LBH-00099878 IP5-00176800
Master NOAH YASHIN
15-06-2023 3 Y 1 M 8 D (M)
Dr. SIRISHA KUSUMA B

GH stimulation test

Name: DOB:

Glucagon stimulation test

- The child should be nil by mouth for at least 8hrs and is allowed only water till the test is completed.
- Insert a wide bore canula, this will allow us to take blood samples every 30 minutes.
- At the time of insertion take a blood sample for GH, glucose and also glucose test at the bedside.
- Give Glucagon IM, dose = 1mg

	Time	Growth hormone	Glucometer blood sugar	Cortisol
1	9:05 AM 0 min	✓	83 mg/dl.	X
2	9:35 AM + 30 min	✓	153mg/dL	X
3	10:05 AM + 60 min	✓	101 mg/dl	X
4	10:35 AM + 90 min	✓	59 mg/dl	X
5	11:05 AM + 120 min	✓	69 mg/dl	X
6	11:35 AM + 150 min	✓	69 mg/dl	X
	+ 180 min	✓	59 mg/dl	X

BG
106
108
109
87
84
89
99

During the test look for signs of hypoglycaemia like

- sweating
- complains of dizziness
- shaky hands

Check the blood sugar at the bedside if it is below 46 mg/dl, it should be corrected and the test continued.

- If the child is able to drink then 100ml – 200ml of Appy juice

OR

- 100ml of Maaza juice.

- If the child is unable to drink then a bolus of 10% dextrose should be given and the blood sugar rechecked 15 minutes later.

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 : IP5-00176800 **Admit Date** : 23-Jul-2026 **Admit Time** : 08:00 AM **UHID** : LBH-00099878

Patient Details :

Patient Name	: Master NOAH YASHIN	**Age**	: 3 Y 1 M 8 D
Guardian	: Mr YASHIN	**DOB**	: 15-06-2023
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: HYDERBAD Kachivani Singaram Hyderabad Telangana INDIA 500088	**Phone No**	: 8884370222
		E-mail	: YASHINIBIDAV@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : ER 04 **Ward Name** : 1B-EMERGENCY

Room No : ER 04 **Admission Type** : First Visit

Contact Details :

Name : Mr YASHIN **Relationship** : Father

Contact Address : HYDERBAD Kachivani Singaram Hyderabad Telangana INDIA 500088 **Phone No** : 8884370222

Signature

Doctor Details :

Doctor Name : Dr. SIRISHA KUSUMA B **Specialisation** : PEDIATRIC ENDOCRINOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant : Dr. JAPA AVINASH

Payment Details :

Deposit Amount : 0.00

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

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ACTIVITY RECORD FOR BILLING

LBH-00099878 IPS-00176800
Master NOAH YASHIN
15-06-2023 3 Y 1 M 8 D (M)
Dr. SIRISHA KUSUMA B

Na _____

UH _____ Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
23/7/26	8 AM.	ER	—	

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
~~23~~/6/26	GRBS - 83mg/dl GH	~~3818~~	Charan.
23/7/26	GH. GRBS - 153mg/dl	3835	Charan
23/7/26	GH. GRBS - 101mg/dl	3846	Charan
23/7/26	GH. GRBS - 59mg/dl	3863	Charan
23/7/26	GH. GRBS - 69mg/dl	3875	Charan
23/7/26	GH - GRBS - 69mg/dl	3891	Charan
28/7/26	GH. GRBS - 59mg/dl	3920	Charan
23/7/26	GRBS (68mg/dL)	3930	Charan

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
23/6/24	Ev placement	(1)	7676	Charan

ANY OTHER INFORMATION

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.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

LBH-00099878 IP5-00176800
Master NOAH YASHIN
15-06-2023 3 Y 1 M 8 D (M)
Dr. SIRISHA KUSUMA B

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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.

		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 :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	

Patient Sticker

FLUID CHART

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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 :**						
	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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THE HUMPTY DUMPTY SCALE 23/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3				
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	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				
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	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				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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				
	TOTAL		11				

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 :		Subha				
	Signature :		S				
	Date :		23/07				
	Time :		11 AM				

Docu. No. RCHBH / FRM / CLINICAL / 005

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DRUG CHART

Date of Admission: 23/7/26 Drug Allergies: NT ☑ 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 ....

Patient Sticker

REGULAR PRESCRIPTIONS

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

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ / Time ▾

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ / Time ▾

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ / Time ▾

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ / Time ▾

LBH-0009978
Master NOAH YASHIN
15-06-2023 3 Y 1 M 8 D (M)
Dr. SIRISHA KUSUMA B

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
23/5/26	8:35 AM	Inj-GLUCAGON	1mg	IM		Subbu, Charan.

Signature .....

VERIFIED BY : Name .....

Master NOAH TASHIN
15-06-2023 3 Y 1 M 8 D (M)
Dr. SIRISHA KUSUMA B

I.V. FLUIDS CHART

Weight. ..... 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 .....

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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: ..... Shifted to: .....

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 : Dr. Baljit

Date & Time : 22/7/26 / 8:15 Am

Nurse Name & Signature: Subhan

Date & Time : 23/07/26 @ 8:30 PM

LBH-00099878 IP5-00176800
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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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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/o/B Resident (Dr. Balaji)	
23/7/26		
8:15 AM	1- CHARGE Syndrome	
		c Short status
		Cat NRC - 8 pm @ 22/7/26
	c/f GH stimulation	test c Glucagon
	O/E, Child - Alert, Agitable	
	CFT < 3sec	
	pulses well felt	Plan
	Vitals	1) 0 min - GH, GRBS, BP
	HR - 110 bpm	↓
	Temp - 97.5°F	2) Inj-GLUCAGON 1mg I2m/stat
	RR - 23/min	↓
	BP - 108/62 (81)	3) 30 min
	SpO2 - 99%	60 min
		90 min → Check
	S/o	120 min GH, GRBS, BP
	RS - BAE+	150 min
	S1S2+	180 min
	PA - soft	4) Vitals monitory
		5) Inform Endocrinologist
	N/B Submit 23/07/26 at 8 AM	(Dr. Balaji)

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order