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 : IP5-00176645 **Admit Date** : 20-Jul-2026 **Admit Time** : 01:04 PM **UHID** : BAH-00635346

Patient Details :

Patient Name	: Baby KOTHAPALLI HARINI RATNAM	**Age**	: 4 Y 8 M 25 D
Guardian	: MRS KONAPAREDDY JYOTHI PRIYA	**DOB**	: 25-10-2021
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H NO 14-20-677/418/B , VIVEKANANDA NAGAR, ALLAPUR Borabanda Hyderabad Telangana INDIA 500018	**Phone No**	: 9985309505/ 7382020330
		E-mail	: JYOTHIPRIYA095@GMAIL.COM

Admission Details :

Bed Type : BASINET **Bed No** : CRDL-DLX308-1 **Ward Name** : 3F-ZONE A

Room No : CRDL-DLX308-1 **Admission Type** : First Visit

Contact Details :

Name : MRS KONAPAREDDY JYOTHI PRIYA **Relationship** : MOTHER

Contact Address : H NO 14-20-677/418/B , VIVEKANANDA NAGAR, ALLAPUR Borabanda Hyderabad Telangana INDIA 500018 **Phone No** : 7382020330

K. Jyothi Priya
Signature

Doctor Details :

Doctor Name : Dr. SRUTHI BALLA **Specialisation** : PEDIATRIC NEPHROLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant : Dr. DR.V.V.R.SATYA PRASAD

Payment Details :

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

Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD

BAH-00635346 IP5-00176645
Baby KOTHAPALLI HARINI RATNAM
25-10-2021 4 Y 8 M 26 D (F)
Dr. SRUTHI BALLA

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ IP No : _____ 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
20/7/26.	1:45pm	ER	308-1	

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
20/07	VBG (POCT), RP2, CRP	72762	Ismail
21/7/26	magnesium, Vit - D (25 Hydroxy)		
	Parathyroid Hormone, Albumin		
	Phosphorous, calcium,	26073063	Durga
	Bicarbonate, electrolytes		
	creatinine, Urea.		
22/7	RP2 · ~~Et plasm~~	26073412	Sayantha

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
20/7	infusion pump	2:00pm		97130547	Walfe

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
20/07	iv placement	1	718472	Ismail

ANY OTHER INFORMATION

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.....

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.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: Harini

UHID ID:

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Baby KOTHAPALLI HARINI RATNAM
25-10-2021 4 Y 8 M 26 D (F)
Dr. SRUTHI BALLA

Department:

Consultant:

BAH-00635346 IP5-00176645
Baby KOTHAPALLI HARINI RATNAM
25-10-2021 4 Y 8 M 25 D (F)
Dr. SRUTHI BALLA

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

c/o vomitings 4-5 episodes
c/o loose stools 2 episodes | 2days back

History of present illness :

c/o vomitings 4-5 episodes
non-bilious / non-projectile | 2days back

c/o loose stools
2 episodes

no h/o fever/cold/cough

18/9/26.

9.1) 11,070 / 20/21 (3.06

urea - 105
Ca - 14.
Creat. 4.2
Na/K/Cl - 133/6/97

BAH-00635346 IP5-00176645
Baby KOTHAPALLI HARINI RATNAM
25-10-2021 4 Y 8 M 25 D (F)
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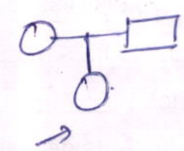
Pediatric Multiorgan History & Physical Examination

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

nil

Birth & Neonatal History:

~~Late~~ preterm/ Bwt- ~~[illegible]~~ 2.5 kg/ NICU stay for 40 days
(33-34 wks)



Birth & Socio Economic History:

About Father :
About Mother : middle
Any additional Information :

Developmental History :

appropriate for age

Immunization History :

vaccinated till date

(P.T.O.)

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Baby KOTHAPALLI HARINI RATNAM
25-10-2021 4 Y 8 M 25 D (F)
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Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs))____12.2 kg____(Centile _____)

On Examination :

Temperature : 98.4°F Pulse Rate : 103/min B.P. 96/50 (61) SPO2 100%

Resp.rate and type of breathing : 22/min

Rash

Lymphadenopathy

Oedema :

Allergies (if any):

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds : BLAE(+), Clear

Any addes sounds :

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1S2 (N)

Any murmur :

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

Per Abdomen :

Inspection

Palpation : Soft, NT

Ausculation :

Spine : External Genitelia :

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

BAH-00635346 IPS-00176645
Baby KOTHAPALLI HARINI RATNAM
25-10-2021 4 Y 8 M 26 D (F)
Dr. SRUTHI BALLA

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15/15

Cranial Nerves :

Motor System:

Nutriton :

Tone: NAD Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials:**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

CKD Stage 3B / HTN
now c uremia

(P.T.O.)

BAH-00635346 IP5-00176845
Baby KOTHAPALLI HARINI RATNAM
25-10-2021 4 Y 8 M 26 D (F)
Dr. SRUTHI BALLA

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: complication

Desired goals of the treatment : Resol^{n} of symptoms

Planned Labs:

VBG
RP2 N/S
CRP 1 smear

Planned Management

1.) IVNS
2.) ceftriaxone
3.) CIC to continue
4.) Lasix (sos)
5.) pantop
6.) ondem sos
7.) levolin 4 hrly
8.) inj. lasix 10mg to give stat after 2 hours of giving maintanance fluids
9.) to give full maintanance for 1 hour → fl b 2/3rd
10.) trole RP2 & inform.

Signature of the Doctor: Madhavi
Name of the Doctor: Madhavi
Date & Time: 26/7/26

Signature of the Consultant:
Name of the Consultant:
Date & Time:

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	3			
7	Nursing plan of care and handover sheets	3			
8	Consultation sheet	1			
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
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	1			
24	Emergency Triage record	1			
25	Pre operative check list	1			
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	2			
30	Intake and Out take chart (fluid chart)	2			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart	1			
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)	1			
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart	1			
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Billing	1			
	Total No. of Pages	28			

Signature and Date :

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

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Baby KOTHAPALLI HARINI RATNAM
25-10-2021 4 Y 8 M 25 D (F)
Dr. SRUTHI BALLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/2021 1:45pm	S/B Dr. Sruthi Balla	
	Met alkalosis H/O vomits & Poor oral intake ? Induced Hypercalcemia	Adv - Continue DNS at full maintainence for 24hours
	O/E: Mild dehydration (+) Pulse volume good. Peripheral pulses weak felt P/A - Soft Rs - clear No crepts	- Watch for urine output keep at ≥1ml/kg/hr ↓ if maintained to give Lasix 10mg IV Stat after 2 hours - Strict I/O charting - Continue CIC - Inform Labs today - 4/M RFT S. Ca S. Magnesium S. PO4 25-OH Vit D3 S. albumin PTH.
6AM		

BAH-00635346 IP5-00176645
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	- Continue BP medications	
	- Hold Rocaltrol till Ca stabilizes	
	- Vitals Charting 3 Hourly.	
	- watch for RD / altered sensorium	
	- Check wt 4/M 6AM.	
	- After 4 hrs	I IVF to 80% maintenance

Docu. No. : RCHBH /FRM / CLINICAL / 088

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/2016. 10AM	S/B	Dr. Sruthi Balla
	Case Received No fever spikes BP's - ok c/o - 914 ml P/A - Soft Rs - clear Hydration good.	Adv 1) Continue same IVFs medications 2) Strict I/o charting 3) Inform todays blood reports 4) Vitals 3 Hrly. 5) Inform SOS
21/7/16	C/D/w Dr. Sruthi mam	plan - Inj Potchlor 2.5ml BD - Inj Lasix 10mg @ 2pm - RBK Sr. Calcium ⇒ thm morning.

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/2021 1:30pm	S/B Dr. Sruthi	
	Case Revised	
	No Vomits	Adv
	U/o good.	
	-	Coulene IVF
	Labs noted -	Inj Lasix 10mg 2pm stat today
	-	I/O charting
	-	Trace Vit D3 PTH report
	-	
		T/M RP2.
		& Plan D/C (SOS) after reports

Docu. No. : RCHBH /FRM / CLINICAL / 088

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 8:30am	c/s/B Resident	
	Δ: CKD secondary to neurogenic bladder now ↑ hypercalcemia	
	CI: ↑ Vit D_3 levels.	
	~~PTH~~	Adv:
	- U/O – 165 ml/24h.	
	- wt - ↓ 200g	1.) Plan (D) today.
	BPs okay.	2.) CIC to continue
	O/E: no dehydration alert stable vitals	3.) PTH report awaited
		Ambule
		Discharge today
		Potklor x 2 days.
Monday ~~Saturday~~ RP2 S.Ca PO4 Spot urine calcr ratio		NO Gemcal NO Rocalbol NO Calcimax

Docu. No. : RCHBH /FRM / ~~CLINICAL~~ / 088 (P.T.O)

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

BAH-00635346 IPS-00176645
Baby KOTHAPALLI HARINI RATNAM
25-10-2021 4 Y 8 M 26 D (F)
Dr. SRUTHI BALLA

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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: 308-1

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	Syrup Wodoris	15ml	P/O	QID		☑C ☐DC
2	Tab AMLODIPINE	2.5mg	P/O	BD		☑C ☐DC
3	Tab PANTOPRAZ.	Nil	1/2tab	BD		☑C ☐DC
4	Cap ROCALTROL	0.25mcg.	P/O	ON		☐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 : Madhu

Date & Time : 20/7/26

Nurse Name & Signature: Susmita

Date & Time : 20/7/26 @ 1:30pm.

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RESULT SHEET

	OPD						
Date	18/7/26	20/7	21/7	22/7			
Time							
Hb	9.1						
PCV	25.7						
RBC	3.11						
WBC	11,070						
N/L	70/21						
Platelets	3.06 lakhs						
CRP		5					
ESR							
PCT							
RBS							
Na	133	132	139	138			
K	6	4.0	3.0	3.7			
Cl	97	94	107	110			
Ca/Mg	14		13.2/2.0				
Phosphate			1.9				
Urea	105	97	71 ↓	51 ↓			
Creatinine	4.2	4.8 ↑	3.8 ↓	3.1 ↓			
ALP							
SGPT							
SGOT							
T.Bill/Conj							
T.Protein							
S.Albumin			4.0				
S.Globulin							
A/G Ratio							
Uric Acid							
S.Amylase							
Sr.Lipase							
Blood Lactate							
S.Cholesterol							
PT/INR							
APTT							
CSF Protein / Sugar							
Cells							
N/L	Bicarb - 22		18	18			

PTH
Vit D3 11.6

(P.T.O)

Date	OPD 18/7/26					
Time						
CUE - Alb	+					
CUE - Sugar	Nil					
CUE - Ketones						
CUE - PUS Cells	3 - 4					
CUE - RBC Cells	0					
CUE	2-3 EC					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
	Creatinine - 9.5					
Urine spot	Uric acid - 8.4					

Culture and Sensitivities : .....

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Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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DRUG CHART

Date of Admission: 20/7/26 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)

DRUG : inj. ondansetron				Date / Time
Dose	Route	Frequency	Start Date	
2mg	IV	SOS	20/7/26	
Doctor's Signature		Valid Period	Pharm.	
madhu				
Additional Instructions: SOS for vomiting				

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 .....

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Baby KOTHAPALLI HARINI RATNAM
25-10-2021 4 Y 8 M 25 D (F)
Dr. SRUTHI BALLA

REGULAR PRESCRIPTIONS

Weight. 12.2 kgs Ward. ....

DRUG : INJ. CEFTRIAXONE

Dose	Route	Frequency	Start Date
600mg	I/V	BD	20/7/26

Name & Signature of the Doctor Starting the Drugs: Madhu

Additional Instructions:

Date ▸ 20/7, 21/7
Time ▾ 10 Am, 10 pm

Stop

Daily Doctor's Endorsement by a Sign

DRUG : INJ. ESOMEPRAZOLE

Dose	Route	Frequency	Start Date
12mg	I/V	OD	20/7/26

Name & Signature of the Doctor Starting the Drugs: Madhu

Additional Instructions:

Date ▸ 20/7, 21/7, 22/7
Time ▾ 6 Am

Daily Doctor's Endorsement by a Sign

DRUG : NEB c̄ LEVOLIN

Dose	Route	Frequency	Start Date
0.63mg	NEB	Q4Hrly	20/7/26

Name & Signature of the Doctor Starting the Drugs: Madhu

Additional Instructions:

Date ▸
Time ▾

STOP

Daily Doctor's Endorsement by a Sign

DRUG : SYRUP. NODOSIS

Dose	Route	Frequency	Start Date
15ml	P/O	QID	20/7/26

Name & Signature of the Doctor Starting the Drugs: Madhu

Additional Instructions:

Date ▸ 20/7, 21/7, 22/7
Time ▾ 12 Am, 6 Am, 12 pm, 6 pm

self

Daily Doctor's Endorsement by a Sign

BAH-00635346
Baby KOTHAPALLI HARINI RATNAM
IP5-00176645
25-10-2021
4 Y 8 M 25 D
Dr. SRUTHI BALLA
(F)

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight ...12.2 kgs... Ward ....

DRUG : Tab. AMLODIPINE

Dose	Route	Frequency	Start Dt.
2.5mg	P/o	BD	20/7/26

Name & Signature of the Doctor Starting the Drugs: Madhu

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾	20/7	21/7	22/7
8 Am	Self	Self	[illegible]
8 PM	Self	[illegible]	

DRUG : Tab. PRAZO PRESS

Dose	Route	Frequency	Start Dt.
2.5	P/o	BD	20/7/26

Name & Signature of the Doctor Starting the Drugs: Madhu

Additional Instructions:
1tab - 2.5mg
1tab ——— 1/2tab

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾	20/7	21/7
6 Am	✓	Self
6 PM	Self	[illegible]

DRUG : Cap. ROCALTROL

Dose	Route	Frequency	Start Dt.
0.25mg	P/o	OD	20/7/26

Name & Signature of the Doctor Starting the Drugs: Madhu

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾

HOLD — Sruthi

DRUG : Syrp POTCHLOR

Dose	Route	Frequency	Start Dt.
2.5ml	PO	BD	21/7

Name & Signature of the Doctor Starting the Drugs: [illegible]

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾	21/7	22/7
6AM	2PM [illegible]	[illegible]
10PM	[illegible]	

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

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

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

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

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

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

Dr. SRUTHI BALLA

Weight. 12·2Kg Ward. ....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
20/7/26 3:20pm	3:20pm	Inj. LASIX	10mg	IV	[illegible]	Swapna / Hitin
21/7	2pm	Inj COSDX	10mg	IV	[illegible]	Sumane / Dusao

3:30 pm

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

Baby KOTHAPALLI HARINI RATNAM
25-10-2021 4 Y 8 M 26 D (F)
Dr. SRUTHI BALLA

IP5-00176645
BAH-0063546

I.V. FLUIDS CHART

Weight. 12.2 Kgs 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
20/7/26	1:20 pm	DNS	I/V	44 ml/hr			20/7		
20/7	5:pm	DNS	IV	35					

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

BAH-00635346 IP5-00176645
Baby KOTHAPALLI HARINI RATNAM
25-10-2021 4 Y 8 M 25 D (F)
Dr. SRUTHI BALLA

Neb- Levalin 4th hrly

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NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
20/7/26	00.00	Neb c Levalin 4:30pm	Vicath	
	01.00	Neb c Levolin - 8:30pm	Sangeetha	
21/7/26	02.00	Neb c Levolin - 12:30pm	Sangeetha	9713784
	03.00			
21/7/26	04.00	Neb c Levolin - 4:30pm	Sangeetha	9713784
21/7	05.00	Neb - Levolin - 8:30 am		Durga
	06.00	Neb - Levolin 12:30 pm		Durga
	07.00	Neb c Levolin 4:30 pm → Stop not connected		Durga
	08.00			
	09.00			
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

BAH-00635346 IP5-00176645
Baby KOTHAPALLI HARINI RATNAM
25-10-2021 4 Y 8 M 25 D (F)
Dr. SRUTHI BALLA

20/7/26

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

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : .... Time:	2:30pm	5:30pm	10pm	2AM	6AM
Doctor / Nurse / Family Concern?					
Temperature (F) (scale 94–104)	98.1°F	98.6°F	98.2°F	98.2°F	98.7°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190) — Note: BP does not score in early warning scoring	121/65 (81)	120/54 (72)	100/62 (74)	100/62	99/71
Heart Rate (Number)	100b/m	110b/m	122b/m	122b/m	113b/m
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)					
Resp Rate (Number)	24b/m	26b/m	26b/m	26b/m	28b/m
Resp Distress — Mod/ Severe / None / Mild					
Receiving O_2(l/min) / O_2Saturations (%)	99%	99%	99%	99%	99%
Conscious Level — Normal / Altered					
GCS *	(15/15)	15/15	(15/15)	(15/15)	(15/15)
TOTAL SCORE Number of shaded boxes	0	0	0	0	0
Pain Score	0	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

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.

Patient Sticker

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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.

I	**IDENTITY:** I am (name), a nurse on ward (X). I am calling about (child X)
S	**SITUATION :** 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	**BACK GROUND :** 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)
A	**ASSESSMENT :** 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.
R	**RECOMMENDATION :** 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-00635346 IP5-00176645
Baby KOTHAPALLI HARINI RATNAM
25-10-2021 4 Y 8 M 26 D (F)
Dr. SRUTHI BALLA

Patient Sticker

125

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

Pratiksha Rainbow Children's Hospital
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/Feb Time:

12.7 kgs

Time	8:30 AM	10:30 am	1 PM	10 PM	2 AM	6 AM
Doctor / Nurse / Family Concern?						
Temperature (°F) (94–104)	97.0 F	97.3 F	97.8 F	98.2 F	98.2 F	97.7 F
Heart Rate (bpm) and Blood Pressure (mmHg) * (50–190)	96/50 (66)	98/50 (66)	85/69 (74)	95/67 (72)	84/55 (62)	100/77 (79)
Heart Rate (Number)	109 bpm	122 bpm	122 bpm	122 b/m	126 b/m	122 b/m
Resp. Rate (bpm) Over 1 Minute) * (10–70)	30	30	30	30	30	30
Resp Rate (Number)	28 b/m	28 bpm	27 b/m	22 b/m	23 b/m	20 b/m
Resp Distress — Mod/ Severe / None / Mild						
Receiving O_2(l/min)						
O_2Saturations (%)	100%	99%	99%	99%	99%	98%
Conscious Level — Normal / Altered						
GCS *	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Note: BP does not score in early warning scoring

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.

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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- 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)
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- 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

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B	**BACK GROUND :** 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)
A	**ASSESSMENT :** 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.
R	**RECOMMENDATION :** 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-00635346 IP5-00176645
Baby KOTHAPALLI HARINI RATNAM
25-10-2021 4 Y 8 M 26 D (F)
Dr. SRUTHI BALLA

22/7

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.
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EARLY WARNING SCORE: CHILDREN'S UNIT

12.5kg

Parameter	Entry
Date : .... Time:	10am
Doctor / Nurse / Family Concern?	
Temperature (F) (94–104)	97.4°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (50–190)	120; 92 (65) 54
Note: BP does not score in early warning scoring	
Heart Rate (Number)	118b/m
Resp. Rate (bpm) (Over 1 Minute) * (10–70)	30
Resp Rate (Number)	30b/m
Resp Distress: Mod/ Severe / None / Mild	
Receiving O_2(l/min)	
O_2Saturations (%)	99%
Conscious Level: Normal / Altered	
GCS *	(15/15)
TOTAL SCORE Number of shaded boxes	0
Pain Score	0
Observer's Initials	[illegible]

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.
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Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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S	**SITUATION :** 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	**BACK GROUND :** 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)
A	**ASSESSMENT :** 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.
R	**RECOMMENDATION :** 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-00635346 IP5-00176645
Baby KOTHAPALLI HARINI RATNAM
25-10-2021 4 Y 8 M 25 D (F)
Dr. SRUTHI BALLA

20/7/26

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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.

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: 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	↓		44 NV						80 ml	0	Lakshmi
	03:00 pm	↓	H2O	-							0	Laxmi
	04:00 pm	DNS		44 NV							0	Laxmi
	05:00 pm	↑	H2O	35 NV						200 NV	0	Laxmi
	06:00 pm			35 NV							0	Laxmi
	07:00 pm										0	Laxmi
Total Intake :		150 ml				**Total Output :** U:						ml
	08:00 pm		H2O	35 ml						150 ml	0	Sangeeta
	09:00 pm										0	Sangeeta
	10:00 pm		H2O	35 ml						180 ml	0	Sangeeta
	11:00 pm	DNS									0	Sangeeta
	12:00 am		H2O	35 ml		NP					0	Sangeeta
	01:00 am		H2O								0	Sangeeta
Total Intake :		105 ml				**Total Output :**				U-2	M-0	
	02:00 am										0	Sangeeta
	03:00 am		H2O	35 ml							0	Sangeeta
	04:00 am										0	Sangeeta
	05:00 am	DNS	H2O	35 ml		NP				372	0	Sangeeta
	06:00 am										0	Sangeeta
	07:00 am		H2O	35 ml						212	0	Sangeeta
Total Intake :		105 ml				**Total Output :**				U-2	M-0	

Total 24 hrs. Intake	310 ml	Total 24 hrs. Output	U - 1120 M - 0

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Baby KOTHAPALLI HARINI RATNAM
25-10-2021 4 Y 8 M 26 D (F)
Dr. SRUTHI BALLA

FLUID CHART

Rainbow® Children's Hospital
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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No. : 2 21/7/20

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			35ml							0	Durga
	09:00 am			35ml						110ml	0	Durga
	10:00 am	DNS		35ml			✓				0	Durga
	11:00 am			35ml							0	Durga
	12:00 pm			35ml						110ml	0	Durga
	01:00 pm			35ml			✓				0	Durga
Total Intake :						Total Output : U - m - 2						
	02:00 pm			35ml							0	Durga
	03:00 pm			35ml						200ml	0	Durga
	04:00 pm	DNS		35ml							0	Durga
	05:00 pm			35ml			✓			100ml	0	Durga
	06:00 pm			35ml							0	Durga
	07:00 pm			35ml							0	Durga
Total Intake :						Total Output : U - m - 1						
	08:00 pm			35ml							0	Sg
	09:00 pm		HNO	35ml							0	Sg
	10:00 pm										0	Sangee
	11:00 pm	DNS	HNO	35ml			✓			390ml	0	Sg
	12:00 am										0	Sangee
	01:00 am		HNO	35ml						240ml	0	Sangee
Total Intake :						Total Output : U - m -						
	02:00 am		HNO								0	Sangee
	03:00 am			35ml							0	Sangee
	04:00 am	DNS	HNO							101ml	0	Sangee
	05:00 am			35ml			✓				0	Sangee
	06:00 am		HNO							400ml	0	Sangee
	07:00 am			35ml							0	Sangee
Total Intake :						Total Output : U - m -						

Total 24 hrs. Intake	Total - 840ml	Total 24 hrs. Output	U 1651ml m - 5

22/7

BAH-00635346 IP5-00176645
Baby KOTHAPALLI HARINI RATNAM
25-10-2021 4 Y 8 M 26 D (F)
Dr. SRUTHI BALLA

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FLUID CHART

Sheet No. : 3

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										0	Jessie
	09:00 am		H2O								0	Jessie
	10:00 am	D									0	Jessie
	11:00 am	N									0	Jessie
	12:00 pm	S	H2O								0	Jessie
	01:00 pm										0	Jessie
Total Intake :						**Total Output :**				U-		M-
	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

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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**	

BAH-00635346 IP5-00176645
Baby KOTHAPALLI HARINI RATNAM
25-10-2021 4 Y 8 M 25 D (F)
Dr. SRUTHI BALLA

308-B

Rainbow® Children's Hospital
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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 20/07/26 Time: 1:40pm

Weight: 12.2kgs Centile: <5th

Height: 97cm Centile: <5th

Inference: underweight child.

RDA: - Calories: 1350kcal/D Protein: 23gm/D

Diet Recommendations: soft diet (low salt).

Re-Assesment: avoid spicy, chilled & outside foods

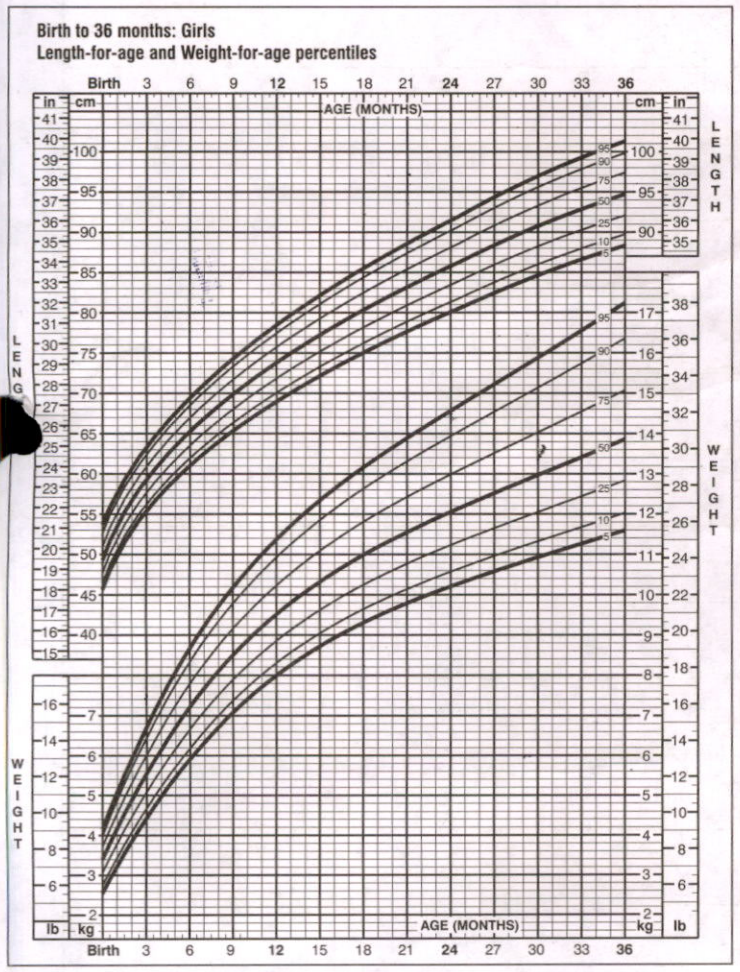
Food Allergies: No Veg/Non-veg Non-veg

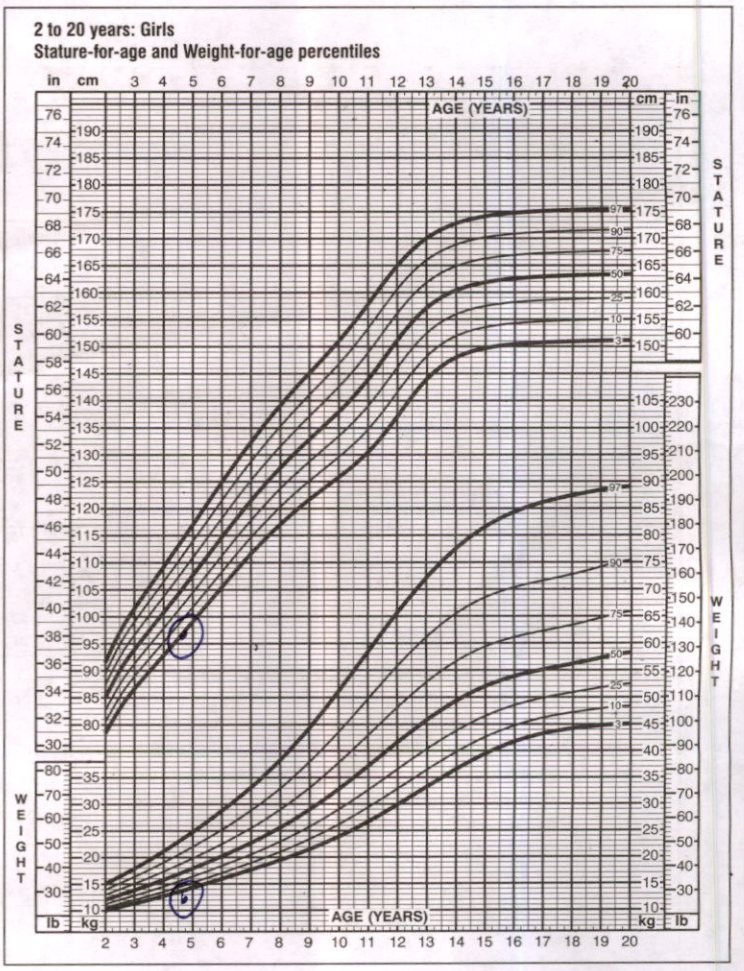
Diagnosis: CKD-3, Hypertension, uremia

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature:

GROWTH CHART (GIRLS)





Dietician's Name Saima

Dietician's Signature Saima

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

(P.T.O.)

Daily Notes:

21/7/26
11am

child is stable, oral intake is better
continue soft, low salt diet

Saima.