

**ACTIVITY RECORD FOR BILLING**


Name : \_\_\_\_\_

UHID No. : \_\_\_\_\_ IF \_\_\_\_\_ Patient: \_\_\_\_\_ Dept : \_\_\_\_\_

Date of Admission: \_\_\_\_\_ if Discharge : \_\_\_\_\_ Time: \_\_\_\_\_

Room / Bed No : \_\_\_\_\_ suggested Billable bed type : \_\_\_\_\_

BAH-00646732 IP5-00174511  
Baby ANANTHULA SHREYANVI  
20-03-2024 2 Y 2 M 9 D (F)  
Dr. NALLA ANURAAG REDDY



**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
29/5/16	8:00pm	ER	141	[Signature]

**Cross Consultation Visit**

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





# PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
30/5.	Lumbar puncture (consisting of sedation) ②.	②	9634754	Savmya.
30/6/26	Chemotherapy	①	9635285	[Signature]

## ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : 2/6/26

Time : 11Am

Prepared By : [Signature]

Staff Nurse [Signature]	Shift / Ward morning oncology	Billing Assistant	Billing Supervisor
----------------------------	-------------------------------------	-------------------	--------------------

**ADMISSION SHEET**

**Registration Details :**



Admission No : IP5-00174511      Admit Date : 29-May-2026      Admit Time : 07:22 PM      UHID : BAH-00646732

**Patient Details :**

Patient Name : Baby ANANTHULA SHREYANVI      Age : 2 Y 2 M 9 D  
Guardian : Mr ANANTHULA NARESH      DOB : 20-03-2024  
Gender : Female      Religion :  
Occupation :      Martial Status : Single  
Address (H) : H NO 20-167/3/1, RAGHAVENDRA NILAYAM, R B NAGAR, STREET NO 8 Hyderabad Airport 1 Hyderabad Telangana INDIA 501218      Phone No : 9573161453/ 9390470685  
E-mail : ANANTHULA.NARESH01@GMAIL.COM

**Admission Details :**

Admission Type : GENERAL WARD      Bed No : GW 141      Ward Name : 1F-GENERAL WARD II  
Room No : GW 141      Admission Type : First Visit

**Contact Details :**

Name : Mr ANANTHULA NARESH      Relationship : Father  
Contact Address : H NO 20-167/3/1, RAGHAVENDRA NILAYAM, R B NAGAR, STREET NO 8 Hyderabad Airport 1 Hyderabad Telangana INDIA 501218      Phone No : 9573161453

  
Signature

**Doctor Details :**

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

**Payment Details :**

Payment Mode : Cash      Deposit Amount : 5000.22  
Payor Name : ICICI LOMBARD GENERAL INSURANCE CO LTD



# Rainbow<sup>®</sup> Children's Hospital

It takes a lot to treat the little.

## PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00646732 IP5-00174511  
Baby ANANTHULA SHREYANVI  
20-03-2024 2 Y 2 M 9 D (F)  
Dr. NALLA ANURAAG REDDY



Patient Name: Baby Ananthula shreyanvi

UHID ID: Bah-00646732

Department: \_\_\_\_\_

Consultant: \_\_\_\_\_



### Pediatric Multiorgan History & Physical Examination

Name : Baby Ananthula Shreyani Age/Sex \_\_\_\_\_

Information given by: Mother Relationship \_\_\_\_\_

#### Chief Presenting Complaints & Duration (Chronologically)

child k/d/o B-cell ALL/  
High count  
CALCA +ve

#### History of present illness :

TEL - AML +ve  
CNS -ve / CPR - on

protocol M

no c/o fever/cold/cough

no vomiting/ loose stool

~~now~~ protocol M.

now for LP and  
chemotherapy

CBP: 11.1  $\frac{2,120}{46.2/39.6}$  2.54



### Pediatric Multiorgan History & Physical Examination

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

---

---

---

---

---

---

---

---

---

---

**Birth & Neonatal History:**

---

---

normal perinatal  
examination

---

---

**Birth & Socio Economic History:**

About Father : \_\_\_\_\_

About Mother : \_\_\_\_\_

Any additional Information : middle

---

---

**Developmental History :**

---

Attained appropriate for age

---

---

**Immunization History :**

---

Immunised till date

---

---



### Pediatric Multiorgan History & Physical Examination

**Anthropometry :**

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_) Height (cms): \_\_\_\_\_ (Centile) \_\_\_\_\_)

Weight (kgs) ) 12.2kg (Centile \_\_\_\_\_)

**On Examination :**

Temperature : 98.2°F Pulse Rate : 120/min B.P. 95/63 SPO2 98-1.0RA

Resp.rate and type of breathing : 26/min  
regular

Rash \_\_\_\_\_

Lymphadenopathy \_\_\_\_\_

Oedema : \_\_\_\_\_

Allergies (if any): \_\_\_\_\_

**Respiratory System :**

Inspection (any s/o distress) : (P)

Air entry & breath sounds : BAFA, clear

Any addes sounds : \_\_\_\_\_

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

**Cardiovascular System :**

Inspection of procordium : (P)

Heart Sounds : S1S2 heard

Any murmur : \_\_\_\_\_

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

**Per Abdomen :**

Inspection (P)

Palpation : Soft, non tender

Ausculation : BS (P)

Spine : (N) External Genitelia : (N)

Relevant data from outside (CT, USG etc.,) \_\_\_\_\_

BAH-00646732 IP5-00174511  
Baby ANANTHULA SHREYANVI  
20-03-2024 2 Y 2 M 9 D (F)  
Dr. NALLA ANURAAG REDDY

**Pediatric Multiorgan ~~inv.~~ & Physical Examination**

**Central Nervous System :**

Level of Consciousness : AVPU/GCS score : Alert/Active

Cranial Nerves : Intact

**Motor System:**

Nutriton : good

Tone: Ⓢ Power SL

Co-ordinator : \_\_\_\_\_

Posture : \_\_\_\_\_

Involuntary Movements : nil.

