

**ACTIVITY RECORD FOR BILLING**

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

UHID No. : \_\_\_\_\_ IF **MAH-00332207** **IP5-00174694**  
**Master V ABHINANDAN** **13-08-2020** **5 Y 9 M 21 D** (M) **Dr. SIRISHA RANI** tant: \_\_\_\_\_ Dept : \_\_\_\_\_

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

Room / Bed No : \_\_\_\_\_ Ward : \_\_\_\_\_ Suggested Billable bed type : \_\_\_\_\_

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
3/6/26	1:00 pm	ER	oncology	Sagoo1

**Cross Consultation Visit**

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

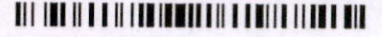






**Rainbow Children's Hospital - Banjara Hills**

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 : IP5-00174694      Admit Date : 03-Jun-2026      Admit Time : 12:29 PM      UHID : MAH-00332207

**Patient Details :**

Patient Name : Master V ABHINANDAN      Age : 5 Y 9 M 21 D  
Guardian : Mr V HANMANATH RAO      DOB : 13-08-2020  
Gender : Male      Religion :  
Occupation :      Martial Status : Single  
Address (H) : H NO 10B-305 PRAJAY CITU APTS NEAR      Phone No : 9989275435/ 9490945777  
ALLWIN CROSSROADS MIYAPUR MIYAPUR      E-mail : saveena.dasari@gmail.com  
Hyderabad Telangana INDIA 500049

**Admission Details :**

Bed Type : GENERAL WARD      Bed No : GW 144 B      Ward Name : 1F-GENERAL WARD II  
Room No : GW 144 B      Admission Type : First Visit

**Contact Details :**

Name : Mr V HANMANATH RAO      Relationship : Father  
Contact Address : H NO 10B-305 PRAJAY CITU APTS NEAR      Phone No : 9490945777  
ALLWIN CROSSROADS MIYAPUR MIYAPUR  
Hyderabad Telangana INDIA 500049

*saveena*  
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 : SELFPAY



## PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Srishe Rani Date : 3/6/20

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

Start Time of Assessment: 12:30pm Weight: 20kg

Allergic History: .....

**Chief Complaints:**  
K/GO Autism spectrum disorder  
Hypactivity & speech delay  
Now admitted for mesenchymal stem cells 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

**Breathing** 

Rate: 24/min SpO<sub>2</sub> on FiO<sub>2</sub> 97% on RA

Rhythm: Regular


Retractions:  Suprasternal  ICR  SCR  
 Sternal  Supraclavicular  Nasal Flaring

Respiratory Noises:  Stridor  Wheezing  Grunting

Air Entry: BILAE

Palpation Findings (If necessary).....

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

**Circulation**  HR: 121/min

BP: 106/64 (71) mmHg

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

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

Muffled Heart Sound:  Yes  No

Engorged Neck Veins:  Yes  No

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

Murmurs:  Yes  No


Liver Span: .....

ECG: .....

Any Signs of Heart Failure:  Yes  No

Any urgent interventions needed:  Yes  No

If Yes .....

**Disability**  GCS: 15/15 AVPU: .....

Pupils:  Responsive  Non-Responsive


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

Active Seizures:  Yes  No Sugars: .....

Signs of Neurological compromise .....

Any urgent interventions needed:  Yes  No

If Yes .....

**Exposure**  Temp.: 98.8 F

Any Rash:  Yes  No

If yes describe the rash .....

Active bleed .....

Lacerations  Abrasions  bruises

Describe: .....

Any urgent interventions needed:  Yes  No

If Yes .....

- 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:** .....

No labs planned

Plain EDTA } collected

**Treatment Planned:** .....


Mesenchymal stem cell infusion

I.V. Ns bolus

Premedication

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. Ramya  
Signature:   
Date & Time: 8/6/26 ; 12:30 pm

Sr. Doctor on Duty (If necessary)  
Name of the Sr. Doctor: .....  
Signature: .....  
Date & Time: .....







## DRUG CHART

Date of Admission: 3/6/2020 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>				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:																					

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

Signature  
VERIFIED BY : Name



**REGULAR PRESCRIPTIONS**

Weight. 20kg Ward. ....

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
3/6/26	2:40pm	Inj AVIL	0.5ml	IV	h	Karima Divya
3/6/26	2:40pm	Inj HYDROCORTISONE	40mg	IV	h	Karima Divya
3/6/26	2:45pm	Inj MESENCHYMAL STEM CELLS infusion	10ml over 10min	IV	h	Karima Divya
3/6/26	3pm	NS bolus (After MSC infusion)	200ml over 1hr	IV	h	Karima Divya

Signature  
VERIFIED BY : Name



MAH-00332207 IP5-00174694  
 Master V ABHINANDAN  
 13-08-2020 5 Y 9 M 21 D (M)  
 Dr. SIRISHA RANI



## 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: ICU 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	BiQ plus Syrup	5ml	PO	OD	3/6/26	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2	Sideron MD 0.5 tab	1 tab	PO	HS		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
3	Anaptec 10 tab	1 tab	PO	OD		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
4	Syp. Smerel	10ml	PO	BD		<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

\* C - Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. RAMYA

Date & Time: 3/6/26 ; 12:15pm

Nurse Name & Signature: [Signature]

Date & Time: 3/6/26 @ 1pm

MAH-00332207 IP5-00174694  
 Master V ABHINANDAN  
 13-08-2020 5 Y 9 M 21 D (M)  
 Dr. SIRISHA RANI



## 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					



MAH-00332207 IP5-00174694  
 Master V ABHINANDAN  
 13-08-2020 6 Y 9 M 21 D (M)  
 Dr. SIRISHA RANI



# 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.

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													
	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													
	11:00 pm													
	12:00 am													
	01:00 am													
<b>Total Intake :</b>						<b>Total Output :</b>								
	02:00 am													
	03:00 am													
	04:00 am													
	05:00 am													
	06:00 am													
	07:00 am													
<b>Total Intake :</b>						<b>Total Output :</b>								
<b>Total 24 hrs. Intake</b>						<b>Total 24 hrs. Output</b>								

Patient Sticker

# 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.
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											
	11:00 pm											
	12:00 am											
	01:00 am											
<b>Total Intake :</b>						<b>Total Output :</b>						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
<b>Total Intake :</b>						<b>Total Output :</b>						

**Total 24 hrs. Intake**

**Total 24 hrs. Output**