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

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Your Right to a Safe Delivery

DISCHARGE AT REQUEST

Name	Baby KAATHYAYANI GOUD	**UHID**	HNH-00006120
Father/Guardian	Mr OMPRAKASH GOUD	**Age/Gender**	1 Y 7 M 12 D/ Female
Address	13-6-458/12 GAYATRI NAGAR KARWAN HYDERABAD, Karwan, Hyderabad, Telangana, INDIA, 500006		
IP No	IP26-00006971	**Admission Date**	28-07-2026
Ref Doctor	Self.		
Discharge Date	29.07.2026		

Consultant:
Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

DIAGNOSIS	ICD CODE
CULTURE POSITIVE URINARY TRACT INFECTION	

History: Baby KAATHYAYANI GOUD is a 1 Y 7 M 12 D , old girl presented with history of loose stools associated with fever since 4 days, cry during urination since 4 days, dull activity and poor oral intake since 2 days, vomitings multiple episodes since 1 day, prior to admission. For the above complaints she was admitted at Rainbow Children's Hospital - for further management.

Name	Baby KAATHYAYANI GOUD	UHID	HNH-00006120
IP No	IP26-00006971	Admission Date	28-07-2026

Outside investigations :
Complete urine examination shows: Pus cells - 35-40, RBCS - 8-10, protein - present, nitrate - negative.

Examination: She was afebrile, maintaining saturations at room air. Her heart rate was 122/min, blood pressure was 92/68 mmHg and RR - 24/min. On examination Signs of dehydration were present, dry lips, oral mucosa, delayed skin turgor, sunken eyes were present. On auscultation of chest, air entry was bilaterally equal with normal heart sounds and there was no murmur. Abdomen was soft, non tender without organomegaly. On neurological examination, she was conscious & alert. Pupils were bilaterally equal & reacting to light. There were no focal neurological deficits.

Weight on admission: 9.2 kilo grams.

Investigations: Enclosed reports.

Initial hemogram showed Hemoglobin of 12.0 gm%, White Blood Cell count of 11590 cells/cumm, platelet count of 3.69 lakhs/cumm and C-Reactive Protein of 5.0 mg/l. Serum Creatinine was 0.2 mg/dl.
Complete urine examination shows: Pus cells - loaded, RBCS - 20-25, protein - present, nitrate - positive.

Ultrasound abdomen shows:
* Internal echoes in urinary bladder - suggested CUE correlation to rule out cystitis.
* Few non specific lower mesentery nodes.
- For clinical correlation.

Name	Baby KAATHYAYANI GOUD	**UHID**	HNH-00006120
IP No	IP26-00006971	**Admission Date**	28-07-2026

Blood culture shows 24 hours no growth.

Urine culture : Gram negative growth (verbal report)

Management: She was admitted in the ward and started on intra venous fluids . She was treated symptomatically with antiemetics, antacids and antipyretics. In view of loose stools, she was administered probiotics and advised gastrodiet.

In view of urine routine showing significant pus cells started on IV antibiotics after sending urine and blood cultures . Usg abdomen was done report suggestive of cystitis . Blood culture 24 hours no growth , final report awaited . Urine culture showed gram negative growth , final report awaited

She was regularly monitored for her loose stool frequency and hydration status. Her loose stools and other symptoms settled gradually.

She remained hemodynamically stable throughout the hospital stay with ongoing management and is being discharged with the following advice.

At the time of discharge : She is active, afebrile and hemodynamically stable.

Medications given during hospital stay:
Injection. Amikacin
Injection. Ceftriaxone
Injection. Esmoprazole
Injection. Ondansetron
Z & D Drops
Pro-GG Drops

Name	Baby KAATHYAYANI GOUD	**UHID**	HNH:00006120
IP No	IP26-00006971	**Admission Date**	28-07-2026

Advice:

* Diet as advised.

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Inj Ceftriaxone	900 mg in 20cc ns over 2 hours	once daily	Till tommorow
2	Injection. Amikacin	140mg	once daily	Till tomorrow
3	NEXPRO 10MG SACHET	1	9am (before food)	2 days
4	Syrup. ONDEM (Ondansetron – 5ml/2mg)	5 ml	7am-7pm (30 minutes before food)	SOS
5	PRO GG drops	15 drops	9am-9pm (after food)	For 2 days
6	Z & D drops (1ml/20mg)	1 ml	9am (after food)	For 12 days
7	Nasoclear nasal drops, 2 drops in each nostril **SOS** for nose block			

Name	Baby KAATHYAYANI GOUD	UHID	HNH-00006120
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Plan: Plan to change to oral antibiotics on followup after urine culture report
Urine culture : Report awaited.

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 3 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
* Tepid sponging if fever > 101 *F.

Review consultation with Dr. SINDHURA MUNUKUNTLA on (30.07.2026) **Thursday** at Himayatnagar in OPD with prior appointment **(Review consultation will be charged)**.

Food instructions while taking medications:
* **Antibiotics** along with food & milk products prevent their absorption of drugs & supplements. Antibiotics can be given 1 hour before food or 2 hours after food based on tolerance of stomach.
* By consuming your **probiotic** with food you provide a buffering system for the supplement and ensure its safe passage through the digestive tract. Aside from protection, food also provides the friendly bacteria in your probiotic the proper food and nourishment to ensure it survives, grows and multiplies in your gut. It is recommended to take probiotics at the END of a meal. Concurrent administration of antibiotics could kill a large number of the organisms, reducing the efficacy of probiotics. Separate administration of antibiotics from probiotics by **atleast two hours.**

Follow up immediately in Emergency Room if high grade fever, vomiting, breathlessness or refusal to feed occurs.

If any Intra Venous antibiotics - will be given in Emergency Room

Name	Baby KAATHYAYANI GOUD	UHID	HNH-00006120
IP No	IP26-00006971	Admission Date	28-07-2026

between 7am - 8am for morning dose, between 2pm-3pm for afternoon dose and between 8pm-9pm for evening dose (Outside medication shall not be allowed within the hospital as per the hospital protocol).

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctor ..... in a language that I can understand and I acknowledge.

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Himayatnagar / Banjara Hills /** Rainbow Clinic **Madhapur / Kukatpally / Vikrampuri / LB Nagar** dial just one toll free number **18002122.**

You can also take appointments at any time by going **online** to our website **www.rainbowhospitals.in**

Registrar/Resident/C.M.O

Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD (F)
16-12-2024 1 Y 7 M 12 D
Dr. SINDHURA MUNUKUNTLA

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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	2			
8	Consultation sheet				
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	1			
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				
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)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale				
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Billing	1			
	Others	5			
	Total No. of Pages	27			

Doc. No. : RCH/ FRM / GENERAL / 126

Signature and Date : 29/07/26 Jyotsna

(P.T.O)

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006971 **Admit Date** : 28-Jul-2026 **Admit Time** : 02:27 AM **UHID** : HNH-00006120

Patient Details :

Patient Name	: Baby KAATHYAYANI GOUD	**Age**	: 1 Y 7 M 12 D
Guardian	: Mr OMPRAKASH GOUD	**DOB**	: 16-12-2024 01:00 AM
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 13-6-458/12 GAYATRI NAGAR KARWAN HYDERABAD Karwan Hyderabad Telangana INDIA 500006	**Phone No**	: 8897894567/ 9381092821
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : ER01 **Ward Name** : GF -EMERGENCY

Room No : ER01 **Admission Type** : First Visit

Contact Details :

Name : Mr OMPRAKASH GOUD **Relationship** : Father

Contact Address : 13-6-458/12 GAYATRI NAGAR KARWAN HYDERABAD Karwan Hyderabad Telangana INDIA 500006 **Phone No** : 8897894567

Signature

Doctor Details :

Doctor Name : Dr. SINDHURA MUNUKUNTLA **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : Self. **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 10000.00

Payment Mode : DC/CC Card **Payor Name** : FAMILY HEALTH PLAN INSURANCE TPA LTD

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 28/7/25 Time of arrival : 1:05AM

Chief Complaints: c/o stomach pain since 2 hours loose motions x 4 days 10 vomiting episodes RBS: .....

Height : ..... Weight : 9.18kg BMI : ..... Head Circumference (<2 years) .....

Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: .....

If yes , identify .....

Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 6 Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker

☐ Character Acute ☐ Location stomach pain ☐ Frequency ..... ☐ Duration .....

RISK FOR FALL:

☐ If patient is < 6 years
tick below fall risk intervention directly

☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☒ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☒ No
- Uses furniture for support ☐ Yes ☒ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☒ No
- Weak ☐ Yes ☒ No
- Impaired ☐ Yes ☒ No

Mental Status: Forgets limitations ☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

☐ Escort while ambulating
☐ Assist Patient
☐ Educate patient and family on fall precautions/prevention

Functional Screening: ☐ No Abnormalities Detected

☐ Mobility Problem
☐ Walking Problem
☐ Developmental Delay
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☐ No Abnormalities Detected

☐ Underweight
☐ Overweight
☐ Feeding Problem
☐ Special diet
☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☐ No

If Yes Consultant Notified: ..... (Date/Time): .....

Social History: Lives With family .....

Siblings in household ☐ Yes ☐ No (if yes How Many?) .....

Time of Initial assessment completed by ER Nurse : @ 1:07AM

Nursing Notes (Including Labs / Medications / Other Care):

Time	Nursing Notes
1:09 AM	Assess The patient condition monitor the vital sign

Samples collected by: /

Samples sent by : / Apurba

Time: /

Time: / 2:50 AM

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out : pretty	**Details of Shift - out**
HR: 122 b/M BP: 82/68 (74) CFT: N/A RR: 24 b/M SPO_2 : 98% GCS: 15/15 Temperature : 98.2 Pain Score: ..... Repeat RBS (if applicable): N/A	Shift - out from ER to: 2nd floor 218 Time of Shift - out: 3:18 AM Handover given to: Sandhya (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): .....

IV placement done

Name of the Nurse : Shirisha

Signature of the Nurse : Sd

Date & Time : 28/7/26 @ 1:12 AM

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00006120 IP26-00006971 Baby KAATHYAYANI GOUD 16-12-2024 1 Y 7 M 12 D (F) Dr. SINDHURA MUNUKUNTLA	28/7/26 @ 2:27 PM	28/7/26 @ 3:18 AM
	Transfer Ordered by Dr. pranav	Reason for Transfer Admission
From Unit GR	To Unit ward (2nd)	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 15-1	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Shirisha	Dr. pranav

Patient & Clinical Records Received by : Sr. Sandhya 28/7/26

Date & Time of Patient Received : @ 3:30 am

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

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ACTIVITY RECORD FOR BILLING

HNH-00006120 IP26-00006971
Name Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA
UHID

---------- Consultant : ---------- Dept : pediatrics

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
28/7/26	3:18 AM	ER	ward	

Cross Consultation Visit

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

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

INVESTIGATIONS

Date	Investigations	Order No.	Sign
28/7/24	CBP, CRP, Blood c/s, Creatinine, VBG	12761	
		Cross check done by Sr. Sandhya	
28/7/24	USG Abdomen	9236	

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Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
28/7/26	Infusion Pump	28/7/26 @3:35 am.	29/7/26 @7:30 am.	17600	Sandhya.

Cross check done

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
28/7/26	2v placement	1	17595	
28/7/26	NHA	1	7716	

cross check done

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

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Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

Patient Name : _____

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

Pediatric Multiorgan History & Physical Examinati

Name : B/o Kavya

Informant Mother Reliability Y

Chief Presenting Complaints & Duration (Chronologically): c/o Fever - 4 days ago ~~for 1 day~~ for 3 days

c/o Loose stool :: 4 day

c/o Pain on Urination :: 4 day

c/o Dull activity & Poor Oral intake :: 2 day

c/o Vomiting :: 1 day

History of present illness :

Child brought with

c/o Fever - 4 days ago for 3 day → High grade.

c/o Loose stool :: 4 day

Multiple episode / day - Watery, Slimy - Mucus

Foul smelling, Non blood stain

c/o Pain on Urination :: 4 day

On & off pain, No c/o Pus Passing

c/o Dull activity & Poor Oral intake :: 2 day

c/o Vomiting :: 1 day, Non bilious / Non projectile

No c/o Cold / Cough

CVE on 23/7

Pus cells → 35-40

Lactocytes → 27

Blood → +

RBC → 8-10

CSE on 25/7 (continued)

Pus - 4-6 c/f

Starch - +

Fat - +

No RBC / Ova / Cyst

→ Stool C/S - Negative

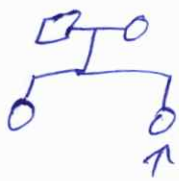
Pediatric Multiorgan History & Physical Examination

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

N/

Birth & Neonatal History :

FT / AGA / CIAB



Birth & Socio Economic History :

About Father : Upper middle class

About Mother :

Any additional Information :

Developmental History :

N

Immunization History :

Upto date

Pediatric Multiorgan History & Physical Exami

Anthropometry

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

Weight (kgs) 9.2 kg (Centile _____)

On Examination :

Temperature : 98°F Pulse Rate: 122/min Description _____

B.P. 82/68 (74) mm/Hg SPO2 97% at _____

Resp. rate and type of breathing : 24/min.

Rash _____ Sign of Dehydration - Sunken eyes, delay skin turg

Lymphadenopathy _____ Dry lips / oral mucosa

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L AE (+)

Any addes sounds : Clear

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1S2 (+)

Any murmur : _____

Relevant date from outside (Chest X-Ray, ECG, ECHO, Etc.,) _____

Per Abdomen :

Inspection (N)

Palpation : Soft

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examinatio

Central Nervous System :

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

Cranial Nerves : WNL

Motor System :

Nutrition :

Tone : Power

Co-ordinator : WNL

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars

Sensory System :

WNL

Bladder / Bowel :

Clinical Summary & Diagnostic :

AFI - D4 - Urinary Tract Infection c
Acute Gastroenteritis c Dehydration

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Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Shock

Desired goals of the treatment :

H-D stability

Planned Labs :

VBG
CBP, CRP, creatinine
Blood C/S
+1 extra plasma

catheter sample [CUE, Urine C/S] sent on OPD baby

RCB shirisha

Planned Management :

Inj Ceftriaxone
Inj Amikacin
Inj Ondem / Inj Esomeprazole
IVF
Pro GG / ZKD

KVB
USG Abdomen - T/m

RBshirisha

Please fill up the following details

1. Name of the Referring Doctor : _____
2. Name of the Referring Hospital : _____
   (Including the name of City)
3. Contact number of the Referring Doctor : _____
   (Preferring Mobile #)
4. Name of the doctor in Rainbow Team Dr. SINDHURA on whose name the patient is being referred

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No: 66970

Doctor's Signature Name _____ Date 28/1/26 Time 10:00 AM

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/7 8AM	C/S/B Dr. Pranav / Dr. Sushanth	
	UTI ~	
	Acute GE ~ Dehydration	
	Fever - ✗	Plan
	Vomiting - ↓	1) Trace take
	Pain on Urination - ✓	2) Inj Ceftriaxone
		Inj Amikacin
	O/E	3) Inj Ondem
	Child asleep	Inj Esomeprazole
	Vitals stable	4) IV F - 2/3 rd @
	R-S - B/L AE @	5) USG Abdomen / KUB - Today.
	P/A - Soft	6) Monitor Vitals
		Pranav
		noted by Sr. Sandhya 28/7/26.

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/7/24 10AM.	c/s/b Dr. Sindhura	
	D- Acute GE / UTI	
	- Febrile is High grade - 103.5°F.	
	- N/V c/o vomiting.	Plan
	- O/E - vitals stable.	- Ct. Ceftriaxone Amikacin.
	S/E - P/A - SNT, NT. BS(+).	- Trace blood d/s, urine d/s.
		- USG Abdomen/KUB today.
		- Ct. Ecosprazole/ ondansetron/ Zinc drops/ Pro Gut drops.
		NB- Mentioned @ 11AM.

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No: 66970

HNH-00006120 IP26-00006971
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/7/26 2 PM	C/s /b Dr. Varun / Dr. Naipunya.	
	Δ - Acute GE / ? UTI.	
	- High grade fever spikes persistent.	
	- Oral intake - Fair.	
	O/E - vitals stable.	Plan
	S/E - P/A - Soft, NT.	- Ct. Ceftriaxone / Amikacin.
		- Trace blood c/s / Urine c/s.
		- Ct. Esomeprazole / ondansetron / Zinc / pro GI drops.
		NB-Mounika @ 2:13 pm

HNH-00006120 IP26-00006971
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PROGRESS NOTES AND DOCTOR'S ORDER

& Time	Progress Notes	Doctor's Order
28/7/26 6:30 pm	UTI R/o. Sindhura	
	? UTI	
	- high grade spikes (+)	
	- no josh clo	
	- oral intake : fair	
	O/E	plan
	vitals : stable	1) Trans Blood cs & nerve cs
	s/t -	2) plan discharge after reports
	P/A - soft	3) ct. antibiotics
		4) cont it as per Rx chart
		5) monitor vitals
		noted by medical

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No: 66970

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/7/26 7:30am	W/B Dr. Rani	
	UTI	
	- fever spikes (+)	
	- no vomiting	
	- oral intake : fair	
	O/E	Plan
	vitals : stable	1) trace blood ch/ nerve ds
	SLE - (N)	2) plan discharge after reports
		3) ct - antibiotics
		4) STOP IVF
	Rx	5) monitor vitals
		NB Snacks 7:30am

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/7/26. 10.40AM	C/s/by. Dr Sindhu	
	UTI	
	U/c/s – G -ve Bacte	
	– No fever.	– Ct IV Ab. (Give tody dose before d/s)
	Vital stable.	– d/s c IV Medication x 1 day.
	S/E NAD.	– (F) final u/c/s.
		– d/s today.
		– R/v Tm ↓ c u/c/s report.
		Epl to chge Ab a/c to reports
		Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

NURSING CARE RECORD

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Date: 27/7/26

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Relieve Pain & Discomfort
- ☐ Maintain Fluid Balance
- ☐ Improve Activity Tolerance
- ☐ Maintain Good Nutritional Status
- ☐ Maintain Skin Integrity
- ☐ Maintain Personal Hygiene
- ☐ Prevent Infection
- ☐ Meet Elimination Needs
- ☐ Ensure Safety
- ☐ Early Ambulation Reduce Anxiety
- ☐ Patient & Family Education
- ☐ Identify Potential Complications
- ☐ Any Others. Specify.....

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	3Am No 8Am	Assess the pt condition. monitor vitals sym cond. maintain I/O chart. Provide the comfortable position. medication give as per as doctor ord.	3Am No 8Am	Assessed the pt condition monitored vitals sym cond maintained I/O chart Provided the comfortable position. medication given as per as doctor order.	→ pt is stable → vitals normal	→ monitor vitals → maintain I/O chart.	Sneha

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD (F)
16-12-2024 1 Y 7 M 12 D
Dr. SINDHURA MUNUKUNTLA

NURSING CARE RECORD

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

Date: 28/7/26

Go
- ☐ Maintain [illegible]
- ☐ Identify Potent[illegible]plications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ Any Others. Specify.....
- ☐ Maintain Fluid Balance
- ☐ Meet Elimination Needs
- ☐ Improve Activity Tolerance
- ☐ Ensure Safety
- ☐ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety
- ☐ Maintain Skin Integrity
- ☐ Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM / 2PM	→ Assess the General Condition of pt → Monitor vitals → Maintain I/o chart → Administer medication.	8AM / 2PM	→ Assessed the general → Monitored vitals → Maintained vitals → Administered medication.	Pt is Stable.	Re-assess vitals	Madhuri
Afternoon	2pm / to / 8pm	→ Assess the general Condition. of pt → Monitor vitals → Maintain I/o chart → T/blood CLS → Urine. CLS	2pm / to / 8pm	→ Assess the general condition of pt → Monitor vitals → Maintain I/o chart → USG. Abdomen done. → Urine CLS	pt is a Stable.	Re-assess the vitals	Madhuri
Night	8pm / 8am	→ Assess the patient general Condition → monitor vitals → Administer medicatn as per doctor's orders.	8pm / 8am	→ Assessed the patient general Condition → monitored vitals → Administered medications as per doctor's orders.	Patient is Stable	Rechecked vitals	

Patient Sticker

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

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NURSING SHIFT HAND OVER FORM

SITUATION

Diagnosis: AGE & UTI

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

Surgery / Procedure:

Post OP Day:

BACKGROUND

Date / Shift	27/7 N1	28/7 M6	28/7/26 E2	28/7/26 N1		
Medical Condition (Any special condition to be noted):						
Diet:	Soft	Soft	soft	soft		

ASSESSMENT

Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Ventilation (RA, NP, NIV, VENTI):	—	—	—	—		
Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vital Signs: Temp:	98.2°F	98.4°F	98.5°F	98.3°F		
Res:	28b/m	28b/m	29b/m	24b/m		
SpO_2:	98%	99%	99%	99%		
Pulse:	112	115b/m	113b/m	112b/m		
BP:	96/59	98/58	98/69	100/70		
LOC:	—	—	—	—		
Fall Risk Score:	—	—	—	—		
Pain Score:	0	0	0	0		
Skin Integrity	—	Good	good	Good		

Recommendations

Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Physiotherapy:	—	—	—	—		
Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Special Diet:	—	—	—	—		
Critical Lab Test / Values:	—	—	—	—		
Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ADL (Dependent / Non Dependent):	—	—	—	—		

Post Operative Procedure Special Orders:	—	—	—	—		
Handed Over By Name :	Sneha	Mounika	Madhuri	Sandhya		
Signature / ID :	Sneha 40603					
Date:	28/7	28/7/26	28/7/26	29/7/26		
Time:	8pm	2pm.	8pm	8am.		
Taken Over By Name :	Mounika	Madhuri	Sandhya			
Signature / ID :						
Date:	28/7	28/7/26	28/7/26			
Time:	8AM	8pm	8pm.			

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:					Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:	
	Surgery / Procedure:					Post OP Day:	
BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non-Dependent):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

HNH-00006120 IP26-00006971
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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... N/A ..... ☐ 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: ..... ~~E.R~~ ..... 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	Z & D Drop	1ml	Po	OD	27/7	☒ C ☐ DC
2	ENTEROGERMINA	1vial	Po	BD	27/7	☐ 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. pranav .....

Date & Time : ..... 28/7/26 @ 2:22pm .....

Nurse Name & Signature: ..... Shirisha .....

Date & Time : ..... 28/7/26 @ 3:18 AM .....

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

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
15-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

wt 9.18 kgs

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Bb/o Kavya Age : Gender: ☐ Male ☐ Female

Date : 28/7/26 Time of Arrival : 1:01 AM

Allergies: ☑ No ☐ Yes ☐ Food ☐ Medications ☐ Blood Transfusion ☐ Other (Specify): ☐ Not known

Source of Information : ☑ Parents ☐ Others (Specify)

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 97.8 F PR: 126/M BP: 82/68(74) mm Hg RR: 24/M SpO_2: 98%

Chief Complaints: c/o stomach pain since 2 hours, loose motions x 1 day, vomiting x 1 episode

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing
☐ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

☑ Stable
☐ Unstable :
- ☐ Not – Life - Threatening
- ☐ Life – Threatening

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☑ 60 min
☐ Level 5 : NON – URGENT : May receive care when convenient	☐ 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

Signature of Parent / Guardian

* CTAS - Canadian Triage and Acuity Scale

Triage Completion Time : .....

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☑ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☑ No
3. Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☑ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☐ Not applicable

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☑ No
   If yes, State Location: .....
2. Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☑ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Shirisha

Signature of Triage Nurse : .....

Date & Time : 28/7/26 @ 1:03 AM

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

Patient Sticke

/ 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 : 28/12 Time: 4am 7am

Doctor / Nurse / Family Concern?

Temperature (F)

104 103 102 101 100 99 98 97 96 95 94

98.2°F 98.4°F

Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring

190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

Heart Rate (Number) 135b/m 132b/m

Resp. Rate (bpm) (Over 1 Minute) *

70 60 50 40 30 20 10

Resp Rate (Number) 25b/m 22b/m

Resp Distress	Mod/ Severe		
	None / Mild		
Receiving O_2(l/min) O_2Saturations (%)		99%	99%
Conscious Level	Normal		
	Altered		
GCS *		14/15	15/15
TOTAL SCORE Number of shaded boxes		0	0
Pain Score		0	0
Observer's Initials		S	S

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)

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

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 28/7/26.. Time:	10am	2pm	6pm	10pm	2am	6am
Doctor / Nurse / Family Concern?						
Temperature (F)	97.5F	98.2F	98.4F	97.9F	98.2F	98.6F
Heart Rate (bpm) and Blood Pressure (mmHg) *						94 / 56
Heart Rate (Number)	120b/m	125b/m	120bm	130b/m	128b/m	110b/m
Resp. Rate (bpm) (Over 1 Minute) *						
Resp Rate (Number)	30b/m	33b/m	30bm	28b/m	30b/m	28b/m
Resp Distress: Mod/ Severe / None / Mild						
Receiving O_2(l/min) O_2Saturations (%)	99%	99%	100%	99%	99%	99%
Conscious Level: Normal / Altered						
GCS *	14/15	14/15	14/15	14/15	14/15	14/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials						

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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- 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)

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
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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.

		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										0	
	03:00 am										0	
	04:00 am										0	
28/11	05:00 am			25ml							0	
	06:00 am	DNS		25ml	NA			NA			0	Sne
	07:00 am			25ml							0	
Total Intake : Taken						**Total Output :** 0 - ml-						

Total 24 hrs. Intake		Total 24 hrs. Output	0 - ml-

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FLUID CHART

Sheet No. : 2

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							
28/7	08:00 am			25ml								
	09:00 am			25ml						✓		
	10:00 am	DNS	Idly	25ml			0				0	
	11:00 am		Mpl	25ml		NA		NA				
	12:00 pm		H2O	25ml								
	01:00 pm				NA							
Total Intake :						**Total Output :** U-1 M-						
28/7	02:00 pm			25ml								
	03:00 pm		Milk	25ml						✓		
	04:00 pm	DNS	Milk	25ml								
	05:00 pm		H2O	25ml			?			✓	?	Nadu
	06:00 pm		Idly	25ml	NA	NA		NA				
	07:00 pm		S	25ml						✓		
Total Intake :						**Total Output :** U-3 M-0						
28/7	08:00 pm			25ml								
	09:00 pm		Rolly	25ml						✓		
	10:00 pm	DNS	+	25ml							0	
	11:00 pm		H2O	25ml								CY
	12:00 am			25ml	NA		0		NA	✓		
	01:00 am			25ml								
Total Intake : Taken						**Total Output :** U-2 M-						
29/7	02:00 am			25ml								
	03:00 am			25ml								
	04:00 am	DNS	H2O	25ml							0	
	05:00 am		+	25ml			0			✓		CY
	06:00 am		Alu	25ml	NA			NA				
	07:00 am			25ml								
Total Intake : Taken						**Total Output :** U- M-						

Total 24 hrs. Intake		Total 24 hrs. Output	

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DRUG CHART

Date of Admission: 28/7/26 Drug Allergies: NKA ☐ 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 : CALPOL DROPS				Date / Time
Dose	Route	Frequency	Start Date	
1·3ml				
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions: 1ml = 100mg				

DRUG : Syp CROCIN-DS				Date / Time
Dose	Route	Frequency	Start Date	
3ml	PO	SOS	28/7	
Doctor's Signature		Valid Period	Pharm.	
Pharm				
Additional Instructions: If T > 100°F				

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

VERIFIED BY : Name ..... Signature

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REGULAR PRESCRIPTIONS

Weight. 9.2 kg Ward. .....

DRUG : Inj CEFTRIAXONE

Dose	Route	Frequency	Start Date
900 mg	IV	Once Daily	28/7

Name & Signature of the Doctor Starting the Drugs: Pravin

Additional Instructions: 100 mg/kg IV over 2 hours

Daily Doctor's Endorsement by a Sign

Date/Time: 28/7 09/7

3:40 pm 3Am

DRUG : Inj AMIKACIN

Dose	Route	Frequency	Start Date
140 mg	IV	Once Daily	28/7

Name & Signature of the Doctor Starting the Drugs: Pravin

Additional Instructions: 15 mg/kg

Daily Doctor's Endorsement by a Sign

Date/Time: 28/7 09/7

4Am

DRUG : Inj ESOMEPRAZOLE

Dose	Route	Frequency	Start Date
10 mg	IV	Once Daily	28/7

Name & Signature of the Doctor Starting the Drugs: Pravin

Additional Instructions: 1 mg/kg

Daily Doctor's Endorsement by a Sign

Date/Time: 28/7 09/7

6Am

DRUG : Inj ONDANSETRON

Dose	Route	Frequency	Start Date
2 mg	IV	TID	28/7

Name & Signature of the Doctor Starting the Drugs: Pravin

Additional Instructions: 0.2 mg/kg

Daily Doctor's Endorsement by a Sign

Date/Time: 28/7 09/7

6Am

2pm

10pm

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Sheet No: .....

REGULAR PRESCRIPTIONS

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

DRUG : Z & D Drops

Dose	Route	Frequency	Start Dt.
1ml	Po	once daily	28/7

Name & Signature of the Doctor Starting the Drugs: Pranav

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time	29/7 29/7
10Am	

DRUG : PRO-GG Drops

Dose	Route	Frequency	Start Dt.
15 drops	Po	BD	28/7

Name & Signature of the Doctor Starting the Drugs: Pranav

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time	29/7 29/7
	3:43
6Am	
6Pm	

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

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 .....

(P.T.O.)

Patient Sticker

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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 ....

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

		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.	

Signature .....

VERIFIED BY : Name ..

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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I.V. FLUIDS CHART

Weight. ....9.22.... Ward. .....

Date	Time	Position 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
28/7	3 AM	IVF - DNS (2/3rd M)	IV	2.5					

Signature .....

VERIFIED BY : Name .....

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RESULT SHEET

Date	28/7/26					
Time						
Hb	12.0					
PCV	33.4					
RBC	4.74					
WBC	11.59					
N/L	633/29.5					
Platelets	369					
CRP	5.0					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine	0.2					
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	23/7/26	28/7/26				
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells	35-40	Loaded				
CUE - RBC Cells	8-10	20-25				
CUE / Lucocyte -	present	present				
Protein →	Present	present				
Nitrite →	Negative	positive				
Blood →	present					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : 28/7/26 Blood C/S →

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.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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Patient S

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 28/7	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4				
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	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					
	Outpatient Area	1	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		10				

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

	Bed in low position		✓			
	Call device within reach		✓			
	Wheels Locked		✓			
	Room free of clutter		✓			
	Adequate lighting		✓			
	Wheel chair support		✗			
	Other Intervention(s) Specify		✗			
	Nurse's Name:		Sneha			
	Signature:		[signature]			
	Date:		29/7			
	Time:		8Am			

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BRADEN 'Q' SCALE

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					Date : 28/7 28/7 29/7		
					Time : 8AM 12AM 8PM		
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	3	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4
				TOTAL SCORE	23	28	28
				Evaluator's Name			

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Docu. No. : RCH /FRM / CLINICAL / 119

Risk Score	Category	Action	Support Surfaces (**Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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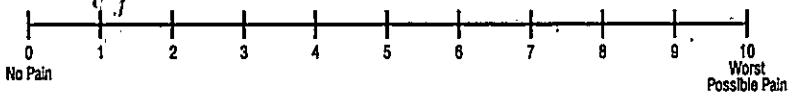
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
28/7	4Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sn
28/7	8Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sneha
28/7	10AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☐ Yes ☑ No	NA	[signature]
28/7	2pm			☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
28/7/26	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 27/1			DAY-2 28/1			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0				
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			NA	NA	NA	NA				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA	NA	NA	NA				
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			NA	NA	NA	NA				
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			NA	NA	NA	NA				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			NA	NA	NA	NA				
		Signature of the Nurse				Sneha	MD						

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :
Signature : Sneha Name : Sneha

Signature of Ward In Charge :
Signature : Balarani Name : Balarani

Patient Sticke

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
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CHECKLIST FOR THROMBOPHLEBITIS

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S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0										
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3										
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
		Signature of the Nurse											

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : ..... Name : .....

Signature of Ward In Charge :

Signature : ..... Name : .....

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby KAATHYAYANI GOUD**	**Age :**	**1 Y 7 M 12 D**
IP No:	**IP26-00006971**	**Sex:**	**Female**
Consultant:	**Dr. SINDHURA MUNUKUNTLA**	**Ward/Bed No:**	**GF -EMERGENCY/ER01**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.....)
3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name: Madikuda Omprakash Goud

Relationship: father

Date: 28/7/26 Time: 2:30 PM

Witness Name:

Witness Signature:

Patient Address:

13-6-458/12 GAYATRI NAGAR
KARWAN HYDERABAD Karwan
Hyderabad Telangana INDIA 500006

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Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

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BILLING POLICY

- Billing cycle: - With effective from 1st January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 12 PM, room rent will be charge for half day extra & post 6 pm, it will be charge for full day. Less than 24 hours stay will be considered as one day.
- As per the GOI guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Card tpaIn the event of TPA/ Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / corporates won't be applicable.
- If the surgery / scans performed in Emergency hours (8pm - 7am), public holiday and on Sunday will be charged TPA processing charges Rs.720 for every TPA route cases.
- All charges vary as per Room category, except Pharmacy and consumables.
- We follows a "No Discounts Policy" kindly cooperate.
- No Duplicate/Second copy of OP OR IP bill is issued.
- ICU/Ward Charges DO NOT INCLUDE - Air Mattress, Monitor, Consultants/ Specialty Doctors Visit, Infusion/syringe pump, Ventilator/C pap, Oxygen, Investigations, Procedures, Consumables, Medicines or any other bedside equipment's/devices etc. (Detailed list can be taken from billing department).

Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants inquire daily about the bill amount from billing section and pay the outstanding as on that day.

Patient bill outstanding should not be increase more than 10,000/-

You are requested to clear your outstanding amount on daily basis before 12 PM.

MODE OF PAYMENT & REFUNDS

- We accept payments by cash (up to Rs 1,99,999/- only), cards, online transfer and Demand Drafts.
- All refund more than Rs.2,000/- will be refund through NEFT in three Bank working days.

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

NOTE: Self - attested Govt. ID proof is mandatory whosoever is signing the undertaking.

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.
Corporate Office: 8-2-19/1/A, Daulet Arcade, Karvy Line, Road No.11, Banjara Hills, Hyderabad - 500 034.
Branches : BANJARA HILLS - T: 2233 4455 | VIKRAMPURI - T: 4246 2200 | KONDAPUR - T: 4246 2400 | MADHAPUR - T: 6464 2020 |KUKATPALLY - T: 4246 2300 | L B NAGAR - T: 7111 1333 | MARATHAHALLI, BENGALURU - T: +91 80 7111 2345 | BANNERGHATTA ROAD, BENGALURU - T: +91 80 2551 2345, HIMAYATNAGAR- T:- 40 48873000

CIN: U85110 TG1998 PTC029914 email : info@rainbowhospitals.in www.rainbowhospitals.in

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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 28/7/26 Time: 8:45 am

Weight: 9.2 kg Centile: < 5th

Height: — Centile: —

Inference: Underweight child.

RDA: — Calories: 1200 kcal/day Protein: 20 gms/day

Diet Recommendations: Soft and bland diet with High fiber diet with liquids

Re-Assesment: NO Junk, Spicy food.

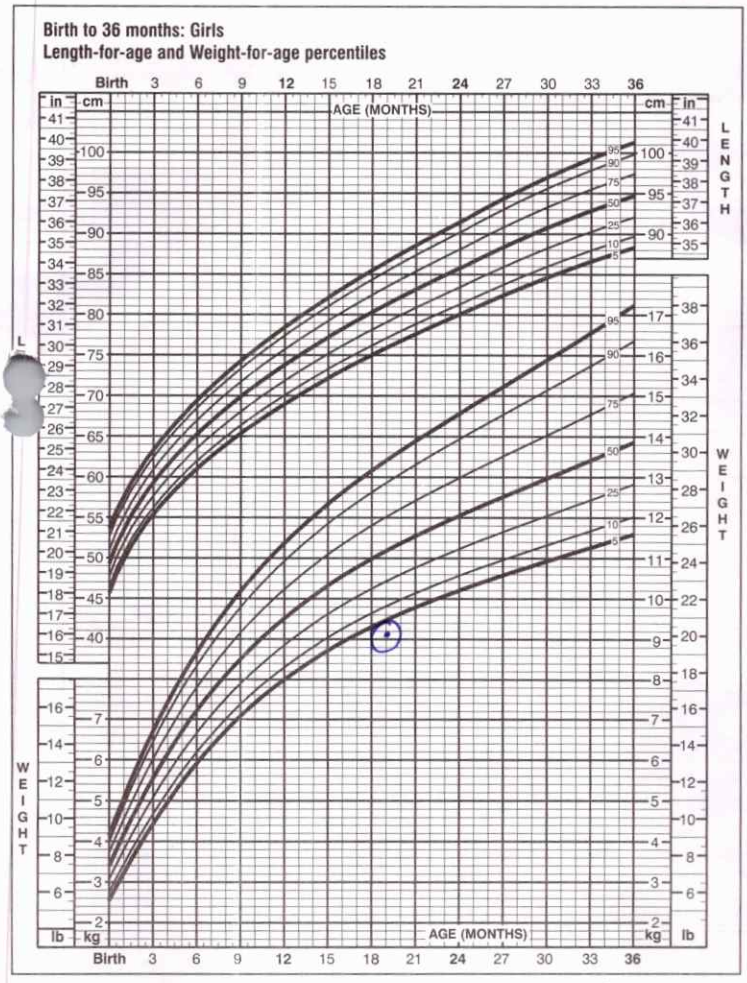
Food Allergies: NO Veg/Non-veg Non veg

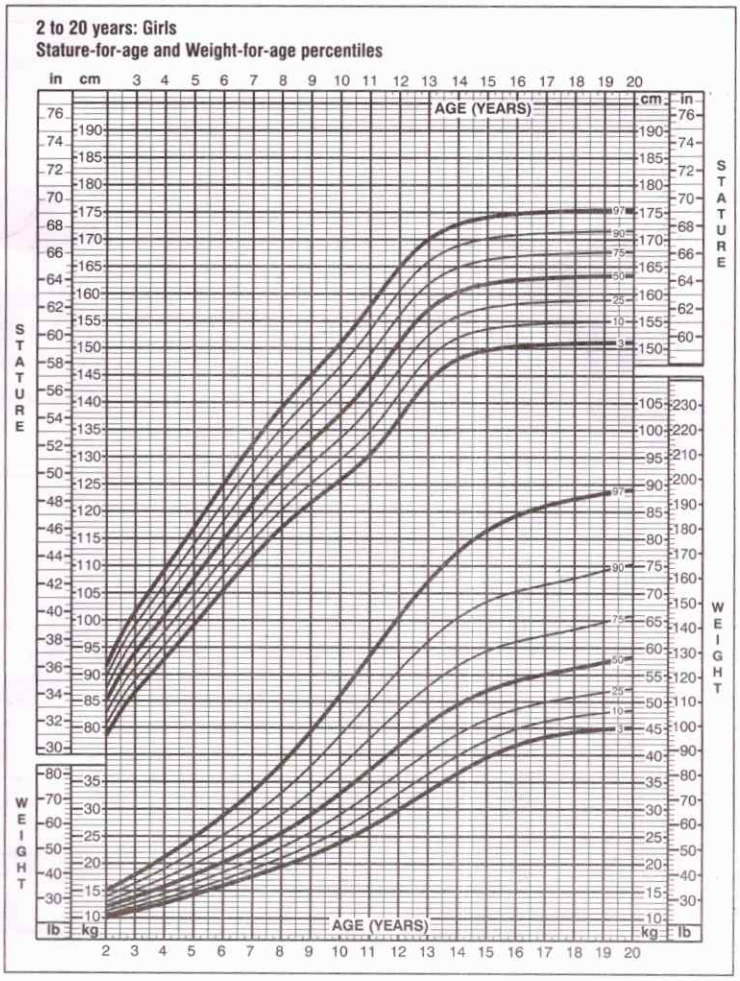
Diagnosis: Acute GE Cdehy & UTI

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature:

GROWTH CHART (GIRLS)





Dietician's Name Syeda Sobiya Zaheen Dietician's Signature Sobiya