**Reflexes :**

DTR Ⓢ Superficials: \_\_\_\_\_  
Plantars \_\_\_\_\_

**Sensory System :**

Bladder / Bowel : regular

**Clinical Summary & Diagnostic:**

Kfdo B cell ALL / High count / CAHA +ve  
TEL-AML+, CNS -ve / GFR on protocol M  
Now for LP & chemotherapy

BAH-00646732 IP5-00174511  
Baby ANANTHULA SHREYANVI (F)  
20-03-2024 2 Y 2 M 9 D  
Dr. NALLA ANURAAG REDDY



### Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: To prevent complications

Desired goals of the treatment: For hemodynamic stability

#### Planned Labs:

CBP  
SAPT  
Creat  
NB. Priyanka.  
29/5/26 @ 10 PM

#### Planned Management

- LP  
- chemotherapy  
- NPO from 7 PM 7 AM  
NB  
penicillin  
29/5/26

Signature of the Doctor: Jy

Name of the Doctor: Sayana

Date & Time: 29/05/26 @ 6:20 PM

Signature of the Consultant: [Signature]

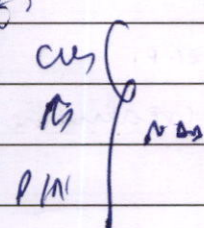
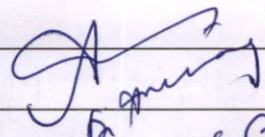
Name of the Consultant: Anurag

Date & Time: 29/5/26 9:30 AM

BAH-00646732 IP5-00174511  
 Baby ANANTHULA SHREYANVI (F)  
 20-03-2024 2 Y 2 M 9 D  
 Dr. NALLA ANURAG REDDY

①

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/5/24 9 AM	S/O Dr. Laxmi / Dr. Sandhya / Dr. Anurag	
	M: Pre-B AU	
	Dr. Protocol M - 4 <sup>th</sup> dose	
	O/E:	
		
	state vitals	
		<p><u>Adv</u></p>
		<ul style="list-style-type: none"> <li>to proceed to IT Today</li> </ul>
		<ul style="list-style-type: none"> <li>Chemo after IT.</li> </ul>
		<ul style="list-style-type: none"> <li>CVE T/m.</li> </ul>
	 Dr. Anurag 3:10 AM	Noted by Soumya 021211 @ 30/5/24 @ 11:30 am.



2

## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/5/26 1:20pm	<p><u>Procedure notes</u></p> <p>Under sterile aseptic precautions, lumbar puncture done. clear CSF seen, intra thecal medications administered. procedure uneventful.</p> <p>vital - stable</p>	<p>Plan</p> <p>1. send SAPT creatinine</p> <p>devar</p> <p><i>noted by Nalla Anuraag Reddy 03/05/26 at 1:20pm</i></p>
31/5/26 9am	<p>B-ALL / Protocol-M 4th dose</p> <p>No fever          No vomiting          No excessive cry at night          vitals - stable</p>	<p>Plan</p> <ol style="list-style-type: none"> <li>Continue chemotherapy</li> <li>continue supportive care</li> <li>WF today</li> </ol> <p><i>A/B done 01/5/26 31/5/26 @ 12pm</i></p> <p><i>devar</i></p> <p><i>31/5/26 @ 10am</i></p>

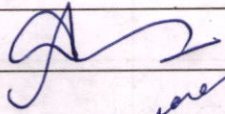
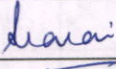
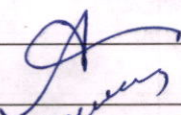
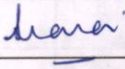
BAH-00646732 IP5-00174511  
 Baby ANANTHULA SHREYANVI  
 20-03-2024 2 Y 2 M 10 D (F)  
 Dr. NALLA ANURAAG REDDY



3



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/6/26 9am	B-ALL   Protocol-m	
	No fever no vomiting	Plan 1. ly folic acid today
	vitals - stable	2. CBP MTx levels } Tlm 3. ct supportive care.
	 Dr. Anuraag Reddy 93555 @ 11:00 AM	 Dr. Anuraag Reddy 93555 @ 12:00 PM
2/6/26 9am	B-ALL   Protocol-m.	
	No fever no vomiting	Plan 1. Trace CBP
	vitals stable	2. d/c today Flu 6/6hr & CBP.
	 Dr. Anuraag Reddy 93555 @ 9:30 AM	



BAH-00646732 IP5-00174511  
 Baby ANANTHULA SHREYANVI  
 20-03-2024 2 Y 2 M 9 D (F)  
 Dr. NALLA ANURAG REDDY



### RESULT SHEET

Date	29/5	2/5/26			
Time	10AM	7:33AM			
Hb	11.1	11.7			
PCV	32.7	36.9			
RBC	9.73	4.01			
WBC	2.12	1.68			
N/L	46/39	50.0/35.7			
Platelets	254	334			
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine	0.3				
ALP					
SGPT	14				
SGOT					
T.Bil/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	31/5/26					
Time						
CUE - Alb						
CUE - Sugar	.					
CUE - Ketones	Negative					
CUE - PUS Cells	2-3					
CUE - RBC Cells	0					
CUE Epithelial cells	- 2-3					
Urobilinogen	- 0.3					
PH	- 7.5					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology :    USG : .....

                  X-Ray : .....

                  ECHO : .....

                  CT : .....

                  MRI : .....

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

BAH-00646732 IP5-00174511  
 Baby ANANTHULA SHREYANVI  
 20-03-2024 2 Y 2 M 10 D (F)  
 Dr. NALLA ANURAAG REDDY



Sheet No: ① REGULAR PRESCRIPTIONS Weight ..... Ward .....

<b>DRUG :</b> <i>ly DEXAMETHASONE</i>				Date Time	<i>30/5/15</i>																	
Dose	Route	Frequency	Start Dt.																			
<i>1.5mg</i>	<i>IV</i>	<i>Q 24h</i>	<i>30/5</i>																			
Name & Signature of the Doctor Starting the Drugs: <i>harai</i>				<i>11:30 AM 30/5/15</i> <i>2pm 30/5/15</i> <i>11:30 AM 30/5/15</i>																		
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign				<i>d d</i> <i>harai</i> <i>10/16</i>																		

<b>DRUG :</b> <i>ly FOLIC ACID</i>				Date Time	<i>11/6/16</i>																	
Dose	Route	Frequency	Start Dt.																			
<i>10mg</i>	<i>IV</i>	<i>Q 8h</i>	<i>1/6</i>	<i>4am</i>	<i>X</i>	<i>12/6</i>	<i>12/6</i>	<i>12/6</i>	<i>12/6</i>	<i>12/6</i>	<i>12/6</i>	<i>12/6</i>	<i>12/6</i>	<i>12/6</i>	<i>12/6</i>	<i>12/6</i>	<i>12/6</i>	<i>12/6</i>	<i>12/6</i>	<i>12/6</i>	<i>12/6</i>	<i>12/6</i>
Name & Signature of the Doctor Starting the Drugs: <i>harai</i>				<i>12pm 12/6/16</i> <i>12pm 12/6/16</i> <i>12pm 12/6/16</i> <i>8pm 12/6/16</i> <i>12pm 12/6/16</i> <i>12pm 12/6/16</i>																		
Additional Instructions: <i>12 pm</i>																						
Daily Doctor's Endorsement by a Sign																						

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

<b>DRUG :</b>				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

BAH-00646732 IP5-00174511  
 Baby ANANTHULA SHREYANVI  
 20-03-2024 2 Y 2 M 10 D (F)  
 Dr. NALLA ANURAAG REDDY



Sheet No: .....

**REGULAR PRESCRIPTIONS**

Weight .....

Ward .....

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

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



# DRUG CHART

Date of Admission: 29/05/26 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)

<b>DRUG :</b> Syrup PARACETAMOL				Date Time															
Dose	Route	Frequency	Start Date																
3ml	PO	6th hrs	29/5																
Doctor's Signature		Valid Period	Pharm.																
Sayanvi		2 days																	
Additional Instructions:																			
(5ml/240mg) (If T=100F)																			

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

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

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



REGULAR PRESCRIPTIONS

Weight 12.2kg Ward .....

0-3

3mg  
 hari

**DRUG:** Inj ONDENSETRON

Dose	Route	Frequency	Start Date	Date/Time
4mg	IV	12th hrs	29/5	29/5 30/5 31/5 1/6 2/6

Name & Signature of the Doctor Starting the Drugs:  
 Jayabni

Additional Instructions:  
 12:30  
 30/5  
 31/5  
 1/6  
 2/6

Daily Doctor's Endorsement by a Sign: d d d

**DRUG:** Syrup DOMSTAL

Dose	Route	Frequency	Start Date	Date/Time
2ml	PO	8th hrs	29/5	29/5 30/5 31/5 1/6 2/6

Name & Signature of the Doctor Starting the Drugs:  
 Jayabni

Additional Instructions:  
 (1ml/1mg)

Daily Doctor's Endorsement by a Sign: d d

**DRUG:** Tab-VORICONAZOLE

Dose	Route	Frequency	Start Date	Date/Time
1/2 tab	PO	OD	29/5	29/5 30/5

Name & Signature of the Doctor Starting the Drugs:  
 Jayabni

Additional Instructions:  
 1 tab = 200mg

Daily Doctor's Endorsement by a Sign: 30/5/20

**DRUG:** Inj VORICONAZOLE

Dose	Route	Frequency	Start Date	Date/Time
1.5mg	IV	Q24h	30/5	

Name & Signature of the Doctor Starting the Drugs:  
 hari

Additional Instructions:

Daily Doctor's Endorsement by a Sign:



Date	Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :		Dose		Dose		Dose		Dose	
Route		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Start Date		Dose		Dose		Dose		Dose	
Name & Signature of the Doctor		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		Dose	
Route		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Start Date		Dose		Dose		Dose		Dose		Dose	
Name & Signature of the Doctor		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:		Dose		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
30/5/26	1:20pm	1ij MIPAZOLAM	0.5mg	IV	d	Nasheena Bhuvana
30/5/26	1:20pm	1ij ETAMINE	10mg	IV	d	Nasheena Bhuvana

Signature: \_\_\_\_\_  
Name: \_\_\_\_\_  
VERIFY





## 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

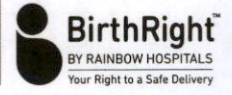
- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION:</b> 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>B</b>	<b>BACK GROUND:</b> 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)
<b>A</b>	<b>ASSESSMENT:</b> 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.
<b>R</b>	<b>RECOMMENDATION:</b> 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)



**PRESCHOOL (1-5 years)**  
**Children's Observation & Early Warning Scoring Chart**



**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date : 16/03 Time: 9am 1pm 4pm 7pm 10pm 3am 6am

Doctor / Nurse / Family Concern? \_\_\_\_\_

Temperature (F)	104							
	103							
	102							
	101							
	100							
	99							
	98							
	97							
	96							
	94							

*Handwritten temperature values and trends:*  
 98.4°F, 97.2°F, 98.5°F, 98.6°F, 98.6°F, 98.6°F, 98.6°F  
 (Note: 98.6°F is written multiple times with arrows indicating a trend)

Heart Rate (bpm) and Blood Pressure (mmHg) *	190							
	180							
	170							
	160							
	150							
	140							
	130							
	120							
	110							
	100							

*Handwritten BP and HR data:*  
 BP: 98/60, 98/56, 99/58, 100/60, 98/59, 100/60, 98/59  
 HR: 105b/m, 108b/m, 117b/m, 108b/m, 112b/m, 106b/m, 112b/m

Resp. Rate (bpm) (Over 1 Minute) *	70							
	60							
	50							
	40							
	30							
	20							
	10							
	0							
	0							
	0							

*Handwritten Resp Rate:* 26b/m, 28b/m, 26b/m, 25b/m, 28b/m, 26b/m, 28b/m

Resp Distress	Mod/ Severe None / Mild							
Receiving O <sub>2</sub> (l/min)	O <sub>2</sub> Saturations (%)	100%	100%	100%	99%	100%	100%	100%
Conscious Level	Normal / Altered	C	C	C	C	C	C	C
GCS *		15/15	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE	Number of shaded boxes	0	0	0	0	0	0	0
Pain Score		0	0	0	0	0	0	0
Observer's Initials		D	D	D	D	D	D	D

**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.

## 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.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION :</b> 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>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> 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)

3

**PRESCHOOL (1-5 years)**  
**Children's Observation & Early Warning Scoring Chart**

Doc. No. : RCH/ FRM / CLINICAL / 125

**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date : 31/5/20	Time: 9am	1pm	4pm	7pm	10pm	3am	6am	
Doctor / Nurse / Family Concern?								
Temperature (F)	104							
	103							
	102							
	101							
	100			98.6 f	98.6 f	98.6 f	98.6 f	
	99	98.4 f						
	98		97.6 f					
	97							
	96							
	94							
Heart Rate (bpm) and Blood Pressure (mmHg) *	190							
	180							
	170							
	160							
	150							
	140							
	130							
	120							
	110							
	100	100 (64)	98 (66)	93 (56)	98 (55)	103 (68)	100 (73)	98 (68)
90								
80								
70								
60								
50								
Heart Rate (Number)	108 bpm	106 bpm	110 bpm	107 bpm	112 bpm	112 bpm	102 bpm	
Resp. Rate (bpm) (Over 1 Minute) *	70							
	60							
	50							
	40							
	30							
	20							
	10							
	Resp Rate (Number)	26 bpm	28 bpm	27 bpm	25 bpm	28 bpm	26 bpm	26 bpm
	Resp Distress	0	0	0	0	0	0	0
	Receiving O <sub>2</sub> (l/min)	100%	100%	99%	100%	100%	100%	100%
O <sub>2</sub> Saturations (%)	100%	100%	99%	100%	100%	100%	100%	
Conscious Level	e	e	c	c	e	c	c	
GCS *	15/15	15/15	15/15	15/15	15/15	15/15	15/15	
<b>TOTAL SCORE</b>								
Number of shaded boxes	0	0	0	0	0	0	0	
Pain Score	0	0	0	0	0	0	0	
Observer's Initials	AD	AD	AD	AD	AD	AD	AD	

**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.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION :</b> 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>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> 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)

②

**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date : 30/5	Time: 9:30	1	4pm	4:30pm	8pm	6pm
Doctor / Nurse / Family Concern?	Am	pm				
Temperature (F)	98°F	97.9°F	98.3°F	98.5°F	98.6°F	98.0°F
Heart Rate (bpm) and Blood Pressure (mmHg) *	92 (57) / 48	91 (61) / 50	90 (61) / 51	92 (70) / 64	92 (70) / 62	90 (70) / 68
Heart Rate (Number)	119b/m	118b/m	121b/m	126b/m	120b/m	118b/m
Resp. Rate (bpm) Over 1 Minute *	26b/m	26b/m	26b/m	26b/m	26b/m	24b/m
Resp Mod/ Severe Distress None / Mild	*				*	*
Receiving O <sub>2</sub> (l/min) O <sub>2</sub> Saturations (%)	98%	99%	99%	98%	99%	99%
Conscious Level Normal / Altered	C	C	C	C	C	C
GCS *	15/15	15/15	15/15	15/15	15/15	15/15
<b>TOTAL SCORE</b>						
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	Am	pm	Am	Am	Am	Am
<b>ACTIONS</b>	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.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION :</b> 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>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> 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)

BAH-00646732 IP5-00174511  
 Baby ANANTHULA SHREYANVI  
 20-03-2024 2 Y 2 M 9 D (F)  
 Dr. NALLA ANURAG REDDY



Doc. No. : RCH/ FRM / CLINICAL / 125

**PRESCHOOL (1-5 years)**  
**Children's Observation & Early Warning Scoring Chart**

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

**BirthRight**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date : 29/3/24 Time: 10pm 3 Am 6pm

Doctor / Nurse / Family Concern?

Temperature (F)	104			
	103			
	102			
	101			
	100			
	99			
	98	98.6 F	98.4 F	98.5 F
	97			
	96			
	94			

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				
Heart Rate (Number)	112 bpm	102 bpm	105 bpm	

Resp. Rate (bpm) Over 1 Minute) *	70				
	60				
	50				
	40				
	30				
	20				
	10				
	Resp Rate (Number)	28 bpm	28 bpm	28 bpm	

Resp Distress	Mod/ Severe None / Mild			
Receiving O <sub>2</sub> (l/min)	O <sub>2</sub> Saturations (%)	100%	100%	100%
Conscious Level	Normal / Altered	C	C	C
GCS *		15/15	15/15	15/15

<b>TOTAL SCORE</b>			
Number of shaded boxes	0	0	0
Pain Score	0	0	0
Observer's Initials	AS	AS	AS

<b>ACTIONS</b> 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.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION:</b> 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>B</b>	<b>BACK GROUND:</b> 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)
<b>A</b>	<b>ASSESSMENT:</b> 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.
<b>R</b>	<b>RECOMMENDATION:</b> 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. : 4

- All measurements in ml.
- Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
- 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	H <sub>2</sub> O	150ml	50ml					150ml		Karin	
	09:00 am	Dosa	1p.c	50ml								
	10:00 am			50ml								
	11:00 am	Dist	1p.c	50ml								
	12:00 pm	H <sub>2</sub> O	150ml	50ml					150ml			
	01:00 pm			50ml								
<b>Total Intake :</b>			600ml			<b>Total Output :</b>					300ml	
	02:00 pm			50ml							Soram	
	03:00 pm	Cur		30ml					150ml			
	04:00 pm	H <sub>2</sub> O	100ml	30ml								
	05:00 pm			30ml								
	06:00 pm	ml	100	30ml					180ml			
	07:00 pm			30ml								
<b>Total Intake :</b>			400ml			<b>Total Output :</b>					330ml	
	08:00 pm			30ml					150ml		Soram	
	09:00 pm	Rice		30ml								
	10:00 pm	H <sub>2</sub> O	100ml	30ml								
	11:00 pm			30ml								
	12:00 am			30ml								
	01:00 am			30ml					50ml			
<b>Total Intake :</b>			280ml			<b>Total Output :</b>					250ml	
	02:00 am			30ml					100ml		Soram	
	03:00 am			30ml								
	04:00 am			30ml								
	05:00 am			30ml								
	06:00 am			30ml								
	07:00 am			30ml					100ml			
<b>Total Intake :</b>			180ml			<b>Total Output :</b>					200ml	

Total 24 hrs. Intake

1,460 - 11,960 Kg

Total 24 hrs. Output

1,080 - 3,680 Kg

# FLUID CHART

Sheet No. : 3

- 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		
3/15/24	08:00 am	H <sub>2</sub> O	100 ml	25+25					200ml		} <i>Am m</i>	
	09:00 am	chips	2 p.c	25+25								
	10:00 am			25+25								
	11:00 am	H <sub>2</sub> O	50 ml	25+25								
	12:00 pm			25+25					150ml			
	01:00 pm			25+25								
<b>Total Intake : 450 ml</b>			<b>Total Output : 350 ml</b>									
	02:00 pm			25+25							} <i>Am m</i>	
	03:00 pm	oil		50 ml					150 ml			
	04:00 pm			50 ml								
	05:00 pm	H <sub>2</sub> O	100 ml	50 ml								
	06:00 pm			50 ml								
	07:00 pm	oil	100 ml	50 ml					150 ml			
<b>Total Intake : 580 ml</b>			<b>Total Output : 300 ml + 100 ml</b>									
	08:00 pm			50 ml					200 ml		} <i>Am m</i>	
	09:00 pm	rice		50 ml								
	10:00 pm	H <sub>2</sub> O	100 ml	50 ml								
	11:00 pm			50 ml								
	12:00 am			50 ml								
	01:00 am			50 ml					50 ml			
<b>Total Intake : 400 ml</b>			<b>Total Output : 200 ml</b>									
	02:00 am			50 ml							} <i>Am m</i>	
	03:00 am			50 ml					250 ml			
	04:00 am			50 ml								
	05:00 am			50 ml								
	06:00 am			50 ml					150 ml			
	07:00 am			50 ml								
<b>Total Intake : 300 ml</b>			<b>Total Output : 400 ml</b>									

**Total 24 hrs. Intake** 1,650; 135.2 cc/kg

**Total 24 hrs. Output** 1,300; 4.43 cc/kg/24hr



# FLUID CHART

Sheet No. : 2

- 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	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage			Urine
	08:00 am											
	09:00 am	H <sub>2</sub> O	100ml.							90ml.		Somya
	10:00 am		N									
	11:00 am		P									
	12:00 pm											
	01:00 pm		0							110ml		
<b>Total Intake :</b>		100ml.			<b>Total Output :</b> 200ml.							
	02:00 pm	rice-curry		50ml								M-1
	03:00 pm			50ml						100ml		
	04:00 pm	water	100ml	50ml								
	05:00 pm	biscuits		50ml								
	06:00 pm			50ml								
	07:00 pm	water	50ml	50ml						130ml		
<b>Total Intake :</b>		450ml			<b>Total Output :</b> 230ml							
	08:00 pm	chapati		25+25								Somya
	09:00 pm	H <sub>2</sub> O	100ml	25+25						100ml		
	10:00 pm			25+25								
	11:00 pm			25+25								
	12:00 am			25+25								
	01:00 am			25+25						100ml		
<b>Total Intake :</b>		400ml			<b>Total Output :</b> 200ml							
	02:00 am			25+25								Somya
	03:00 am			25+25						200ml		
	04:00 am			25+25								
	05:00 am			25+25								
	06:00 am			25+25								
	07:00 am			25+25						150ml		
<b>Total Intake :</b>		300ml			<b>Total Output :</b> 350ml							
<b>Total 24 hrs. Intake</b>		1,250ml ; 102.4 cc/kg			<b>Total 24 hrs. Output</b>							
					980 ; 3.2 cc/kg/hr							



# FLUID CHART

Sheet No. : 1

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 Thrombophlebitis 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												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm	Rice											
	11:00 pm	Two 100ml								200ml			
	12:00 am												
	01:00 am												
<b>Total Intake : 100ml</b>						<b>Total Output : 200ml</b>							
	02:00 am									150ml			
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am									50ml			
<b>Total Intake : 100</b>						<b>Total Output : 250ml</b>							

**Total 24 hrs. Intake** 100ml = 819 cal/kg

**Total 24 hrs. Output** 450 = 3,07 cal/kg

BAH-00646732 IP5-00174511  
Baby ANANTHULA SHREYANVI  
20-03-2024 2 Y 2 M 10 D (F)  
Dr. NALLA ANURAAG REDDY



# CONSENT FOR CHEMOTHERA

Patient Name : Shreyanvi Age : 2y Gender : Male  Female

UHID No : BAN-00646732 Department : PNO Date : 30/5/26

Type of Chemotherapy : Intravenous

The type of reactions, nature of the major risks and complications arising from the treatment despite precautions has been explained to me. These can include Bone Marrow depression with subsequent infections, bleeding, nausea, vomiting, diarrhea, mouth ulcers, alopecia, fever, phlebitis, ulceration at the site of injection organ injuries etc.

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

Explained

I understand that no promise of cure or freedom from risk can be given. During the course of treatment I will report any symptoms if they become bothersome.

I have read the above and have no further questions about the treatment to be given.

**Patient Attendant :**

Signature : A. Smit

Name : Sai Smiti

Relationship with Patient: Mother

Date & Time : 30/5/26 at 3pm

**Witness :**

Signature : Smiti

Name : Sai Smiti

Date & Time : 30/5/26 at 3pm

**Doctor (who is taking the consent):**

Signature : [Signature]

Name : Dr. Nalla

Date & Time : 30/5/26 at 3pm

## కీమో థెరపీ కొరకు అంగీకారం

రోగి పేరు : ..... వయస్సు ..... లింగం పు  స్త్రీ

యు.హెచ్.ఐ.డి. .... రిజిస్ట్రేషన్ నెం.: ..... విభాగము .....

తేదీ .....

**కెమోథెరపీ రకాలు:** .....

ఈ చికిత్స చేయు సమయములో తగు జాగ్రత్తలు తీసుకున్న సంభవించు వివిధ రకములైన ప్రమాదాలు తలెత్తే సమస్యల నాకు డాక్టర్ వివరించబడింది. వీటిలో ఎముక మజ్జ మాంద్యం, తదుపరి అంటువ్యాధులు, రక్తస్రావం, వికారం, వాంతులు, విరేచనాలు, నోటి పూతల, అలోపేసియా, జ్వరం, ప్లేబిటిస్, అవయవ గాయాలు, ఇంజెక్షన్ ఉన్న ప్రదేశంలో పుండ్లు మొదలైనవి కలగవచ్చు ఈ విధానం యొక్క ప్రయోజనాలు మరియు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు.

డాక్టర్ నీకు ఈ ప్రక్రియ వల్ల కలుగు లాభాలు మరియు ప్రత్యామ్నాయాలు వివరించారు .....

చికిత్స వల్ల కలుగు ఫలితాలు గురించి ఏ విధమైన వాగ్దానం ఇవ్వలేరని నేను అర్థం చేసుకున్నాను. చికిత్స సమయంలో ఏవైనా లక్షణాలు ఇబ్బందికరంగా ఉంటే నేను డాక్టర్ కి తెలియపరుస్తాను.

నేను చికిత్స గురించి పూర్తిగా తెలుసుకున్నాను, చికిత్స గురించి తదుపరి ప్రశ్నలు లేవు.

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము .....

సంతకము .....

పేరు .....

పేరు .....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

తేదీ మరియు సమయము .....

సంతకము .....

పేరు .....

BAH-00646732 IP5-00174511  
Baby ANANTHULA SHREYANVI  
20-03-2024 2 Y 2 M 10 D (F)  
Dr. NALLA ANURAAG REDDY



# CONSENT FOR SPECIAL PROCEDURES

Patient Name : Shreyanvi Gender:  Male  Female

UHID No : BAH-00646732 Department : PTHO Date : 30/5

I A. Narek S/D/W/O Paibnetli

Here by give consent for procedure of : Lumbar puncture

For my patient, Named : shreyanvi

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

Bleeding, infection, trauma to top

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: Dr. Sivani?

**Patient Attendant :**

Signature : [Signature]

Name : A. Narek

Relationship with Patient: Father

Date & Time : 30/05/2026 @ 10 AM

**Witness :**

Signature : [Signature]

Name : Sunmya

Date & Time : 30/5 @ 10 AM

**Doctor (who is taking the consent) :**

Signature : [Signature]

Name : Dr. Sivani

Date & Time : 30/5/26; 10 AM

# ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు ..... లింగం  పురుషుడు  స్త్రీ

యు.హెచ్.ఐ.డి ..... విభాగం ..... 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-00646732 IP5-00174511  
Baby ANANTHULA SHREYANVI  
20-03-2024 2 Y 2 M 10 D (F)  
Dr. NALLA ANURAAG REDDY

Patient Sticker



## 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. Srinisho 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: A. Naredi  
Name: A. Naredi  
Relationship with patient: Father  
Date & Time: 30/5/2026

**Witness:**

Signature: Saumya  
Name: Saumya  
Date & Time: 30/5/2026 10 AM

**Doctor (who is taking consent):**

Signature: (Signature) Name: Dr Sai Date: 30/5 Time: 10 AM

Patient Sticker

# 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, అలర్జి ప్రతిచర్యలు, ఎగువ శ్వాసనాళ అడ్డంకి, లాలింజోస్టానమ్, 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 ప్రశ్నలన్నీ, 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: .....

Patient



## Moderate Sedation Flow-Sheet

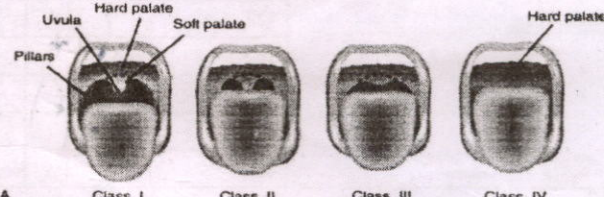
### Immediate Pre-Sedation Assessment

B.P	PR	R.R	Temp	SPO <sub>2</sub>	Pain Score	Weight
90/58	103b/t	26b/t	98°F	98%	0	12.2kg

Diagnosis: BALL

Procedure: Lumbar puncture

Comorbidities: NO

<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  <b>ASA Physical Status</b> <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 <u>15/15</u>  <input checked="" type="checkbox"/> IV Site: Gauge:  Sedation Plan: <u>IV</u>  Allergies: <u>NO</u>	<b>AIRWAY EVALUATION</b> <b>Mouth:</b> <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  <b>Neck:</b> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Decreased ROM <input type="checkbox"/> Thyromental Distance Less Than 6 cm <input type="checkbox"/> Short Neck   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 (O<sub>2</sub> 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 <sub>2</sub> Sat%	O <sub>2</sub> Supplementation	Comments / Initials
Baseline	95/53	102b/s	26b/s	99%	-	

DRUG & IV Fluid: (including Nitrous Oxide)	ROUTE	DOSE	TIME GIVEN	SUBSEQUENT DOSES AND TIME
100mg MEROPENEM	IV			
100mg MIPRANOLAM	IV	0.5mg	11:20pm	
100mg KETAMINE	IV	10mg	11:20pm	

Doctor Notes: ..... Child heterotopia w/ CN .....

Time of transportation to post sedation care room: ..... 132 ..... LOC: ..... Alert .....

Doctor Name: ..... Dr. Sandhya ..... Signature: ..... [Signature] .....

**Post Sedation Care Room**

Time	Monitoring	ECG	NBP	Oximeter	Pain Score (0-10)	Sedation Score (0-4)
180						
160						
140						
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 <sub>2</sub> > 92% on room air = 2	BP +/- 20 mm hg of pre-op = 2
Two extremities = 1	Arousal on calling = 1	Dyspnea, limited breathing = 1	Needs oxygen to maintain Sat O <sub>2</sub> > 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: ..... Sandhya .....  
Date: ..... 30/5/26 ..... Time: ..... 11:20pm .....

Signature: ..... [Signature] .....

Consultant Name: ..... Dr. Sandhya .....

Signature: ..... [Signature] .....

Stamp



124

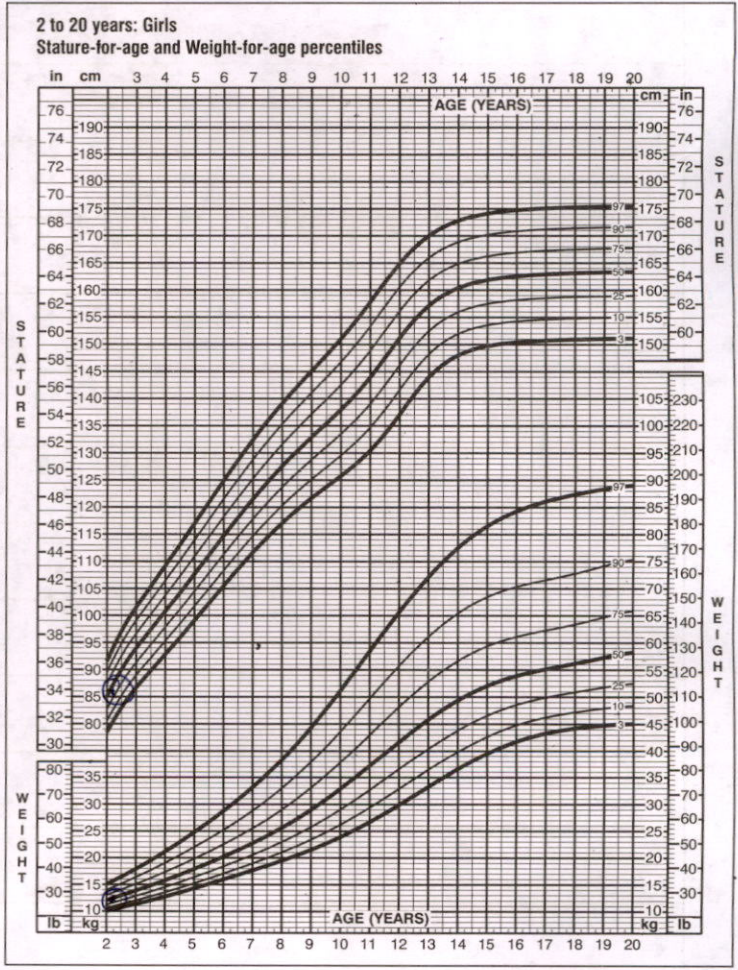
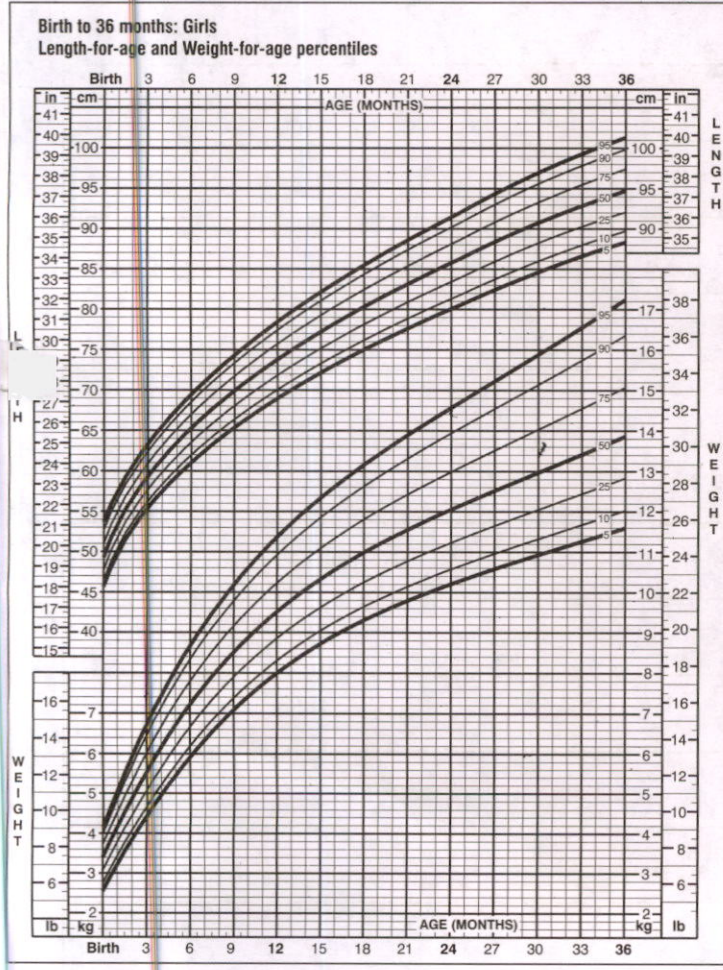


# NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 1/6/28 Time: 4pm

Weight: 12.2 kgs Centile: > 25<sup>th</sup>  
 Height: 80cms Centile: > 25<sup>th</sup>  
 Inference: well child.  
 RDA: - Calories: 1250kcal/d Protein: 29g/d  
 Diet Recommendations: soft high protein diet  
 Re-Assessment: Avoid spicy, chilled and outside foods.  
 Food Allergies: NO Veg/Non-veg: neg  
 Diagnosis: K110 Bcell ALL / High count / CA11A +ve TFI-AML + CNS -ve. Now For chemotherapy.  
 Nutritional Intervention -  Oral  Enteral  Parenteral  
 Patient's Signature: Parent's don't need dietician. Don't charge for NHA.

## GROWTH CHART (GIRLS)



Dietician's Name: N. Nikitha

Dietician's Signature: N. Nikitha

