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 : IP5-00174647 **Admit Date** : 02-Jun-2026 **Admit Time** : 01:07 PM **UHID** : RCWH.0000101831

Patient Details :

Patient Name	: Baby MANYA SRIVASTAVA	**Age**	: 17 Y 11 M 19 D
Guardian	: Mr SANJAY KUMAR SRIVASTAVA	**DOB**	: 14-06-2008
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: FLAT NO. 203, TIRUMALA GARDEN, NAVEEN NAGAR, ROAD NO 01 Banjara Hills Hyderabad Telangana INDIA 500034	**Phone No**	: 9866648023/ 8106856262
		E-mail	: SANJAY.SRIVASTAVA2005@GMAIL.CO

Admission Details :

Bed Type : DELUXE ROOM **Bed No** : DLX 309 **Ward Name** : 3F-ZONE A

Room No : DLX 309 **Admission Type** : First Visit

Contact Details :

Name : Mr SANJAY KUMAR SRIVASTAVA **Relationship** : Father

Contact Address : FLAT NO. 203, TIRUMALA GARDEN, NAVEEN NAGAR, ROAD NO 01 Banjara Hills Hyderabad Telangana INDIA 500034 **Phone No** : 9866648023

Signature

Doctor Details :

Doctor Name : Dr. SIRISHA RANI **Specialisation** : HEMATO ONCOLOGY

Referral Doctor : SELF **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : VOLO HEALTH INSURANCE TPA PVT LTD

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ACTIVITY RECORD FOR BILLING

Name :_____

RCWH.0000101831 IP5-00174647
Baby MANYA SRIVASTAVA
14-06-2008 17 Y 11 M 19 D (F)
Dr. SIRISHA RANI

UHID No. : _____ nsultant: _____ Dept : _____

Date of Admission: ___ ate of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
2/6	1:50pm.	ER	309	

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
2/6	Infusion pump	2:40pm		9639605	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
02/08	IV Placement	(1)	33231	Samra

ANY OTHER INFORMATION

DO not charge for NHA Nikita

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

RCWH.0000101831 IP5-00174647
Baby MANYA SRIVASTAVA
14-06-2008 17 Y 11 M 19 D (F)
Dr. SIRISHA RANI

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Sirisha Rani Date : 2/6/24

Type of Admission: ☑ OPD ☐ ER ☐ Referral (if referral, Doctor's Name: .....

Start Time of Assessment: ..... Weight: 50kg

Allergic History: .....

Chief Complaints: .....
Treated for Medulloblastoma
& Rt facial Nerve palsy - LMN type
left hemiparesis - Chronic progressive
ataxia
NOW admitted for Mesenchymal
stem cell Infusion.

Pediatric Assessment Triangle

A Appearance - TICLS .....

B Breathing
- ☐ ↑ WOB
- ☐ ↓ WOB
- ☑ Normal
- ☐ Gasping / Apnea

C Circulation
- ☑ Normal
- ☐ Abnormal
  - Pallor ☐
  - Cyanosis ☐
  - Mottling ☐
  - Bleeding ☐

Initial Physiological Status: ☑ Stable ☐ Unstable
- Life Threatening ☐
- Non Life Threatening ☐

Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Significant Past History: .....

Medication History: .....

Relevant Investigations: .....

Primary Assessment

Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Breathing
Rate: 18/min SpO_2 on FiO_2 96% on RA
Rhythm: Regular
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: BILAT(+)
Palpation Findings (If necessary).....

Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Circulation

HR: 74/min

CFT: Central .... Peripheral ....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

BP: 105/62(79) mmHg

Pulse Volume: Central .... Peripheral ....

If in Shock: Compensated .... Hypotensive ....

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: ....

ECG: ....

Any Signs of Heart Failure: ☐ Yes ☐ No

Disability

GCS: 15/15 AVPU: ....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

Pupils: Responsive ☑ Non-Responsive ☐

Size: Right .... Left ....

Active Seizures: ☐ Yes ☑ No Sugars: ....

Signs of Neurological compromise ....

Exposure

Temp.: 98.4°F

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

Any Rash: ☐ Yes ☑ No,

If yes describe the rash ....

Active bleed ....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: ....

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings: ....

Labs Planned: ....

Plain, EDTA Collected in ER

Treatment Planned: ....

- Tab Pan-D 40 mg 1 tab OD
- Premedication
- Mesenchymal stem cell transfusion
- IV fluids.

NB [illegible] 02/06 @ 1:50pm

Need for Oxygen: ☐ Yes ☐ No if yes Low Flow ☐ High Flow ☐ PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): ....

Assessment done by

Name of the Doctor: Dr. Ranaye

Signature: [signature]

Date & Time: 2/6/26 ; 1pm

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: ....

Signature: ....

Date & Time: ....

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

RCWH.0000101831 IP5-00174647
Baby MANYA SRIVASTAVA
14-06-2008 17 Y 11 M 19 D (F)
Dr. SIRISHA RANI

UHID ID: _____

Department: _____

Consultant: _____

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

History of present illness :

Patient Sticker

Pediatric Multiorgan History & 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 :

Immunization History :

(P.T.O.)

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms)_____(Centile _____) Height (cms): _____(Centile)_____)

Weight (kgs))_____(Centile _____)

On Examination :

Temperature : _____ Pulse Rate :_____ B.P. _____ SPO2 _____

Resp.rate and type of breathing : _____

_____

Rash_____

Lymphadenopathy_____

Oedema :_____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any addes sounds : _____

Relevant data from outside (Chest X-Ray, ABG,etc.,) _____

_____

_____

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds :_____

Any murmur :_____

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : _____

_____

_____

Per Abdomen :

Inspection_____

Palpation :_____

Ausculation :_____

Spine :_____External Genitelia : _____

Relevant data from outside (CT, USG etc.,) _____

_____

_____

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____

_____

_____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR **Superficials:**

Plantars _____

Sensory System :

_____

_____

_____

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

_____

_____

_____

_____

(P.T.O.)

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

_____

_____

Desired goals of the treatment : _____

_____

_____

Planned Labs:

_____

_____

_____

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_____

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_____

_____

_____

_____

Planned Management

_____

_____

_____

_____

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_____

Signature of the Doctor: .....

Name of the Doctor: .....

Date & Time: .....

Signature of the Consultant: .....

Name of the Consultant: .....

Date & Time: .....

RCWH.0000101831 IP5-00174647
Baby MANYA SRIVASTAVA
14-06-2008 17 Y 11 M 19 D (F)
Dr. SIRISHA RANI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6 6 pm	C/S/B Dr Anuraag C/S/B Resident	
	A: K/c/o medulloblastoma now c̄ (R) LMN facial palsy. & (L) hemiparesis for MSCT today O/E: alert. stable vitals	Adv 1) Mesenchymal stem cell transfus[ion] today 2) Monitor for adverse reaction 3) (D) after completion of transfusion
		Dr [signature] 43?? @ 4:30pm

Patient Sticker

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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
[redacted]	Tab Amantadine	1 tab	PO	BD	1/6	☑C ☐DC
2	Tab Mito Q 7	1 tab	PO	OD	1/6	☑C ☐DC
3	Tab Ruvitelin vit D_3	1 tab	PO	OD	1/6	☑C ☐DC
4	Tab MiKOB SL	1 tab	PO	OD	1/6	☑C ☐DC
5	Syp. Citibest-P	5 ml	PO	OD	1/6	☑C ☐DC
6						☐C ☐DC
[redacted]						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. RAMYA

Date & Time : 2/6/26 ; 1pm

Nurse Name & Signature: Jaanya

Date & Time : 02/06/26 @ 1:50pm

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14-06-2008 17 Y 11 M 19 D (F)
Dr. SIRISHA RANI

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Sheet No: .....

REGULAR PRESCRIPTIONS

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

DRUG : CITIBEST -P Syrup

Dose	Route	Frequency	Start Dt.
5ml	PO	Q24H	21/6/26

Name & Signature of the Doctor Starting the Drugs: Dr Ramya

Additional Instructions: 9pm

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : Tab PANTOPRAZOLE

Dose	Route	Frequency	Start Dt.
1Tab	PO	Q24H	21/6/26

Name & Signature of the Doctor Starting the Drugs: Dr. Ramya

Additional Instructions: 1Tab = 40mg)

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

Signature .....

VERIFIED BY : Name .....

Patient Sticker

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾

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

Docu. No. : RCHBH /FRM / CLINICAL / 108

RCWH.0000101831 IP5-00174647
Baby MANYA SRIVASTAVA
14-08-2008 17 Y 11 M 19 D (F)
Dr. SIRISHA RANI

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DRUG CHART

Date of Admission: 02/06 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 .....

Baby MANYA SRIVASTAVA
14-06-2008 17 Y 11 M 19 D (F)
Dr. SIRISHA RANI

REGULAR PRESCRIPTIONS

Weight. 50kg Ward. .....

DRUG : Tab AMANTADINE

Dose	Route	Frequency	Start Date
	PO	Q12H	2/6/24

Name & Signature of the Doctor Starting the Drugs: Dr Ramya

Additional Instructions: 1tab (10am) (Morning) 1tab → ½ tab (Night) 10PM

Daily Doctor's Endorsement by a Sign

Date / Time: 10AM

DRUG : ~~Cap NEURO~~ MITOQ7 tablet

Dose	Route	Frequency	Start Date
1tab	PO	Q24H	2/6/24

Name & Signature of the Doctor Starting the Drugs: Dr Ramya

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 9PM

DRUG : REVITALISE Vit D3 Capsule

Dose	Route	Frequency	Start Date
1Cap	PO	Q24H	2/6/24

Name & Signature of the Doctor Starting the Drugs: Dr Ramya

Additional Instructions: Once a month x6m

Daily Doctor's Endorsement by a Sign

Date / Time:

DRUG : MICOB SL tablet

Dose	Route	Frequency	Start Date
1tab	PO	Q24H	2/6/24

Name & Signature of the Doctor Starting the Drugs: Dr Ramya

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 4PM

Patient Sticker

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

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.	

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
2/6/26	3.40pm	Inj AVIL	1ml	IV		Susmita Mondal
2/6/26	3.40pm	Inj HYDROCORTISONE	100mg	IV		Susmita Mondal
2/6/26	3.45pm	Inj MESENCHYMAL STEM CELLS	10ml over 10-15min	IV		Susmita Mondal

Signature .....

VERIFIED BY : Name

Baby MANYA SRIVASTAVA
14-06-2008 17 Y 11 M 19 D (F)
Dr. SIRISHA RANI

I.V. FLUIDS CHART

Weight. 50kg Ward. .....

		mposition 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
2/6/26	2:40 pm	DNS	IV	80					

Signature .....

VERIFIED BY : Name .....

RCWH.0000101831 IP5-00174647
Baby MANYA SRIVASTAVA
14-06-2008 17 Y 11 M 19 D (F)
Dr. SIRISHA RANI

2/6/26

. No. : RCHBH/ FRM / CLINICAL / 127

TEENAGE (12 + years)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Parameter	Entry
Date : .... Time:	3pm
Doctor / Nurse / Family Concern?	
Temperature (°F) (104, 103, 102, 101, 100, 99, 98, 97, 96, 95, 94)	97.8°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50) Note: BP does not score in early warning scoring	112/72
Heart Rate (Number)	100
Resp. Rate (bpm) (Over 1 Minute) (70, 60, 50, 40, 30, 20, 10)	
Resp Rate (Number)	18/m
Resp Distress — Mod/ Severe	
Resp Distress — None / Mild	
Receiving O_2 (l/min)	
O_2 Saturations (%)	100%
Conscious Level — Normal	
Conscious Level — Altered	
GCS *	(15/15)
TOTAL SCORE Number of shaded boxes	0
Pain Score	2
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.

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Dr. SIRISHA RANI

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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 2/6/26 Time: 2pm

Weight: 50 kgs Centile: > 10th

Height: 156 cms Centile: > 10th

Inference: underweight child

RDA: Calories: 2000 kcal/d Protein: 36 g/d

Diet Recommendations: Normal high protein diet

Re-Assesment: Avoid spicy, chilled, outside foods

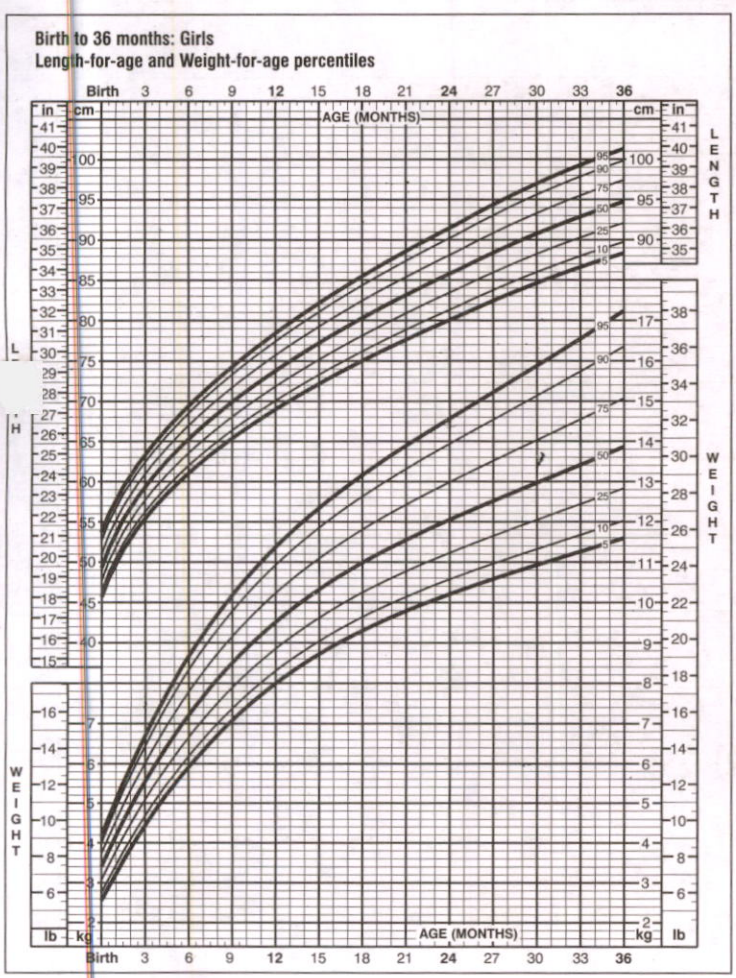
Food Allergies: No Veg/Non-veg Non-veg

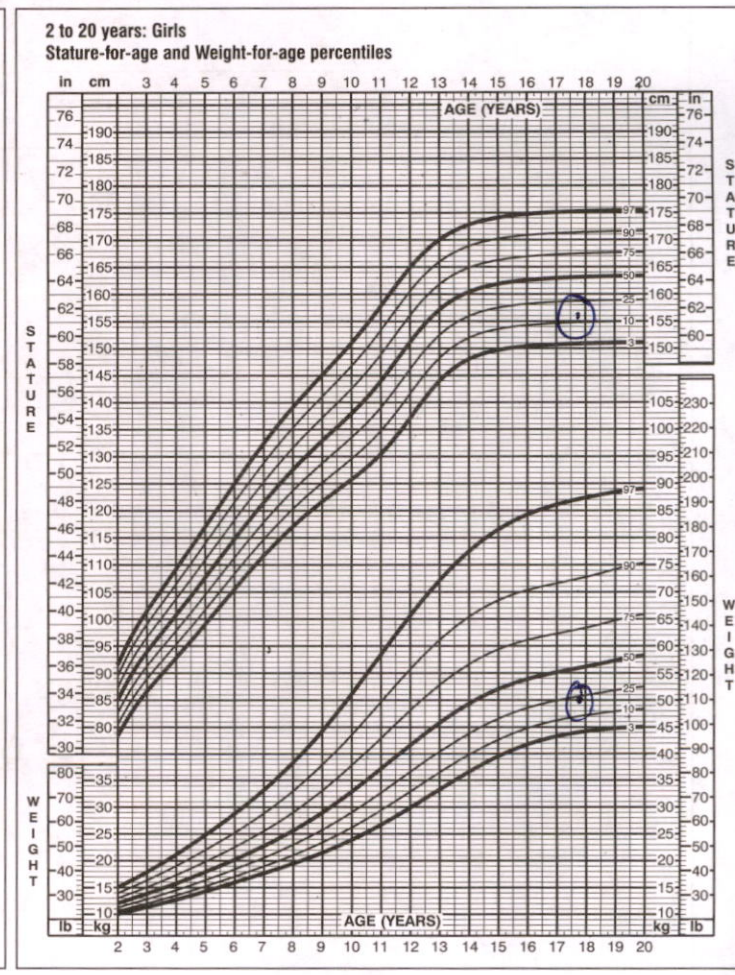
Diagnosis: K/C/O Medulloblastoma now for stem cell transfusion

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Parents dont want dietitian. Do not charge for NHA.

GROWTH CHART (GIRLS)





Dietician's Name Nikitha Dietician's Signature Nikitha

Docu. No. : RCHBH / FRM / CLINICAL / 161

(P.T.O.)

Daily Notes: