BAH-00397361 IP5-00176762
Baby NAVYA SREE
03-09-2011 14 Y 10 M 19 D (F)
Dr. Prashant Bachina

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	1			
7	Nursing plan of care and handover sheets	1			
8	Consultation sheet				
9	General consent for treatment				
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaestesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)				
33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Total No. of Pages	14			

Signature and Date :

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU / 2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

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 : IP5-00176762 **Admit Date** : 22-Jul-2026 **Admit Time** : 11:58 AM **UHID** : BAH-00397361

Patient Details :

Patient Name	: Baby NAVYA SREE	**Age**	: 14 Y 10 M 19 D
Guardian	: MRS.PRONEETHA	**DOB**	: 03-09-2011
Gender	: Female	**Religion**	: Hindu
Occupation	:	**Martial Status**	: Single
Address (H)	: PLOT NO. 259,MANGAPURAM COLONY Alwal Hyderabad Telangana INDIA 500010	**Phone No**	: 7032789690/ 8125227733
		E-mail	: proneethap@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER 02 **Ward Name** : 1B-EMERGENCY

Room No : ER 02 **Admission Type** : First Visit

Contact Details :

Name : MRS.PRONEETHA **Relationship** : MOTHER

Contact Address : PLOT NO. 259,MANGAPURAM COLONY Alwal Hyderabad Telangana INDIA 500010 **Phone No** : 7032789690

Signature

Doctor Details :

Doctor Name : Dr. Prashant Bachina **Specialisation** : PEDIATRIC GASTROENTEROLOGY AND HEPATOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant : Dr. JAPA AVINASH

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 15000.00

Payor Name : SELFPAY

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ALBUMIN 20%

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~~BLOOD~~ PRODUCTS TRANSFUSION MONITORING FORM

Date: 22/07/2026 Time: 12:40pm

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: Over Planned duration of Transfusion: 6 hours

Check for Correct Unit: ☑ Correct Patient: ☑

Blood products cross checked by: Nurse 1: NR. Praveen Nurse 2: NR. Geethika

Before starting transfusion vitals: Temp: 98.°F HR 84bpm RR: 21 b/m BP: 113/79 (93) SpO_2 100 %

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO_2	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
22/7	15 Min 12:55pm	86b/m	98.0°F	117/76 (88)	99%	—	—	—	—
22/7	15 Min 1:10pm	78b/m	98.2°F	111/76 (88)	100%	—	—	—	—
22/7	30 Min 1:40pm	76b/m	98.0°F	108/75 (87)	100%	—	—	—	—
22/7	30 Min 2:10pm	78 b/m	98.1°F	118/89 (100)	100%	—	—	—	—
22/7	30 Min 2:40pm	82b/m	98.5°F	113/77 (96)	100%	—	—	—	—
22/7	1 Hr 3:40pm	79b/m	98.0°F	109/73 (89)	100%	—	—	—	—
22/7	1 Hr 4:40pm	83b/m	98.2°F	114/76 (89)	99%	—	—	—	—
22/7	5:40pm	72b/m	98.0°F	107/74 (88)	98%	—	—	—	—
22/7	6:40pm								

Comments: .....

.....

Name of the Incharge-Nurse: Samyuktha Name of the Nurse: Abhishek

Signature of the Incharge-Nurse: Signature of the Nurse: Abhi

Date & Time: 22/07/26 Date & Time: 22/7/26 @ 12:40pm

Docu. No. : RCHBH /FRM / CLINICAL / 078

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BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: ..... Time: .....

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: ..... Planned duration of Transfusion: .....

Check for Correct Unit ☐ Correct Patient ☐

Blood products cross checked by: Nurse 1: ..... Nurse 2: .....

Before starting transfusion vitals: Temp: ..... HR ..... RR ..... BP: ..... SpO ..... %

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO$_2$	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
	15 Min								
	15 Min								
	30 Min								
	30 Min								
	30 Min								
	1 Hr								
	1 Hr								

Comments: .....

.....

Name of the Incharge-Nurse: ..... Name of the Nurse: .....

Signature of the Incharge-Nurse: ..... Signature of the Nurse: .....

Date & Time: ..... Date & Time: .....

Doc. No.: RGNSH /FRM / CLINICAL / 078

CONSENT FOR BLOOD TRANSFUSION

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Name: Nalya Sree Age: 14yr Gender: Male ☐ Female ☑

UHID.No : BAH-00397361 Date: 22/07/2026

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 Immunodeficiency 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):

Signature: .....

Name: Praneeth

Date & Time 22/7/26 @ 12:33 pm

Doctor (Who is talking the consent)

Signature: Dr. Ramya Sammeta

Name: Dr. Ramya

Date & Time 22/7/26 12:33 pm

Witness

Signature: .....

Name: T. Geethika

Date & Time 22/7/26 @ 12:33 pm

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : NAVYA SREE Age : 14 Y **Gender:** ☐ Male ☑ Female

Date : 22/07/26 Time of Arrival : 10.30 am Triage Completion Time : 10.32 am

Allergies: ☑ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): ..... ☐ 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: 98.4°F PR: 94/m BP: 117/75 (85) RR: 20/m SpO: 99%

Chief Complaints: Come for ~~HHD~~ Transfusion Albumin 20%. Post liver transplant.

