

LBH-00135916 IPS-00176595
Baby CHATRAGADDA AARADHYA
21-08-2021 4 Y 10 M 28 D (F)
Dr. SRIPARTHA KRISHNA



Entered

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Fc not done

SURGERY DETAILS

Date : *19/7/26*

Patient Name: *ch. Aaradhya* Date of Birth: Age: *4y*

Gender: *Female* Ward: *P.O.T.* UHID No.:

Date of Surgery: *19/7/26* ☒ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery: *RIGHT FTP CRANIOTOMY AND EDH EVALUATION*

Time in : *3:30 AM*

Time Out : *5:45 AM*

	NAME	AMOUNT
1. Surgeon	<i>Dr. SRIPARTHA</i>	<i>RF-64420</i>
2. Anaesthetist	<i>DR. Saritha</i>	<i>AF-22550</i>
3. Assistant Surgeon		<i>OT-51538</i>
4. OT Technician	<i>Prashanth</i>	<i>OTC-9500</i>
5. Circulating Nurse	<i>Kalyan</i>	<i>ASF-6442</i>
6. Assistant Nurse	<i>Bobi, Bikkalai</i>	<i>AAF-6442</i>
		<i>CSSD-1933</i>

Special Equipment: ☐ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others *NEURODRILL -> 9710643*

Signature of the Surgeon *[Signature]*
Sripartha

Signature of Circulating Nurse *[Signature]*

Order No: *9710644*

Order by: *Kalyan*

Bn

MLC

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ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

Date of Admission: _____

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

LBH-00135916 IP5-00176595
Baby CHATRAGADDA AARADHYA (F)
21-08-2021 4 Y 10 M 28 D
Dr. SRIPARTHA KRISHNA



Attendant: _____ Dept: _____

Time of Discharge : _____ Time: _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
19/07	1:57 AM	ER	OT	df
20/7	3:00 PM	OT PICU	PICU 144-A	(Signature)

Cross Consultation Visit

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

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
19/7/26	Inv monitor Inf pump Sur pump O ₂	6.10 AM	10 am	9710640	Subank
20/7/26	Inv. monitor INF. pump INF. pump Sur. pump	STOP		9710640 9710640 9711631 9710640	Juni

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
19/7	PAC	} ①	} 9710617	} Ky
	Catheterisation			
	Arterial line			
21/8	AIHA		06219	Q
Any				
21/8/26				

ANY OTHER INFORMATION

ABG ②

USG abdomen ②

Date: 22/8/26

Time: 10:30 am

Prepared By: Shailaja

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Shailaja	Ward		

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176595

Admit Date : 19-Jul-2026

Admit Time : 01:10 AM UHID : LBH-00135916

Patient Details :

Patient Name : Baby CHATRAGADDA AARADHYA

Age : 4 Y 10 M 29 D

Guardian : Mr CHATRAGADDA ABEDNEGO

DOB : 21-08-2021

Gender : Female

Religion :

Occupation :

Martial Status : Single

Address (H) : #PLOT NO 254/1 SRI SAI RAM NAGAR Kapra
Hyderabad Telangana INDIA 500062

Phone No : 7995992372/ 9246877737

E-mail : nomailid@gmail.com

Admission Details :

Bed Type : PICU

Bed No : PICU 223

Ward Name : 2F-PICU II

Room No : PICU 223

Admission Type : First Visit

Contact Details :

Name : Mr CHATRAGADDA ABEDNEGO

Relationship : Father

Contact Address : #PLOT NO 254/1 SRI SAI RAM NAGAR Kapra
Hyderabad Telangana INDIA 500062

Phone No : 7995992372 / 9246877737

Signature

Doctor Details :

Doctor Name : Dr. SRIPARTHA KRISHNA YERRAMILLI

Specialisation : PEDIATRIC NEURO SURGERY

Referral Doctor : DR. RAVI TEJA

Phone No : 8056083066

Co-Consultant : Dr. KAPIL BHAGWATRAO SACHANE/ Dr.
ABHISHEK RAVINDRA JAIN/ Dr. KOKKULA
PRANEETH

Payment Details :

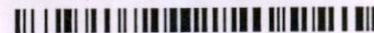
Deposit Amount : 100000.00

Payment Mode : DC/CC Card

Payor Name : SELFPAY

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176595 Admit Date : 19-Jul-2026 Admit Time : 01:10 AM UHID : LBH-00135916

Patient Details :

Patient Name	: Baby CHATRAGADDA AARADHYA	Age	: 4 Y 10 M 28 D
Guardian	: Mr CHATRAGADDA ABEDNEGO	DOB	: 21-08-2021
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: #PLOT NO 254/1 SRI SAI RAM NAGAR Kapra Hyderabad Telangana INDIA 500062	Phone No	: 7995992372 / 9246877737
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type	: PICU	Bed No	: PICU 223	Ward Name	: 2F-PICU II
Room No	: PICU 223	Admission Type	: First Visit		

Contact Details :

Name	: Mr CHATRAGADDA ABEDNEGO	Relationship	: Father
Contact Address	: #PLOT NO 254/1 SRI SAI RAM NAGAR Kapra Hyderabad Telangana INDIA 500062	Phone No	: 7995992372 / 9246877737

Signature

Doctor Details :

Doctor Name	: Dr. SRIPARTHA KRISHNA YERRAMILLI	Specialisation	: PEDIATRIC NEURO SURGERY
Referral Doctor	: DR. RAVI TEJA	Phone No	: 8056083066
Co-Consultant	: Dr. KAPIL BHAGWATRAO SACHANE/ Dr. KOKKULA PRANEETH		

Payment Details :

Payment Mode	: DC/CC Card	Deposit Amount	: 100000.00
		Payor Name	: SELFPAY

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176595 Admit Date : 19-Jul-2026 Admit Time : 01:10 AM UHID : LBH-00135916

Patient Details :

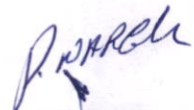
Patient Name	: Baby CHATRAGADDA AARADHYA	Age	: 4 Y 10 M 28 D
Guardian	: Mr CHATRAGADDA ABEDNEGO	DOB	: 21-08-2021
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: #PLOT NO 254/1 SRI SAI RAM NAGAR Kapra Hyderabad Telangana INDIA 500062	Phone No	: 7995992372 / 9246877737
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type : DAY CARE Bed No : PRE OP 401 Ward Name : 4F-OT COMPLEX
Room No : PRE OP 401 Admission Type : First Visit

Contact Details :

Name : Mr CHATRAGADDA ABEDNEGO Relationship : Father
Contact Address : #PLOT NO 254/1 SRI SAI RAM NAGAR Kapra Phone No : 7995992372 / 9246877737
Hyderabad Telangana INDIA 500062


Signature

Doctor Details :

Doctor Name : Dr. SRIPARTHA KRISHNA YERRAMILLI Specialisation : PEDIATRIC NEURO SURGERY
Referral Doctor : self Phone No :
Co-Consultant : Dr. KOKKULA PRANEETH

Payment Details :

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

Patient Sticker
1034-00135916
1144-A

DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	2			
5	In-patient Medical record	1			
6	Doctors progress sheets	10			
7	Nursing plan of care and handover sheets	5			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery	1			
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation	2			
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia& post)	1			
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	2			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)	1			
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list	1			
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
Extra		4			
Total No. of Pages		59			

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



Gynaecology

CONSUMABLES OF OT

Circ: Technician: *prashant* Date: *19/7/26* Time: *2:30 AM*

Anaesthesia Disposables			Surgical Disposables			Disposables (Baby Side)		
Issued	Qty	Used	Issued	Qty	Used	Issued	Qty	Used
ET tube	4	5	Major Pack	1	1	Inj Vit K skin stapler	1	2
LMA			Sutures	242	—	Cord Clamp	2	2
ECG leads : A/P/N	5H	—	padding 3-0-0-0 5-0-6-0	242	1	Suction Catheter		
HME filter : A/P/N	1H	1	monocryl 3-0-0-0, PDS	242	—	Feeding Tube	1	1
Syringes : 10 cc	10	5	monocryl 3-0-0-0, silk 3-0	242	—	Vaccum Suction Set		
05 cc	10	5	Gloves 9915	242	—	Surgical Gloves		
02 cc	10	5	6, 6 1/2, 2, 2 1/2	242	1	Gauze Pack		
01 cc	5	5	PF 6, 6 1/2, 2, 2 1/2	242	3	Syringe 1ml / 2ml		
Cautery plate : A/P/N	1	1	Surgical blade	141	142	Surgical Blade # 20		
IV set + Blood set	1	1	NG tube			Koochies (S)	2	2
RL 15% PDS D maronitol	14H	14	Cautery pencil	1	1	NS 500ml	1	1
NS 10ml / 100ml / 500ml / 1000ml	542	142	Koochies			Transfix	1	1
minipipe + vasobir	1H	0	Ointments			10cc, 2cc, 1cc	242	242
08mase P	1	—	Suction Catheter			1cc	1	—
Fentanyl	1	1	Cap, Mask	5/5	10/10	Inj-Cor C Ashwin	1	1
Morphine			Gauze Pack	5H	142	Trimmer blade	1	1
Ketamine 100	1	—	Mop Pack			multi tube holder	1	1
Propofol	8	2	Steristrip	1	1	protogons	8	—
Rocuronium	1	1	Underpad	1	1	60g layall + gauze	945	1
Glycopyrolate	1	1	Draw sheet	1	1	Tranxat + Dixa	14	14
Myopyrolate 100	2	2	Abgel	1	1	Soc tpmline	943	14
Ondansetron	1	1	Foleys catheter 8/10	141	1	Stop cord + Drumd	5H	24
Pencan 25g/ Spinal Needle 22			Urobag	141	1	Temperature Corall tray	14	—
Bupivacaine 0.25%	1	—	Chest Drainage Catheter			Seleo 24/24	242	—
Bupivacaine 0.25% (Heavy)			Romodrain bag			Betadine + Baboprep	14	—
Antibiotics Tazim (Sams)	1	T	Bandage			11NO Blad + 300 8/8/8	14	—
Amikacin + Sams + Cef		—	Tegaderm			Heparine thepale	145	1
Suppositories	14H	—	Ioban	1	—	Kelly tube 8/10	14	—
namol : 80mg / 250mg / 170 mg			Double J Stent			Cemba cover	1	—
Supridol : 100mg			Vaccum Suction set	2	1	microscope cover	14	—
Justin : 12.5 mg / 25mg / 100mg	14H	—	Plastic Bed Sheet	1	—	Tegadampad	1	—
Tab. Misoprost : 200mg			Betadine Solution	1	1	Tegaderm without pad	1	—
Vacuum set	1	1	Microshield	1	1	30g pad (Bip)	1	—
Oral airway 0.1	1	—	Cotton Balls	1	—	18g wst	1	1
Oral airway 16/18	14	—	Latex Gloves	1	8P	20g	3	3
20gayum + 100cm	943	142	Ramdione Scrub	1	1	Q 8/8	3	3
Low cannula 8/8/8	842	242	Saral			Gauze	5	0

Surgeon Anaesthesiologist Nurse OT Technician
Order No. : *9710690* Ordered by : *Prashant*
Doc. No. : RCH / FRM / GENERAL / 125
Prashant Acharya
Prashant - 242

815-83746

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 Your Right to a Safe Delivery

ADMISSION CRITERIA – PICU

Admission / Transfer from:

☒ Emergency ☐ Outpatient (OPD) ☐ Ward ☐ Operation Theater ☐ Others:

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

- ☐ All patients requiring mechanical ventilation;
- ☐ Patients with impending respiratory failure;
 - ☐ Upper airway obstruction;
 - ☐ Lower airway obstruction;
 - ☐ Alveolar disease; and
 - ☐ Unstable airway;
- ☐ All Paediatric patients after successful resuscitation;
- ☐ **Comatose Patients;**
 - ☐ Meningitis, encephalitis; ☐ Hepatic encephalopathy; ☐ cerebral malaria;
 - ☐ Head injury; ☐ Poisonings; and ☐ Status epilepticus;
- ☐ **All types of shock/hemodynamic instability:**
 - ☐ Septic shock;
 - ☐ Hypovolemic shock; (Bleeding emergencies such as gastrointestinal bleeding, bleeding diathesis, disseminated intravascular coagulation; Cardiogenic shock; myocarditis, cardiomyopathy, congenital heart disease; Neurogenic shock; and Multiple trauma;
- ☐ Cardiac arrhythmias after consulting with the treating consultant
- ☐ Hypertensive Emergencies;
- ☐ Severe acid base disorders;
- ☐ Severe electrolyte abnormalities;
- ☐ Diabetic ketoacidosis (Ph<7.2, altered sensorium, hyperglycemia)
- ☐ Acute renal failure; Patients requiring acute hemodialysis, hemofiltration and peritoneal dialysis;
- ☐ **Post-Operative Patients;**
 - ☐ Requiring ventilation;
 - ☐ Unstable patients; and
 - ☐ Post-operative patients after open heart surgery, neurosurgery, thoracic surgery and other patients after major general surgery with potential for respiratory/haemodynamic instability;
- ☐ Patients requiring nitric oxide therapy;
- ☐ Malignant hyperpyrexia;
- ☐ Acute hepatic failure
- ☐ Severe dehydration with mental status change;
- ☐ Asthma requiring hourly nebulization/getting tired with increasing oxygen requirement/mental status change.
- "UNSTABLE" PATIENT IS DEFINED AS**
 - ☐ HR < 50 or > 160 per minute or more than upper normal limit according to age. BP<90 systolic and < 50 diastolic an or requiring inotropic support. Arrhythmia or risk of sudden arrhythmia.
 - ☐ Signs of peripheral poor perfusion or suspicion of any type of shock.
 - ☐ Capillary refill time > 4seconds.
 - ☐ Children Blood pressure (Syst.) < [70 + (2× age "Years")].
- Respiratory failure or high risk of failure or airway obstruction:**
 - ☐ Respiration rate < 5 per minute below the normal or > 10-15 per minute above the normal range for age.
 - ☐ O2 Saturation <90 % or need for O2 >4 Litres per minute by normal face mask. Abnormal ABG: PH < 7.25, PaO2 < 60 torr, PaCO2 > 50 torr.
 - ☐ Distress and risk of exhaustion
- ☐ **Change of level of consciousness: GCS <13.**
- ☐ **Persistent oliguria with acidosis.**

Signature of the Doctor: Name of the Doctor: Date & Time:

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DISCHARGE CRITERIA – PICU

Discharge to:

☐ HDU / Step down ICU

☐ Ward

☐ Outside Facility

☐ Others:

Tick (✓) any of the following criteria requiring discharge / transfer from PICU

- ☐ Stable hemodynamic parameters.
- ☐ Stable respiratory status (patient extubated with stable arterial blood gases) and airway patency at least for 24 hours with no respiratory distress needing continuous monitoring.
- ☐ Minimal oxygen requirements that do not exceed patient care unit guidelines.
- ☐ Intravenous inotropic support, vasodilators, and antiarrhythmic drugs are no longer required or, when applicable, low doses of these medications can be administered safely in otherwise stable patients in a designated patient care unit.
- ☐ Cardiac dysrhythmias are controlled.
- ☐ Neurologic stability with control of seizures.
- ☐ Removal of all hemodynamic monitoring catheters.
- ☐ Routine peritoneal or hemodialysis with resolution of critical illness not exceeding general patient care unit guidelines.
- ☐ Patients with mature artificial airways (tracheostomies) who no longer require excessive suctioning.

Signature of the Doctor:

Name of the Doctor :

Date & Time:



Rainbow[®] Children's Hospital

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

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Baby CHATRAQADDA AARADHYA
21-08-2021 4 Y 10 M 28 D (F)
Dr. SRIPARTHA KRISHNA



MLC



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

c/o trauma fall from ht

History of present illness :

Alleged H/O fall from 3 feet ht
yesterday: 17/7/26 4:30pm
c/o decreased & multiple episodes
of vomiting :: today morning.
@ 11AM 18/7/26
CT outside - large subdural hematoma
= thickness 10-3mm @ R temporoparietal.

Interacting = parents but excessive
devoidness.

Received 2% NS @ 3 loading dose
2mg levipil loading dose.
& 10% Dextrose bolus.



MLC

Pediatric Multiorgan History & Physical Examination

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

e

Birth & Neonatal History:

(N) perinatal transition

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

developed as per age

Immunization History :

immunised



MHC

Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____

Weight (kgs)) 17kg (Centile _____)

On Examination :

Temperature : 98.5° F Pulse Rate : 120/min B.P. 103/82 SP02 97.5° F

Resp. rate and type of breathing : 25/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BAG ⊕

Any addes sounds : ⊕

Relevant data from outside (Chest X-Ray, ABG, etc.,) /

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S1S2 ⊕

Any murmur : ⊕

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : /

Per Abdomen :

Inspection _____

Palpation : Soft, NT

Ausculation : BS ⊕

Spine : _____ External Genitelia : _____

Relevant data from outside (CT, USG etc.,) _____



MLC

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : E4 V5 M6.

Cranial Nerves : NAD

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : N

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Traumatic brain injury
plan for sdc decompression

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: to prevent complication

Desired goals of the treatment: Hemodynamic stability

Planned Labs:

CBA, PTNR, SElectroly,
Blood grouping
VBG
done
CT head plain

Planned Management

- NPO
- IV fluids
- Plan (R) FTP
craniotomy & SDH
evaluation
- 1 unit PRBC ~~reserve~~
reserve

Signature of the Doctor: \$

Name of the Doctor: Sanithi

Date & Time: 19/7/26 1:30 AM

Signature of the Consultant: [Signature]

Name of the Consultant: SRIPARTHA Y

Date & Time: 19/7/26 2am

Date & Time	Progress Notes	Doctor's Order
19/11/2026 @ 6:30pm	Counselling room-2	Dr. S. S. Patel Dr. Monish
	Child underwent surgery which revealed extradural hemorrhage and there is also underlying edema of the brain. We have done a craniotomy to reduce the pressure effects on brain. There is also bleeding below the layer of the brain and we noted the underlying brain swelling. Surgery was successful. We will observe and if child bleeding we will start clear liquids. Neurology team will come and review and long term effects of surgery also been explained. Risk of worsening brain edema also been explained. <u>K. B. Monish</u> Nephrology	V. Chandra <u>Patel</u>



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/07/26 12:45 am	A/h/o Fall onto ground level on 18/07/26 at 4pm	
	N/o Headache	
	N/o Vomiting (+) - Multiple episodes	
	No N/o ENT Bleed/Seizures/Neck pain	
	O/E Euvsmc	
	Active, Alert	HR: 95/min
	Reptk - B/L 3mm, R/L	RR: 92/47 mty
	Good anti-gravity movements in all four limbs	SpO2: 99% on Room air
CT 8/0 18/07/26 11am	10.3mm (R) Temporo-parieto-occipital SDH with Mass effect	
	Plan • Start Antiedema/AEDs	
	• Family counselled regarding need for intervention	
	- Surgery: (R) FFP Craniotomy and SDH Evacuation	
	and possible risks and complications, benefits	
	• Repeat CT Scan	
	• Collect Blood Workup & arrange Crossmatch	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/08/2021 08:00 AM	<u>S/B Protam</u> <u>A</u> Right Temp 100.0 F acute SDH - S/P Craniotomy + Sequestration History noted.	<u>Adv</u> ① continue Nasal prongs at 2 L/min
	<u>Issues</u> ① Hypotension during surgery ② Hypoglycemia Spike on low flow oxygen SpO₂: Input: 578 ml Output: 400 ml Blood Cos - (150 ml - 100 ml) Chest: B/L A/D Equal. IMBs. NA: Soft BSO CO: B/L Pupils Equal 4mm HR: 118/min BP: 110/55 mmHg SpO₂: 98% on 2 L/min	② Continue - Cefotaxime - Zk. Keypill - Zk. Esmogette - Zk. Ondansetron - 37 NS - DNI @ 60% comp ③ Send CBP. ④ Electrolyte ABG ⑤ SpO₂ & Chauby ⑥ Neuroprotective Mannitol ⑦ Watch for sepsis Thank H's Jay



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Date & Time	Progress Notes	Doctor's Order
19/1/20 8am	<u>o/s B Neuro Exam</u> Post traumatic (P) temporo-parietal 2PH o/P evacuation	
	<u>o/s</u> conscious, coherent Drivable Bd pupils 2mm, RT No facial weakness Speech good Dane (R) good ambulatory movements	<u>plan</u> ① continue scan & ② so decide on 3rd - ME plan

Date & Time	Progress Notes	Doctor's Order
8/2/26 8:30 AM	C/S/B Dr. Praneeth.	
	Assist Right temporo parietal plan. EOT s/p craniotomy evaluation post-op.	1. allow oral feeds - 2. Monitor sensorium w/f seizures - 3. continue 3% NS 1ml/kg/hr - 4. Keep in place today - 5. CBP, S. electrolytes qpm.
	on low-flow oxygen 2L NP thermodynamically stable no fever spikes.	
	Vitals. TIR- 110 BP- 100/60 (70) mmHg. RR- 20.	noted by Anest Dr. Praneeth

(P.T.O.)

FLUIDS STATUS NUTRITION AND G.I.	☒ NPO ☐ PO feeds ☐ NG Feeds ☐ NJ Feeds ☐ GT Feeds	
	I / O / Balance : <u>+2</u> / (+/-) Input : <u>2.7</u> ml/k/d UO : <u>2.6</u> ml/kg/hr Stools :	
	NG output : PO intake :	
	Feed Formula : Feed Schedule :	
	IV Fluids - Type of IVF : <u>DNS</u> @ <u>30 ml/hr</u> ml / hr (..... times maintenance)	
	TPN : ☐ Yes ☐ No - If yes, details :	
	 % of Dext, Glu Inf Rate (mg/kg/min) Amino Acids (gm/kg/day) Lipids (gm/kg/day)	
	 Cal/kg/d Nitrogen Trace elements & MVI	
	Labs : Na <u>138</u> K <u>4.7</u> Cl <u>112</u> Ca Mg P HCO3 Sr. Amylase : Sr. Lipase :	
	Latest LFT :	
Abd Exam : <u>soft</u>		
Any organomegaly ? ☐ Yes ☒ No - If yes, describe :		
Plan (G.I. & Liver) :		
.....		
INFECTION	☐ Febrile ☒ Afebrile Current Antibiotics Details (antibiotic name and day #) : <u>Aug cefotaxime - D 1</u>	
	Cultures Sent ? ☐ Yes ☒ No - If yes, details :	
	Describe c/s Reports :	
	Other Labs (Latex, Serology, etc) :	
Ongoing Antibiotics :		
NEPHROLOGY ISSUES	Sr. Creat : <u>0.4</u> Bld. Urea : Other Relevant Labs :	
	P.D. ☐ Yes ☒ No - If yes, details :	
	Diuretics : ☐ Yes ☒ No - If yes, details :	
	Catheterized : ☒ Yes ☐ No - If yes, then day of Catheter :	
	Relevant Radiology (USC, MCUG radioisotope scan etc) :	
	Plan of Care :	
HEMATOLOGY	Relevant Labs (CBP etc) : <u>19/12/26</u>	
	Any Coagulopathy : <u>9.7 9560 2.23</u>	
	Relevant Transfusion History : <u>86</u>	
	Plan of Care : <u>11</u>	
CARE PROTOCOLS	VAP Bundle Used ? : ☐ Yes ☒ No ☐ NA	
	CRBSI Bundle Used ? : ☐ Yes ☒ No ☐ NA	
	CA - UTI Bundle Used ? : ☐ Yes ☒ No ☐ NA	
	Patient Managed as per Relevant Protocols : ☐ Yes ☐ No ☐ NA	
If yes, then details :		
Pending Lab Results : ☐ Yes ☒ No		
If yes, then details :		
Pending Consultations : ☐ Yes ☒ No		
If yes, then details :		
FINAL COMMENTS	<u>Monitor sensorium</u>	
	<u>w/rt seizures</u> <u>pupil monitoring</u>	

