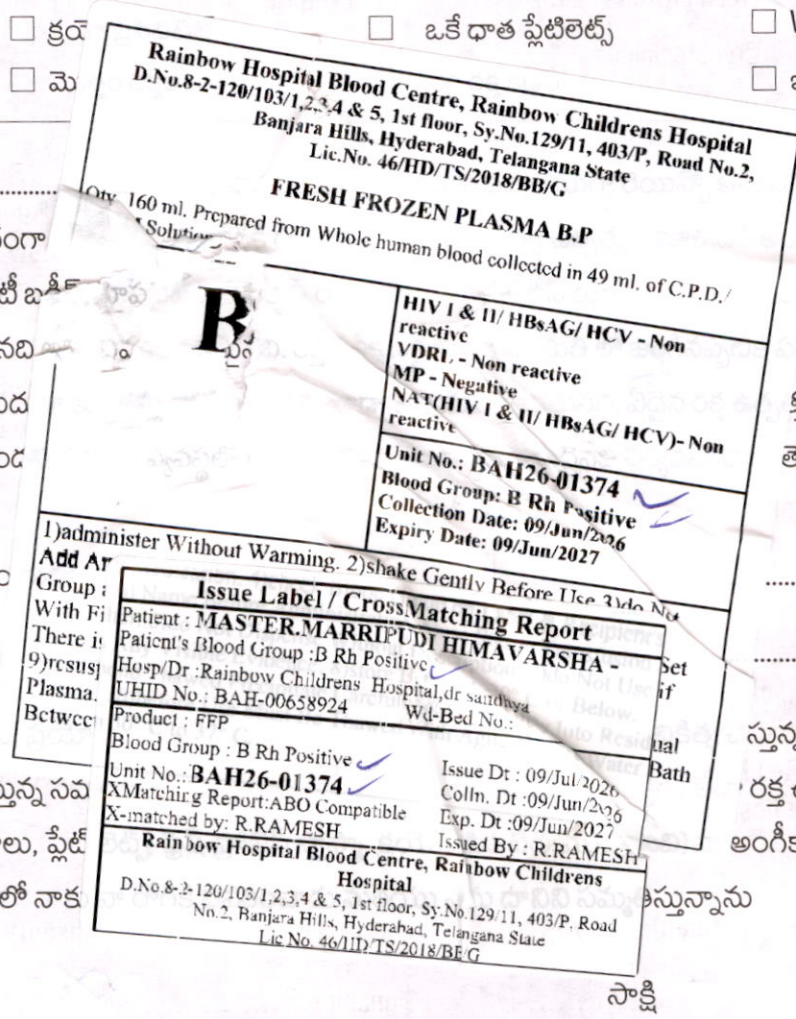
UHID. సంఖ్య : ..... తేదీ: .....

రక్త ఉత్పత్తి రకాలు:

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

☐ క్రయో ☐ ఒకే దాత ప్లేటిలెట్స్ ☐ Whole Blood

☐ మె ☐ ఇతరులు.....



నేను ..... ీ అడ్మిట్ అయి ఉన్నపుడు పూర్తి చికిత్సలో భాగంగా ..... కారం తెలుపుతున్నాను. దాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బ..... మరియు సిఫ్లిస్ లక్షణాలు లేవని పరీక్షించి బడినది ..... క్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుద ..... ల్ల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం వుండ ..... తెలెత్తవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం .....

....

పైన పేర్కొన్న అన్ని ప్రమాదా ..... స్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. చికిత్స చేస్తున్న సవ ..... రక్త ఉత్పత్తులు ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ ..... అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాక ..... ిస్తున్నాను

సహాయకుడు(అటెండెంట్) సాక్షి

సంతకము ..... సంతకం .....

పేరు ..... పేరు .....

తేదీ మరియు సమయము ..... తేదీ మరియు సమయము .....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము .....

పేరు .....

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09-08-2024 1 Y 11 M 0 D (M)
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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) : 15.7kg	Body Surface Area: 0.65	Diagnosis: T-ALL	Protocol: T-ALL EOI / 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.
10/7	9 AM	Inj METHOTREXATE Inj CYTARABINE Inj HYDROCORTISONE	8 mg 20 mg 10 mg	LT	STAT	d	Pooja sushma	10/7	d	Pooja sushma
9/7	6.50pm	Inj VINCRISTINE in 10ml NS	0.9 mg	IV	over 10 min	d	Merlin priyanka	9/7	d	Merlin priyanka
9/7	7.05pm	Inj DAUNORUBICIN in 200ml ½ DNS	14mg	IV	50ml/hr	d	Merlin priyank	9/7	d	Some Anam

