DISCHARGE SUMMARY

Name	Master MAKADIA YEDHANT KUMAR	**UHID**	HNH-00009736
Father/Guardian	Mr MAKADIA DEPESH KUMAR	**Age/Gender**	1 Y 3 M 22 D/ Male
Address	14-09-833 jummerath bazer opp lalbhavan hyderbad, Jiaguda, Hyderabad, Telangana, INDIA, 500006		
IP No	IP26-00006830	**Admission Date**	13-07-2026
Ref Doctor	Self.		
Discharge Date	15.07.2026		

Consultant:
Dr. ANIKET ANIL PARASHAR
MBBS - MD
TSMC/FMR/08568, dr.aniket.p@rainbowhospitals.in

DIAGNOSIS	ICD CODE
SUSPECTED URINARY TRACT INFECTION (ACUTE FEBRILE ILLNESS)	
FEBRILE SEIZURE (1ST EPISODE) with MODERATE ANEMIA.	

History: Master MAKADIA YEDHANT KUMAR , 1 Y 3 M 22 D , old boy presented with the history of fever, cold and cough and loose stools since 1 day, 1 episode of seizure in the form of uprolling of eyeballs / generalised tonic clonic movements of lasting for 1 minute followed by post ictal drowsiness on the day

Name	Master MAKADIA YEDHANT KUMAR	**UHID**	HNH-00009736
IP No	IP26-00006830	**Admission Date**	13-07-2026

of admission. For the above complaints, he was investigated and treated at nearby hospital. In view of persistence of symptoms, he was admitted at Rainbow Children's Hospital - Himayatnagar for further management.

Examination: He was afebrile, . His heart rate was 138 /min and Respiratory Rate - 36/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. Pallor was noted. On auscultation, air entry was bilaterally equal. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, he was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure.

Weight on admission : 8.6 kilograms.

Investigations: Enclosed reports.

VBG showed pH of 7.32, pCO2 of 37.5 mmHg, pO2 of 47 mmHg, HCO3 of 19.1 mmol/L and BE of -6.6 mmol/L.

GeneXpert FluA+FluB+RSV, SARS-CoV-2 were sent, which was negative. Adenovirus PCR was not detected.

Initial hemogram showed Hemoglobin of 9.4 gm%, White Blood Cell count of 8890 cells/cumm, platelet count of 3.85 lakhs/cumm and C-Reactive Protein of 43 mg/l. Magnesium was 2.1 mg/dl. Complete urine examination shows 5-6 pus cells, 3-5 epithelial cells.

Ultrasound abdomen shows

Name	Master MAKADIA YEDHANT KUMAR	**UHID**	HNH-00009736
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* Right kidney size just below the normal for age with normal morphology.
* Few non specific lower mesentery nodes.

Management: He was admitted in the ward and started on Intra Venous fluids and Intra Venous antibiotics. He was treated symptomatically with antacids and antipyretics. He was started on febrile seizure prophylaxis with Frisium.

He was regularly monitored for fever spikes, hemodynamic & neurological status. His fever spikes gradually settled and there were no further seizure episodes during hospital stay.

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

Parents were counselled regarding the nature of febrile seizures and measures to reduce fever during future febrile episodes. They were also educated regarding use of intranasal Midazolam spray for termination of future seizure episodes, if any.

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

Medication during hospital stay:
Syrup. Clobazam
Syrup. Xyzal
Pro GG Sachet
Syrup. Zinconia

Advice:
* Diet as advised.

Name	Master MAKADIA YEDHANT KUMAR	UHID	HNH-00009736
IP No	IP26-00006830	Admission Date	13-07-2026

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. TAXIM-O FORTE (100mg/5ml)	2.5ml	8am - 8pm (after food)	For 5 days.
2	Syrup. Xyzal	2.5ml	once at bedtime (after food)	For 3 days.
3	Syrup. ZINCONIA	5 ml	10am (after food)	For 12 days
4	PRO GG SACHET	1 SACHET	9am-9pm (after food)	For 3 days
5	Nasoclear nasal drops, 2 drops in each nostril **SOS** for nose block			

Febrile Seizure Prophylaxis:
* Syrup. Crocin DS (Paracetamol = 5ml/240mg) 2.5 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
* Tepid sponging if fever > 101 *F.
* Syrup. Clobium (Clobazam - 1ml/2.5mg) 1 ml twice daily for 3 days every time with fever.
* Medistat - nasal spray (Midazolam = 1.25mg/puff), 1 puff intranasal (into each nostril) for future seizures.

Review consultation with Dr. ANIKET ANIL PARASHAR on Friday(17.07.2026) at

Name	Master MAKADIA YEDHANT KUMAR	**UHID**	HNH-00009736
IP No	IP26-00006830	**Admission Date**	13-07-2026

in OPD with prior appointment **(Review consultation will be charged).**

Food instructions while taking medications:
* **Antibiotics** along with food & milk products prevent their absorption of drugs & supplements. Antibiotics can be given 1 hour before food or 2 hours after food based on tolerance of stomach.

Follow up immediately in Emergency Room if high grade fever, vomiting, abnormal behavior, altered sensorium or seizure 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.

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**

Name	Master MAKADIA YEDHANT KUMAR	**UHID**	HNH-00009736
IP No	IP26-00006830	**Admission Date**	13-07-2026

Registrar/Resident/C.M.O

Dr. ANIKET ANIL PARASHAR
MBBS - MD
TSMC/FMR/08568, dr.aniket.p@rainbowhospitals.in

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ACTIVITY RECORD FOR BILLING

Name: ----- HNH-00009736 IP26-00006830 ----------
Master MAKADIA YEDHANT KUMAR
UHID No : -- 21-03-2025 1 Y 3 M 22 D (M) -------- Consultant : ---------- Dept : ----------
Dr. ANIKET ANIL PARASHAR
Date of Adm ---------- Date of Discharge : ---------- Time: ----------

Room / Bed No : ---------- Ward : ---------- Suggested Billable bed type : ----------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
13/7/26	8:25 Am	ER	220	A.D
14/7	11 Am	220	218	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
13/7/26	CBP, CRP, Magnesium Respiratory panel VBG	11607 11608	
14/7/26	CUE	11694	
15/7	USG abdomen	8535	

Cross checked done by SrCh

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
23/2	Infusion Pump	9am	18/2/26 @10pm	213294	[signature]
			Cross	checked	done by Sm

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
13/7/26	IV placement	(1)	13264	
13/7/26	NHA	(1)	13498	

Cross checked done by

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow®
Children's
Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

HNH-00009736 IP26-00006830
Master MAKADIA YEDHANT KUMAR
21-03-2026 1 Y 3 M 22 D (M)
Dr. ANIKET ANIL PARASHAR

Patient Name : _____

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

Name : ______ Age/Sex ______

Informant ______ Reliability ______

Chief Presenting Complaints & Duration (Chronologically):

c/o fever] :: 1 day
c/o cold, cough]
c/o loose stools :: 1 day
c/o seizure like activity - 1 hour ago

History of present illness :

child was apparently normal 1 day ago,
then developed fever - mod grade,
not a/w chills, relieved on medications

c/o cold - a/w running nose
cough :: dry cough

c/o loose stools - 3-4 episodes (mod. quantity)
greenish / no blood.

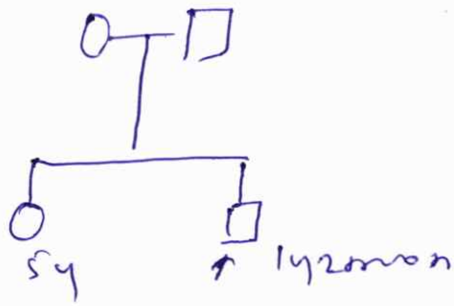
c/o seizure like activity - GTCS type,
stiffening of limbs a/w ē uprolling
of eyes for 30-1 min sec
Hb
- 1 episode of vomiting
- no post ictal drowsiness.

- Passing urine adequately.

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

Birth & Neonatal History :

Term / c/s / ~2.5kg / no NICU admission



Birth & Socio Economic History :

About Father :

About Mother : sibling - h/o febrile sz

Any additional Information :

Developmental History :

upto date

Immunization History :

upto date.

