

BAH-00660543 IP5-00176250
Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 20 D (M)
Dr. SIRISHA RANI



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

BirthRight™
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Your Right to a Safe Delivery

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No : _____ 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
11/7/26	10:20 am	ER	ance 145	

Cross Consultation Visit

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

[illegible]

11/11/26

CBP

9346

Ismael

A handwritten signature in blue ink on lined paper. The signature consists of a large, stylized 'S' followed by a vertical line and a small 'e'. The 'S' is formed by a single continuous stroke that loops around. The vertical line is straight, and the 'e' is a small, simple loop. The signature is written on a set of horizontal lines, with a vertical line intersecting the middle of the 'S' and the 'e'.

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
11/7/26	chemotherapy	①	966641 u	

ANY OTHER INFORMATION

Do not charge for RTA with

.....

.....

.....

.....

.....

Date : 12/7/26

Time : 10:15am

Prepared By : Swarche

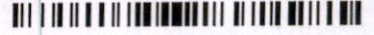
Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Swarche	145		



Rainbow Children's Hospital - Banjara Hills

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 : IP5-00176250 Admit Date : 11-Jul-2026 Admit Time : 09:53 AM UHID : BAH-00660543

Patient Details :

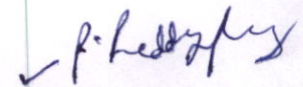
Patient Name	: Master POGULA REDDY BANDHAV	Age	: 4 Y 2 M 20 D
Guardian	: Mr POGULA REDDY PAVAN	DOB	: 21-04-2022
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: 13/349/J-14 NEAR CHAITHANYA SCHOOL Vaim Palle Cuddapah Andhra Pradesh INDIA 516329	Phone No	: 9550942903/ 9642403644
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD Bed No : SW 145 Ward Name : 1F-VIBGYOR
Room No : SW 145 Admission Type : First Visit

Contact Details :

Name	: Mr POGULA REDDY PAVAN	Relationship	: Father
Contact Address	: 13/349/J-14 NEAR CHAITHANYA SCHOOL Vaim Palle Cuddapah Andhra Pradesh INDIA 516329	Phone No	: 9550942903 / 9642403644


Signature

Doctor Details :

Doctor Name	: Dr. SIRISHA RANI	Specialisation	: HEMATO ONCOLOGY
Referral Doctor	: AARTHI	Phone No	:
Co-Consultant	: Dr. NALLA ANURAAG REDDY		

Payment Details :

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



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PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00660543 IP5-00176250
Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 20 D (M)
Dr. SIRISHA RANI



Patient Name:

POGULA REDDY BANDHAV.

UHID ID:

Department:

Consultant:



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: Mother Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

T-cell ALL / High count, PPR, CNS negative /
on induction

History of present illness :

Admitted for 4th chemo.

No Hb fever, cough noted

29/7/22 - 11/1620/99000

RBS 205, fibrinogen 115.

B positive

BAH-00660543 IP5-00176250
Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 20 D (M)
Dr. SIRISHA RANI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/20 2:50pm	<u>Procedure event</u> As procedure couldnot be performed. and CSF flow couldnt be achieved so procedure was <u>ABANDONED</u> . IT chemotherapy <u>not delivered</u> . Plan at later date.	<u>Ahanksha</u>
11/7/20 5:45pm	Tcell Aul High count / WBC 9.1-W-3. no fever no vomiting	<u>Adv</u> 1) start chemio 2) it supportive care <u>Ahanksha</u>



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



10.3 / 11.4 (all) - TC - 1740

CHEMOTHERAPY PRESCRIPTION

All the chemotherapy medications are high risk / high alert drugs.
While administering chemotherapy drugs watch for nausea, vomiting, rashes,
urine output and any local extravasation of the drug.

Sheet No. : ①	Weight (kg) : 18.4	Body Surface Area: 0.7	Diagnosis: T-ALL	Protocol: Induction wk-3
---------------	--------------------	------------------------	------------------	--------------------------

DATE	TIME	Composition of Chemotherapy (if infusion, mention ml / hr = Mcg / kg / min. etc.)	DOSE	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
11/7/26	hold 3pm	lyg METHOTREXATE lyg CYTARABINE lyg HYDROCORTISONE	12mg 30mg. 15mg	IT	STAT	d		11/7/26		
③ 12/7/26		lyg VINCRISTINE in 10ml NS	1mg.	IV	once 10min	d				
① 11/7/26	6:20 pm	lyg DAUNORUBICIN. in 300ml 1/2 NS	16mg	IV	60ml/hr	d	Soma. Nisha	11/7/26		meha Rama chandra
② 11/7/26.		lyg PEG-ADARUNATE	1000mg 1m.		hold Nisha					

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MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER

Shifted to: ONCO

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	SIP-SERAN	5ml	PO	12H Monday Wednesday, Friday	10/7/26	☒ C ☐ DC
2	SIP-CALCIMAX PLUS	5ml	PO	24H	10/7/26	☒ C ☐ DC
3	SIP-VITAMIN-D3	5ml	PO	weekly once	10/7/26	☒ C ☐ DC
4	T-Dexamethasone	1/2	PO	12H	10/7/26	☒ C ☐ DC
5	T-Tricor 106	1/2	PO	24H	10/7/26	☒ 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 : N. Prashanth Kumar

Date & Time : 10/7/26, 9:20 am

Nurse Name & Signature : Sagar

Date & Time : 11/7/26 @ 9:50 am

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RESULT SHEET

Date	11/7/26				
Time					
Hb	10.3				
PCV	31.9				
RBC	3.62				
WBC	1740				
N/L	43/52				
Platelets	114000				
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					

g/e

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.) :



Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

ces/ ~~new~~ stay $\oplus$ 15 days.



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Normal for age

Immunization History :

Immunized till 18 m of age.



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

lube

Desired goals of the treatment: _____

Resolute growth

Planned Labs:

CBP

NIB

sagan

11/7/26

Planned Management

NPO for 8:40 am

LP

chemotherapy

FFP 2 units

NIB

sagan

11/7/26

Signature of the Doctor: _____

N. Prash

Name of the Doctor: _____

N. Prash

Date & Time: _____

11/7/26, 9:40 am

Signature of the Consultant: _____

Dr. Sirisha Rani

Name of the Consultant: _____

Dr. Sirisha Rani

Date & Time: _____

12/7/26 @ 10:00 am

Weight 18.6 kg Ward

REGULAR PRESCRIPTIONS				Weight	Ward
DRUG : TAB. Dexamethasone				Date	11/7/17
Dose	Route	Frequency	Start Dt.	Time	
1/2 tab	PO	12H	11/7/16		
Name & Signature of the Doctor Starting the Drugs: N. Pearson				Sammore	
Additional Instructions: (1 tab = 4mg)				8pm	
Daily Doctor's Endorsement by a Sign				d	

DRUG : T-LANZOLOL DT				Date	11/7
				Time	12/7
Dose	Route	Frequency	Start Dt.		
2 tabs	po	24H	11/7		
Name & Signature of the Doctor					
Starting the Drugs:					
N. Praveen. Gam home					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

[illegible][illegible]



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																			

Signature

VERIFIED BY : Name



DRUG CHART

Date of Admission: 11/7/20 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			

DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			

DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			



Weight. 18.6 kg Ward. _____

Page: 2/4



Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

Drug :

Route

Start Date

Name & Signature of the Doctor

Additional Instructions:

VARIABLE DOSE

Date
Time

Nurse Sig.

Nurse Sig.

Nurse Sig.

Nurse Sig.

DRUG :

Route

Start Date

Name & Signature of the Doctor

Additional Instructions:

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
11/7/26	12:20 PM	FFP	2 UNIT over 30 mins	IV	N. P. M.	Surbha Swamy
11/7/26	4:15 PM	ly. LASIX	8 mg at End of transfusion	IV	N. P. M.	Surbha Swamy
11/7/26	11 AM	ly. AVIL	0.3 ml	IV	N. P. M.	Surbha Swamy
11/07/26	2:20 PM	INJ. KETAMINE	10 mg	IV	Hdd	
11/07/26	2:20 PM	Inj MIDAZOLAM	1 mg	IV	Hdd	

I.V. FLUIDS CHART

Weight. 18.6kg Ward.



Concentration of I.V. Fluid
in ml/hr = Mcg/kg/min. etc)

Concentration of I.V. Fluid in ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
--	-------	--------------------	----------------	---------------	---------------------	----------------	---------------

11/2/20
2PM

DNS

IV

55

N. Patel

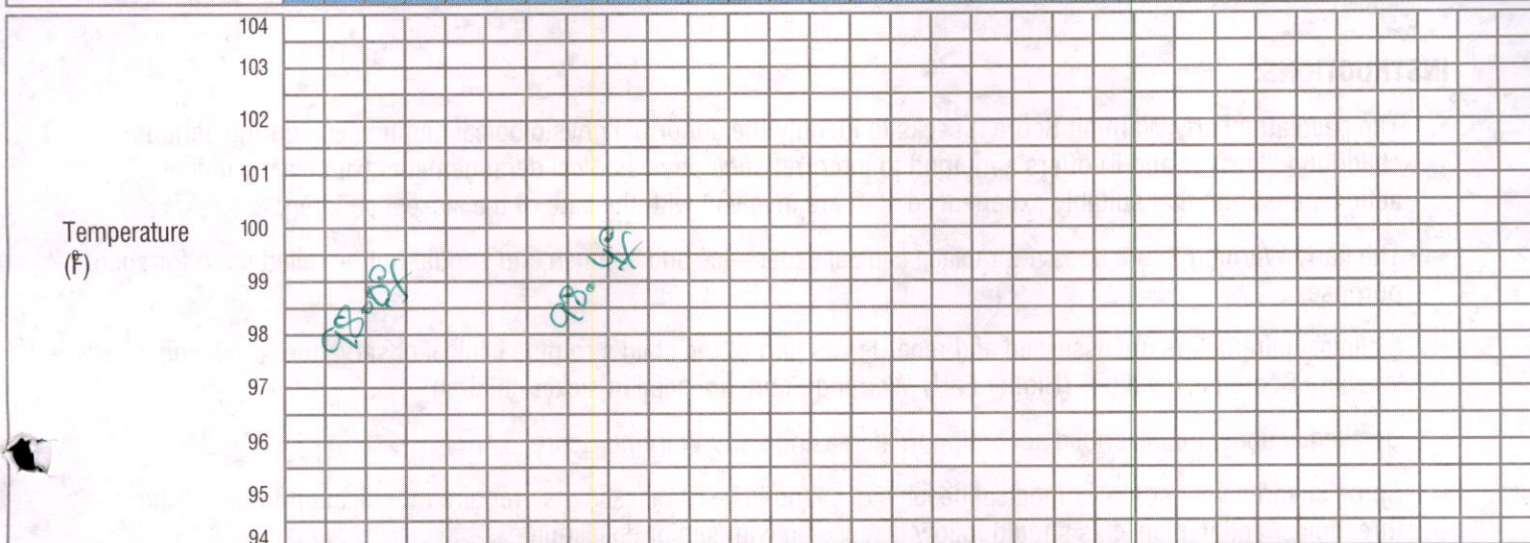
[Handwritten signature]

[Large handwritten signature]

Signature

VERIFIED BY : Name

Date: 11/2/26 Time: 2 PM 6 PM

[illegible]

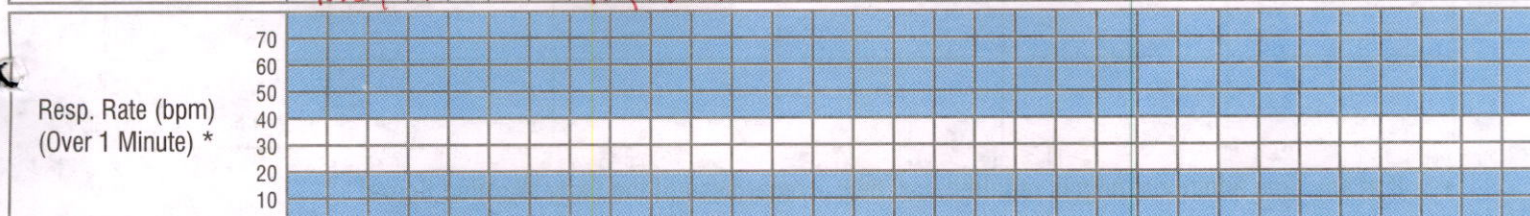
and

Blood Pressure
(mmHg) *

Note:

BP does not score in early warning scoring

Heart Rate (Number)



Resp Rate (Number)

Resp	Mod/ Severe
Distress	None / Mild

Receiving O ₂ (l/min)	O ₂ Saturations (%)
0	95.0
1	95.0
2	95.0
3	95.0
4	95.0
5	95.0
6	95.0
7	95.0
8	95.0
9	95.0
10	95.0
11	95.0
12	95.0
13	95.0
14	95.0
15	95.0
16	95.0
17	95.0
18	95.0
19	95.0
20	95.0
21	95.0
22	95.0
23	95.0
24	95.0
25	95.0
26	95.0
27	95.0
28	95.0
29	95.0
30	95.0
31	95.0
32	95.0
33	95.0
34	95.0
35	95.0
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37	95.0
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73	95.0
74	95.0
75	95.0
76	95.0
77	95.0
78	95.0
79	95.0
80	95.0
81	95.0
82	95.0
83	95.0
84	95.0
85	95.0
86	95.0
87	95.0
88	95.0
89	95.0
90	95.0
91	95.0
92	95.0
93	95.0
94	95.0
95	95.0
96	95.0
97	95.0
98	95.0
99	95.0
100	95.0

Conscious Level	Normal Altered
-----------------	-------------------

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

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.

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)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/7/26	Time: 6 pm	10 pm		
Doctor / Nurse / Family Concern?	11 AM	2 pm	6 pm	10 pm
Temperature (°F)	97.5 F	98.3 F	98.7 F	98.9 F
Heart Rate (bpm)	105 bpm	106 bpm	103 bpm	100 bpm
Blood Pressure (mmHg) *	110/80 (88)	106/84 (84)	103/68 (68)	100/50 (62)
Heart Rate (Number)	105 bpm	106 bpm	103 bpm	100 bpm
Resp. Rate (bpm) (Over 1 Minute) *	28 bpm	28 bpm	28 bpm	26 bpm
Resp Mod/ Severe Distress None / Mild				
Receiving O ₂ (l/min)				
O ₂ Saturations (%)	99%	99%	98%	99%
Conscious Level Normal / Altered				
GCS *	15/15	15/15	15/15	15/15
TOTAL SCORE	1	1	1	1
Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials				

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.
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Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

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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)



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								
11/7	08:00 am					/		/	/		0		
	09:00 am					/	✓	/	/		0	Sue	
	10:00 am	DNS	N	FFP		/		/	/		0		
	11:00 am		P	F		/		/	/	✓	0	Sue	
	12:00 pm			SSM		/		/	/		0		
	01:00 pm			SSM		/		/	/		0	Sue	
Total Intake :					Total Output :								
11/7	02:00 pm			SSM		/		/	/		0		
	03:00 pm			SSM		/		/	/	✓	0	Sue	
	04:00 pm			SSM		/		/	/		0		
	05:00 pm	DNS		SSM		/	NO	/	/		0	Sue	
	06:00 pm			SSM		/		/	/	✓	0	Sue	
	07:00 pm					/		/	/		0		
Total Intake :					Total Output :								
	08:00 pm			55ml		/		/	/		0		
	09:00 pm			55ml		/		/	/		0		
	10:00 pm	DNS	20ly	55ml		/	✓	/	/		0	Pam	
	11:00 pm			55ml		/		/	/		0		
	12:00 am			55ml		/		/	/		0		
	01:00 am			55ml		/		/	/		0		
Total Intake :					Total Output :								
	02:00 am			55ml		/		/	/		0		
	03:00 am			55ml		/		/	/		0		
	04:00 am	DNS		55ml		/		/	/		0	Pam	
	05:00 am			55ml		/		/	/		0		
	06:00 am			55ml		/		/	/		0		
	07:00 am		20ly	55ml		/		/	/		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					
			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															



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 11/7/26

Assessment: Baby having poor oral Intake

Goals

- | | | | | | |
|---|---|--|---|--|--|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☒ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☒ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☒ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
11AM	→ Assess the general condition of the child	11:5am	→ Assessed the general condition of the child.	By done all procedure baby is good
11:36 AM	→ Monitor the vital signs	11:4	→ Monitored the vital signs	
12p	→ Baby having Npo	12:30 PM	→ Npo from 8:40 am.	
1:30 PM	→ Administer medication as per doctor order	2pm	→ Administered medication as per doctor order	

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name: Swarnam

Date & Time: 11/7/26

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 11/7/20

Assessment: Baby having dull activity

Goals

- ☐ Maintain Airway and Oxygenation
☒ Maintain Personal Hygiene
☐ Identify Potential Complications
☐ Relieve Pain & Discomfort
☒ Prevent Infection
☐ Any Others. Specify.....
☒ Maintain Fluid Balance
☐ Meet Elimination Needs
☐ Improve Activity Tolerance
☒ Ensure Safety
☒ Maintain Good Nutritional Status
☐ Early Ambulation Reduce Anxiety
☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the general condition of the patient	2:30 PM	Assessed the general condition of the patient	Baby condition is good
3pm	monitor the vitals signs	3:30 PM	monitored the vitals signs	
4pm	maintain I/O chart	4:30 PM	maintained I/O chart	
5pm	Administer medication as per as chart	5:30 PM	Administered medication as per as chart	
6pm	Ensure the patient safety	6pm	Ensured the patient safety	

Re-Assessment: Re - Assessment

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Nikita

Date & Time: 11/7/20 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 12/7/2026

Assessment: Baby is having pain under tongue

Goals

- | | | | | | |
|---|---|--|---|--|--|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☒ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☒ Prevent Infection | ☒ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the general condition of the baby	8:10 pm	→ Assessed the general condition of the baby	The baby condition is Improving slowly
10pm	→ provide comfortable bed and position	10:10 pm	→ provided comfortable bed and position	
12Am	→ monitor vital signs	12:10 AM	→ monitored vital signs	
6Am	→ connect IV fluids	6:10 AM	→ connected IV fluids	
8Am	→ Administer medication as per doctor order	8:10 AM	→ Administered medication as per doctor order	

Re-Assessment: Baby is having discomfort

Special Notes:

Nurse Signature: Rama

Nurse Name: Rama

Date & Time: 11/7/26 8AM



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 12/7/26

Assessment: Baby having discomfort, poor oral intake

Goals

- | | | | | | |
|---|---|--|---|--|--|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☒ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☒ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☒ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the general condition of the child	8:15 am	→ Assessed the general condition of the child.	PT is good
10am	→ Monitor the vitals signs	10:30 am	→ Monitored the vitals signs.	
11am	→ Maintain IV Fluids → provide comfortable position	12:30 pm	→ ONS 50 ml/hr. → provided comfortable position	
12pm	→ maintain I & O chart → Administer medication as per doctor orders	12:30 pm	→ Administered I & O chart → Administered medication as per doctor order.	

Re-Assessment:

Special Notes:

Nurse Signature: *[Signature]*

Nurse Name: Suvareng

Date & Time: 12/7/26 @ 1pm

BAH-00660543 IP5-00176250
Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 20 D (M)
Dr. SIRISHA RANI



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

11/7 12/7/26

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3			
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2	2				
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1			
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1			
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
TOTAL			11	11			

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		Yes	Yes				
Call device within reach		Yes	Yes				
Wheels Locked		Yes	Yes				
Room free of clutter		Yes	Yes				
Adequate Lighting		Yes	Yes				
Wheel Chair Support		No	No				
Other Intervention(s) Specify		No	No				
Nurse's Name :		Sagan	Rama				
Signature :		[Signature]	[Signature]				
Date :		11/7	12/7				
Time :		9:30 AM	6 AM				



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sirisha Rani Department: ER Date of Admission: 11/7/26

SITUATION	Diagnosis: <u>B-cell all</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:		
BACKGROUND	Area	<u>ER</u>	<u>1st floor</u>	<u>1st floor</u>	
	Shift Time	<u>10:20 AM</u>	<u>11 AM - 2 PM</u>	<u>2 PM - 8 PM</u>	
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>Nil</u>	<u>NA</u>	<u>NA</u>	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ASSESSMENT	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98°F</u>	<u>96.1°F</u>	<u>98°F</u>
		Res:	<u>24 bpm</u>	<u>24</u>	<u>22bpm</u>
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>99%</u>
		Pulse:	<u>82 bpm</u>	<u>105</u>	<u>110 bpm</u>
		BP:	<u>95/52</u>	<u>100/67</u>	<u>100/70</u>
	Fall Risk Score:	<u>11</u>	<u>11</u>	<u>11</u>	
	Pain Score:	<u>0</u>	<u>0/10</u>	<u>0/10</u>	
Recommendations	Safety Needs:	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>Nil</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>Nil</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>Nil</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Sagan</u>	<u>Sagar</u>	<u>Nikita</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>11/7/26</u>	<u>11/7/26</u>	<u>12/7/26</u>	
Time:		<u>10:20am</u>	<u>2pm</u>	<u>8am</u>	
Taken Over By Name :		<u>Swaran</u>	<u>Nikita</u>	<u>Rama</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>11/7/26</u>	<u>11/7</u>	<u>12/7/26</u>	
Time:		<u>10:30am</u>	<u>2pm</u>	<u>8am</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area							
	Shift Time							
BACKGROUND	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:						
	Res:							
	SpO ₂ :							
	Pulse:							
	BP:							
	Fall Risk Score:							
	Pain Score:							
Recommendations	Safety Needs:							
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:							
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:							
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature :								
Date:								
Time:								
Taken Over By Name :								
Signature :								
Date:								
Time:								



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/7/26	9:30 AM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil Nil	
11/7/26	5pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Nikid
12/7/26	4 AM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rama
12/7/26	9 AM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Ramen
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

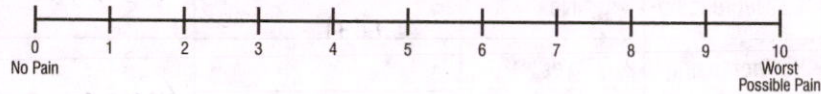
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





BRADEN 'Q' SCALE

					Date : 9/17/26	12:13 PM		
					Time : 9:30 am	6 AM		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4		
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4		
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4		
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE		28	28
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name		S	P

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
11/7/26	9:30 am	7.	Infection control measures	M	4	0	1	1	-	[Signature]
11/7/26	12pm	9	Soft high protein diet	M	1	0	1	1	-	[Signature]

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)							
Learning Barriers: 1. No Learning Barriers 4. Language Barrier 7. Impaired Thought Process/Cognitive limitations 10. Financial Difficulties 13. Cultural/Religion Practice 2. Physical Impairment 5. Educational Level 8. Responsibilities at Home 11. Beliefs and Values 14. Others (Specify) 3. Emotional Barriers 6. Desire / Motivate to Learn 9. Cultural Differences 12. Impaired Vision/ or Hearing							
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed							
Mechanism/s to overcome barrier/s: 1. None 3. Reassurance & Support 5. Respect values & beliefs 7. Other, Specify 2. Obtain translator 4. Teach Family / Others 6. Respect Cultural / Religion Preference							
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review							



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
11/7/26 9:30 AM	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	T-AN	Hemodynamic stability	LP chemo 3MA	[Signature]	☐ Nursing ☐ Others:
11/7/26 9:30 AM	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	Chemotherapy	H- Stability	Vitals monitoring	[Signature]	☒ Medical ☐ Others:
11/7/26 12pm	☐ Medical ☐ Nursing ☒ Others: Dietician	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	T cell ALL	Soft high protein diet	RDA e- 1350 kcal/d p- 23g/d	[Signature]	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Pogula Reddy Bandhav Age : 4 years Gender: ☒ Male ☐ Female
Date : 11/07/26 Time of Arrival : 9:10 am Triage Completion Time : 9:12 am
Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): Nil ☐ Not known any drug Allergies
Source of Information : ☒ Parents ☐ Others (Specify) _____
Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance ☒ Normal ☐ Sick Looking	Work of Breathing ☒ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea	☐ Stable ☐ Unstable : ☐ Not - Life - Threatening ☐ Life - Threatening
Circulation / Colour ☒ Normal ☐ Abnormal ☐ Bleeding		

Initial Vital Signs: Temp: 98.80° PR: 120b/m BP: 115/52 RR: 26b/m SpO₂: 99%
Chief Complaints: came for LP and chemotherapy Life: Test All

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☒ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☐ 60 min
☐ Level 5 : NON - URGENT : May receive care when convenient	☐ 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

P: Reddy
Signature of Parent / Guardian

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
3. Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☐ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☒ Not applicable

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☐ No
If yes, State Location: _____
2. Are your parents / close contacts at home healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☐ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Neeraj

Signature of Triage Nurse : Neeraj

Date & Time : 11/07/26 @ 9:12 am

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 11/7/26 Time of arrival : 3:12
Chief Complaints : Chemotherapy & LP RBS :
Height : 104.5 cm Weight : 18.6 kg BMI : Head Circumference (<2 years)
Allergies : ☐ Yes ☒ No Medications ☐ Blood Transfusion ☐ Food ☐ Other :
If yes, identify Nil
Pain Screening : ☐ Yes ☒ No If Yes, Pain Score : 0 Pain Tool Used : ☐ N Pass ☐ FLACC ☐ Wong Baker
☐ Character Nil ☐ Location Nil ☐ Frequency Nil ☐ Duration Nil

RISK FOR FALL:

☒ If patient is < 6 years
tick below fall risk intervention directly

☐ If Patient is > 6 years

Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☐ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☐ No
- Uses furniture for support ☐ Yes ☐ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☐ No
- Weak ☐ Yes ☐ No
- Impaired ☐ Yes ☐ No

Mental Status: Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- ☒ Escort while ambulating
- ☒ Assist Patient
- ☒ Educate patient and family on fall precautions/prevention

Functional Screening: ☒ No Abnormalities Detected

- ☐ Mobility Problem
- ☐ Walking Problem
- ☐ Developmental Delay
- ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

- ☐ Underweight
- ☐ Overweight
- ☐ Feeding Problem
- ☐ Special diet
- ☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☒ No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With Family

Siblings in household ☐ Yes ☐ No (if yes How Many?) 1 sister

Cultural & Spiritual Needs: ☐ Yes ☐ No if Yes specify Nil Inform consultant for positive criteria.

Time of Initial assessment completed by ER Nurse : 11/7/26

Nursing Notes (Including Labs / Medications / Other Care):

Time	Nursing Notes
9:50 am	→ ASSESS the pt & conscious
	→ seen Dr. prathiba
	→ vitals checked & Record.

Samples collected by:
Time:

Samples sent by :
Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :	Details of Shift - out
HR: 103 b/m BP: 105/52 CFT: 22sec RR: 24 b/m SPO ₂ : 100 % GCS: 15/15 Temperature : 98°F Pain Score: 0 Repeat RBS (if applicable): Nil	Shift - out from ER to: 145 over Time of Shift - out: 10:20 am Handover given to: Sworeng (Nurse's Name)

Tick as applicable:
☐ MLC
☐ LAMA
☐ BROUGHT DEAD

Procedures done with details (if any):

Pick line have

Name of the Nurse : Sagan
Signature of the Nurse :

Date & Time : 11/7/26 @ 9:50 am

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00660543 IPS-00176250 Master POGULA REDDY BANDHAV 21-04-2022 4 Y 2 M 20 D (M) Dr. SIRISHA RANI 		Date & Time of Admission 11/7/26 @ 9:53 am	Date & Time of Transfer Order 11/7/26 @ 10:20 am
		Transfer Ordered by Dr. Ramya	Reason for Transfer Admission
From Unit FR	To Unit one 145	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what? P. hoodie op file	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring NR. Sagar		Name of Person Ordered Transfer Dr. Ramya	
Patient & Clinical Records Received by : Swarna			
Date & Time of Patient Received : 11/7/26 @ 10:30 am			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

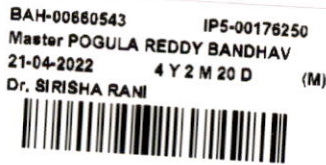
☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

CONSENT FOR BLOOD TRANSFUSION

Name:
UHID.No :



Age: 48 Gender: Male ☒ Female ☐

Date: 11/7/26

Type of Blood Product: ☒ Fresh Frozen Plasma ☐ Packed Red Blood Cells ☐ Random Donor Platelets
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood
☐ Albumin ☐ Red Blood Cell ☐ Others

I hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immuno-deficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in the "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Doctor (Who is talking the consent)

Signature: M. Haritha

Signature: T. Panam

Name: M. Haritha

Name: T. Panam

Date & Time: 11/7/26

Date & Time: 11/07/26

Witness

Signature:

Name:

Date & Time:

రక్త మార్పిడి కొరకు అంగీకార పత్రము

రోగి పేరు: వయస్సు: లింగము ☐ పురుషుడు ☐ స్త్రీ
UHID. సంఖ్య: తేదీ:

రక్త ఉత్పత్తి రకాలు:

- | | | |
|---|---|---|
| ☐ తాజా ఘనీభవించిన ప్లాస్మా | ☐ ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు | ☐ Random Donor Platelets |
| ☐ క్రయోప్రెసిపిటేట్ | ☐ ఒకే ధాత ఫ్లేటిలెట్స్ | ☐ Whole Blood |
| ☐ మొత్తం రక్తం | ☐ ఎర్ర రక్త కణం | ☐ ఇతరులు..... |

నేను ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడిస్, హైపటెటిస్ జి సర్ఫేస్ యాంటిజన్, హైపటెటిస్ యాంటిబడిస్, మలేరియా మరియు సిఫ్లిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణయ కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలెత్తవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు

పైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి చికిత్స చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. చికిత్స చేస్తున్న సమయంలో అన్ని రకముల రక్తమార్పిడులకు (మొత్తం రక్తం / లేదా రక్త ఉత్పత్తులు ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ఫ్రెష్ ఫ్రాజెన్ ప్లాస్మా, క్రయోప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకం

పేరు

పేరు

తేదీ మరియు సమయము

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

BAH-0060543 IP5-00176250
Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 20 D (M)
Dr. SIRISHA RANI



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 11/7/26 Time: 12:20pm

Blood Group of the Patient: Blood Group on the Blood Bag:

Blood Bank Issue No: Date of Collection: Date of Expiry:

Date & Time of Starting Transfusion: 11/7/26 @ 12:20 Planned duration of Transfusion: over 30 min

Check for Correct Unit: ☐ Correct Patient: ☐

Blood products cross checked by: Nurse 1: Sushma Nurse 2: Sudhanya

Before starting transfusion vitals: Temp: 96.1°F HR 110 RR: 26 BP: 101/67 SpO₂ 99A

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
<u>11/7/26</u>	15 Min	<u>105</u>	<u>97.1°F</u>	<u>101/67</u>	<u>98%</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	15 Min	<u>110</u>	<u>98.5°F</u>	<u>105/77</u>	<u>99%</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	30 Min								
	30 Min								
	30 Min								
	1 Hr								
	1 Hr								

Comments: nil

Name of the Incharge-Nurse: Nareja

Name of the Nurse: Sudhanya

Signature of the Incharge-Nurse: [Signature]

Signature of the Nurse: [Signature]

Date & Time: 11/7/26 @ 12:40pm

Date & Time: 11/7/26 @ 12:40pm

BAH26-01145



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

FRESH FROZEN PLASMA B.P

Qty. 200 ml. Prepared from Whole human blood collected in 63 ml. of C.P.D./
 SAGM Solution.

B

HIV I & II/ HBsAG/ HCV - Non
 reactive
 VDRL - Non reactive
 MP - Negative
 NAT(HIV I & II/ HBsAG/ HCV)- Non
 reactive

Unit No.: BAH26-01145
 Blood Group: B Rh Positive
 Collection Date: 13/May/2026
 Expiry Date: 13/May/2027

1)administer Without Warming. 2)shake Gently Before Use.3)do Not
 Add Any Medication. 4)check Blood Group on Label & Recipient's
 Group and Name Before Administration. 5)use Sterile Transfusion Set
 With Filter. 6)do Not Dispense Without Prescription. 7)do Not Use if
 There is any leakage.

Issue Label / CrossMatching Report

9)resus
 Plasma
 Between

Patient : Master POGULA REDDY BANDHAV
 Patient's Blood Group : B Rh Positive
 Hosp/Dr : Rainbow Childrens Hospital, DR. SIRISHA RANI
 UHID No.: BAH-00660543 Wd-Bed No.:

Product : FFP

Blood Group : B Rh Positive

Issue Dt : 11/Jul/2026

Unit No.: BAH26-01145

Colln. Dt : 13/May/2026

XMatching Report: ABO Compatible

Exp. Dt : 13/May/2027

X-matched by: B.Abbhishek

Issued By : B.Abbhishek

**Rainbow Hospital Blood Centre, Rainbow Childrens
 Hospital**

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



DISCHARGE PLANNING FORM

Nationality: Indian

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: 12/7/20

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☐ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication ☒ Yes ☐ No

☐ Bathing ☒ Yes ☐ No

☐ Eating ☒ Yes ☐ No

☐ Walking ☐ Yes ☒ No

☐ Dressing ☐ Yes ☒ No

☐ Toileting ☐ Yes ☒ No

Explain
to
mother

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: personal hygiene

☐ Patient's Educational Topic/s discussed with the:

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Swarna

Date and Time: 12/7/20 @ 10:30am



145

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 11/7/26 Time: 12pm

Weight: 18.6kg Centile: 97th

Height: 107.5cm Centile: >97th

Inference: Obese child

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

Diet Recommendations: soft high protein diet

Re-Assessment: Avoid spicy, chilled, outside foods

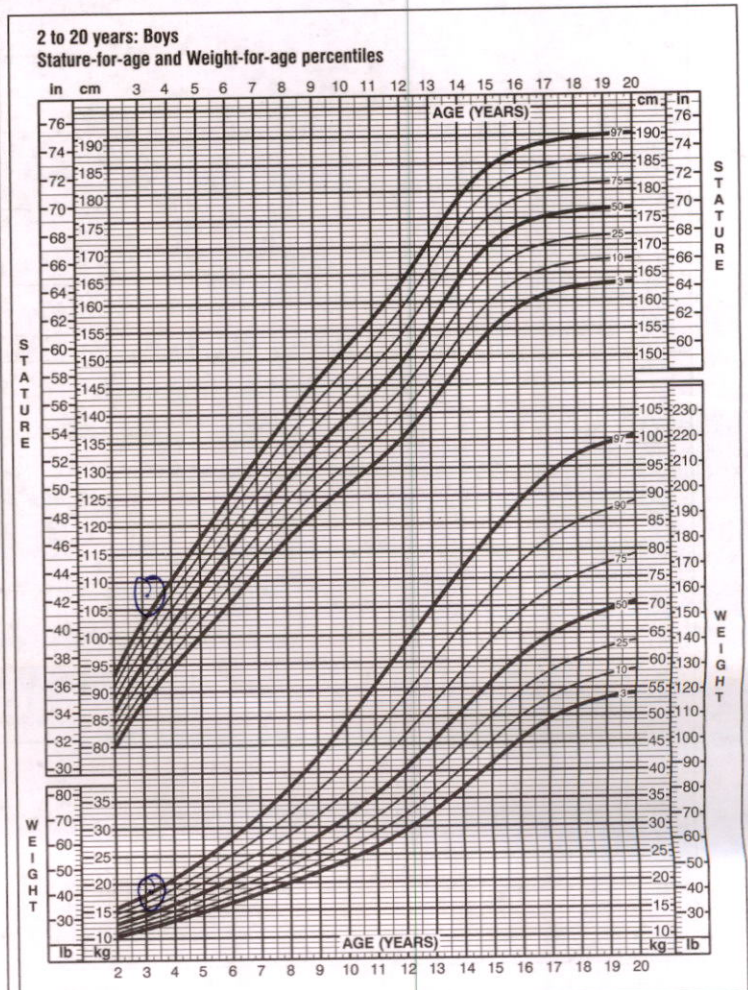
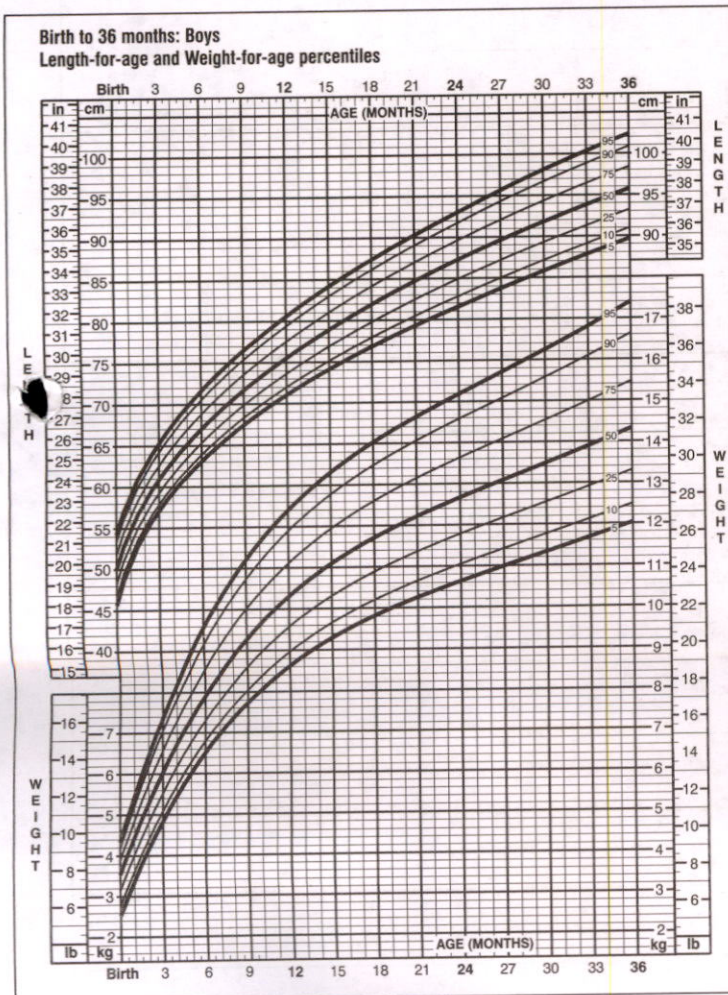
Food Allergies: NO Veg/Non-veg: Non-veg

Diagnosis: T-cell All

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Parents dont want dietitian - DO not charge for NHA

GROWTH CHART (BOYS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha

[illegible]