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

BAH-00658924 IP5-00176150
Baby Of MARRIPUDI HIMAVARSHA (
09-08-2024 1 Y 11 M 0 D (M)
Dr. SANDHYA VADDADI

105

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 9/7/26 Time: 3pm

Weight: 15.7kgs Centile: >97th

Height: 94cms Centile: >97th

Inference: Obese child

RDA: – Calories: 1200 kcal/d Protein: 20g/d

Diet Recommendations: Soft high protein diet

Re-Assesment: Avoid spicy, chilled, Outside foods

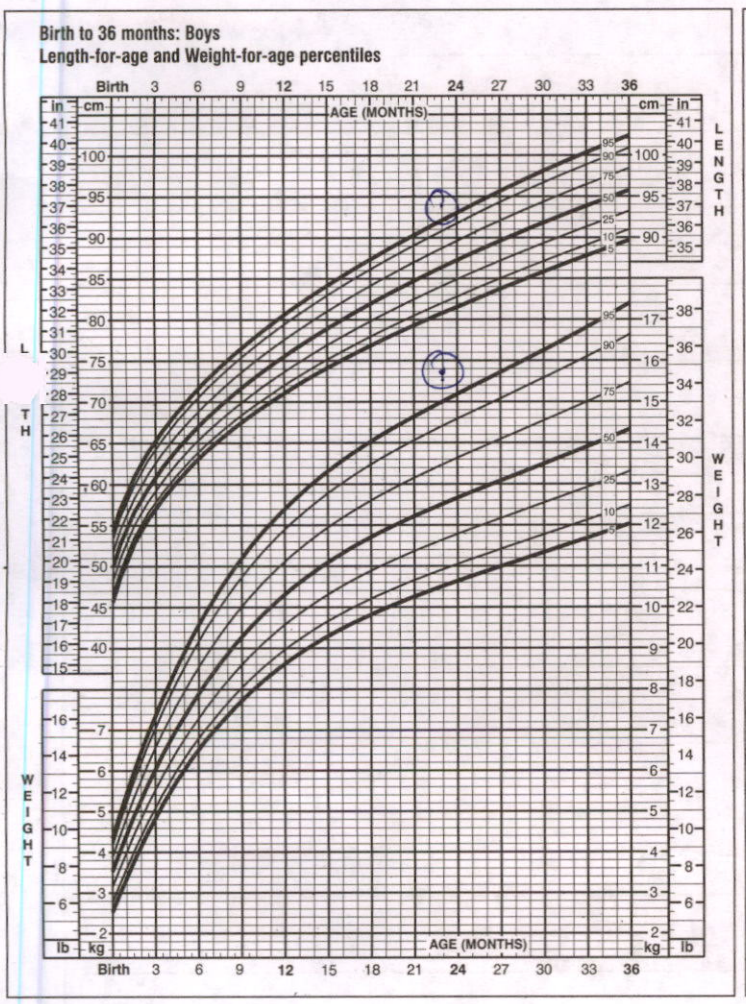
Food Allergies: NO Veg/Non-veg Veg

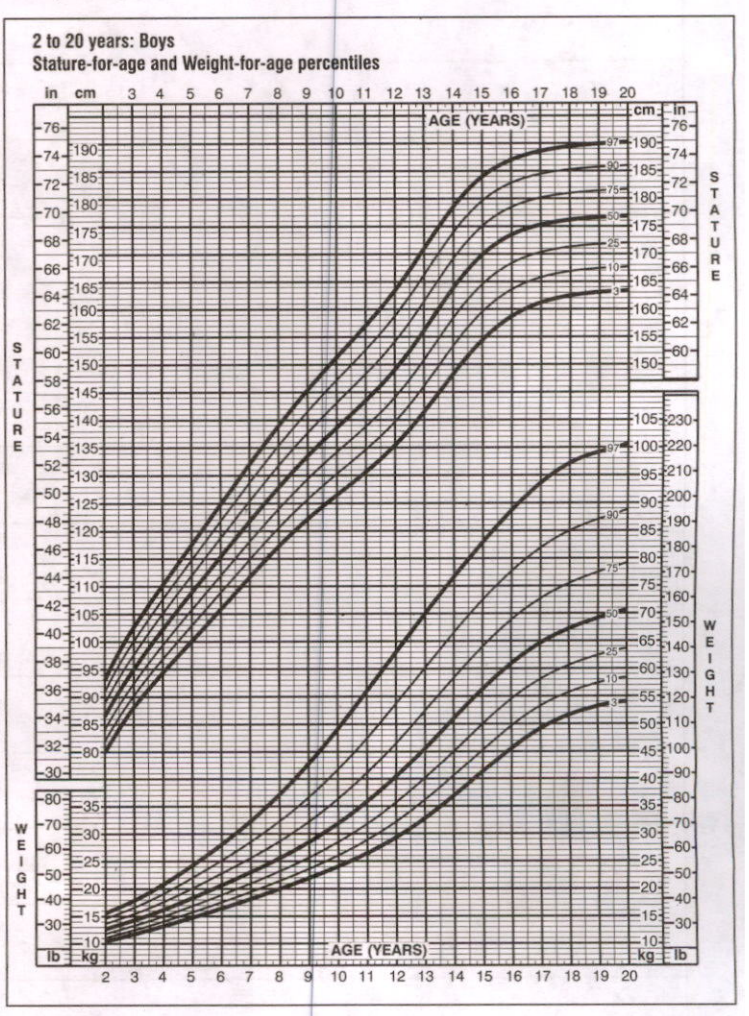
Diagnosis: T- ALL / mediastenal mass

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Parents dont want dietitian. Do not charge for NH

GROWTH CHART (BOYS)





Dietician's Name Nikitha Dietician's Signature Nikitha

Docu. No. : RCHBH /FRM / CLINICAL / 160 (P.T.O.)

Daily Notes: