



DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	3			
7	Nursing plan of care and handover sheets	3			
8	Consultation sheet				
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	1			
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	1			
23	Medication Reconciliation	1			
24	Emergency Triage record				
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				
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 extras	1			
		6			
	Total No. of Pages	28			

DISCHARGE SUMMARY

Name	Baby Of VINEETHA PARCHA	UHID	HNH-00016224
Father/Guardian	Mr AJEETESH JOSHUA	Age/Gender	0 Y 0 M 1 D/ Female
Address	13-3-506/320/121/92.IMAMPURA, Jiaguda, Hyderabad, Telangana, INDIA, 500006		
IP No	IP26-00006675	Admission Date	28-06-2026
Ref Doctor	Self.		
Discharge Date	30.06.2026		

Consultant:

Dr. S TEJASWI REDDY

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

DIAGNOSIS	ICD CODE
TERM (37 weeks)/AGA/BABY GIRL/ O-A INCOMPATIBILITY	

History: Baby Of VINEETHA PARCHA is a term (37 weeks) baby girl, delivered to a primi mother by elective LSCS on 28.06.2026 at 9.30 am with birth weight of 2.6 kgs in Rainbow Children's Hospital, Himayatnagar Hyderabad. Baby cried immediately after birth. Apgar scores were 8/10 at 1 min, 9/10 at 5 min. Inj. Vitamin K 1mg IM was given after delivery. Delayed cord clamping done. Fetal presentation was Vertex.

Name	Baby Of VINEETHA PARCHA	UHID	HNH-00016224
IP No	IP26-00006675	Admission Date	28-06-2026

Maternal History: Mrs. VINEETHA PARCHA is a 32 years old primi mother.

G1 - Present pregnancy, spontaneous conception, had regular Antenatal checkup's, received 2 doses of Injection. Tetanus Toxoid. Antenatal scans were normal. No history of Pregnancy Induced hypertension/ Urinary Tract Infection/ Antepartum Haemorrhage/ Hypothyroidism/ Gestational Diabetes Mellitus/ Oligohydramnios/ Polyhydramnios/ Prolonged Rupture Of Membranes/ Fever.

Mother's Blood group is O positive. Baby's blood group is A positive.

Examination: Baby was euthermic (36.5 *C), euvolemic and was maintaining saturations at room air. On auscultation of chest, air entry was bilaterally equal with normal heart sounds. Bilateral femoral pulses well felt. Abdomen was soft with no organomegaly. Cry, tone and activity were good. Anterior fontanelle was at level. No obvious external congenital anomalies were noted clinically. All external orifices were patent and open. All neonatal reflexes were normal.

Anthropometry:

Weight at birth : 2.6 kgs.
Weight at discharge : 2.46 kgs.
Head Circumference : 33 cms.
Length : 47 cms.

Investigations: Enclosed reports.

Management:

Course during hospital:

Serum bilirubin at 48 hours of life was 9.6 mg/dl with indirect fraction of 9.5 mg/dl.

Name	Baby Of VINEETHA PARCHA	UHID	HNH-00016224
IP No	IP26-00006675	Admission Date	28-06-2026

Feeding: Breast feeding was initiated (First feed was given within 30 minutes), measured feeds were started. Baby tolerated the feeds well.

Vaccination: Baby was given following vaccination:

Vaccine Name	Status	Date
BCG	Given	29.06.2026
OPV	Given	29.06.2026
HEPATITIS B	Given	29.06.2026

TEOAE (Transient Evoked Otoacoustic Emissions): Hearing test:
Parents not willing .

Thyroid function test : Sent on 30.06.2026, report awaited.

SPO2 : 99% at room air

Red Reflex: Present & Symmetrical

Hip Examination was normal.

Baby tolerating feeds well, hemodynamically stable, passed urine and meconium, hence being discharged with the following advice.

Condition at discharge: Baby is pink, warm, active and on direct breast feeds + measured feeds.

Advice:

Keep the baby clean & warm

Regular breast feeding

Name	Baby Of VINEETHA PARCHA	UHID	HNH-00016224
IP No	IP26-00006675	Admission Date	28-06-2026

Continue direct breast feeds + measured feeds as advised.

Monitor urine output

Immunization as per schedule

Vitamin D3 Drops (1ml/800IU) 0.5ml once daily till further advice (after 5 days of life).

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

Plan:

1. Newborn screening advanced / Newborn screening-4 to be done on followup.
2. Hearing test (TEOAE-Transient Evoked Otoacoustic Emissions) to be done on followup.
3. Serum Bilirubin to be done on followup.

Review consultation with Dr. S TEJASWI REDDY on Thursday(02.07.2026) 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 explained by doctor in a language that I can understand and I acknowledge.

Name	Baby Of VINEETHA PARCHA	UHID	HNH-00016224
IP No	IP26-00006675	Admission Date	28-06-2026

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 / Vikramপুরi / 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

CONSENT FOR FORMULA FEEDS

HNH-00016224 IP26-00006675
Baby Of VINEETHA PARCHA
28-06-2025 0 Y 0 M 1 D (F)
Dr. S TEJASWI REDDY

Patient Name : Age : Gender : ☐ Male ☐ Female

UHID No : Reg. No. : Department : Date :

I Mr / Mrs. : aged years, hereby declare that I have

admitted my ☐ son / ☐ daughter in the Neonatal Intensive Care Unit of Rainbow Children's Hospital, Hyderabad on

..... I hereby give consent for formula feed for my child. Doctors have explained me

about the formula feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature :

Name :

Relationship with Patient :

Date & Time :

Witness :

Signature :

Name :

Date & Time :

Doctor (who is taking the consent) :

Signature :

Name :

Date & Time :

డబ్బా పాలు పట్టించుటకు సమ్మతి పత్రం

రోగి పేరు : వయస్సు లింగం పు ☐ స్త్రీ ☐

యు.హెచ్.ఐ.డి. రిజిస్ట్రేషన్ నెం.: విభాగము

తేదీ

నేను శ్రీ/శ్రీమతి వయస్సు సంవత్సరాలు

నా కుమార్తె/కుమారుడు రెయిన్ఫో ఆసుపత్రిలో నవజాత శిశువుల ఇంటెన్సివ్ కేర్ లో 'అడ్మిట్' చేసినాము మరియు (ఫార్ములా

ఫీడ్) డబ్బా పాలు పట్టించుటకు నా పూర్తి అంగీకారం తెలుపుచున్నాను. డాక్టర్లు డబ్బా పాలు త్రాగించడం వల్ల కలుగు

ఉపయోగాలు, ప్రత్యామ్నాయాలు, మరియు నష్టాలు గురించి నాకు అర్థమైన భాషలో వివరించారు.

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006675 Admit Date : 28-Jun-2026 Admit Time : 10:49 AM UHID : HNH-00016224

Patient Details :

Patient Name	: Baby Of VINEETHA PARCHA	Age	: 0 D
Guardian	: Mr AJEETESH JOSHUA	DOB	: 28-06-2026 09:30 AM
Gender	: Female	Religion	:
Occupation	:	Martial Status	:
Address (H)	: 13-3-506/320/121/92.IMAMPURA Jiaguda Hyderabad Telangana INDIA 500006	Phone No	: 7013196241/ 9949550005
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type : BASINET Bed No : CRDL-HNPDA-415-1 Ward Name : 4F -OT
Room No : CRDL-HNPDA-415-1 Admission Type : First Visit

Contact Details :

Name : Mr AJEETESH JOSHUA Relationship : Father
Contact Address : 13-3-506/320/121/92.IMAMPURA Jiaguda Phone No : 7013196241
Hyderabad Telangana INDIA 500006



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

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00016224 IP26-00006675 Baby Of VINEETHA PARCHA 28-08-2026 0Y0M0D1H (F) Dr. S TEJASWI REDDY 		Date & Time of Admission 28/6/26 @ 10:14 AM	Date & Time of Transfer Order 28/6/26 @ 2:40 PM
		Transfer Ordered by Dr. Tejaswi	Reason for Transfer Observation
From Unit MICU	To Unit Room C	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 25	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 Sis. Monika		Name of Person Ordered Transfer Dr. Tejaswi Reddy	
Patient & Clinical Records Received by : Priyanka			
Date & Time of Patient Received : 28/6/26 @ 3pm			

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

Date	Time	Investigation	Result	Order No.	Signature
28/6/26	11:30AM	blood grouping		10522	Sin
					Cross checked
					Jane
28/6	10AM	SBR TFT		6500	Sin
					checked down
					by Sin
					Cross

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Vineetha Age : Father's Name : Age :
Date of Birth : Date of Admission : UHID No.:
NICU Consultant : Dr. Tejaswi Referring Consultant :
Transferring Unit : ☐ OT ☐ Labour Room ☐ ER ☐ Ward
Transported ? ☐ Yes ☐ No - If yes : ☐ Long (> 30 kms) ☐ Short (< 30 kms)

BIRTH INFORMATION

Name : B/o Vineetha Mother's Blood Group : O Positive
Gender : ☒ M ☐ F Blood Group : Birth Weight (gms) : 2600g Length (cms) : 46cm
Date of Birth : 28/6/26 Time of Birth : 9:30AM OFC (cms) : 32cm
Place of Birth : RCA Estimated Gesth Age : 37 weeks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 32yrs Ht : Wt : BMI : Married Life : LMP : 12/10/25 EDD : 19/7/26
Conception : Spontaneous or with Rx : Spontaneous
Booked at what GA : AN Steroids Drugs / Doses :
Last Scans Details : Single / cephalic / ~~Post~~ placenta - Ant. Uls. Grade III
TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs
Consanguinity : ☐ Yes ☐ No
If yes, degree of consanguinity : ☐ 1 ☐ 2 ☐ 3

H/o PIH (after 20 weeks) / PE

How many Drugs / Doses / Since how long :

H/o value of recent BP recording, proteinuria, edema,
oliguria, any investigations (LFT, platelet count) :

IUGR - when detected :

Doppler (Increased Resistance / ADEF / REDF /

Redistribution in MCA) / Ductus Venosus :

AFI :

H/o GDM/ pre GDM/ on diet or insulin

Controlled or not, recent values, HbA1 values :

Compliance with Rx :

Scans : LGA, TIFFA , Fetal Echo :

H/o Hypothyroidism : when diagnosed ? Medication?

Any other Chronic Medical Problems, when detected

drugs ?

(Anemia, SLE, Jaundice, CHD, Heart Disease)

Infection : H/O, Fever

(☐ Malaria ☐ UTI ☐ TORCH ☐ TB ☐ HIV ☐ HBV)

UTI : when : Any culture :

PPROM : Duration : ☐ Uterine Tenderness ☐ Foul Smelling Liquor ☐ HVS (if taken) - Results :

Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

G: P: A: L:

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details

PERINATAL HISTORY

Treating Obstetrician : Dr. Subhashini Hospital : RCH ☒ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS: ☒ Elective ☐ Emergency Indication :

Specify the reason :

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitation : ☐ Yes ☐ No

Cord ABG :

Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : Weeks :

SIGN	0	1	2
COLOUR	Blue or Pale	Acrocyanotic	Completely Pink
HEART RATE	Absent	< 100 Minutes	> Minutes
REFLEX IRRITABILITY	No Response	Grimace	Cry or Active Withdrawal
MUSCLE TONE	Limp	Some Flexion	Active Motion
RESPIRATION	Absent	Weak Cry; Hypoventilation	Good, Crying

TOTAL

1 Minute	5 Minutes	10 Minutes
1	1	
1	1	
1	2	
2	2	
2	2	
1	1	
8/10	9/10	

Resuscitation			
Minutes	1	5	10
Oxygen			
PPV / NCPAP			
ETT			
Chest Compressions			
Epinephrine			

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

+ (37 wks) | 2-6 kg | AUA | EL LSG



Baby cried immediately after birth



Cord clamped & cut



Reg. vit-K given



Vitals - stable.



Shifted to mother side

Investigation details in previous Hospital :

Feeding History :



Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

T (37 wks) / 2.6 kg / AGA / Female / LSCS.

VITALS : Temperature : 36.5°C HR : 142 RR : NIBP : CFT : CBSC

Color of the extremities : pink

Jaundice : Pallor : SpO2 :

Anthropometry : Birth Weight : Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD :
 Fontanelles :
 Sutures
 Shape / Moulding :
 Edema / Bruising :
 Size - (H.C.) :



Facies :
 (Any Facial
 Dysmorphism)



**NECK and
 CLAVICLES :**

Range of Motion :
 Asymmetry :
 Masses :



EYES :

Symmetry :
 Red Reflex :
 Discharge :

yet to be done

**EARS, NOSE
 MOUTH and
 THROAT :**

Ear set / Shape :
 Periauricular Pits / Tags :
 Nasal shape / Patency :
 Palate :
 Gums :
 Lips :
 Tongue :



**THORAX and
 BREASTS :**

Shape of Thorax :
 Position of Nipples and Number :



**ABDOMEN and
 UMBILICUS :**

Shape :
 Organomegaly :
 Bowel Sounds :
 Umbilical Stump :
 Discharge :

2A + IV

GENITALIA :

Labia / Hymen :
 Testicles/penis :
 Anus :

female genitalia
 patent

HERNIAL ORIFICES



TRUNK and SPINE :



SKIN LESIONS :

EXTREMITIES :

Fingers / Toes :
 Arms / Legs :
 Deformities :
 Mobility :
 Hip Joint Examination :





SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern: ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress : RR : SCR / ICR / See - Saw breathing :

Scoring of respiratory distress if present (Silverman or Downe's) :

Mention if baby is on : ☐ Hood box ☐ CPAP ☐ Ventilator

Settings :

Spo2 : Auscultation : Breath Sounds : Added Sounds :

Cardiovascular System :

HR : 142 BP : Precordial Activity : (P)

Femoral Pulses : WF Murmurs : (P)

Other Peripheral Pulses : Signs of Cardiac Failure : (P)

Abdomen :

Shape : Hernia orifice :

Palpation : soft, not Anal Patency : Patent

Palpable masses : Umbilical Cord : 2A + 1V.

Abdominal girth : First urine passed : (P)

Meconium passed : (P)

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

Nerves :

(P)

Motor System :

Passive Tone : (P)

Active Tone : (P)

Neonatal Reflexes : (P)

Grasp : ☒ Palmar ☒ Plantar ☐ Sucking ☒ Rooting ☐ Crossed adductor : (P)

Moro's : DTR : (P)

ATNR : Skull and Spine : (P)



Any Congenital Anomalies :

Diagnosis :

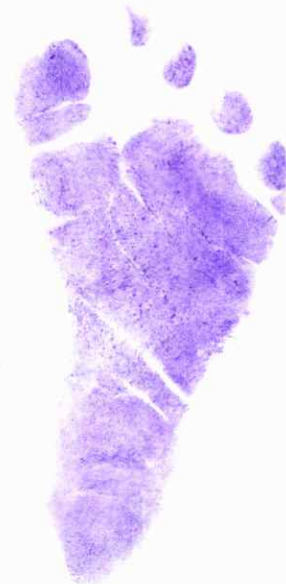
Term (37 weeks) | 2.6 kg | AGA | CIAB | EL LSQ

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name :

Date & Time :

[Signature]

Dr. N. Praveen

28/6

Consultant :

Signature :

Name :

Date & Time :

PLEASE FILL UP THE FOLLOWING DETAILS

1. Name of the referring Doctor :
2. Name of the referring Hospital :
Address :
Contact Numbers :
3. Contact Details of the referring Doctor :
Mobile No. : E-mail ID :
4. Name of the Doctor in Rainbow Team :
..... on whose name the patient is being referred.



AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Present Issues :

Vital : ☐ HR : ☐ RR : ☐ BP : ☐ SPO2 : Weight :

Any Oxygen requirement :

Systemic :

Medications :

Plan during ward follow up :

DBF 2nd hour hb bumping
At birth vaccination ^{OPB} Hep-B
BCG
Blood grouping
SBR } us Hol.
NBS
OAE

Feeding Plan at the time of shifting :

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

feeding time
9.50 to 10:00 AM

HNH-00016224 IP26-00006675
 Baby Of VINEETHA PARCHA
 28-06-2026 0 Y 0 M 0 D 14 H (F)
 Dr. S TEJASWI REDDY



GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/6/26 - 8 AM	c/s/hy. <u>Dr. Anuha</u> / <u>Dr. Arshu</u> Tum / 2.64 / AQA / F / CIAB.	
	Baby act, Euthic Pink	T wt - 2.480 kg (↓) wt lon - (2.60 kg) 20 ggs c/o - passed x5. s/o - passed x6
	vital stable	
	<u>slc</u> BLAC ⊕ ANBS ⊕	<u>Plan</u>
	(EUS) size ⊕ No mumm.	✓ DOF Ale gth buiping ✓ warm care
		✓ Chul - 4/limb spoz ✓ vaccination - pending
29/6/26	BCG OPV Hep-B given	✓ Monitor vitals Noted by <u>Divya</u> 29/6/26 @ 8 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/6/26 10:10 AM	S/B Dr. Tejaswi B Tula/Au/E / C IAD Baby Eutermic CNS - S ₁ , S ₂ ⊙ Rt - BU - AIE ⊙ - PIA 50h CTA 50h B/G Red reflex - ⊙	Plan - DBF + Bupr 2 nd L - Warm lex - Monitor vitals - Lactation consultation ✓ - SBR NBS } @ 9:30 AM OAE } T/M - 30/6/26
		Per Dr. Tejaswi
		N.B Anusha @ 2:30 PM

Dr. S. TEJASWI REDDY
 Registration No: 94868

Date & Time	Progress Notes	Doctor's Order
29/6 3pm	<u>CS/B De Spandana</u> <u>37th-Ten / ASA / Female / 2.6 kg / En / SCS</u> Baby Ranthelani Cry } Tone } Good Activity } CVS - S, S, ⊕ R-S - B/LAE ⊕ PIA - Soft P.S.W.	<u>Plan</u> 1) Warm bath 2) DBF f/b bagging O₂s 3) FSR } NBS } + addl needs. OAE } T/m 9:30 A 4) Monitor Vitals Infu SAS



GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/26 9:35 AM	S/B Dr. Tejaswi Term /AGA/ LSCS	
	Euthermic t-wt - 2450g (120g ↓) Baby is active wt loss Accepting well orally urine & stool - passing adequately vitality stable	Adv Discharge @ request [SBR] @ 9:30 AM NBS • OAE today • Plan discharge acc to SBR • Counselling on lactational practices
1:30 PM	SBR - 9.6 9.5 0.1	Pln 1) D/C Today & Flup Thursday
	Dr. S TEJASWI REDDY Registration No: 94068	

Patient Sticker



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

HNH-00016224 IP26-00006675
 Baby Of VINEETHA PARCHA
 28-06-2026 0 Y 0 M 0 D 1 H (F)
 Dr. S TEJASW REDDY



210

100% 99% 99%

Baby blood group: A positive

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

RESULT SHEET

Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

INFANT (<1 year)
Children's Observation &
Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 28/6/26	Time: 11 AM	3 PM	6 PM	10 PM	2 AM	6 AM
Doctor/Nurse/Family Concern?						
Temperature (°F)	98.2	98.7	98.2	98.7	97.7	98.7
Heart Rate (bpm)						
and						
Blood Pressure (mmHg) *						
Note: BP does not score in early warning scoring						
Heart Rate (Number)	130	144	140bpm	130bpm	140bpm	138bpm
Resp. Rate (bpm) (Over 1 Minute) *						
Resp Rate (Number)	30	44	40bpm	30bpm	40bpm	30bpm
Resp Mod/ Severe Distress None / Mild						
Receiving O ₂ (l/min) O ₂ Saturations (%)	99%	99%	100%	99%	100%	100%
Conscious Level Normal / Altered						
GCS *						
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials						

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 incharge and PICU /NICU fellow or PICU/NICU 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.

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 Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

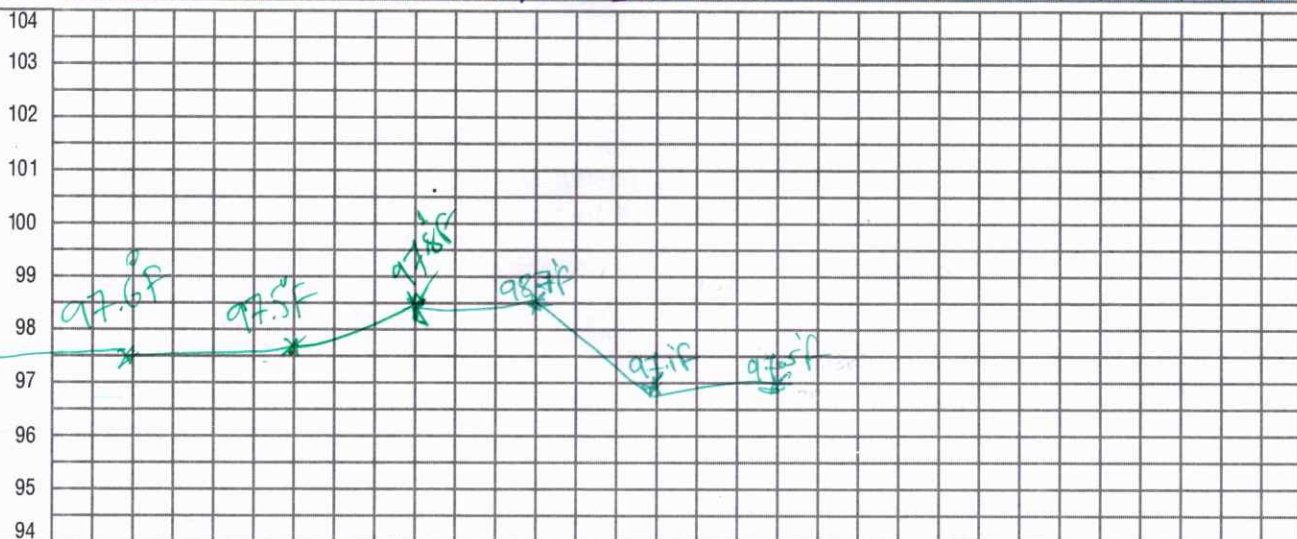
INFANT (<1 year)
**Children's Observation &
 Early Warning Scoring Chart**

NING SCORE: CHILDREN'S UNIT

Date: 29/6/26 Time: 10am 2pm 6pm 10pm 2am 6am

Doctor/Nurse/Family Concern?

Temperature
 (°F)

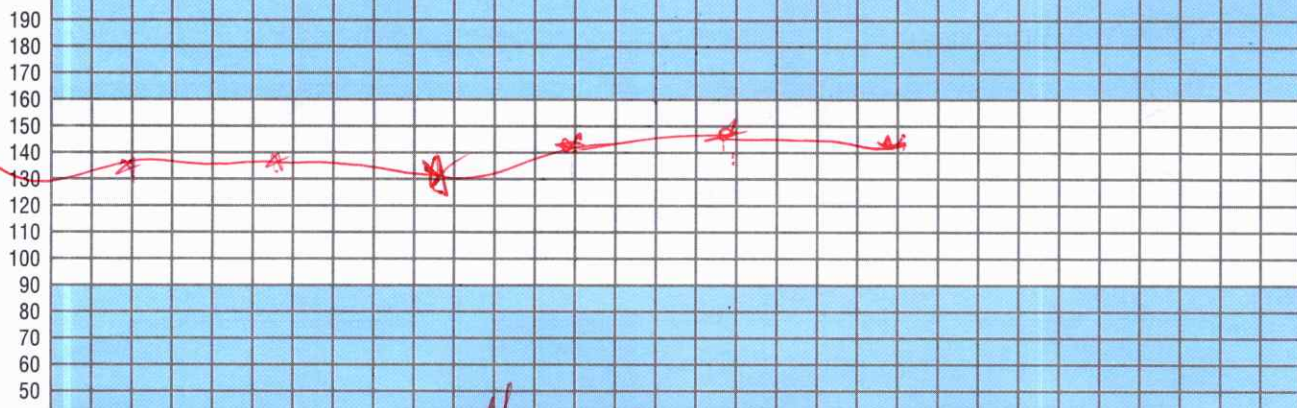


Heart Rate
 (bpm)

and

Blood Pressure
 (mmHg) *

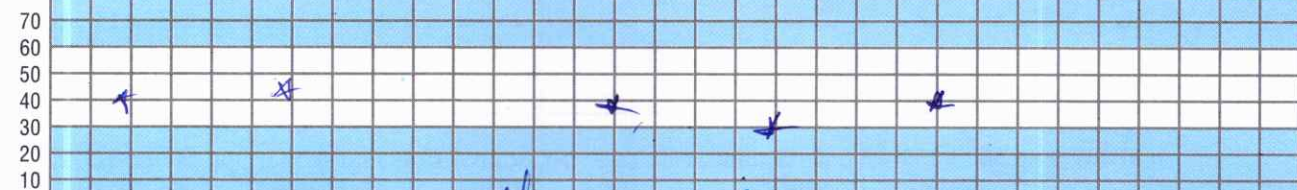
Note:
 BP does not score
 in early
 warning scoring



Heart Rate (Number)

138bpm 140bpm 140bpm 142bpm 150bpm 148bpm

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



Resp Rate (Number)

38bpm 40bpm 46bpm 40bpm 30bpm 40bpm

Resp Mod/ Severe
 Distress None / Mild

Receiving O₂ (l/min)
 O₂ Saturations (%)

99% 99% 100% 100% 99% 100%

Conscious Level
 Normal Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0 0 0 0 0 0
 0 0 0 0 0 0
 A A A A A A

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 incharge and PICU /NICU fellow or PICU/NICU 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.

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)

* 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)



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	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo- phlebitis Score	
			Mouth	I.V	N.G							
28/6/26	08:00 am											1 0 1 1 1 1
	09:00 am											
	10:00 am	DBF										
	11:00 am											
	12:00 pm	DBF										
	01:00 pm											
Total Intake : 4 taken						Total Output : passed						
28/6	02:00 pm	DBF										1 1 1 1 1 1
	03:00 pm											
	04:00 pm	DBF										
	05:00 pm											
	06:00 pm	DBF										
	07:00 pm											
Total Intake : 3 taken						Total Output : 2 passed						
28/6/26	08:00 pm											1 1 1 1 1 1
	09:00 pm	DBF										
	10:00 pm											
	11:00 pm	DBF										
	12:00 am											
	01:00 am	DBF										
Total Intake : 3 taken						Total Output : 2 passed						
29/6/26	02:00 am											1 1 1 1 1 1
	03:00 am	DBF										
	04:00 am											
	05:00 am	DBF										
	06:00 am											
	07:00 am	DBF										
Total Intake : 3 taken						Total Output : 2 passed						

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
29/6/20	08:00 am												
	09:00 am		DBF										
	10:00 am												
	11:00 am		DBF										
	12:00 pm												
	01:00 pm		DBF										
Total Intake : Taken						Total Output : U- m-							
29/6/20	02:00 pm		DBF										
	03:00 pm												
	04:00 pm		DBF										
	05:00 pm												
	06:00 pm		DBF										
	07:00 pm												
Total Intake :						Total Output :							
29/6/20	08:00 pm												
	09:00 pm		DBF										
	10:00 pm												
	11:00 pm		DBF										
	12:00 am												
	01:00 am		DBF										
Total Intake : taken						Total Output : U- 2m-2							
30/6/20	02:00 am												
	03:00 am		DBF										
	04:00 am												
	05:00 am		DBF										
	06:00 am												
	07:00 am		DBF										
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

INH-00016224 IP26-00006675
 Baby Of VINEETHA PARCHA
 8-06-2026 0Y0M0D1H (F)
 P. S TEJASWI REDDY



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						

Patient Sticker

FLUID CHART

Sheet No. :

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

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							



BRADEN 'Q' SCALE

					Date :	28/6	28/6	28/6/26	29
					Time :	11/6	12/6	11/6	11/6
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	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.		4	4	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	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	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	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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	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	4
TOTAL SCORE						28	28	28	28
Evaluator's Name						TEJASWI REDDY	TEJASWI REDDY	TEJASWI REDDY	TEJASWI REDDY

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

INH-00016224
Baby Of VINEETHA PARCHA
18-06-2026
Dr. S TEJASW REDDY
IP26-00006675
0 Y 0 M 0 D 1 H (F)

BRADEN 'Q' SCALE

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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

				Date: 29/6/2026		
				Time: 2:30 PM		
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	3
"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.	4	1
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	2
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	3
FRICION-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	3
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
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.	3	4
				TOTAL SCORE	23	20
				Evaluator's Name	S. Tejasw Reddy	

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

HNH-00016224

IP26-00006675

Baby Of VINEETHA PARCHA

28-06-2026 0 Y 0 M 0 D 1 H (F)

Dr. S TEJASWI REDDY



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date	
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time	
						28/6	28/6	28/6	29/6	29/6				
						146	142	141	146	142				
						0	0	0	0	0				
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	NR	NA	NR	NA	NA				
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)	NR	NA	NR	NA	NA				
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	NR	NA	NR	NA	NA				
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	NR	NR	NR	NR	NA				
Vital Signs HR RR, BP, SaO₂	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	NR	NR	NR	NA	NA				
Premature Pain Assessment: Scoring +3 if less than 28 weeks gestation age / Corrected Age +2 if 28 - 31 weeks gestation age / Corrected Age +1 if 32 - 35 weeks gestation age / Corrected Age Intervention Deep Sedation: Score = -10 to -5 Light Sedation: Score = -5 to -2 Pain Score less than or equal to 3 – No Intervention Pain Score greater than 3 – Intervention						Gestational Age / Corrected Age	37w	37w	37w	37w	37w			
						Total Pain / Agitation Score	-	-	-	-	-			
						Intervention	-	-	-	-	-			
						Effectiveness	-	-	-	-	-			
						Signature	NR	NR	NR	NR	NR			

NPASS: Neonatal Pain, Agitation & Sedation Scale

	Sedation	Pain / Agitation
How to use	- Observe the infant for a minute before selecting a score for each behavior. - Stimulate the infant and observe and select a score for each behavior. - Select only one numeric value (Highest) per behavior.	- Observe the infant for a minute before selecting a score for each behavior. - Select only one numeric value per behavior.
Scoring/ Documentation	- Sedation scores are negative scores only - Add the scores from the 5 individual behavior areas to generate a total NPASS Sedation score! (Do not add points for correcting gestational age) - NPASS Sedation total score has a range from 0 to -10 possible. - Document total NPASS Sedation score in the medical record.	- Pain/Agitation scores are positive scores only - Determine if scoring needs to be adjusted based on the patient's gestational age. See Premature Pain Assessment criteria. - Add the scores from the 5 individual behavior areas and for corrected gestational age (if indicated) to generate a total NPASS Pain/Agitation score. - NPASS Pain/Agitation total score has a range from 0 to 13 possible. - Document the total NPASS Pain/Agitation score in the medical record
Interpretation	- Desired levels of sedation vary according to the situation. - Discuss and determine sedation goal with provider. "Deep sedation": goal score of -10 to -5 - Deep sedation is not recommended unless an infant is receiving ventilator support, related to the high potential for hypoventilation and apnea "Light sedation": goal score of -5 to -2 - Reassess patient per frequency in local sedation policy - A negative score without the administration of opioids/ sedatives may indicate: - The premature infant's response to prolonged or persistent pain/stress - Neurologic depression, sepsis, or other pathology	- Does not provide pain intensity rating. - Any score greater than 3 indicates the possibility of the presence of pain in the infant - Continue evaluation to determine individualized patient interventions (non-pharmacological and pharmacological). - Reassess patient per frequency of local pain policy. - If upon reassessment, the NPASS pain/agitation total score remains consistent or higher, consider pharmacologic intervention.



NURSING CARE RECORD

Date: 28/6/26

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	8AM	→ Assess the baby condition	8AM	→ Assessed the baby condition			
	2PM	→ monitor vitals → maintain I/O chart	2PM	→ given emg and baby feed	Now pt. is stable	Re-checked vitals	Madhvi
Afternoon	4PM	→ plan for vitals	4PM	→ vitals checked & recorded			
	8PM	→ plan for I/O Chart. → plan for DBF	8PM	→ maintain I/O chart. → maintain DBF	→ vitals normal	→ pt's stable	Madhvi
Night	8PM	→ assess the baby condition	8PM	→ assessed the baby condition			
	8AM	→ monitor vitals → maintain I/O chart → baby DBF and hourly care	8AM	→ monitored vitals & recorded → maintained I/O chart → baby DBF 2nd hourly → vaccination IM	→ baby is stable now	→ rechecked vitals	Dr. J

HNH-00016224 IP26-00006675
 Baby Of VINEETHA PARCHA
 28-06-2026 0 Y 0 M 0 D 14 H (F)
 Dr. S TEJASWI REDDY

Patient S

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: 29/6/20

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	8pm	→ Assess Baby condition → monitor the vitals → maintain I/O chart → DBF every 2nd hourly	8pm	→ Assessed Baby condition → monitored vitals → maintained I/O chart → DBF every 2nd hourly	Baby is stable Rechecked vitals vaccination done	Re-Assess the baby condition	Anusha
Afternoon	2pm	Assess the baby condition - Monitor vitals & record - Maintain I/O chart - DBF every 2nd hourly	2pm	Assessed the baby condition - Monitored vitals & record - Maintained I/O chart - DBF 2nd hourly	Baby is stable now	Re-checked vitals	JR
Night	8pm	Assess the baby condition about the vitals about the I/O chart	8pm	Assessed the baby condition about the vitals about the I/O chart	was ok	Rechecked the vitals	JS

HNH-00016224 IP26-00006675
 Baby Of VINETHA PARCHA
 28-06-2026 0 Y 0 M 0 D 14 H (F)
 Dr. S TEJASWI 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 | ☐ 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							

Patient Sticker

NURSING CARE RECORD

Date:

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							

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time	28/6 MG	28/6 E2	28/6/26 N1	29/6/26 MG	29/6 E2	29/6 AM
	Medical Condition (Any special condition to be noted):							NB
ASSESSMENT	Allergy:		☐ 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
	Vital Signs:	Temp:	97.5	98.1	98.5	97.5	97.8	98.2
	Res:	18	20	20	20	20	20	
	SpO ₂ :	99	99	99	99	100	98	
	Pulse:	142	144	138	128	130	135	
	BP:	-	-	-	-	-	-	
Fall Risk Score:		-	-	-	-	-		
Pain Score:		-	-	-	-	-		
Recommendations	Safety Needs:		-	-	-	-	-	
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:		-	-	-	-	-	
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:		-	-	-	-	-	
Post Operative Procedure Special Orders:			-	-	-	-	-	
Handed Over By Name :			Moni	Madhvi	Divya	Anusha	Priyanka	Shruti
Signature :			(Signature)	(Signature)	(Signature)	(Signature)	(Signature)	(Signature)
Date:			28/6	28/6	29/6/26	29/6/26	29/6/26	29/6/26
Time:			2pm	8am	8am	2pm	3pm	2pm
Taken Over By Name :			Madhvi	Priyanka	Anusha	Priyanka	(Signature)	(Signature)
Signature :			(Signature)	(Signature)	(Signature)	(Signature)	(Signature)	(Signature)
Date:			28/6	28/6/26	29/6/26	29/6/26	29/6	29/6
Time:			8pm	8pm	8am	2pm	5	5

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

(Select and 'tick mark' [✓] the boxes as applicable)

Baby's Name: Dr. Vineetha Mother's Name: Mrs. Vineetha

Date of Birth: 28/6/26 Time of Birth: 9:30 AM Gender: ☐ Male ☒ Female

Birth Weight: 2.600 Kgs HC: 32 cm Length: 32.46 cm

Meconium in Liquor: ☐ Yes ☐ No Cried at Birth: ☒ Yes ☐ No

Term / Pre-term / Post-term:

Resuscitated: ☐ Yes ☐ No Blood Group: Mother: O positive Baby:

Feeding: ☒ Breast Feeding ☐ Formula ☐ Both First Feed Time:

AFFIX MOTHER'S
 IDENTIFICATION LABEL

Mode of Delivery: ☐ Normal ☒ LSCS - Emergency/ Elective ☐ Instrumental ☐ AVD

Indication:

Physical Assessment of New Born:

Temp: 97.2 °C HR: 132 /Min RR: /Min BP: 110/70 SpO₂: 99%

Pain Score: (Follow N Pass)

Fall Risk Assessment: ☒ Yes ☐ No Score: (Fill the Humpty Dumpty Sheet)

Risk in Pressure Sore: ☐ Yes ☐ No (Braden Q Score) (Fill the Braden Q Sheet)

Behaviour Status on admission: ☐ Sleeping ☐ Crying ☐ Calm ☐ Drowsy

Findings:

General Appearance: Posture: ☐ Well-Flexed ☐ Asymmetry

Skin: ☒ Pink ☐ Meconium Stain ☐ Others, Specify:

Nursing Management: (Please strike through If not applicable e.g. Yes / ~~No~~)

Vitamin K 1 mg I.M Administered: Yes / No

Routine Care Provided: Yes / No

Capillary Blood Glucose Monitoring Done: Yes / No

Neonatal Screening Done: Yes / No

1. Nutritional Screening: Feeding Problem Yes / No

2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / No

3. Socio History: Siblings Yes / No

All information obtained from ☒ Mother ☒ Father ☐ Other Family Member

Newborn Screening Discussed: Yes / No

Nurse Name: Moulika

Signature: (Signature)

Date & Time: 28/6/26

13



HNH-00016224 IP26-00006675
Baby Of VINEETHA PARCHA
28-06-2026 0 Y 0 M 0 D 1 H (F)
Dr. S TEJASWI REDDY



DATE : 28/6.

NEWBORN ANOMOLY ASSESSMENT CHECKLIST

S.NO	ASSESSMENT PARAMETERS	CHECKED BY REGISTRAR	CHECKED BY CONSULTANT	REMARKS
1.	Palate	No cleft Palate	No cleft Palate	
2	Pre natal teeth	Absent	Absent	
3	Anal opening	Patent	Patent	
4	Genitalia	(N) Female Genitalia	(N) Female genitalia	
5	Spine	(N)	(N)	
6	Red reflex	yet to be done	yet to be done	-Bic-present
7	4 limb saturation (before discharge)	yet to be done	yet to be done	(N)

Ped.Registrar signature

Ped.Consultant signature

GENERAL CONSENT FOR TREATMENT

Patient Name: Baby Of VINEETHA PARCHA Age : 0 Y 0 M 0 D 1 H
IP No: IP26-00006675 Sex: Female
Consultant: Dr. S TEJASWI REDDY Ward/Bed No: 4F -OT/CRDL-HNPDA-415-1

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 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:

Ajithesh

Relationship:

HUSBAND

Date:

28/06/2026

Time:

11-21 AM.

Patient Address:

13-3-506/320/121/92,IMAMPURA
Jaguda Hyderabad Telangana INDIA
500006

Witness Name:

Witness Signature:

S. Suresh Kumar

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 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

