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 : IP5-00174644 **Admit Date** : 02-Jun-2026 **Admit Time** : 12:42 PM **UHID** : BAH-00657900

Patient Details :

Patient Name	: Master VIVAAN DEV CHOUHAN	**Age**	: 7 Y 7 M 23 D
Guardian	: Mr KAPIL DEV CHOUHAN	**DOB**	: 10-10-2018
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H NO 4-33-11/1/A, VENKATESHWARA NAGAR Kukatpally Hyderabad Telangana INDIA 500072	**Phone No**	: 9966666051/ 9985823428
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : HO DC 3 **Ward Name** : 1F-HEMATO-ONCOLOGY

Room No : HO DC 3 **Admission Type** : First Visit

Contact Details :

Name : Mr KAPIL DEV CHOUHAN **Relationship** : Father

Contact Address : H NO 4-33-11/1/A, VENKATESHWARA NAGAR Kukatpally Hyderabad Telangana INDIA 500072 **Phone No** : 9966666051

Signature

Doctor Details :

Doctor Name : Dr. NALLA ANURAAG REDDY **Specialisation** : HEMATO ONCOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

BAH-00657900 IP5-00174644
Master VIVAAN DEV CHOUHAN
10-10-2018 7 Y 7 M 23 D (M)
Dr. NALLA ANURAAG REDDY

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ADMISSION CRITERIA – ONCOLOGY

Admission / Transfer from:

☑ Emergency ☐ Outpatient (OPD) ☐ Ward ☐ Operation Theater ☐ Others: .....

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

- ☐ For Chemotherapy-Day Care or IP Admission as per the Type of Chemotherapy
- ☐ Febrile Neutropenias (ANC <500 cells / mm3)
- ☐ Netropenic Enterocolitis
- ☐ Mucositis Induced Significant Diarrohea or Pain
- ☐ Neurological Complications (like Seizures, Bleeding, Thrombosis) that can arise while on Chemotherapy Treatment or at the Time of Presentation and also for other Systemic Problems like Pancreatitis during Chemotherapy
- ☐ Management of Oncological Emergencies
- ☑ Bleeding Problems (where it is indicated)
- ☐ Evaluation and Management of Severe Anemias
- ☐ Day Care Admissions for PRBC Transfusions
- ☐ Evaluation and Management of Sick Children who come with Hematological Problems like Severe Anemia like Autoimmune Hemolytic Anemia/ Bleeding/ Others
- ☐ Primary Immunodeficiency Disorders with Infections that Warrants Hospitalisation
- ☐ Management and Evaluation of Hemophagocytic LymphoHisticytosis
- ☐ Any Systemic Disorders with Significant Hematological issues like JRA / SLE with Secondary HLH

Signature of the Doctor: .....

Name of the Doctor: Sharan

Date & Time: 2/6 @ 12pm

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DISCHARGE CRITERIA – ONCOLOGY

Discharge to:

☐ HDU / Step down ICU ☐ Ward ☐ Outside Facility ☐ Others: .....

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

☐ Completion of chemotherapy, with no debilitating side effects.

☐ Resolution of febrile episode, with no fever>24hrs and Absolute Neutrophil count (ANC)> 500cells/mm3.

☐ Admitted patients - Once the admitting problem gets resolved or made a plan to manage further on out-patient basis.

Signature of the Doctor: .....

Name of the Doctor : .....

Date & Time: .....

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ BAH-00657900 IP5-00174644
Master VIVAAN DEV CHOUHAN
10-10-2018 7 Y 7 M 23 D (M)
Dr. NALLA ANURAAG REDDY

Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
2/6/20	1:10pm	ER	Oncology	Anees

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
2/6	Bone marrow Aspiration/ Biopsy	26056053	[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
02/06	IV placement — Done on OP	Bed-2		Sanchy
2/6	Bone marrow			
	Conscious Sedation }	(2)		Dr.
	[Kindly Enter this in procedure]			

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : 2/6 Time : 5pm Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Dr.	Evng ONCW		

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Anurag Reddy Date : 2/6/26

Type of Admission: ☐ OPD ☑ ER ☐ Referral (if referral, Doctor's Name: .....

Start Time of Assessment: ..... Weight: 18 kg

Allergic History: .....

Chief Complaints: ~~Fever~~ Cold } since 3days - Above complaints
Admitted on 31/5/26 @ RCH, Hyderabad
↓
Baby Child have fever high grade along with platelets got fixed upto 2000

Pediatric Assessment Triangle

A Appearance - TICLS .....

B Breathing
- ☐ ↑ WOB
- ☐ ↓ WOB
- ☑ Normal
- ☐ Gasping / Apnea

C Circulation
- ☑ Normal
- ☐ Abnormal
  - Pallor ☐
  - Cyanosis ☐
  - Mottling ☐
  - Bleeding ☐

Initial Physiological Status: ☑ Stable ☐ Unstable
- Life Threatening ☐
- Non Life Threatening ☐

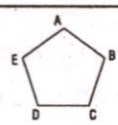
Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Significant Past History: .....

Medication History: .....

Relevant Investigations: .....

Primary Assessment



Airway

☑ Open
☐ Maintainable
☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Breathing

Rate: 28/min. SpO_2 on FiO_2 98% on RA
Rhythm: Regular
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: BILAE(+)
Palpation Findings (If necessary).....

Any urgent interventions needed: ☐ Yes ☐ No
If Yes .....

Circulation

HR: .....

CFT — Central ..... / Peripheral .....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

BP: ..... mmHg

Pulse Volume: Central ..... / Peripheral .....

If in Shock: Compensated ..... / Hypotensive .....

Muffled Heart Sound: ☐ Yes ☑ No

Engorged Neck Veins: ☐ Yes ☑ No

Murmurs: ☐ Yes ☑ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☐ No

Disability

GCS: ..... AVPU: .....

Pupils: Responsive ☐ Non-Responsive ☐

Size — Right ..... / Left .....

Active Seizures: ☐ Yes ☐ No Sugars: .....

Signs of Neurological compromise .....

.....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Exposure

Temp.: .....

Any Rash: ☐ Yes ☐ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Final Physiological Status:

☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings: .....

Labs Planned: .....

Labs done @ RCH - Hydemeyer

Treatment Planned: Bone marrow biopsy + Aspiration L CA @ 2pm.

- NPO from 8am
- IV fluids
- Continue medications as per previous prescriptions (Ceftriaxone, Pan, Levocet)

Need for Oxygen: ☐ Yes ☑ No if yes Low Flow ☐ High Flow ☐ PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): .....

Assessment done by

Name of the Doctor: Dr. RAMYA

Signature: .....

Date & Time: 2/6/26 ; 11:30 pm

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: .....

Signature: .....

Date & Time: .....

BAH-00657900 IP5-00174644
Master VIVAAN DEV CHOUHAN
10-10-2018 7 Y 7 M 23 D (M)
Dr. NALLA ANURAAG REDDY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/26 3pm.	Procedure notes	
	Under sterile aseptic precautions, bone marrow aspiration & biopsy done. procedure uneventful vitals - stable	
		Plan 1. Monitor vitals 2. Send BMA + biopsy [signature]
		NIB [signature] 1182 2/6 [signature]

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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MEDICATION RECONCILIATION FORM

Drug Allergies: NO

☐ 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: Hemetonco..

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	Inj Ceftriaxone	900mg	IV	BD	2/6/26	☑ C ☐ DC
2	Inj Pan [illegible]	18mg	IV	OD	2/6	☑ C ☐ DC
3	Syp levocetirizine	5ml	PO	BD	2/6	☑ 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 : [signature] Dr. RAMYA

Date & Time : 2/6/26; 11:30am.

Nurse Name & Signature: Anmul [signature]

Date & Time : 2/6/26 11:40Am

Docu. No. : RCHBH /FRM / GENERAL / 090

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RESULT SHEET

Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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.,) : .....

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DRUG CHART

Date of Admission: 2/6/26 Drug Allergies; .... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line / 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 .... Signature ....

Dr. NALLA ANURAAG REDDY

REGULAR PRESCRIPTIONS

Weight. 18 kg Ward.

DRUG : Inj CEFTRIAXONE

Dose	Route	Frequency	Start Date
900 mg	IV	Q12H	2/6/26

Date / Time: 2/6 — 6am ✓, 6pm

Name & Signature of the Doctor Starting the Drugs: Dr Ramya

Additional Instructions: 50mg/kg/dose

Daily Doctor's Endorsement by a Sign

DRUG : Inj PANTOPRAZOLE

Dose	Route	Frequency	Start Date
18 mg	IV	OD	2/6/26

Date / Time: 2/6 — 6am

Name & Signature of the Doctor Starting the Drugs: Dr Ramya

Additional Instructions: 1mg/kg/dose

Daily Doctor's Endorsement by a Sign

DRUG : Syp. LEVOCETIRIZINE

Dose	Route	Frequency	Start Date
5ml	PO	BD	2/6/26

Date / Time: 2/6 — 8am ✓, 8p

Name & Signature of the Doctor Starting the Drugs: Dr Ramya

Additional Instructions: (5ml/2.5mg)

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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Dr. NALLA ANURAAG REDDY

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

DRUG :	Date➤ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
		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
2/6		Inj MIDAZOLAM	1mg	IV		RM/S Susmitha
2/6		Inj KETAMINE	10mg	IV		HOLD

Signature
VERIFIED BY : Name

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Dr. NALLA ANURAAG REDDY

I.V. FLUIDS CHART

Weight. 18kg Ward. .....

