

DISCHARGE SUMMARY

Name	Baby Of SANDHYA LOYA	UHID	HNH-00016297
Father/Guardian	Mr RAMAN LOYA	Age/Gender	0 Y 0 M 5 D/ Male
Address	3-6-175, hyderguda, Himayathnagar, Hyderabad, Telangana, INDIA, 500029		
IP No	IP26-00006760	Admission Date	06-07-2026
Ref Doctor	SELF		
Discharge Date	07.07.2026		

Consultant:

Dr. S TEJASWI REDDY

MBBS, MD Pediatrics, DM Neonatology
APMC/FMR/94068

DIAGNOSIS	ICD CODE
NEONATAL HYPERBILIRUBINEMIA	

History: Baby Of SANDHYA LOYA is a 0 Y 0 M 5 D old baby boy presented with history of yellowish discolouration of skin and eyes since 1 day prior to admission. For the above complaints, he was investigated on OPD basis (transcutaneous bilirubin was 15.3 mg/dl). In view of hyperbilirubinemia, he was admitted to Rainbow Children's Hospital, Himayathnagar for further management.

Name	Baby Of SANDHYA LOYA	UHID	HNH-00016297
IP No	IP26-00006760	Admission Date	06-07-2026

Birth history: Baby Of SANDHYA LOYA is a term (37 weeks +3 days) / AGA / baby boy of birth weight 2.88 kgs, born to primi mother delivered by NVD (Induced vaginal delivery) on 01.07.2026 at 05:19 pm. Baby had weak cry after birth, cyanosed, and poor tone. Apgar scores and resuscitation details were 5/10 at 1 min, 7/10 at 5 min, 9/10 at 10 mins. Baby improved with stimulation and DR- CPAP, developed respiratory distress for which baby was admitted to NICU Rainbow Children's Hospital - for further management.

Examination: He was euthermic, euvolemic & maintaining saturations at room air. Heart Rate- 128/min and Respiratory Rate - 38/min. Icterus was present. Chest was clear with normal heart sounds. Abdomen was soft without organomegaly. Cry, tone, activity and newborn reflexes were normal. There were no obvious external congenital anomalies.

Weight on admission : 2.87 kilo grams.

Weight at discharge : 2.92 kilo grams.

Investigations: Enclosed reports.

Management: He was admitted in ward. His transcutaneous bilirubin on admission (done on OP basis) was 15.3 mg/dl. He was started on double surface phototherapy. Baby was continued on demand breast feeds + measured feeds. Last serum bilirubin on 6 days of life was 9.5 mg/dl with indirect fraction of 9.4 mg/dl. This does not come under phototherapy range, hence phototherapy was stopped.

He remained hemodynamically stable and is being discharged with the following advice.

At the time of discharge : Baby was active, afebrile, hemodynamically

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stable, maintaining temperature, accepting & tolerating feeds well.

Advice:

Warmth care.

Exclusive breast feeding.

Continue direct breast feeds + measured feeds as advised.

Burping after each feed.

Monitor urine output.

Immunization to be given as per schedule.

Vitamin D3 Drops (1ml/800IU) 0.5ml once daily till further advice.

Nasoclear Nasal drops 2 drops in each nostril SOS for nose block.

Plan:

- 1. Thyroid profile report to be done collected on followup.**
- 2. Hearing test (TEOAE-Transient Evoked Otoacoustic Emissions) to be done on followup.**
- 3. Serum bilirubin to be done / decided on followup.**

Review consultation with Dr. S TEJASWI REDDY on Thursday (09.07.2026) in OPD at Himayatnagar with prior appointment **(Review consultation will be charged).**

Review back to Hospital:

If baby is not feeding continuously for > 6 hours, If breathing fast, Fever or poor activity or lethargy, Bluish discolouration of lips, Increase in jaundice, Abnormal movements occurs.

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

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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. S TEJASWI REDDY
MBBS, MD Pediatrics, DM Neonatology
APMC/FMR/94068

HNH-00016297
 Baby Of SANDHYA LOYA
 01-07-2026 0 Y 0 M 6 D (M)
 Dr. S TEJASWI REDDY



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 Hospital
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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	1			
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				
20	Consent for HIV test				
21	Anaesthesia 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	1			
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				
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	22			

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

Signature and Date : 07/07/26
 (P.T.O.)

[Signature]

ADMISSION SHEET

Registration Details :


Admission No : IP26-00006760 **Admit Date :** 06-Jul-2026 **Admit Time :** 02:09 PM **UHID :** HNH-00016297

Patient Details :

Patient Name :	Baby Of SANDHYA LOYA	Age :	0 Y 0 M 5 D
Guardian :	Mr RAMAN LOYA	DOB :	01-07-2026 05:19 PM
Gender :	Male	Religion :	
Occupation :		Martial Status :	
Address (H) :	3-6-175, hyderguda Himayathnagar Hyderabad Telangana INDIA 500029	Phone No :	8008015927/ 8919105375
		E-mail :	8008015927@email.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 RAMAN LOYA **Relationship** : Father
Contact Address : 3-6-175, hyderguda Himayathnagar Hyderabad
Telangana INDIA 500029 **Phone No** : 8008015927


Signature

Doctor Details :

Doctor Name : Dr. S TEJASWI REDDY **Specialisation** : NEONATOLOGY
Referral Doctor : SELF **Phone No** :
Co-Consultant :

Payment Details :

Deposit Amount : 15000.00
Payment Mode : DC/CC Card **Payor Name** : SELFPAY



ACTIVITY RECORD FOR BILLING

Name: --- **HNH-00016297** **IP26-00006760**
Baby Of SANDHYA LOYA
01-07-2026 **0 Y 0 M 5 D** (M)
Dr. S TEJASWI REDDY
 UHID No :  Consultant : _____ Dept : _____
 Date of Admission : _____ Time : _____ Date of Discharge : _____ Time : _____
 Room / Bed No : 317 Ward : 302bu Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/1/26	2:30 PM	ER	302bu 317	A.D.

Cross Consultation Visit

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

[illegible]

Sign

Investigations



1/1/26

SBR
TFT

~~Cross checked done~~

[illegible]

PROCEEDURE

HNH-00016297 IP26-00006760
 Baby Of SANDHYA LOYA
 01-07-2026 0 Y 0 M 5 D (M)
 Dr. S TEJASWI REDDY



Date	Proceedure	Security	Order No.	Signature

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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**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

HNH-00015297 IP26-00005760

Baby Of SANDHYA LOYA

01-07-2026 0 Y 0 M 5 D (M)

Dr. S TEJASWI REDDY



Patient Name : BI

- 1 sd / moe

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____

HNH-00016297 IP26-00006760
Baby Of SANDHYA LOYA
01-07-2026 0 Y 0 M 6 D (M)
Dr. S TEJASWI REDDY

History & Physical Examination

Name : _____

Age/Sex _____

Informant _____

Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

no yellowish discoloration of skin
*sclera since 1 day

History of present illness:

Term (37wks+3d) / AGA / 2.88kg / NVD
Delayed transition / TTNB+ / IDM

Mother Blood group: - B Positive

Baby Blood group: - B Positive

TCB - 15.3 g/dl

Pediatric Multiorgan History & Physical Examination

HNH-00016297 IP26-00006760
Baby Of SANDHYA LOYA
01-07-2026 0 Y 0 M 6 D (M)
Dr. S TEJASWI REDDY



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

Birth & Neonatal History :

Birth & Socio Economic History :

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Immunization History :

BCG
Hep-B 0 dose
DPV - 0 dose } given

Pediatric Multiorgan History & Physical E

HNH-00018297 IP26-00005760
Baby Of SANDHYA LOYA
01-07-2028 0 Y 0 M 6 D (M)
Dr. S TEJASWI REDDY



Anthropometry

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

Weight (kgs) 2.82 kg (Centile _____)

On Examination :

Temperature : _____ Pulse Rate: _____ Description _____

B.P. _____ SPO2 _____ at _____

Resp. rate and type of breathing : _____

1 breath @

Rash _____

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BL - ACF @

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S₁, S₂ @

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : PLA - 204

Ausculation : _____

Spine: _____ External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

HNH-00018297 IP26-00006760
Baby Of SANDHYA LOYA
01-07-2026 0 Y 0 M 5 D (M)
Dr. S TEJASWI REDDY



Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

Cranial Nerves : Normal

Motor System :

Nutrition : (N)

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Plantars _____

Superficials :

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

Δ Neonate 1 Hyperbilirubinemia

Dr. S TEJASWI REDDY
REGISTRATION NO. 44089

Pediatric Multiorgan History & Physical Exam

HNH-00016297 IP26-00006760
 Baby Of SANDHYA LOYA
 01-07-2026 0 Y 0 M 5 D (M)
 Dr. S TEJASWI REDDY



Preventive aspects of the treatment :

Phototherapy

Desired goals of the treatment :

Taunder subside

Planned Labs :

*SBR } - Tammoxone
 TFT } morning @ 6 AM*

Notes by @

(A)

Planned Management :

*- Double surface
 Phototherapy - eyes
 and genitalia flat covered*

- DRE + 2nd ly + Buprpy

*- VITAMIN D₃ drops
 0.5m OD*

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 *A - Tej* _____ on
 whose name the patient is being referred

Doctor's Signature Name _____ Date _____ Time _____

Dr. S. TEJASWI REDDY
 Registration No: 94068

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7 7:00 PM	CLSI/13 Dr. Spandana NNS Euthectic C/T/A - Good. Vitals - Stable RIs / NAD PIA	Plan - SBR] @ 6:00 AM TFT] - DBF 2nd hourly for burping + FF - Cont DSPT - Monitor vitals
		Dr. Spandana Pasupuleti Consultant Neonatologist and Pediatrician Reg. No: 30925
7/7 7:30 PM	CLSI Dr. Banar / Dr. Naipany T.WT - 2.920 kg (↑ 50g) Baby ↓ DSPT Euthectic C/T/A } Good Tone } Activity }	Plan 1) Tm SBR TFT 2) C/T - DSPT 2/4 (R) 3) DBF 1/6 burping 2/4 + FF 4) Monitor Vitals

HNH-00016297 IP26-00006760
Baby Of SANDHYA LOYA
01-07-2026 0Y0M5D (M)
Dr. S TEJASWI REDDY

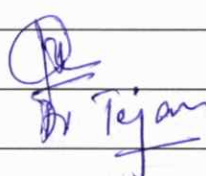


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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26 10am	MB is dynamic - feeds - urine - stools ✓ <u>SIR - 9.5</u> <u>OLE</u> meals: stable SE - normal.	Plan 1) discharge today 2) home care 3) DBT every 2nd h 4) monitor intake 5) trace friend people 6) Review on Monday Friday  Dr. Tejas
	Dr. S. TEJASWI REDDY Registration No: 94068	
	noted by S. Sandhya 7/7/26 10:am	

HNH-00018297 IP28-00006760
 Baby Of SANDHYA LOYA
 01-07-2028 0 Y 0 M 6 D (M)
 Dr. S TEJASWI REDDY



DRUG CHART

Date of Admission: Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS/ PRN (As Required Medication)

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

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

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

Signature
 VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 2.87kg Ward.

DRUG : <u>DROP VITAMIN-D₃</u>				Date Time	<u>6/8</u>	<u>11</u>														
Dose	Route	Frequency	Start Date																	
<u>0.5ml</u>	<u>Oral</u>	<u>OD</u>	<u>6/7</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>B. Sreyhan BS</u>																				
Additional Instructions: <u>(1ml = 800 IU Vitamin D₃)</u>																				
Daily Doctor's Endorsement by a Sign																				

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

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

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



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

Weight. Ward.

[illegible]

VERIFIED BY : Name Signature

MEDICATION RECONCILIATION FORM

Drug Allergies: No ☐ 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: 317 3rd Floor.

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Sreejan

Date & Time : 6/7/26 @ 2:10pm

Nurse Name & Signature: Amritha

Date & Time : 6/7/26 @ 2:10pm

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

Date: 6/7 Time: 10pm 2pm 6am

* 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.

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)

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 P. 01-07-2026
 Dr. S TEJASWI REDDY
 IP26-00006760
 0 Y 0 M 6 D (M)

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

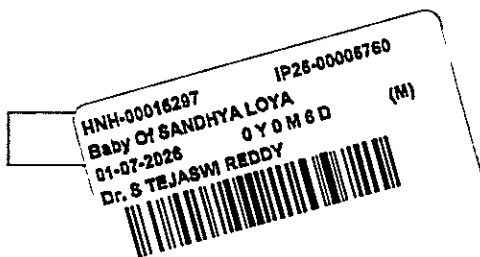
BirthRight[™]
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 Your Right to a Safe Delivery

FLUID CHART

Sheet No. :

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

Date	Time	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse		
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine				
			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													



FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			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

HNH-00016287
 Baby Of SANDHYA LOYA
 01-07-2026 0 Y 0 M 6 D
 Dr. S TEJASWI REDDY (M)

NURSING CARE RECORD



Date:6.6.....

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	8 pm to 8 am	→ Assess the baby condition → Maintain S/O chart → Monitor vitals & record → Administer medication as per drug chart	8 pm to 8 am	→ Assessed the baby condition → Maintained S/O chart → Administered 100 mg of paracetamol	→ Baby is stable	→ Rechecked vitals	

HNH-00016297 IP26-00008760
 Baby Of SANDHYA LOYA
 01-07-2026 0 Y 0 M 6 D (M)
 Dr. S TEJASW REDDY



NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Date:

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ 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							
Afternoon							
Night							



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	NNT							
BACKGROUND	Area	Shift Time	07/7	N1				
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:	98.4					
	Res:	20						
	SpO ₂ :	99+						
	Pulse:	105						
	BP:	100/60						
	Fall Risk Score:	1						
Pain Score:	1							
Recommendations	Safety Needs:	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:							
	Special Diet:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:							
Post Operative Procedure Special Orders:								
Handed Over By Name :		Sund						
Signature :		[Signature]						
Date:		17/07/2026						
Time:		8 AM						
Taken Over By Name :								
Signature :								
Date:								
Time:								

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area						
	Shift Time						
ASSESSMENT	Medical Condition (Any special condition to be noted):						
	Allergy: ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No						
ASSESSMENT	Tubes/Drains/Catheter: ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No						
	Vital Signs:	Temp:					
		Res:					
		SpO ₂ :					
		Pulse:					
		BP:					
		Fall Risk Score:					
		Pain Score:					
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							



BRADEN 'Q' SCALE

					Date :			
					Time :	7:00		
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.				
"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.	2			
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.	3			
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.	3			
FRICITION-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."	5			
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.	2			
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.	2			
TOTAL SCORE					7			
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

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

PATIENT TRANSFER FORM

Patient Name & UHID No. HHN-00016297 IP26-00006760 Baby Of SANDHYA LOYA 01-07-2026 0 Y 0 M 5 D (M) Dr. S TEJASWI REDDY 		Date & Time of Admission 6/7/26 @ 2:09 PM	Date & Time of Transfer Order 6/7/26 @ 2:40 PM
		Transfer Ordered by Dr. Sreejan	Reason for Transfer Admission
From Unit ER	To Unit 3rd floor 317	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File _____	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		Name of Person Ordered Transfer Dr. Sreejan	
Patient & Clinical Records Received by : Pragyanka @ 6/7/26 @ 2:50 PM			
Date & Time of Patient Received : 1			

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

Fore head - 13.1 mm
wt - 2.8 kg
cmt. 15.3

EMERGENCY ROOM TRIAGE FORM

Patient's Name : B/o sandhya Age : 5d Gender : ☒ Male ☐ Female

Date : 6/7/26 Time of Arrival : 2:2 PM

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: 98 PR: 109 bpm BP: 98/ RR: 28 SpO₂: 98%

Chief Complaints: feverish discolour of skin

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance

☒ Normal

☐ Sick Looking

☒ Normal

Circulation / Colour

☐ Abnormal

☐ Bleeding

Work of Breathing

☒ Normal

☐ Decreased

☐ Increased

☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

☒ Stable

☐ Unstable :

☐ Not - Life - Threatening

☐ Life - Threatening

Triage Classification

☐ Level 1 : Resuscitation

☐ Level 2 : EMERGENT : Life or limb threatening

☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening

☐ Level 4 : LESS URGENT : Significant illness but not life threatening

☐ Level 5 : NON - URGENT : May receive care when convenient

CTAS

☐ Immediate

☐ < 15 min

☐ 30 min

☒ 60 min

☐ 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.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 2:4 PM

Communicable Disease Triage Screening

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

- Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
- Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
- 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

- 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:
- 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 : Ameyam

Signature of Triage Nurse : (Signature)

Date & Time : 6/7/26 @ 2:5 PM

Docu. No. : RCH / FRM / CLINICAL / 085

HNH-00016297 IP26-00006760
 Baby Of SANDHYA LOYA
 01-07-2026 0 Y 0 M 5 D (M)
 Dr. S TEJASWI REDDY

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 6/7/26 Time of arrival : 2:20 AM,

Chief Complaints: No responsive discoloration of skin

Height : Weight : 2.87 Head Circumference (<2 years)

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

If yes, identify

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

☐ Character ☐ Location ☐ Frequency ☐ Duration

RISK FOR FALL:

If patient is < 6 years ☐ Yes ☒ No

If 'Yes' tick below fall risk intervention directly

If Patient is > 6 years

If 'Yes' 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 : 2:50 PM

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

Time	Nursing Notes
	Assessed The Patient Condition
	vital checked,

Samples collected by:

Time:

Samples sent by :

Time:

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 108b/min BP: - CFT: - RR: - SPO2 at FiO2: - GCS: - Temperature: 38.3°C Pain Score: 0 Repeat RBS (if applicable): -	Shift - out from ER to: 317 3rd Floor Time of Shift - out: 2:40pm Handover given to: - (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

Name of the Nurse : Anupam

Signature of the Nurse : [Signature]

Date & Time : 26/7/20 @ 2:50pm

GENERAL CONSENT FOR TREATMENT

Patient Name: Baby Of SANDHYA LOYA Age : 0 Y 0 M 5 D
IP No: IP26-00006760 Sex: Male
Consultant: Dr. S TEJASWI REDDY 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:

Relationship:

Date: 06-07-2026

Time: 14:09

Witness Name: Yaseen ali Khan

Witness Signature:

Patient Address:

3-6-175, hyderguda Himayathnagar
Hyderabad Telangana INDIA 500029

HNH-00016297 IP26-00006760
Baby Of SANDHYA LOYA
01-07-2026 0 Y 0 M 5 D (M)
Dr. S TEJASWI REDDY



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

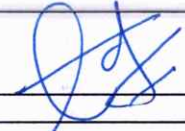
COUNSELLING SHEET

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State
Housing Board Himayatnagar, Hyderabad- 500029

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

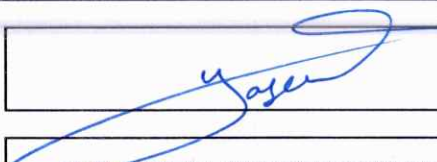
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	TWIN SHARING / OBSERVATION(LDR) / SHARED WARD	PRIVATE / DELUXE ROOM	PICU / NICU / HDU	SEPARATED FROM TARIF	12 TO 12 NOON BILLING POLICY
BED CHARGES			HNH-00016297 Baby Of SANDHYA LOYA 01-07-2026 0 Y 0 M 5 D (M) Dr. S TEJASWI REDDY 	PHARMACY	2pm - 12:00 PM
				INVESTIGATION	
DOCTORS CHARGES				CROSS CONSULTATION	PHONES ARE NOT ALLOWED IN PICU(PHOTOGRAPHY AND VIDEOGRAPHY STRICTLY PROHIBITED)
				CONSUMABLES	VISITING HOURS 04:00pm TO 05:00pm.
				BLOOD PRODUCTS	
	OXYGEN				
NURSING CHARGES				HFNC / VENTILATOR / C PAP / HFO / NIV / NIV-C PAP	IN ICU EITHER MOTHER OR FATHER ALLOWED(NO VISITORS)
				EQUIPMENT	
DIET CHARGES				PROCEDURE	OUTSIDE FOOD AND MEDICATION NOT ALLOWED
				NEBULISATION	
TOTAL	13,350/-	17,250		MRD, DRUG ADMINISTRATION, INSURANCE PROCESSING FEE (IF ANY)	
PATIENT NAME				AGE/SEX	
UHID			INSURANCE NAME		


ATTENDENT SIGNATURE

CAUTION
DEPOSIT

15/-
20/-


COUNSELLING PERSON SIGNATURE

DSPT - 4000 P/A.