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.P
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 : Ramya

Signature of Triage Nurse : Ramya

Date & Time : 22/07/26 @ 10.32 am

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 22/07/26 Time of arrival : 10:34Am post liver Transfusion.

Chief Complaints: came for Albumin Transfusin 20ml RBS: .....

Height : 148cm Weight : 48-20Kg BMI : Nil Head Circumference (<2 years) Nil

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: Nil

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: Nil (Date/Time): .....

Social History: Lives With parents

Siblings in household ☐ Yes ☑ No (if yes How Many?) Nil

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

Time of Initial assessment completed by ER Nurse : 10:35Am

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

Time	Nursing Notes
10:37 Am	* Assess the pt condition * Monitor vital sign's. * Seen by Dr. Ramya. * IV placement done

Samples collected by: / Nr. Karthik Time: / 10:40am

Samples sent by : Time:

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 98bl/m BP: 117/85 CFT: <2sec RR: 24bl/m SPO_2 : 100% GCS: 15/15 Temperature : 98°F Pain Score: 0/10 Repeat RBS (if applicable):	Shift - out from ER to: / ER Time of Shift - out: / OC Handover given to: (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV placement done 22 gauge

Name of the Nurse : Keerthi Signature of the Nurse : KJ

Date & Time : 22/07/26 @ 11Am.

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ACTIVITY RECORD FOR BILLING

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Name :_____ _____

UHID 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
22/7		ER	ER(DC)	Geetha.

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

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
22/7/24	Cardiac Monitor	11:50AM		6233	Charan
	Infusion pump	12:40pm			

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
12/7/26	IV placement Albumin transfusion	1	6231	Charan

ANY OTHER INFORMATION

....

....

....

....

....

....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 12:20pm	post tx	
	C/S/B Dr - Ramya sammeta ER Resident	
	k/c/o post liver transplant with AGN (MPGN)	
	i/v/o hypoalbuminemia	
	now came for albumin transfusion	
	O/E pt c/c	
	Temp - 98.4°F	
	HR - 94bpm	
	Bp - 117/75 (85)	Rx
	RR - 20/min	→ Inj 20% Albumin
	SpO_2 - 99% ERA	transfusion over 5hr
	CVS - S1S2+	- Inj Avil
	RS - BAE+	- Inj hydrocortisone
	P/A soft	- Inj lasix (midway) &
	non tender	Endway
		- vitals monitoring
22/7/26 Inv	- Serum Albumin 1.6g/dl	
	Calcium - 7.7	
	Na/K/Cl - 138/3.6/112	Rx
		[signature]

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☑ 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: 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	Tab - OMNACORTR	20mg	PO	OD	2/7/26	☐ C ☑ DC
2	Tab - PANTOPRAZOLE	40mg	PO	OD	21/7/26	☐ C ☐ DC
3	Tab - Shelcal	250mg	PO	BD	21/7/26	☐ C ☐ DC
4	~~Tab - AIDACTONE~~	~~25mg 1tab~~	~~PO~~	~~R~~		☐ C ☐ DC
5	TAB - TACROLIMUS	0.5mg	PO	BD	21/7/26	☐ C ☐ DC
6	TAB - MOFECON-S	360mg	PO	BD	21/7/26	☐ C ☐ DC
7	SYP BEVON	5ml	PO	BD	21/7/26	☐ C ☐ DC
8	TAB ENAM	2.5mg	PO	OD	21/7/26	☐ C ☐ DC
9	TAB. UPRISE D3	1tab.	PO	Wkly once	18/7/26	☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Ramya Sammeta

Date & Time : 22/7/26 12:30 pm

Nurse Name & Signature: T. Santhi, T. Teja

Date & Time : 22/07/26 @ 1230 pm

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DRUG CHART

Date of Admission: 22/7/26 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 : ~~INJ AVIL~~				Date / Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG : ~~INJ~~				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 .....

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REGULAR PRESCRIPTIONS

Weight. 46-87 Ward. ....

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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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.	

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
22/7/26	Hold	Inj AVIL	1ml	IV	[illegible]	Anil / [illegible]
22/7/26	Hold	Inj. HYDROCORTISONE	100mg	IV	[illegible]	Anil / [illegible]
22/7/26	12:40pm	Inj. ALBUMIN 20%	100ml over 6hr	IV	[illegible]	[illegible] / [illegible]
22/7/26	3:52pm	Inj LASIX	23 mg (midway) &	IV	[illegible]	[illegible] / [illegible]
22/7/26	5:05 pm	Inj LASIX	23mg (End way)	IV	[illegible]	Anil / [illegible]
22/7/26						

BAH-00397361 IP5-0017[illegible]
Baby NAVYA SREE
03-09-2011 14 Y 10 M 19 D (F)
Dr. Prashant Bachina

I.V. FLUIDS CHART

Weight. 46-52k Ward. .....

		position 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 .....