

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP _____ ant: _____ Dept : _____

Date of Admission: _____ Discharge : 4/6/26 Time: _____

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

BAH-00655429 IP5-00174682
Master MD HASAN AKRAM (M)
28-10-2019 6 Y 7 M 6 D
Dr. SIRISHA RANI



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<u>3/6/26</u>	<u>10:30Am</u>	<u>ER</u>	<u>109</u>	<u>Lavanya</u>

Cross Consultation Visit

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

ADMISSION SHEET

Registration Details :



Admission No : IP5-00174682 Admit Date : 03-Jun-2026 Admit Time : 09:17 AM UHID : BAH-00655429

Patient Details :

Patient Name : Master MD HASAN AKRAM Age : 6 Y 7 M 6 D
Guardian : Mr MD IRSHAD AKRAM DOB : 28-10-2019
Gender : Male Religion :
Occupation : Martial Status : Single
Address (H) : DARUSSALAM RAMANA ROAD Bankipur Patna Phone No : 9910405565/ 7569838222
Bihar INDIA 800004 E-mail : MDIRSHADAKRAM@GMAIL.COM

Admission Details :

Bed Type : SEMI PRIVATE Bed No : SPVT 109 Ward Name : 1F-VIBGYOR
Room No : SPVT 109 Admission Type : First Visit

Contact Details :

Name : Mr MD IRSHAD AKRAM Relationship : Father
Contact Address : DARUSSALAM RAMANA ROAD Bankipur Phone No : 9910405565 / 7569838222
Patna Bihar INDIA 800004


Signature

Doctor Details :

Doctor Name : Dr. SIRISHA RANI Specialisation : HEMATO ONCOLOGY
Referral Doctor : Self Phone No :
Co-Consultant : Dr. SANDHYA VADDADI

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00655429 IP5-00174682
Master MD HASAN AKRAM
28-10-2019 6 Y 7 M 6 D (M)
Dr. SIRISHA RANI



Patient Name:

MD HASAN AKRAM

UHID ID:

Department:

Consultant:



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

case of T lymphoblastic lymphoma
cvs negative on uricentine

History of present illness :

↓
Admitted for up, chemotherapy

29 H₂ fever cough cold

28/05/28 - H₂ 10
WBC - 6.55
PL - 226
N/L - 65/30

BAH-00655429 IP5-00174682
Master MD HASAN AKRAM
28-10-2019 6 Y 7 M 6 D (M)
Dr. SIRISHA RANI



Pediatric multiorgan Physical Examination

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

Birth & Neonatal History:



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Normal for age

Immunization History :

Immunized till date



History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): 121 (Centile _____)
Weight (kgs)) 19.96 (Centile _____)

On Examination :

Temperature : 98.1°F Pulse Rate : 125/min B.P. 105/55 (66) SPO2 98.1% R/A
Resp. rate and type of breathing : 24/min

Rash _____
Lymphadenopathy _____
Oedema : _____
Allergies (if any): _____

Dental Caries ⊕

Respiratory System :

Inspection (any s/o distress) : _____
Air entry & breath sounds : _____
Any added sounds : _____
Relevant data from outside (Chest X-Ray, ABG, etc.,) 3/4 clear

Cardiovascular System :

Inspection of precordium : _____
Heart Sounds : _____
Any murmur : _____
Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : 5/2 ⊕

Per Abdomen :

Inspection _____
Palpation : _____
Auscultation : _____
Spine : _____ External Genitalia : _____
Relevant data from outside (CT, USG etc.,) soft

BAH-00655429 IP5-00174682
Master MD HASAN AKRAM
28-10-2019 6 Y 7 M 6 D (M)
Dr. SIRISHA RANI



& Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Alert

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

ICLLO T-lymphoblastic leukaemia, CNS @ on Inductro
Admission for IP
Chemotherapy



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Infection

Desired goals of the treatment: Hemodynamic stability

Planned Labs:

CBP
RBS
Fibrinogen
MB Annex
3/6/20

Planned Management

LP
chemotherapy
MB Annex
3/6/20

Signature of the Doctor: N.P.S
Name of the Doctor: Dr. N. Peethiker
Date & Time: 03/06/20, 9 am

Signature of the Consultant: [Signature]
Name of the Consultant: Dr. Sirisha Rani
Date & Time: [Blank]



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.



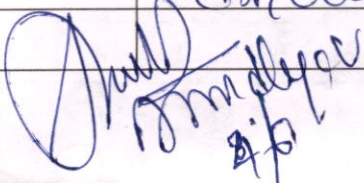
Sheet No. 1 Weight (kg) : 17kg Body Surface Area: 0.7 Diagnosis: T lymphoblastic lymphoma Protocol:

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.
3/6/26	2pm	INT METHOTREXATE INT CYTARABINE INT HYDROCORTISONE	12mg 30mg 5mg	INTRATHECAL	stat	<i>[Signature]</i>	Swarna Sourav	3/6/26	A	Sourav Sourav
3/6	4:30pm	INT DAUNORUBICIN with 300ml 1/2 DNS	15mg	IV	@ 50ml/hr	<i>[Signature]</i>	Susmita Divya	3/6/26	<i>[Signature]</i>	ptuber kanyas
4/6	8:10pm	INT VINCRISTINE with 10ml NS	1mg	iv	<i>[Signature]</i> over 10min	<i>[Signature]</i>	palakesh arye	4/6/26	<i>[Signature]</i>	palakesh arye

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6/26 3pm	Evening rounds	
	T-lymphoblastic lymphoma: on induction	
	No fever vitals - stable	1. Chemotherapy today Vincristine TIm
		2. Collect 2 extra EDTA TIm. 2-Dexamethasone today
		3. discharge TIm. Flv - 10/6. <u>Sevan</u>
4/6 11am	SIB nasally	(P) O/C today ↓ ct Dexa tapering as advised ct supportive care Flv on 10/6 O/C, ceftazidime
		

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 Dr. SIRISHA RANI



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					

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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: ICU Shifted to: Ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. AMLODIPINE 2.5mg	1/2	PO	24H		<input type="checkbox"/> C <input type="checkbox"/> DC
2	SYP. SEPTIRAN	5ml	PO	12H nandays		<input type="checkbox"/> C <input type="checkbox"/> DC
3	SYP. MORTEL	5ml	PO	24H		<input type="checkbox"/> C <input type="checkbox"/> DC
4	SYP. CALUMAX PLUS	5ml	PO	24H		<input type="checkbox"/> C <input type="checkbox"/> DC
5	30					<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: N. Prashanth - N. Pr

Date & Time: 03/06/26, 9am

Nurse Name & Signature: Annab

Date & Time: 3.6.26 9:20 Am



DRUG CHART

Date of Admission: 3/6/20 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:																					

Signature
VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 19.96 kg Ward.

DRUG : <u>ly. ONDANSETRON</u>				Date Time	<u>2/6</u>														
Dose	Route	Frequency	Start Date																
<u>4mg</u>	<u>IV</u>	<u>BH</u>	<u>03/6</u>																
Name & Signature of the Doctor Starting the Drugs: <u>N. Peatwisha</u>																			
Additional Instructions: <u>6pm</u>																			
Daily Doctor's Endorsement by a Sign																			

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

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

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

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 Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : ... 2/6/20 Time:

Doctor / Nurse / Family Concern? SPM NP GM

Temperature (F)	104			
	103			
	102			
	101			
	100			
	99			
	98	X 98.1 F	97.5 F	97.5 F
	97			
	96			
	95			
	94			

Heart Rate (bpm) and Blood Pressure (mmHg) *	190			
	180			
	170			
	160			
	150			
	140			
	130			
	120	110	109	101
	110	(65)	(70)	(68)
	100			
	90			
80				
70				
60				
50				

Heart Rate (Number) 115bpm 128b 110b

Resp. Rate (bpm) (Over 1 Minute) *	70			
	60			
	50			
	40			
	30			
	20			
	10			

Resp Rate (Number) 24b/min 28b 28b

Resp Distress Mod/ Severe None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 99% 98% 98%

Conscious Level Normal Altered

GCS * 15/15 15/15 15/15

TOTAL SCORE			
Number of shaded boxes	1	1	1
Pain Score	0	0	0
Observer's Initials	S	S	S

- ACTIONS**
- 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.

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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 Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

BAH-00655429 IP5-00174662
 Master MD HASAN AKRAM
 28-10-2019 6 Y 7 M 6 D (M)
 Dr. SIRISHA RANI

Patient

3/6/26



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	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	chem											
	05:00 pm	fruit											
	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							

BAH-00655429 IP5-00174682
 Master MD HASAN AKRAM
 28-10-2019 6 Y 7 M 6 D (M)
 Dr. SIRISHA RANI



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.

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



Moderate Sedation Flow-Sheet

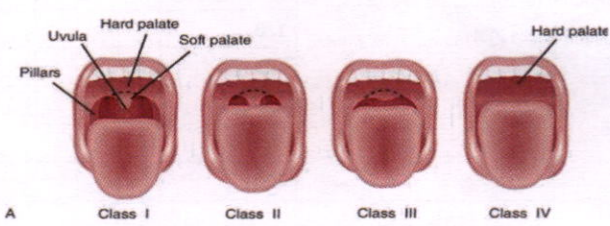
Immediate Pre-Sedation Assessment

B.P	PR	R.R	Temp	SPO ₂	Pain Score	Weight

Diagnosis: T lymphoblastic lymphoma

Procedure: lumbar puncture with intrathecal chemotherapy

Comorbidities:

<input checked="" type="checkbox"/> Risk, benefits & alternatives discussed; <input checked="" type="checkbox"/> Patient understand & elects to proceed <input checked="" type="checkbox"/> Consents for procedure and sedation signed and dated ASA Physical Status <input type="checkbox"/> ASA PS 1: Healthy Patient <input checked="" type="checkbox"/> ASA PS 2: Mild Systemic Disease, no functional limitations <input type="checkbox"/> ASA PS 3: Severe Systemic Disease, functional limitations <input type="checkbox"/> ASA PS 4: Severe Systemic Disease, constant threat to life <input type="checkbox"/> ASA PS 5: Moribund Patient unlikely to survive 24 hrs. <input type="checkbox"/> ASA PS 6: A declared braindead patient whose organs are being removed for donor purposes <input type="checkbox"/> E: Emergency procedure GCS: E M V	AIRWAY EVALUATION Mouth: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Loose Teeth <input type="checkbox"/> Small Mouth <input type="checkbox"/> Protruding Incisors <input type="checkbox"/> Receding Lower Jaw <input type="checkbox"/> Dentures Neck: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Decreased ROM <input type="checkbox"/> Thyromental Distance Less Than 6 cm <input type="checkbox"/> Short Neck 
<input checked="" type="checkbox"/> IV Site: Gauge: <u>Line Crosshair</u>	
Sedation Plan: <u>ketamine, midazolam</u>	
Allergies: <u>-</u>	
	Mallampati Class: <input checked="" type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV

Monitoring of Patient Intra – Procedure

Procedure Monitoring

Heart Rate (HR), Respiratory Rate (RR), Oxygen Saturation (O₂ 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						

DRUG & IV Fluid: (including Nitrous Oxide)	ROUTE	DOSE	TIME GIVEN	SUBSEQUENT DOSES AND TIME
INT KETAMINE	10 mg	IV	2pm	
INT MIDAZOLAM	1 mg	IV	2pm	

Doctor Notes: Stable

Time of transportation to post sedation care room: LOC:

Doctor Name: Ar Senelkye Signature: 

Post Sedation Care Room

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

TOTAL ALDRETTE SCORE AT DISCHARGE =
 (If 9 and more patient can discharge from post Sedation care unit)

Activity :	Consciousness:	Respiration:	Oxygen Saturation:	Circulation:
Four extremities = 2	Fully awake = 2	Breathe Deep= 2	Sat O ₂ >92 % on room air = 2	BP +/- 20 mm hg of pre-op = 2
Two extremities = 1	Arousal oncalling=1	Dyspnea, limited breathing = 1	Needs oxygen to maintain Sat O ₂ >90% = 1	BP +/- 20-50 mm hg of pre-op = 1
No extremities = 0	Unresponsive=0	Apnea = 0	Saturation <90% with oxygen = 0	Bp +/-50 mm hg of Pre-Op = 0

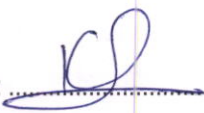
Patient Discharge Time:

Nurse Name:

Signature:

Date: Time:

Consultant Name: Ar Sirima BANI

Signature: 

Stamp



CC - SPECIAL PROCEDURES



Patient Name : MD HASAN AKRAM Gender: Male Female

UHID No : Department : ONCOLOGY Date : 3/6/26

I S / D / W / O

Here by give consent for procedure of : Lumbar puncture with catheters

For my patient, Named : MD HASAN AKRAM chemotherapy

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

Headache, vomiting, pain, seizure,
neurotoxicity.

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:

Patient Attendant :

Signature :

Name :

Relationship with Patient:

Date & Time :

Witness :

Signature :

Name :

Date & Time :

Doctor (who is taking the consent) :

Signature : [Signature]

Name : MRS SANDHYA V

Date & Time : 3/6/26

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు బింగం పురుషుడు స్త్రీ

యు. హెచ్.ఐ.డి బిభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

.....

.....

.....

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు (అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

BAH-00655429 IP5-00174682
 Master MD HASAN AKRAM
 28-10-2019 6 Y 7 M 6 D (M)
 Dr. SIRISHA RANI




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
Lumbar puncture
- 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. 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:
 Relationship with patient:
 Date & Time:

Witness:
 Signature:
 Name:
 Date & Time:

Doctor (who is taking consent):
 Signature: [Signature] Name: Dr. Semelhya V Date: 3/1/20 Time:

ప్రాసీజరల్ సెడేషన్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: రోగి రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, క్రింది విషయాలను అంగీకరిస్తున్నాను:

నాకు తెలిసిన భాషలో, వైద్యులు ఈ క్రింది ప్రాసీజర్ కు ఇచ్చే సెడేషన్ గురించి పూర్తి వివరాలు నాకు తెలిపారు:

- సెడేషన్ వల్ల సంభవించగల సాధ్యమైన క్రింది సమస్యలు/ప్రమాదాలు గురించి నాకు తెలిపారు: గుండె వేగం మారడం, రక్తపోటు మారడం, ఆక్సిజన్ అవసరం, అలర్జిక్ ప్రతిచర్యలు, ఎగువ శ్వాసనాళ అడ్డంకి, లాలింజోస్పాసమ్, 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 ప్రశ్నలన్ని, 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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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 3/6/20 Time: 10Am

Weight: 19.96 kgs Centile: >10th

Height: 114cm Centile: >10th

Inference: underweight child.

RDA: — Calories: 1450kcal/d Protein: 23g/d

Diet Recommendations: Child is on NPO

Re-Assessment: _____

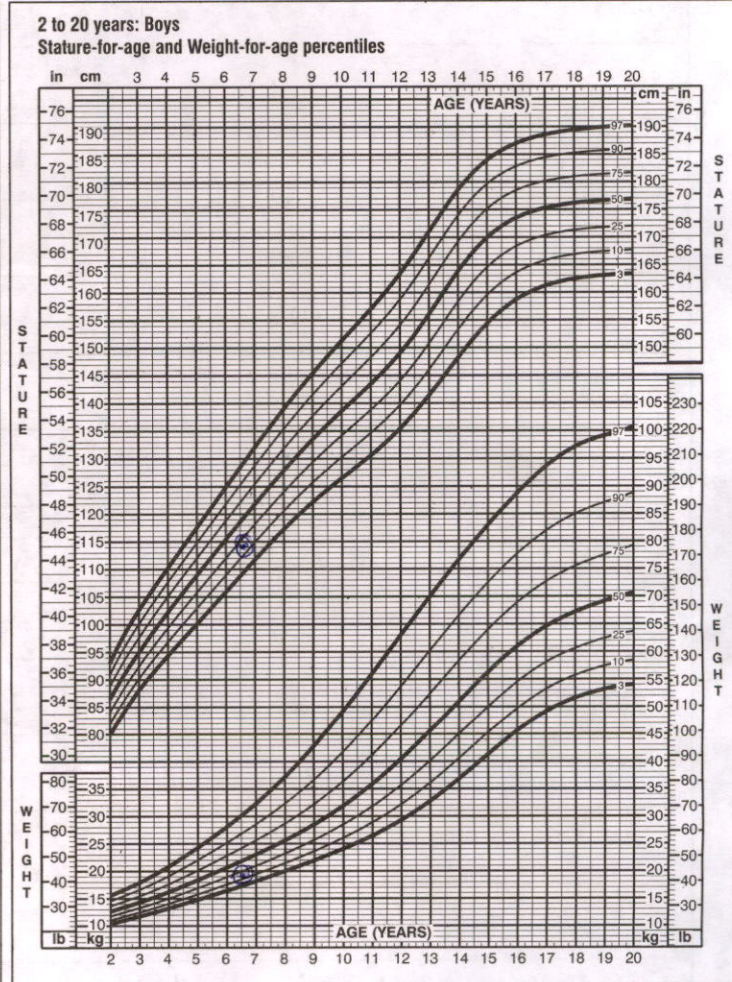
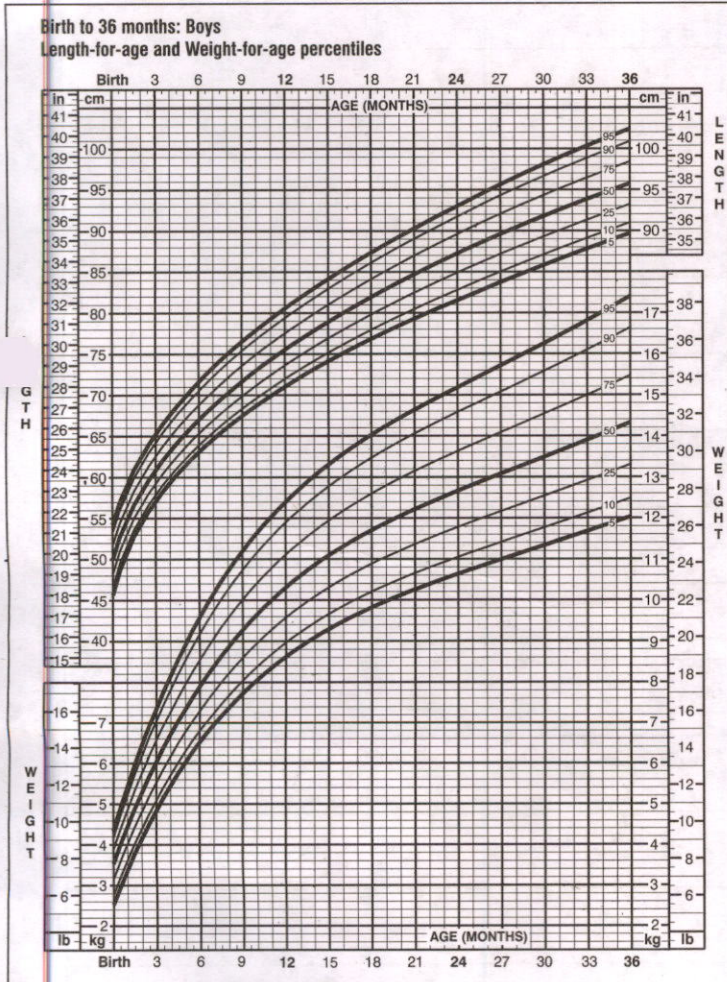
Food Allergies: NO Veg/Non-veg: Non-veg

Diagnosis: K/L10 T-Lymphoblastic Leukemia, CVS ⊖ on Induction, for chemotherapy.

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: Parent's Don't need dietitian, Don't change for NHA.

GROWTH CHART (BOYS)



Dietician's Name: Moulan

Dietician's Signature: Moulan