 Doctor's Name (Handover given) : Dr. Nathan

 Signature : [Signature]

 Date & Time : 19/12/26 8AM

 Doctor's Name (Handover taken) : Dr. Luvu

 Signature : [Signature]

 Date & Time : 19/12/26 8:30AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7	USG Abdomen 11:10 AM L - 92 mm (N) Sp - 62 mm RK - 73 x 33 mm / Normal LK - 74 x 34 mm GB & Pancreas - (N) UB - Partially distended with Foley's bulb inside Lung - No significant abnormality.	
19/7/26	cls/B Dr. Sandeep 4 pm. Δs:- Traumatic SDH s/p Right frontotemporo-parietal craniotomy + SDH evacuation on room air hemodynamically stable HR - 110/min BP - 100/60 mm Hg No s/o ↑ ICP 1 elo fever - low grade cris:- GUS 15/15 pupils B/L 3mm, reacting to light	Plan 1) Send Trace CBP. S. electrolytes 2) continue 3% NS @ 15 ml/hr 3) monitor pupils / hourly. 4) S. electrolytes tomorrow morning.

noted by Amu

Dr. Sandeep

LBH-00135916
Baby CHATRAGADDA AARADHYA
21-08-2021 4 Y 10 M 28 D (F)
Dr. SRIPARATHA KRISHNA

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DAILY ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 19/7/26 Day of Admission : 2 Today's Date & Time : 20/7/26, 6A

PRISM - III Score in first 24hrs. of Admission : Today's SOFA Score :

OVERVIEW	Diagnosis: Traumatic SDH with SLP (R) fronto-temporo-parietal craniotomy + SDH evacuation.	Current Issues: $\rightarrow$ 1cm $\oplus$ $\rightarrow$ mild irritability.
	VITAL SIGNS Today's Wt. (kg): Temp.: Blood sugar issues:	
RESPIRATORY SYSTEM	Respiratory System Findings: (Air entry, breath sounds, s/o distress etc.): All $\oplus$ chest clear.	
	CXR: 98% JNA	
	SPO ₂ : 98% JNA O ₂ by NC / FM / NRB mask / Oxyhood, at L/min	
	Ventilatory Support: ☐ Yes ☐ No - Day # of Vent: Nitric Oxide: ☐ Yes ☐ No - If Yes, details:	
	Ventilatory Settings: Leak around ETT: Delivered Vt:	
	ABG: EtCO ₂ : P/F ratio: O.I:	
	Chest Physiotherapy Plan: Suctioning Needs:	
	Any Nebbs: ICD? ☐ Yes ☐ No, if Yes, details:	
	Plan of care: $\rightarrow$ 4 same	
CARDIO VASCULAR SYSTEM	Cardio Vascular System Clinical Exam. (Heart sounds, murmur etc.): No murmur	
	Quality of Pulses: good cap refill Time: 2 sec Liver Edge: 2 cm below Rt costal margin	
	Blood Pressures: NIBP: IBP: CVP:	
	Infusion of: ☐ Dopamine mcg / kg / min - ☐ Dobutamine mcg / kg / min	
	☐ Epinephrine mcg / kg / min - ☐ Nor Epinephrine mcg / kg / min	
	☐ Milrinone mcg / kg / min	
	Any Other Infusions:	
	Last 2D Echo Findings:	
	Size of the heart and lung fields in latest CXR:	
	Arterial line in situ: ☒ Yes ☒ No Place of art, line & its condition:	
Central line in situ: ☐ Yes ☐ No Place of central line & its condition: $\oplus$ radial.		
Day of arterial line: Day of Central line:		
Plan of Care: $\rightarrow$		
CNS	Neuro Exam: GCS = (15/15) with mild irritability	
	Pupils: SL Pupils R $\oplus$, 8mm	
	Sedation Used? ☐ Yes ☒ No Any paralysis? ☐ Yes ☐ No	
	Types of Sedation: Types of Paralysis:	
	Relevant CT Scan, MRI EEG, Neurosonogram etc.:	
Plan of Care: $\rightarrow$ target T Anti-Epileptic measures		
Ramsay Sedation Score:		

+579ml + we balance

4/10/15 10/11/15

FLUIDS STATUS NUTRITION AND G.I	☐ NPO ☐ PO feeds ☐ NG Feeds ☐ NJ Feeds ☐ GT Feeds I / O / Balance : / (+/-) Input : ml/k/d UO : ml/kg/hr Stools : NG output : PO intake : Feed Formula : Feed Schedule : IV Fluids - Type of IVF : @ ml / hr (..... times maintenance) TPN : ☐ Yes ☐ No - If yes, details : % of Dext, Glu Inf Rate (mg/kg/min) Amino Acids (gm/kg/day) Lipids (gm/kg/day) Cal/kg/d Nitrogen Trace elements & MVI Labs : Na K Cl Ca Mg P HCO3 Sr. Amylase : Sr. Lipase : Latest LFT : Abd Exam : Any organomegaly ? ☐ Yes ☐ No - If yes, describe : Plan (G.I. & Liver) :	
	☒ Febrile ☐ Afebrile Current Antibiotics Details (antibiotic name and day #) : Cultures Sent ? ☐ Yes ☐ No - If yes, details : Describe c/s Reports : Other Labs (Latex, Serology, etc) : Ongoing Antibiotics :	
	Sr. Creat : Bld. Urea : Other Relevant Labs : P.D. ☐ Yes ☒ No - If yes, details : Diuretics : ☐ Yes ☒ No - If yes, details : Catheterized : ☐ Yes ☒ No - If yes, then day of Catheter : Relevant Radiology (USC, MCUG radioisotope scan etc) : Plan of Care :	
	Relevant Labs (CBP etc) : Any Coagulopathy : Relevant Transfusion History : Plan of Care :	
	CARE PROTOCOLS VAP Bundle Used ? : ☐ Yes ☒ No ☐ NA CRBSI Bundle Used ? : ☐ Yes ☒ No ☐ NA CA - UTI Bundle Used ? : ☐ Yes ☒ No ☐ NA Patient Managed as per Relevant Protocols : ☐ Yes ☐ No ☐ NA If yes, then details :	
	Pending Lab Results : ☐ Yes ☐ No If yes, then details : Pending Consultations : ☐ Yes ☐ No If yes, then details :	
	FINAL COMMENTS -> DS. Electrolytes -> E see Nat & decide on -> Restrict fluid to 700ml	

