MAH-00332207 IP5-00176038
Master V ABHINANDAN
13-08-2020 5 Y 10 M 23 D (M)
Dr. SIRISHA RANI

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	01			
2	Discharge Summary	01			
3	Nursing Initial assessment	01			
4	Patient Transfer form	01			
5	In-patient Medical record	01			
6	Doctors progress sheets	01			
7	Nursing plan of care and handover sheets	01			
8	Consultation sheet	01			
9	General consent for treatment	01			
10	Consent for Surgery	—			
11	Consent for blood transfusion	01			
12	Consent for chemotherapy	—			
13	Consent for high risk	—			
14	Consent for Restraint	—			
15	LAMA consent	—			
16	Consent for special procedure / Sedation	—			
17	Consent for Formula feed	—			
18	Consent for MTP	—			
19	Consent for Radiological Investigations	—			
20	Consent for HIV test	—			
21	Anaestesia notes (Pre Anaesthesia& post)	—			
22	Neonatal Admission/Delivery/Physical Exam	—			
23	Medication Reconciliation	01			
24	Emergency Triage record	01			
25	Pre operative check list	—			
26	Surgical safety checklist	—			
27	Operation Theatre notes	—			
28	Nurses clinical Presentation	—			
29	TPR & BP chart	01			
30	Intake and Out take chart (fluid chart)	01			
31	Drug chart (Regular Prescription)	01			
32	Investigation Values (result sheet)	01			
33	Nebulization chart	—			
34	Nutritional review chart	—			
35	Intensive care unit (ICU Charts)	—			
36	Consent for Admission in PICU / NICU	—			
37	The Humpty dumpty scale	01			
38	Braden Q Scale	01			
39	Bed side check list	—			
40	PICU bed formula Dilution feeds	—			
41	Gastro monitoring chart	—			
42	Rch ED doctors note	01			
43	BP Monitoring chart	0—			
44	RBS monitoring chart	01			
	Total No. of Pages	20			

Signature and Date : 06/8/23

(P.T.O)

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176038 **Admit Date** : 06-Jul-2026 **Admit Time** : 02:43 PM **UHID** : MAH-00332207

Patient Details :

Patient Name	: Master V ABHINANDAN	**Age**	: 5 Y 10 M 23 D
Guardian	: Mr V HANMANTH RAO	**DOB**	: 13-08-2020
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: FLAT NO 305 , BLOCK 10B , PRAJAY CITY APARTMENTS MIYAPUR Hyderabad Telangana INDIA 500049	**Phone No**	: 9989275435/ 9490945777
		E-mail	: saveena.dasari@gmail.com

Admission Details :

Bed 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 V HANMANTH RAO **Relationship** : Father

Contact Address : FLAT NO 305 , BLOCK 10B , PRAJAY CITY APARTMENTS MIYAPUR Hyderabad Telangana INDIA 500049 **Phone No** : 9490945777

Hanmanth Rao

Signature

Doctor Details :

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

Referral Doctor : SELF **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

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BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 06/07/2020 Time: 3:30 pm

Blood Group of the Patient: – Blood Group on the Blood Bag: –

Blood Bank Issue No: – Date of Collection: – Date of Expiry: –

Date & Time of Starting Transfusion: – Planned duration of Transfusion: Over 2 hours

Check for Correct Unit: ☑ Correct Patient: ☑

Blood products cross checked by: Nurse 1: NR-Jenitha Nurse 2: NR-Josh

Before starting transfusion vitals: Temp: 98.4°F HR 104bts RR: 26bts BP: 98/61(74) SpO_2 98% in RA

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO_2	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
4:30	15 Min	98bt	97.4	102/61	98%	–	–	–	–
5:00pm	15 Min	94bt	97.6°	100/58	92%	–	–	–	–
	30 Min								
	30 Min								
	30 Min								
	1 Hr								
	1 Hr								

Comments: NO Reactions During Tx.