		Composition of I.V. Fluid (Concentration ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
2/6/26		DNS (2/3rd maintenance)	IV	39					

Signature .....

VERIFIED BY : Name .....

Patient

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FLUID CHART

Sheet No. : (1)

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
2/6												
	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

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

Date	Time	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
2/6	08:00 am										0	
	09:00 am	Milk	70								0	
	10:00 am										0	
	11:00 am		90								0	
	12:00 pm										0	
	01:00 pm		0							900ml	0	
Total Intake :						**Total Output :** 900ml						
	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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Doc. No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 2/6/26	Time:	8pm
Doctor / Nurse / Family Concern?		
Temperature (F)	104 / 103 / 102 / 101 / 100 / 99 / 98 / 97 / 96 / 95 / 94	x 97.3F
Heart Rate (bpm) and Blood Pressure (mmHg) * Note: BP does not score in early warning scoring	190 / 180 / 170 / 160 / 150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50	96 / 75 / 60
Heart Rate (Number)		101b/m
Resp. Rate (bpm) (Over 1 Minute) *	70 / 60 / 50 / 40 / 30 / 20 / 10	•
Resp Rate (Number)		20b/m
Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O_2 (l/min)		
O_2 Saturations (%)		15/lr
Conscious Level	Normal	0
	Altered	/
GCS *		0
TOTAL SCORE Number of shaded boxes		0
Pain Score		
Observer's Initials		[illegible]

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

Pratiksha Rainbow Children's Hospital
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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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10-10-2018 7 Y 7 M 23 D (M)
Dr. NALLA ANURAAG REDDY

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CONSENT FOR SPECIAL PROCEDURES

Patient Name : Vivaan dev Gender: ☑ Male ☐ Female

UHID No : BAH00657900 Department : PHO Date : 2/6/26

I Bhavani S / D / W / O Kapil Dev

Here by give consent for procedure of : Bone marrow aspiration + biopsy

For my patient, Named : Vihaan Dev

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

Bleeding, infection, dry tap

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

Explained

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr. Roi

Patient Attendant :

Signature :

Name : Bhavani

Relationship with Patient: Mother

Date & Time : 2/6/26 @ 2:5pm

Witness :

Signature :

Name : Bhavani

Date & Time : 2/6/26 @ 2:5pm

Doctor (who is taking the consent) :

Signature :

Name : Dr Roi

Date & Time : 2/6/26; 2pm

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 .....

Patient Sticker

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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 BMA + Biopsy
- 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. ~~Vivaan dev~~ Dr. SIRISHA 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: .....

Name: Bhavani

Relationship with patient: Mother

Date & Time: 2/6/26 @ 2:15pm

Witness:

Signature: .....

Name: Bhavani

Date & Time: 2/6/26 @ 2:15pm

Doctor (who is taking consent):

Signature: ..... Name: Dr Soi Date 2/6/26 Time: 2pm

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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Moderate Sedation Flow-Sheet

Immediate Pre-Sedation Assessment

B.P	P.R	R.R	Temp	SPO_2	Pain Score	Weight
100/67/72	110/min	28/min	98.6F	100%	0	

Diagnosis: Thrombocytopenia + Evaluation

Procedure: BMA + Biopsy.

Comorbidities: No

- ☑ 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 15/15

☑ IV Site: Gauge:

Sedation Plan: IV

Allergies: NO

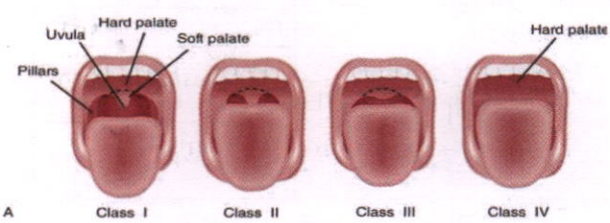
AIRWAY EVALUATION

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	100/69/77	110bh	28h	100%		

DRUG & IV Fluid: (including Nitrous Oxide)	ROUTE	DOSE	TIME GIVEN	SUBSEQUENT DOSES AND TIME
INJ MIDAZOLAM	IV	1mg	12:30 PM	
INJ KETAMINE	IV		HOLD	

Doctor Notes: child tolerated well

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

Doctor Name: Dr. Soi   Signature: [signature]

Post Sedation Care Room

Time																						
Monitoring ECG NBP Oximeter	180																					
Pain Score (0-10)	160																					
Sedation Score (0-4)........	140																					
	120	100																				
	100																					
	80	80																				
	60	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: 12:10h

Nurse Name: Dnye   Signature: [signature]

Date: 2/6   Time: 12pm

Consultant Name: Dr. Anwoog   Signature: [signature]

Stamp