Doctor's Name (Handover given) : *[Signature]*

Signature : *[Signature]*

Date & Time : *20/10/15 10/11/15*

Doctor's Name (Handover taken) : *[Signature]*

Signature : *[Signature]*

Date & Time : *20/10/15 10/11/15*

Date & Time	Progress Notes	Doctor's Order				
19/7/26 9pm	<u>C/S/B Neuroteam</u> Post Traumatic (R) temporo-parietal EDH s/p evacuation					
		<u>POD-1</u>				
	<u>Issues</u> : Fever spikes (+) No seizures. ↓↓ Irritability (+) ⇒ consolable.					
	<u>O/E</u> : Child conscious E4 V5 M6. oriented B/L pupils normal size, reacting to light EOM - full Tone - <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>N</td><td>N</td></tr><tr><td>N</td><td>N</td></tr></table>	N	N	N	N	<u>Adv</u> ① w/f vitals ② GCS / pupil monitoring
N	N					
N	N					
	B/L symmetrical antigravity movements (+) vitals - stable					



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/R Dr Kapil	Plan
20/07/26 10:15a	Δ: Traumatic Spite Slp Frontal Parieto temporal craniotomy - Evaluation.	1) shift to ward 2) INT VITAMINE SM IN stat 3) stop H2O
	AG = 15/15 moving all four limbs.	M.B. Stank 20/07 10:30 AM
		W.H. Omms
20/07/26	cl/b Neuro Team Doing well Not accepting oral Feeds	
	OK Euvolemia Good antigravity movements in all four limbs (R) periorbital edema	
		Plan • Enlarge orally • (R) Eye Care • Shift to ward • Remove art. line & Foley's Catheter

Date & Time	Progress Notes	Doctor's Order
07/26 11Am	<u>Shift out Summary</u> D: Traumatic SDH T s/p R parieto s/p R fronto parieto Temporal Craniotomy <u>T evacuation.</u> - Child is Hemodynamically stable, on room air, GCS-15/15. - Talking well orally <u>Plan:-</u> - Child to wear - Continue Antibiotics - R eye care	

R. SRIPARTHA KRISHNA



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Date & Time	Progress Notes	Doctor's Order
20 Feb 2016 6:45 PM	Feb Neuro exam - No new issues - 1 more spike today - no orbital irritability of All in intact front - (N) tone, power & reflexes. No nuchal or cerebellar signs	Adv: - vitals. - Ambulate - local intubation <i>[Signature]</i>



Date & Time	Progress Notes	Doctor's Order
21/2/26	10 AM - No further issues - Calm & healthy. of: from (N) - All in contact - tone, power & reflexes - No nuchal or cerebellar signs	Adv: - Dr. Newcombe regarding of plan. oral intake → monitor 1/0 Abhi



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 9am	C/S/B Neuroteam post Traumatic - (RT) temporoparietal acute EDH c mass effect S/P - (RT) Frontotemporoparietal hinge Craniotomy & augmentative duroplasty c evacuation	
	Issues: No fresh complaints No fever spikes / vomiting / seizures peri-orbital edema ↓ ↓ Accepting feeds - (N) Urine / stool - (N)	
	O/E: Child conscious HME - (N) ; GCS - 15/15 B/E pupils - NSRL EOM - full Tone, power - DTR - (N) Vitals - stable	Adv ① wff vitals ② plan ① after discussion neurosurgical opinion
	Plan: • Discharge today Continue: Syp ZIPRAX-50 7ml (40mg) BD x 3 days Abhishek Syp ZBUGESIC 6.5ml PO TDS x 2 days → SD Syp SMUTH 5ml PO SOS - Constipation F-BACT OINTMENT	
	Review on 01.08.26 RCH LB Nagan	Sripurtha

LBH-00135916 IP5-00176595
Baby CHATRAGADDA AARADHYA
21-08-2021 4 Y 10 M 28 D (F)
Dr. SRIPARTHA KRISHNA



MLC

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RESULT SHEET

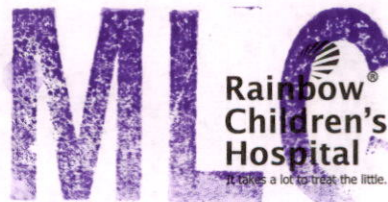
B6 - Dne.

Date	18/7	19/7	19/7	20/7/26		
Time		8AM	4PM	6:30 AM		
Hb	12.1	9.7 ↓	9.5 ↓			
PCV	33	30	28.8			
RBC	4.3	3.68	3.57			
WBC	15.62k	9560 ↓	14,180 ↑			
N/L	(72/17)	86/11	86/8			
Platelets	2.70 L.	2.23 lakh	2.16 L ↓			
CRP						
ESR						
PCT						
RBS						
Na	139	138	136	134		
K	4.6	4.7	4.0	3.6		
Cl	106	112	109	107		
Ca/Mg						
Phosphate						
Urea						
Creatinine	0.4					
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	19 / 1.3					
APTT	33					
CSF Protein / Sugar						
Cells						
N/L						

LBH-00135916 IP5-00176595
Baby CHATRAAGADDA AARADHYA
21-08-2021 4 Y 10 M 28 D (F)
Dr. SRIPARTHA KRISHNA



Patient S



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: 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						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ 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 : Saritha

Date & Time : 19/7/26 1:20 PM

Nurse Name & Signature : Randey

Date & Time : 19/7/26 2:00 PM



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: 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	Zy- LEFOTAXIME	850mg	IV	BD	20/7/20	☒ C ☐ DC
2	Zy- ESMOPRAZOLE	17mg	IV	OD	20/7	☒ C ☐ DC
3	Syp. LEVIPIL	3.5ml	PO	BD	20/7	☒ C ☐ DC
4	Syp. Paracetamol (240mg/5ml)	5ml	PO	TID	20/7	☒ 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: Dr. Vijay Shekar

Date & Time: 20/7/20, 11 AM

Nurse Name & Signature: Tanya

Date & Time: 20/7/20 @ 3 PM

Date of Admission: 19/7/20 Drug Allergies: Not known any Drug Allergies

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.

VERIFIED BY: Name



REGULAR PRESCRIPTIONS

Weight. 17kg Ward. PW

VERIFIED

DRUG : INJ. CEFOTAXIME				Date Time	19/07 10AM
Dose 850mg	Route IV	Frequency BD	Start Date 19/07		
Name & Signature of the Doctor Starting the Drugs: <i>Sripartha</i>					
Additional Instructions:				10PM to 12PM 12PM to 2PM 2PM to 4PM 4PM to 6PM 6PM to 8PM 8PM to 10PM 10PM to 12PM	
Daily Doctor's Endorsement by a Sign				↓	
DRUG : 2g PARACETAMOL				Date Time	19/07 6AM
Dose 250mg	Route IV	Frequency TDS	Start Date 19/07		
Name & Signature of the Doctor Starting the Drugs: <i>Sripartha</i>				2PM to 4PM 4PM to 6PM 6PM to 8PM 8PM to 10PM 10PM to 12PM	
Additional Instructions:				10PM to 12PM 12PM to 2PM 2PM to 4PM 4PM to 6PM 6PM to 8PM 8PM to 10PM 10PM to 12PM	
Daily Doctor's Endorsement by a Sign				↓	
DRUG : INJ. EMESET				Date Time	19/07 6AM
Dose 2mg	Route IV	Frequency TDS	Start Date 19/07		
Name & Signature of the Doctor Starting the Drugs: <i>Sripartha</i>				2PM to 4PM 4PM to 6PM 6PM to 8PM 8PM to 10PM 10PM to 12PM	
Additional Instructions:				10PM to 12PM 12PM to 2PM 2PM to 4PM 4PM to 6PM 6PM to 8PM 8PM to 10PM 10PM to 12PM	
Daily Doctor's Endorsement by a Sign				↓	
DRUG : 2mg ESMOPRAZOLE				Date Time	19/07 6AM
Dose 17mg	Route IV	Frequency OD	Start Date 19/07		
Name & Signature of the Doctor Starting the Drugs: <i>Sripartha</i>				2PM to 4PM 4PM to 6PM 6PM to 8PM 8PM to 10PM 10PM to 12PM	
Additional Instructions:				10PM to 12PM 12PM to 2PM 2PM to 4PM 4PM to 6PM 6PM to 8PM 8PM to 10PM 10PM to 12PM	
Daily Doctor's Endorsement by a Sign				↓	

VERIFIED



Sheet No:

REGULAR PRESCRIPTIONS

Weight 17kg Ward PJL

DRUG: <u>Syp-LEVIPIL</u>				Date Time	<u>19/02</u>															
Dose	Route	Frequency	Start Dt.																	
<u>300mg</u>	<u>PO</u>	<u>BD</u>	<u>19/02</u>	<u>8 AM</u>	<u>21/02</u>															
Name & Signature of the Doctor Starting the Drugs:																				
<u>[Signature]</u>																				
Additional Instructions:				<u>10pm Hal</u>																
Daily Doctor's Endorsement by a Sign				<u>[Signature]</u>																
DRUG: <u>Syp-LEVIPIL</u>				Date Time	<u>20/2</u>															
Dose	Route	Frequency	Start Dt.																	
<u>3.5ml</u>	<u>PO</u>	<u>BD</u>	<u>20/2</u>	<u>10 AM</u>	<u>21/02</u>															
Name & Signature of the Doctor Starting the Drugs:																				
<u>[Signature]</u>																				
Additional Instructions:				<u>10ml = 100mg</u>																
Daily Doctor's Endorsement by a Sign				<u>[Signature]</u>																
DRUG: <u>Syp- PARACETAMOL</u>				Date Time	<u>20/2</u>															
Dose	Route	Frequency	Start Dt.																	
<u>5ml</u>	<u>PO</u>	<u>TID</u>	<u>20/2</u>	<u>6 AM</u>	<u>21/02</u>															
Name & Signature of the Doctor Starting the Drugs:																				
<u>[Signature]</u>																				
Additional Instructions:				<u>5ml = 240mg</u>																
Daily Doctor's Endorsement by a Sign				<u>[Signature]</u>																
DRUG: <u>LACRIGEL OINTMENT LA</u>				Date Time	<u>20/2</u>															
Dose	Route	Frequency	Start Dt.																	
<u>LA</u>	<u>LA</u>	<u>TDS</u>	<u>20/02</u>	<u>6 AM</u>	<u>21/02</u>															
Name & Signature of the Doctor Starting the Drugs:																				
<u>[Signature]</u>																				
Additional Instructions:				<u>over @ Eye</u>																
Daily Doctor's Endorsement by a Sign				<u>[Signature]</u>																



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : REFRESH TEARS				Date Time	20/7	21/7															
Dose	Route	Frequency	Start Dt.	12 AM	X	12 PM															
2 Drops	LA	QUN	20/07	8 AM	X	12 PM															
Name & Signature of the Doctor Starting the Drugs: <i>Sripartha</i>				8 AM	X	12 PM															
				12 PM	(2)	2 PM															
				4 PM	✓	8 PM															
				8 PM	✓																
Additional Instructions: <i>on R eye.</i>																					
Daily Doctor's Endorsement by a Sign																					
DRUG : SYP SMOOTH				Date Time	20/7	21/7															
Dose	Route	Frequency	Start Dt.	10 AM	X	12 PM															
SML	PO	BD	20/07	4 PM	X	12 PM															
Name & Signature of the Doctor Starting the Drugs: <i>Sripartha</i>				10 PM		12 PM															
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG : SYP ZBUGESIC				Date Time	21/7	22/7															
Dose	Route	Frequency	Start Dt.	6 AM	X	12 PM															
6.5ml	PO	TDS	21/07	6 AM	X	12 PM															
Name & Signature of the Doctor Starting the Drugs: <i>Sripartha</i>				2 PM		12 PM															
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG : T-BACT OINTMENT				Date Time	21/7	22/7															
Dose	Route	Frequency	Start Dt.	6 AM	X	12 PM															
Topical	LA	TDS	21/07	6 AM	X	12 PM															
Name & Signature of the Doctor Starting the Drugs: <i>Sripartha</i>				2 PM		12 PM															
Additional Instructions: <i>over Cranial wound</i>																					
Daily Doctor's Endorsement by a Sign																					

Signature

VERIFIED BY : Name

Weight Ward

DRUG : NEOSPORIN POWDER				Date Time
Dose	Route	Frequency	Start Dt.	
Epical	LA	BD	21/07	10 AM
Name & Signature of the Doctor Starting the Drugs: <i>[Signature]</i>				
Additional Instructions: OVER PERMANENT ERECTION				10 PM
Daily Doctor's Endorsement by a Sign				

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

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

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

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

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

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

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

VERIFIED BY : Name Signature



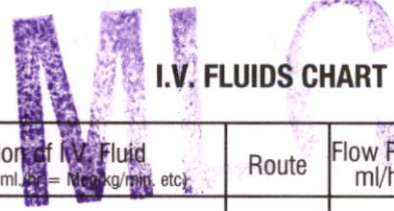
Weight. 17 kg Ward. 10

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
19/8/2021	3:45 PM	PARACETAMOL	250 mg	IV	[Signature]	[Signature]
19/8/2021	3:45 PM	CARTRIAXONE	600 mg	IV	[Signature]	[Signature]
20/8/21	10:15 a	INT VITK	5mg	IV	[Signature]	[Signature]



I.V. FLUIDS CHART

Weight. 17kg. Ward. 01

Signature
VERIFIED BY : Name

Composition of IV Fluid (If infusion, mention ml/kg = mg/kg/min, etc)		Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
DNS @100% maint		IV	54 ml/hr					
19/8/20	3% NaCl	IV	15	Y				
11/8/20	IVF-DNS (1ml/kg/hr)	IV	15	Y				
19/8/20	3:30AM RINGAR LAOTAT	IV	100/hr					
19/8/20	20% D	IV	30ml					
19/8	6:30AM DNS	IV	20					
19/8	6:30AM 3% Na	IV	15					

[illegible]

$98 \text{ n}^{\circ} \text{E}$
 $\rightarrow 97 \text{ n}^{\circ} \text{E}$
 $\rightarrow 98 \text{ n}^{\circ} \text{E}$
 $\rightarrow 99 \text{ n}^{\circ} \text{E}$
 $\rightarrow 99 \text{ n}^{\circ} \text{E}$
 $\rightarrow 99 \text{ n}^{\circ} \text{E}$
 $\rightarrow 97 \text{ n}^{\circ} \text{E}$

Heart Rate (Number)

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

117
(60)
79
101m

100
(59)
59
100m

97
(52)
59
104m

107
(67)
55
111m

115
84
[coupling]
70
109m

92
77
62
110m

97
78
69
92m

[illegible]

GCS *

[illegible]

Observer's Initials

boxes		-						?			>				o			1			-					o
	B																	m								

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.

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)



PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 20/7	Time: 6:00 PM	10 PM	2 PM												
Doctor / Nurse / Family Concern?															
Temperature (°F)	104	103	102	101	100	99	98	97	96	95	94				
(Syr - paracetamol 5ml given) 100.1°F 98.3°F 98.3°F															
Heart Rate (bpm)	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50
Blood Pressure (mmHg) *	107	108	102	(82)	(78)	(62)	70	60	63						
Note: BP does not score in early warning scoring															
Heart Rate (Number)	108b/m	112h	108h												
Resp. Rate (bpm) (Over 1 Minute) *	70	60	50	40	30	20	10								
Resp Rate (Number)	26b/m	28h	28h												
Resp Distress	Mod/ Severe	None / Mild													
Receiving O ₂ (l/min)															
O ₂ Saturations (%)	99%	99%	99%												
Conscious Level	Normal	Altered													
GCS *	15/15	15/15	15/15												
TOTAL SCORE															
Number of shaded boxes	1	1	1												
Pain Score	0	0	0												
Observer's Initials	C	C	C												

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

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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)



FLUID CHART

Sheet No. : 1

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

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	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			30ml							
	04:00 pm	↑		30ml						0	
	05:00 pm	ORIS	Orally	30ml						0	
	06:00 pm	↓		30ml						0	
	07:00 pm	↓		-						0	
Total Intake :					Total Output :						
	08:00 pm									0	
	09:00 pm									0	
	10:00 pm									0	
	11:00 pm									0	
	12:00 am									0	
	01:00 am									0	
Total Intake :					Total Output :						
	02:00 am									0	
	03:00 am									0	
	04:00 am									0	
	05:00 am									0	
	06:00 am									0	
	07:00 am									0	
Total Intake :					Total Output :						
Total 24 hrs. Intake					Total 24 hrs. Output						



FLUID CHART

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
21/8			Mouth	I.V	N.G								
	08:00 am												
	09:00 am	NO											
	10:00 am	W/P											
	11:00 am												
	12:00 pm												
01:00 pm													
Total Intake :						Total Output :							
21/8	02:00 pm												
	03:00 pm												
	04:00 pm	NO											
	05:00 pm	W/P											
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
22/8	08:00 pm												
	09:00 pm												
	10:00 pm	NO											
	11:00 pm	W/P											
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
22/8	02:00 am												
	03:00 am												
	04:00 am	NO											
	05:00 am	W/P											
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

SURGICAL SAFETY CHECKLIST

Surgeon : DR. Sri. Althe
Asst. Surgeon :
Anaesthetist : DR. S. S. S. S.
Scrub Nurse : B. K. K. K.

Patient Name : Ch. Aaradhya Age : 4y Gender : F
UHID No. : Surgery Name : Cranial
Date : 19/7/26 In-time : Out-time :



Before Induction of Anaesthesia >>

SIGN IN	Time: <u>2:42</u>
Patient Has Confirmed	
Identity	☒ Yes ☐ No
Site	☒ Yes ☐ No
Procedure	☒ Yes ☐ No
Consent	☒ Yes ☐ No
Site Marked	☐ Yes ☐ No ☐ NA
Anaesthesia Safety Check Completed	☐ Yes ☐ No
Pulse Oximeter on Patient & Functioning	☐ Yes ☒ No
Does Patient have a:	
Known Allergy?	☐ Yes ☒ No
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available	☐ Yes ☐ No
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☒ No ☐ NA
Blood Units Reserved	☒ Yes ☐ No ☐ NA
Has Antibiotic Prophylaxis been given within the last 60 minutes?	
	☐ Yes ☒ No ☐ NA
Signature : <u>A</u>	
Name : <u>DR. B. K. R. R. R.</u>	

Before Skin Incision >>

TIME OUT	Time: <u>3:48am</u>
Confirm all team members have introduced themselves by Name and Role ☒ Yes ☐ No	
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm	
Correct Patient (Check ID Band)	☒ Yes ☐ No
Correct Site	☒ Yes ☐ No
Correct Procedure	☒ Yes ☐ No
Anticipated Critical Events	
Surgeon Reviews:	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? <u>1 sand my none</u>	
Anaesthesia Team Reviews:	
Are There Any Patient-specific Concerns? <u>bleeds 1st problem</u> ☒ Yes ☐ No ☐ NA	
Nursing Team Reviews:	
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☒ Yes ☐ No ☐ NA	
Is Essential Imaging Displayed? ☒ Yes ☐ No ☐ NA	
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☒ Yes ☐ No	
Signature : <u>K. K. K.</u>	
Name : <u>K. K. K.</u>	

Before Patient Leaves Operating Room

SIGN OUT	Time:
Nurse Verbally Confirms with the Team:	
The Name of the Procedure Recorded	☐ Yes ☐ No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☐ Yes ☐ No ☐ NA
The Specimen is Labelled (including patient name)	☐ Yes ☐ No ☐ NA
Whether there are any Equipment Problems to be addressed	☐ Yes ☐ No ☐ NA
To Surgeon, Anaesthetist and Nurse:	
What are the key concerns for recovery and management of this patient? ☐ Yes ☐ No	
Signature : <u>Dr. S. R. P. A. R. T. H. A. K.</u>	
Name : <u>Dr. SRIPARTHA Y</u>	

SURGICAL SAFETY CHECKLIST

Surgeon :
 Asst. Surgeon :
 Anaesthetist :
 Scrub Nurse :

Patient Name : Age : Gender :
 UHID No. : Surgery Name :
 Date : In-time : Out-time :



Before Induction of Anaesthesia ➤ ➤

SIGN IN		Time:.....
Patient Has Confirmed		
Identity	☐ Yes ☐ No	
Site	☐ Yes ☐ No	
Procedure	☐ Yes ☐ No	
Consent	☐ Yes ☐ No	
Site Marked	☐ Yes ☐ No ☐ NA	
Anaesthesia Safety Check Completed	☐ Yes ☐ No	
Pulse Oximeter on Patient & Functioning	☐ Yes ☐ No	
Does Patient have a:		
Known Allergy?	☐ Yes ☐ No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	☐ Yes ☐ No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☐ No ☐ NA	
Blood Units Reserved	☐ Yes ☐ No ☐ NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?	☐ Yes ☐ No ☐ NA	
Signature :		
Name :		

Before Skin Incision ➤ ➤

TIME OUT		Time:.....
Confirm all team members have introduced themselves by Name and Role ☐ Yes ☐ No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	☐ Yes ☐ No	
Correct Site	☐ Yes ☐ No	
Correct Procedure	☐ Yes ☐ No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? ☐ Yes ☐ No ☐ NA		
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns? ☐ Yes ☐ No ☐ NA		
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☐ Yes ☐ No ☐ NA		
Is Essential Imaging Displayed? ☐ Yes ☐ No ☐ NA		
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☐ Yes ☐ No		
Signature :		
Name :		

Before Patient Leaves Operating Room

SIGN OUT		Time:.....
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	☐ Yes ☐ No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☐ Yes ☐ No ☐ NA	
The Specimen is Labelled (including patient name)	☐ Yes ☐ No ☐ NA	
Whether there are any Equipment Problems to be addressed	☐ Yes ☐ No ☐ NA	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient? ☐ Yes ☐ No		
Signature :		
Name :		

LBH-00135916 IP5-00176595
Baby CHATRAGADDA AARADHYA
21-08-2021 4 Y 10 M 28 D (F)
Dr. SRIPARtha KRISHNA

Patient



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 19/7

Department : Duration of Procedure : 2h

Name of Surgeon : DR. Sai partha Date of Admission : 19/7

Bundle Care Criteria : (Tick (✓) if done)

		Staff Signature
1.	Antibiotic given prior to surgery ? ☐ Yes ☒ No ☒ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☐ Yes ☒ No Name of the Antibiotic : P.j. Tazem (850mg)	
2.	Hair Removal ☒ Yes ☒ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☒ Operating Room ☐ Other : Skin preparation done (cleanse surgical area with antiseptic agent)? ☒ Yes ☐ No	
3.	Patient's body temperature immediately post operation (Recovery Room) 35 °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Prashanth Date & Time of antibiotic administration : 19/7/26 @ 3:30pm Date & Time procedure started : 19/7/26 @ 3:38am	

- Ensure form is filled in completely by assigned staff whenever patient had surgery
- If any bundle care criteria has not been observed or unmet, assigned staff must inform infection control nurse for management
- All forms (Bundle care and when required SSI form) are completed properly
- Forms must always be kept in Infection Control folder in respective department

Docu. No. : RCHBH/ FRM / CLINICAL / 038



OPERATION THEATER NOTES

Patient's Name : Age : Gender : ☐ Male ☐ Female

UHID No.: Weight : Height :

Surgeon : Dr. SRIPARTHA Y Asst. Surgeon :

Anesthetist : Dr. SARITHA / Dr. Ramya OT Nurse: BIKHAI / BOGI OT Technician: PRASANTH

Pre-Operative Diagnosis: RIGHT TEMPOROPARIETAL ACUTE SDH WITH MASS EFFECT

Surgical Procedure : RIGHT FRONTOTEMPOROPARIETAL HINGE CRANIOTOMY AND
AUGMENTATIVE DURAPLASTY

Indications for Surgery : RAISED ICP

Date : 19/7/26 Start Time : End Time :

Pre Operative Preparations:

3X BETADINE

Post Operative Diagnosis: RIGHT TEMPOROPARIETAL EXTRADURAL HEMORRHAGE
WITH MASS EFFECT

Peri-Operative Complications: NONE

Operation Notes: 1) Patient laid Supine under GA.

2) Right Frontotemporoparietal retroauricular incision made and
flap raised

3) Subgaleal and submuscular hematoma noted

4) Right Frontotemporoparietal Craniotomy made

5) ~ 20 cc of extradural hematoma evacuated

6) Underlying brain bulge noted.

7) Augmentative Duraplasty with pericranial patch done Brain
pulsatile

8) Hinge craniotomy done

9) Wound closed in layers



POST-SURGICAL CARE PLAN FORM

Procedure Done: (R) FTP Hinge Craniotomy & Augmentative Duroplasty

Post-Surgical Diagnosis: (R) Temporoparietal ENH with Mass effect

Post-Operative Monitoring Parameters /Frequency:

VITALS Q1H
PUPILS Q2H
GCS Q2H

Wound Care:

DRESSING

Drain /Special Lines/Catheters:

Foley's CATHETER IN SITU

Special Patient Positioning and Requirements: 1) HEAD END ELEVATION - 30°
2) HEAD IN NEUTRAL, MIDLINE

Nutritional Instructions:

NPO TILL FURTHER ORDERS

When to Start Mobilization:

REST TILL FURTHER ORDERS

Special Referrals:

The new order for all required medications documented in the doctor order/medication sheet:

☒ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)


Sripartha

Date: 19/07/26 Time: 5:30am

Note: Plan of care will be readjusted if necessary.



144A

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 9/7/26 Time: 3pm

Weight: 17kgs Centile: 72th

Height: 107cms Centile: 50th

Inference: well child

RDA: — Calories: 1350kcal/d Protein: 23g/d

Diet Recommendations: soft diet

Re-Assessment: Avoid spicy, chilled and outside foods

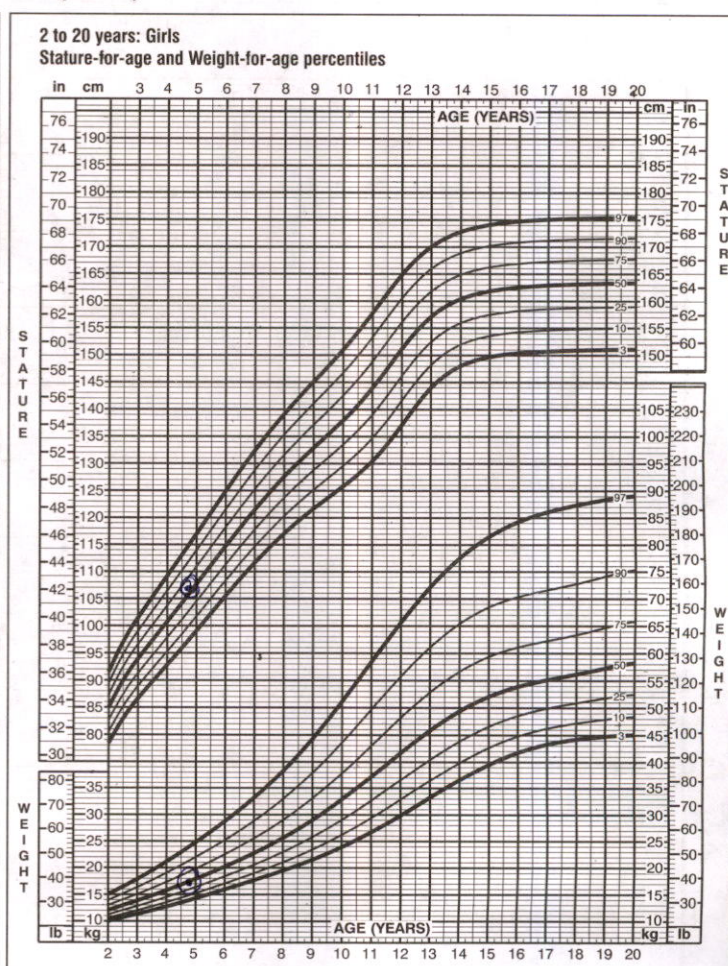
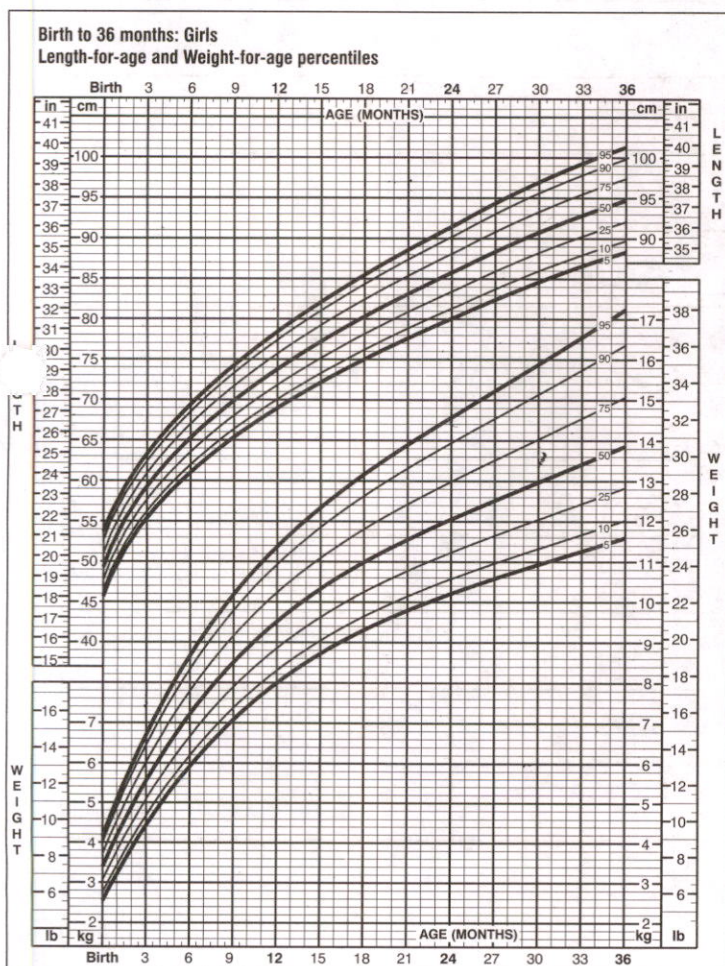
Food Allergies: No Veg/Non-veg veg

Diagnosis: Traumatic SDH + SLP (R) Frontoparieto Temporal Craniotomy

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: *[Signature]*

GROWTH CHART (GIRLS)



Dietician's Name: Monica

Dietician's Signature: Monica

Daily Notes:

2/12/26
11am

child is stable. oral intake is well.
continue to soft diet

- Nililtra

22/7/26
10am

Child is stable. Oral Intake is Better
Continue to soft diet.

- Moultin