RCWH.0000216347 IP5-00176693
Master RISHI
22-10-2013 12 Y 8 M 29 D (M)
Dr. Leena Priyambada (Diabetes

CLONIDINE STIMULATION TEST

Patients name: RISHI

UHID: RCWH-0000216347.

DOB: 22-10-2013

The child should have been fasting for at least 8hrs

Time	Blood pressure	PR	GRBS	Growth hormone
0 min 8:21am	94/68	87 bpm	92 mg/dl	✓

Tablet clonidine to be given orally – 8:21 am.
Dose : 150 mcg

30 min after tablet 8:51am	94/55	88 bpm.	95 mg/dl	✓
60 min after tablet 9:21am	101/60	60 bpm.	88 mg/dl.	✓
90 min after tablet 10:21am.	94/58	52 bpm	98 mg/dl	✓
120 min after tablet	90/53	58 bpm.	103 mg/dl	✓

After the test is completed then the child should eat and drink and have a repeat blood pressure done, if normal can be discharged and seen in clinic with the results.

Name of Nurse: Khushi
21/07/26.

Signature of the nurse:

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 : IP5-00176693 **Admit Date** : 21-Jul-2026 **Admit Time** : 08:28 AM **UHID** : RCWH.0000216347

Patient Details :

Patient Name	: Master RISHI	**Age**	: 12 Y 8 M 29 D
Guardian	: Mr GIRISH KUMAR	**DOB**	: 22-10-2013
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: FLAT NO.109,, . HANGING GARDENS, ROAD NO.10, Banjara Hills Hyderabad Telangana INDIA 500034	**Phone No**	: 9866530000
		E-mail	: na123@rainbowhospitals.in

Admission Details :

Bed Type : DAY CARE **Bed No** : ER 07 **Ward Name** : 1B-EMERGENCY

Room No : ER 07 **Admission Type** : First Visit

Contact Details :

Name : Mr GIRISH KUMAR **Relationship** : Father

Contact Address : FLAT NO.109,, . HANGING GARDENS, ROAD NO.10, Banjara Hills Hyderabad Telangana INDIA 500034 **Phone No** : / 9866530000

Signature

Doctor Details :

Doctor Name : Dr. Leena Priyambada (Diabetes Clinic) **Specialisation** : PEDIATRIC ENDOCRINOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : SELFPAY

RCWH.0000216347 IP5-00176693
Master RISHI
22-10-2013 12 Y 8 M 29 D (M)
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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Rishi Age : 12 yrs **Gender:** ☑ Male ☐ Female

Date : 21/7/26 Time of Arrival : 7:40 AM Triage Completion Time : 7:42 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

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing
☑ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS
☑ Stable
☐ Unstable :
☐ Not – Life - Threatening
☐ Life – Threatening

Initial Vital Signs: Temp: 98.2°F PR: 82 b/m BP: 94/69 (78) RR: 22 b/m SpO2: 100%

Chief Complaints: c/o cause for growth hormone stimulation test

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

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 : Bhavani Signature of Triage Nurse : .....

Date & Time : 21/7/26 @ 7:42 AM

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 21/07/26 Time of arrival : 7:43a

Chief Complaints: Come for growth hormone Stimulation test. RBS: —

Height : — Weight : 30 kgs 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: 0/10. 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?) —

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

Time of Initial assessment completed by ER Nurse : 7:43a

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

Time	Nursing Notes
	Dr. Somasree assessed the child.
	IV planet done.
	Sample sent
	~~applied~~ ~~dd~~ Tab. clonidine given

Samples collected by: /Chaxon Time:

Samples sent by : Time: / 8:40 a

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: 92 bpm BP: 99/62 CFT: <sec	Shift - out from ER to: /
RR: 20 bpm SPO_2 : 99%	Time of Shift - out: ER.
GCS: 15/15 Temperature : 97.2°F	Handover given to: Ram Care
Pain Score: 0/10	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV planet

Name of the Nurse : Deepanjali. Signature of the Nurse:

Date & Time : 21/07/26 @ 8:30 a

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : ____ RCWH.0000216347 IP5-00176693 Master RISHI 22-10-2013 12 Y 8 M 29 D (M) Dr. Leena Priyambada (Diabetes ___Consultant:_____ Dept :_____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
21/7	–	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
21/7/24	TFT, Lipid profile LH, FSH, Testosterone Ca, Creatinine, Vit D	Opbasis	Charan
21/7/24	GH, (0' sample) GRBS (post) (92 mg/dl)	3041	Charan
21/7/24	GH, GRBS (1st sample) - 95 mg/dl	3046	Charan
21/7/24	GH, GRBS (2nd sample) — 88 mg/dl	3054	Charan
21/7/24	GH, GRBS (3rd Sample) — 98 mg/dl	3066	Charan
21/7/24	GH, GRBS (4th Sample) - 103 mg/dl	3081	Charan

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
21/7/26	IV placement	(1)	3883	

ANY OTHER INFORMATION

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.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

RCWH.0000216347 IP5-00176693
Master RISHI
22-10-2013 12 Y 8 M 29 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26 7:40 am	c/o likely CD GP came for GH Stimulation test.	Adv
	Pt alert, conscious	- NPO
	Vitals stable	- 0min : GH, GRBS, LH, FSH, testosterone, total Ca^{2+}, 25(OH)vit D creatinine
	Chest - B/L AE +	? clonidine 150 mcg
	CVS - NAD	- 30 mins : GH, GRBS
	P/A - soft.	- 60 mins : GH, GRBS
		- 90 mins : GH, GRBS
		-120 mins : GH, GRBS
		Under cardiac monitoring
		NB
		Chorion 21/7/26 @ 10:30 AM Somashree
21/7/26 10:40 AM	S/B . Dr. Leena Priyambada.	
	. GHST done successfully.	
	. R/V - Thursday ~11-12 morning for reports.	R/V Thursday morning
	Leena	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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Master RISHI
22-10-2013 12 Y 8 M 29 D (M)
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DRUG CHART

Date of Admission: 21/7/26 Drug Allergies: ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

VERIFIED BY : Name ..... Signature .....

RCWH.0000216347 IP5-00176693
Master RISHI
22-10-2013 12 Y 8 M 29 D (M)
Dr. Leena Priyambada (Diabetes

REGULAR PRESCRIPTIONS Weight. .... Ward. ....

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				

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				

RGWH.0000216347 IP5-00176693
Master RISHI
22-10-2013 12 Y 8 M 29 D (M)
Dr. Leena Priyambada (Diabetes

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
21/7/26	7:45 am	T. CLONIDINE	150 mcg	PO	AP	Anxcb Clem.

Signature

VERIFIED BY : Name

Patient Sticker

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: ER. 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 : Somashree

Date & Time : 21/7/26

Nurse Name & Signature: [illegible]

Date & Time : 21/7/26 @ 8:30 a

RCWH.0000216347 IP5-00176693
Master RISHI
22-10-2013 12 Y 8 M 29 D (M)
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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 : .....

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.....

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Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

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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**	