Name of the Incharge-Nurse: NR-Jenitha Name of the Nurse:

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

Date & Time: 06/07/2020 Date & Time: 06/07/20 @

CONSENT FOR BLOOD TRANSFUSION

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Name: V. ABHINANDAN Age: 54Y Gender: Male ☑ Female ☐

UHID.No : MAH-00332207 Date: 06/07/2026

Type of Blood Product:

☐ Fresh Frozen Plasma	☐ Packed Red Blood Cells	☐ Random Donor Platelets
☐ Cryoprecipitate	☐ Single Donor Platelet	☐ Whole Blood
☐ Albumin	☐ Red Blood Cell	☑ Others MESENCHYMAL CELLS

I ..... hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immunodeficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that —

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Signature: Saveena

Name: V. Saveena

Date & Time 6/7/26; 3:15 PM

Doctor (Who is talking the consent)

Signature:

Name: Dr: Ramya

Date & Time 6/7/26; 3 pm

Witness

Signature: Saveena

Name: V. Saveena

Date & Time 6/7/26; 3:15PM

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ACTIVITY RECORD FOR BILLING

Name :_____

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UHID No. : _____ | Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/7/2020	4pm	GR	ER	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
6/7/20	CARDIAC Monitor / Infusion pump	4pm	—	90472	[signature]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
6/7/2026	IV placement	1	90482	[illegible]
6/7/2026	IV Medications	1	90482	[illegible]

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Sirisha Rani Date : 6/7/26

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

Start Time of Assessment: ..... Weight: 21 Kgs

Allergic History: .....

Chief Complaints: .....
K/C/O Autism Spectrum disorder
& Hyperactivity
↓
Now came for Mesenchymal stem cell transfusion

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 ☐

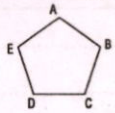
Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Significant Past History: .....

Medication History: .....

Relevant Investigations: .....

Primary Assessment



Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

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

Breathing

Rate: ..... SpO_2 on FiO_2 98% on RA

Rhythm: Regular

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: B/L AE (+)

Palpation Findings (If necessary) .....

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

Circulation

HR: .....

CFT — Central .....
Peripheral .....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

BP: ..... 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.: 97.8°F

Any urgent interventions needed: ☐ Yes ☑ No

Any Rash: ☐ Yes ☑ No,

If Yes .....

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: .....

.....

.....

.....

.....

.....

.....

Treatment Planned: .....

.....

.....

.....

.....

.....

.....

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

Final Diagnosis with possible Differential Diagnosis (If necessary): K/C/O Autism

Assessment done by

Name of the Doctor: Dr. Ramya

Signature: .....

Date & Time: 6/7/26;

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: .....

Signature: .....

Date & Time: .....

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 4:30pm	Daycare notes. K/C/O Autism for MSC infusion No fresh issues doing well Vitals (N) CVS RS } (N) P/A	Adv 1) Give MSC 2) D/C 3) F/u 1 month Anantha NB Continue 06/07/2026 @ 4:30

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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MEDICATION RECONCILIATION FORM

Drug Allergies: .... ☑ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER Shifted to: ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Tab Sizadon	5mg.	PO	OD	5/7/26	☑ C ☐ DC
2	Syp BIQ	5ml	PO	OD	5/7/26	☑ 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. Ramya

Date & Time : 6/7/26 ; 1:45pm

Nurse Name & Signature: T. Janthine

Date & Time : 6/7/26 1:45p

Docu. No. : RCHBH /FRM / GENERAL / 090

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DRUG CHART

Date of Admission: ..... 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 ..... Signatur

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REGULAR PRESCRIPTIONS

Weight. 21.4kg Ward. .....

DRUG : Tab DEXAMETHASONE

Dose	Route	Frequency	Start Date
1/2 tab	PO	BD	6/7/26

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

Additional Instructions:
1 tab = 4mg.

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : Syp. SUCRAL

Dose	Route	Frequency	Start Date
10ml	PO	BD	6/7/26

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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

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
6/7/26	3:30pm	Inj AVIL	0.5ml	IV		Karthik Jothi
6/7/26	3:32pm	Inj HYDROCORTISONE	40mg	IV		Karthik Jothi
6/7/26	4:40pm	Inj MESENCHYMAL STEM CELLS	10ml over 10min slowly	IV		Pooja Karthik. Pooja
6/7/26	4:45pm	NS bolus	200ml	IV		Karthik. praveen

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

Patient Sticker

I.V. FLUIDS CHART

Weight. 21. 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
6/3/26		DNS	IV	60.					

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