imulation test

Name: Liam Yashin. DOB:

Glucagon stimulation test

- The child should be nil by mouth for at least 8hrs and is allowed only water till the test is completed.
- Insert a wide bore canula, this will allow us to take blood samples every 30 minutes.
- At the time of insertion take a blood sample for GH, glucose and also glucose test at the bedside.
- Give Glucagon IM, dose = 1mg

	Time	Growth hormone	Glucometer blood sugar	Cortisol	BP
9 Am	0 min	✓	78 mg/dL	X	92/
9:30 Am	+ 30 min	✓	147 mg/dL	X	101/
10 Am	+ 60 min	✓	87 Omg/dL	X	95/
10:30 Am	+90 min	✓	59 mg/dL	X	89/
11 Am	+ 120 min	✓	66 mg/dl	X	88/
11:30 Am	+ 150 min	✓	55 mg/dL	X	91/
	+ 180 min	✓	61 mg/dl	X	101/

During the test look for signs of hypoglycaemia like

- sweating
- complains of dizziness
- shaky hands

Check the blood sugar at the bedside if it is below 46 mg/dl, it should be corrected and the test continued.

- If the child is able to drink then 100ml – 200ml of Appy juice

OR

- 100ml of Maaza juice.
- If the child is unable to drink then a bolus of 10% dextrose should be given and the blood sugar rechecked 15 minutes later.

G Haran Karthik

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 : IP5-00176799 **Admit Date** : 23-Jul-2026 **Admit Time** : 07:54 AM **UHID** : LBH-00099877

Patient Details :

Patient Name	: Master LIAM YASHIN	**Age**	: 3 Y 1 M 8 D
Guardian	: Mr YASHIN	**DOB**	: 15-06-2023
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: D2, 205, Singapore Township, Pocharam Kachivani Singaram Hyderabad Telangana INDIA 500088	**Phone No**	: 8884370222/ 8884370222
		E-mail	: yashinbidar@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 : Mr YASHIN **Relationship** : Father

Contact Address : **Phone No** : 8884370222

Signature

Doctor Details :

Doctor Name : Dr. SIRISHA KUSUMA B **Specialisation** : PEDIATRIC ENDOCRINOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant : Dr. JAPA AVINASH

Payment Details :

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

Payor Name : SELFPAY

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ACTIVITY RECORD FOR BILLING

LBH-00099877 IP5-00176799
Master LIAM YASHIN
15-06-2023 3 Y 1 M 8 D (M)
Dr. SIRISHA KUSUMA B

Name _____

UHID _____ 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
23/07/23	8 AM	CVP	—	Subhan

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
23/7/26	GRBS → 78mg/dl. GH	3810	Charan
23/7/26	GH. GRBS = 147mg/dl	3834	Charan
23/7/26	GH. GRBS - 87mg/dl	3844	Charan
23/7/26	GH. GRBS - 59 mg/dl	3861	Charan
23/7/26	GH. GRBS - 66mg/dl	3873	Charan
23/7/26	GH. GRBS - 55 mg/dl.	3890	Charan
23/7/26	GH. GRBS - 61mg/dl.	3917	Charan
23/7/26	GRBS - 89mg/dl.	3929	Charan

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
23/7/19	IV placement	①	7671	Kiran

ANY OTHER INFORMATION

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.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

LBH-00099877 IP5-00176799
Master LIAM YASHIN
15-06-2023 3 Y 1 M 8 D (M)
Dr. SIRISHA KUSUMA B

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/7/26	R/S/N Resident	
	DS:- Cherfe Syndrome & Short Stature.	
	Case for GH Stimulation	Plan
	O/E	- Inj Glucagon 1mg i.m Stat.
	RR - BPM (T), Conducted Sounds (T)	- 0 min - GH, GRBS, BP
	CVS - S1 S2 (+)	- 30 min
	P/A (N).	60 min
	VSS - Temp - 97°F	90 min GH, GRBS
	PR - 108/min	120 min BP.
	BP - 89/50 (60)	150 min
	RR - 25/min.	180 min
	SpO2 - 99% on RA	- Monitor HR
		- Inform Endocrinologist
		Dr
	N/B Dubnay 23/07/26 at 8 AM	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

LBH-00099877 IP5-00176799
Master LIAM YASHIN
15-06-2023 3 Y 1 M 8 D (M)
Dr. SIRISHA KUSUMA B

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DRUG CHART

Date of Admission: 23/7/26 Drug Allergies: Nil ☐ 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 .....

LBH-000[illegible]

Master LIAM YASHIN

15-06-2023 3 Y 1 M 8 D (M)

Dr. SIRISHA KUSUMA B

REGULAR PRESCRIPTIONS

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

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

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

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

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

LBH-00099877 IP5-00176799
Master LIAM YASHIN
15-06-2023 3 Y 1 M 8 D (M)
Dr. SIRISHA KUSUMA B

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

DRUG :	Date ▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
		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
23/7/26	8:30 AM	Inj. GLUCAGON	1mg	IM		Yasmin Ichaiah

Patient Sticker

I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign

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

LBH-00099877 IP5-00176799
Master LIAM YASHIN
15-05-2023 3 Y 1 M 8 D (M)
Dr. SIRISHA KUSUMA B

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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: BR Shifted to: .....

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : ..... Dr-Bhagyi .....

Date & Time : 23/7/26 ; 8:15 AM .....

Nurse Name & Signature: Subhan .....

Date & Time : 23/7/26 at 8:20 AM .....

LBH-00099877 IP5-00176799
Master LIAM YASHIN
15-06-2023 3 Y 1 M 8 D (M)
Dr. SIRISHA KUSUMA B

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RESULT SHEET

Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

LBH-00099877 IP5-00176799
Master LIAM YASHIN
15-06-2023 3 Y 1 M 8 D (M)
Dr. SIRISHA KUSUMA B

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

Patient Sticker

FLUID CHART

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Sheet No. : .....

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	

LBH-00099877 IP5-00176799
Master LIAM YASHIN
15-06-2023 3 Y 1 M 8 D (M)
Dr. SIRISHA KUSUMA B

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THE HUMPTY DUMPTY SCALE 23/07/23

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3				
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2				
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1				
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1				
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1				
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1				
	TOTAL		11				

Intervention : -Fall Risk : Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position		Yes				
	Call device within reach		Yes				
	Wheels Locked		Yes				
	Room free of clutter		Yes				
	Adequate Lighting		Yes				
	Wheel Chair Support		NO				
	Other Intervention(s) Specify		NO				
	Nurse's Name :		Subra				
	Signature :		S				
	Date :		23/07/23				
	Time :		11AM				

Docu. No. RCHBH / FRM / CLINICAL / 005

LBH-00099877 IP5-00176799
Master LIAM YASHIN
15-06-2023 3 Y 1 M 8 D (M)
Dr. SIRISHA KUSUMA B

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sirishakusum Department: pead endocrinology Date of Admission: 23/07/20

SITUATION

Diagnosis: charge syndrome

Any Infection: ☐ Yes ☐ No ☐ Not Known
If Yes Specify: .....

BACKGROUND	Area / Shift Time	EB20 11:20 PM					
	Medical Condition (Any special condition to be noted):	Nil					
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.2F					
	Res:	26 b/m					
	SpO_2:	98% RA					
	Pulse:	110 b/m					
	BP:	101/56 (71)					
	Fall Risk Score:	11					
	Pain Score:	0/10					
Recommendations	Safety Needs:	side rails					
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	Nil					
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	Nil					
Post Operative Procedure Special Orders:		Nil					
Handed Over By Name :		Subhra					
Signature :		S					
Date:		23/07					
Time:		@ 11:50 PM					
Taken Over By Name :							
Signature :							
Date:							
Time:							

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							