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 8.6 kg (Centile _____)

On Examination :

Temperature : 98.4°F Pulse Rate: 138 bpm Description _____

B.P. _____ SPO2 98% at RA

Resp. rate and type of breathing : 36 rpm

_____

Rash ⊖

Lymphadenopathy ⊖

Oedema : ⊖

Respiratory system :

BAE ⊕ clear

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any addes sounds : _____

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

_____

_____

Cardiovasclular System :

S1 S2 ⊕ no murmur

Inspection of procordium : _____

Heart Sounds : _____

Any murmur : _____

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

_____

_____

Per Abdomen :

Soft, no HSM.

Inspection _____

Palpation : _____

Ausculation : _____

Spine: _____ External Genitelia : _____

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

_____

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

Cranial Nerves : _____

_____

_____

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes : N

DTR **Superficials :**

Plantars _____

Sensory System :

_____

_____

_____

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

simple febrile seizures (1st episode)

_____

_____

_____

_____

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

- UBP, URP, VBG
- LFT, S. mg
- Resp. panel

NTB Amplan

Planned Management :

1) IVF
2) PLM
3) Fluconazole
4) Symptomatic

NTB Amplan

Please fill up the following details

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

Dr. ANIKET PARASHAR
Reg. No:

Doctor's Signature Name _____ Date 13/1/26 Time 9 Am

HNH-00009736 IP26-00006830
Master MAKADIA YEDHANT KUMAR
21-03-2025 1 Y 3 M 22 D (M)
Dr. ANIKET ANIL PARASHAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/7/25 11:30 AM	S/B Dr. Aniket	
	Δ Simple febrile seizure	Plan
	A	- cf CLOBAZAM
	CVS - S1, S2 (+)	
	RS - BL-AE (+)	- Trace reports
	P/A - soft	- Encourage orally
	Sleeping	
		N/B [signature]
		Dr. ANIKET PARASHAR Reg. No: 08568 [signature]
13/7 2:00 pm	C/S/B. Dr. Naipuye.	
	Simple febrile seizure c̄ Moderate Anemia (nutritional)	
	fever (+) - 100.1°F	Plan
	Oral intake - fair.	- Cont Clobazam, Zincovel
	R/S - B/L AE (+)	- Trace report.
	P/A - soft, NT.	
		- Send CUE.
		- Start. Ceftriaxone.
		- Monitor vitals

N/B [signature] [signature]

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Cls/13 Dr - Dilnaz	
13/7 5:00pm	Simple febrile seizure c Modete Anemia	
	fever (+)	
		Plan
	oral intake - fair.	
		Trace B/cls
	R/s - B/L AE	- Cont Clobazam
	P/A - Soft, NT	
		Cont PROCG
		Zinconey
		Cont ceftriaxone
		N/B Opute
		Dilnaz

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/7 8 AM	C/S/B Dr Pranav / Dr. Prashanthi	
	Simple Febrile Seizure c̄ Moderate Anemia	
	Fever ⊕	
		Plan
	Oral intake - Fair	1) Cd - Clobazam Ceftriaxone
	Child alert	2) Cd - Pro 65 Zincon
	Vitals stable	
	Afebrile	3) Syp Zyzal
	R-S - B/L AE ⊕	4) Monitor Vitals
	P/A - soft	5) Trace blood C/S
		N/B Dr.
		[signature]

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Master MAKADIA YEDHANT KUMAR
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/7/26 10:00 am	S/B Dr. Aniket P	
	Fever low grade	
	oral intake reduced.	
	vitals stable.	
	No further seizures.	
		Advice:
		- shift to ward.
		- Trace CUE, blood C/S.
		N/B [signature]
		[signature] Dr. Aniket P

Dr. ANIKET ANIL PARASHAR Reg. No: 08568

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...OGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/7/26 · 2pm ·	S/B Dr. Archana / Dr. Naipunya ·	
	No fever spikes ✗ 1 day No seizure activity noted Accepting orally - fair ✓ passed ·	Adv · · Ct Ceftriaxone · Ct Clobazam & xyzal · · Ct rest same · watch for seizure activity · TPR/IDC · · (T) Blood C&S ·
	O/E Vitally stable S/E WNL ·	
14/7/26 · 6pm ·	S/B Dr. Aniket ·	
	Afebrile No fresh complaints	Adv · - (S) reine C&S with next fever spike · - (D) chx if no fever ·
	O/E Vitally stable S/E WNL ·	Dr. ANIKET PARASHAR Reg. No: 08568 Dr Aniket

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21-03-2025 1 Y 3 M 22 D (M)
Dr. ANIKET ANIL PARASHAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B Dr. Nameen / Dr. Sreeghan	
15/2/26 6:40 Am	Simple febrile seizures (1st episode)	
	Fever spikes –	Plan
	oral intake fair	① ct ceftriaxone
	Chest clear	② ct clobazam
	P/A soft.	③ w/f seizure episodes
		④ Monitor vitals
	CVS – S1 S2 +	⑤ Trace blood c/s
	N – grl – ACFD	⑥ Plan D/C.
	P/A soft	
15/2/26 10 Am	S/B Dr. Aniket	
		Adv –
	No fever spikes	• (S) USG abdomen
	No fresh complaints	• ct oral Taxim
		• Discharge on nidaz m/s
	o/E vitally stable.	
	S/E wnl.	Dr. Aniket R. Aniket

Dr. ANIKET PARASHAR Reg. ...

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

HNH-00009736 IP26-00006830
Master MAKADIA YEDHANT KUMAR
21-03-2025 1 Y 3 M 22 D (M)
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DRUG CHART

Date of Admission: 13/7/26 Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR
- Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES
- Nurses must follow strictly the FIVE RIGHTS before administration of medication.
  1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG: SYP CROCIN-DS	Dose	Route	Frequency	Start Date	Date/Time	Verified by
	2.6ml	PO	SOS/6th h	13/7		
Doctor's Signature	Valid Period	Pharm.				
Additional Instructions: if temp >100.4°F						

DRUG: MIDAZ SPRAY	Dose	Route	Frequency	Start Date	Date/Time	Verified by
	1 puff	IN (EN) one nostril	SOS	13/7		
Doctor's Signature	Valid Period	Pharm.				
Additional Instructions: if seizure activity (+)						

DRUG: PROMITE ORS	Dose	Route	Frequency	Start Date	Date/Time
	50-100ml	PO	SOS	13/7	
Doctor's Signature	Valid Period	Pharm.			
Additional Instructions: after every loose stool					

Dr. Dhakshayani Dr. Dhakshayani

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

HNH-00009736 IP26-00006830
Master MAKADIA YEDHANT KUMAR
21-03-2025 1 Y 3 M 22 D (M)
Dr. ANIKET ANIL PARASHAR

REGULAR PRESCRIPTIONS

Weight. 8.6kg Ward. .....

DRUG : SYP CLOBAZAM

Dose	Route	Frequency	Start Date
1ml	PO	BD	13/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

(1ml = 2.5mg).

Daily Doctor's Endorsement by a Sign

Date / Time: 13/7 14/7

DRUG : SYP XYZAL

Dose	Route	Frequency	Start Date
2.5ml	PO	HS	13/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 14/7

DRUG : PRO 4g sachet

Dose	Route	Frequency	Start Date
1sachet	PO	BD	13/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 14/7

DRUG : SYP ZINCONIA

Dose	Route	Frequency	Start Date
5ml	PO	OD	13/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 14/7

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Master MAKADIA YEDHANT KUMAR
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Verified by Dr. Dhakshayani

REGULAR PRESCRIPTIONS

Sheet No: .... Weight 8.6 kg Ward ....

DRUG : Inj. Ceftrixone.

Dose	Route	Frequency	Start Dt.	Date/Time		
500mg	IV.	BD	13/7 8am		14/7	15/7

Name & Signature of the Doctor Starting the Drugs: Aneef

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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

Patient Sticker

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

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

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

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

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

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

Docu. No. : RCH /FRM / CLINICAL / 108

HNH-00009736 IP25-00006830
Master MAKADIA YEDHANT KUMAR
21-03-2026 1 Y 3 M 22 D (M)
Dr. ANIKET ANIL PARASHAR

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

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

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

Signature .....

VERIFIED BY : Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

HNH-00009736 IP26-00006830
Master MAKADIA YEDHANT KUMAR
21-03-2026 1 Y 3 M 22 D (M)
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I.V. FLUIDS CHART

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

Date	Time	Description of I.V. Fluid (Infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
13/7/26	8:15 pm	IVF- PLASMALYTE (2/1 main)	IV	20 ml/hr					

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

HNH-00009736 IP26-00006830
Master MAKADIA YEDHANT KUMAR
21-03-2025 1 Y 3 M 22 D (M)
Dr. ANIKET ANIL PARASHAR

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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: .....

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. Tanvi

Date & Time : 13/7/26 @ 7:30 Am

Nurse Name & Signature: Anupam

Date & Time : 13/7/26 @ 7:35 Am

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

HNH-00009736 IP26-00006830
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RESULT SHEET

Date	13/2					
Time						
Hb	9.4					
PCV	29.7					
RBC	4.68					
WBC	8.89					
N/L	60.2/80.4					
Platelets	385					
CRP	43.0					
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	14/7/16					
Time						
CUE - Alb						
CUE - Sugar	Nil					
CUE - Ketones	Present					
CUE - PUS Cells	5-6					
CUE - RBC Cells	Nil					
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Flu Panel Adenovirus / Negative

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

Patient Sticke

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/ 125

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

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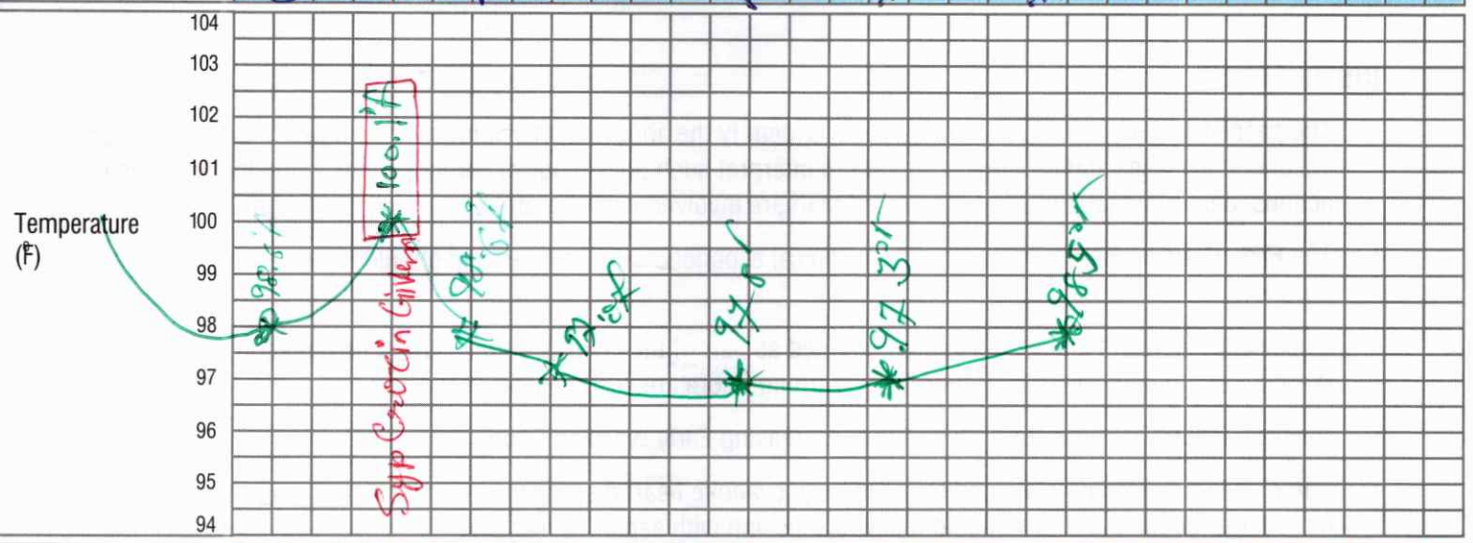
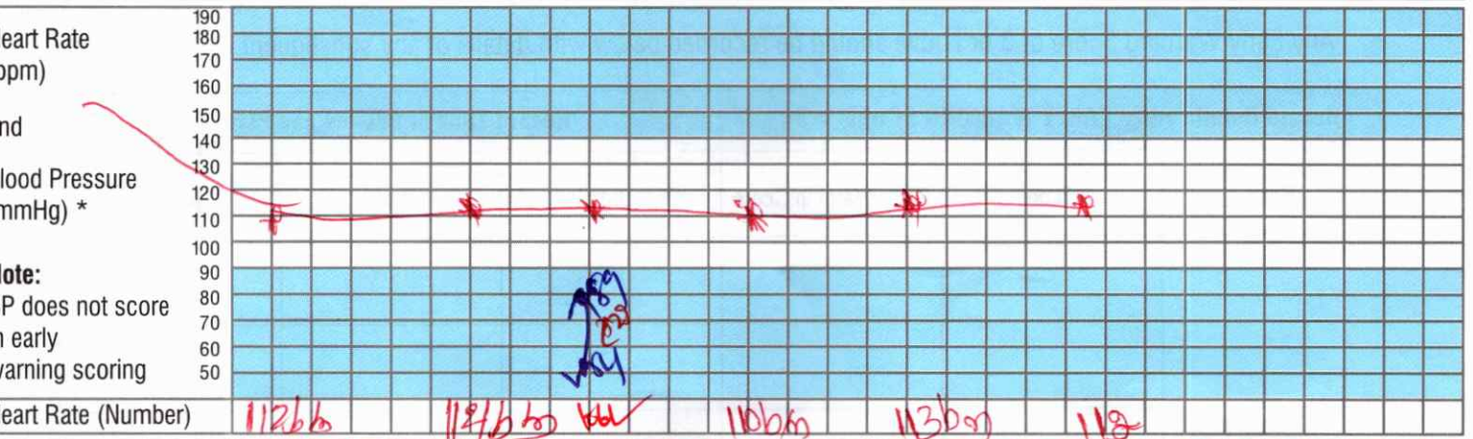
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 13/7/26 Time: 10 1 2 6pm 10 pm 2 Am 6 Am

Doctor / Nurse / Family Concern? Am Pm Pm Pm Am Am





Heart Rate (Number) 112bm 114bm 110bm 113bm 118

Resp Rate (Number) 28bm 26bm 28bm 28bm 28bm

Resp Distress	Mod/ Severe / None / Mild				
Receiving O_2(l/min) O_2Saturations (%)	100%	100%	100%	100%	100%
Conscious Level	Normal / Altered				
GCS *			15/15	15/15	15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0
Pain Score	0	0	0	0	0
Observer's Initials					

ACTIONS NB: Scores 3 should be recorded overleaf	
Score 1	: Continue normal observation by staff nurse
Score 2	: Shift in charge nurse to be informed and continue hourly observations
Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
Score 4	: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
Score 5 & 6	: Shift in charge AND PICU fellow or PICU consultant to be informed.

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	**IDENTITY:** I am (name), a nurse on ward (X). I am calling about (child X)
S	**SITUATION :** I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	**BACK GROUND :** Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

Patient Sticker

HNH-00009736 IP26-00006830
Master MAKADIA YEDHANT KUMAR
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/ 125

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

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

Date : 14/3/25 Time:	10	2	6	10 PM	2 AM	6 AM
Doctor / Nurse / Family Concern?						
Temperature (F)	98.6	98.6	98.6	98.3	97.8	98.4
Heart Rate (bpm) and Blood Pressure (mmHg) *						
Heart Rate (Number)	128 bpm	130 bpm	128 bpm	130 bpm	129 bpm	125 bpm
Resp. Rate (bpm) (Over 1 Minute) *						
Resp Rate (Number)	28 bpm	28 bpm	28 bpm	28 bpm	29 bpm	28 bpm
Resp Distress: Mod/ Severe / None / Mild						
Receiving O_2(l/min) O_2Saturations (%)	99%	99%	99%	99%	99%	99%
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						

Note: BP does not score in early warning scoring

ACTIONS NB: Scores 3 should be recorded overleaf	
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Doc. No. : RCH/ FRM / CLINICAL / 125

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

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

Date : ...15/9/25... Time:

Doctor / Nurse / Family Concern?

Temperature (F)
104 103 102 101 100 99 98 97 96 95 94

Heart Rate (bpm)
and
Blood Pressure (mmHg) *
190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

Note:
BP does not score in early warning scoring

Heart Rate (Number)

Resp. Rate (bpm) (Over 1 Minute) *
70 60 50 40 30 20 10

Resp Rate (Number)

Resp Distress: Mod/ Severe | None / Mild

Receiving O_2(l/min)
O_2Saturations (%)

Conscious Level: Normal | Altered

GCS *

TOTAL SCORE
Number of shaded boxes

Pain Score

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.
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JID 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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
13/7	08:00 am											
	09:00 am											
	10:00 am	plenty										
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :								Total Output :				
13/7	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm	plenty										
	06:00 pm											
	07:00 pm											
Total Intake :								Total Output :				
13/7	08:00 pm											
	09:00 pm											
	10:00 pm	plenty										
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :								Total Output :				
14/7	02:00 am											
	03:00 am											
	04:00 am	plenty										
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :								Total Output :				

Total 24 hrs. Intake		Total 24 hrs. Output	

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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: Nature of Fluid	Route: Mouth	Route: I.V	Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
14/7	08:00 am			20ml						✓		
	09:00 am	plasmalyte	khichdi + H2O	20ml							0	Jalu
	10:00 am			20ml			Nil	NA				
	11:00 am			20ml	NA					✓		
	12:00 pm											
	01:00 pm						✓					
Total Intake :	Taken					**Total Output :**				U-2	M-1	
14/7	02:00 pm			20ml								
	03:00 pm	plasmalyte	khichdi + H2O	20ml						✓		
	04:00 pm			20ml				NA				
	05:00 pm			20ml	NA						0	
	06:00 pm			20ml								
	07:00 pm			20ml						✓		
Total Intake :	Taken					**Total Output :**				U-2	M-0	
14/7	08:00 pm			20 ml								
	09:00 pm	plasmalyte	khichdi + H2O.	20ml						✓	0	
	10:00 pm			20ml			✓					
	11:00 pm			20ml						✓		
	12:00 am				NA		✓	NA				
	01:00 am											
Total Intake :	Taken					**Total Output :**				U-	M-	
15/7	02:00 am			20ml								
	03:00 am			20ml						✓		
	04:00 am	plasmalyte		20ml							0	
	05:00 am			20ml						✓		
	06:00 am			20ml				NA				
	07:00 am			20 ml.	NA							
Total Intake :	Taken					**Total Output :**				U-	M-	

Total 24 hrs. Intake	

Total 24 hrs. Output	

Patient S

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FLUID CHART

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		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
15/7/25	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :		Taken				**Total Output :**				U-	M-	
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	

Patient Sticker

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		Intake				Output						
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Total Intake :						**Total Output :**						
	02:00 pm											
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	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	

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NURSING CARE RECORD

Rainbow Children's Hospital — It takes a lot to treat the little.
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Date: 13/4/26

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 Note the i/c admission Medication Maintain i/o chart	8am	Assessed the baby Checked v/s admission of vital signs i/o chart	Admission noted	Reassess the baby gen.	[illegible]
Afternoon		DAY					
Night	8pm to 8am	Assess the patient. Monitor vitals/record. Maintain I/O chart. Provide the comfortable position. Medication given as per as doctor ord.	8pm to 8am	Assessed the patient. Monitored vitals/signs. Maintained I/O chart. Provided the comfortable position. Medication given as per as doctor.	Pt is stable. Vitals normal	Monitor vitals. Maintaining I/O chart	[illegible]

Docu. No: RCH /FRM / CLINICAL / 148

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Patient Sticker

NURSING CARE RECORD

Rainbow® Children's Hospital
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BirthRight BY RAINBOW HOSPITALS
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Date: 18/7/26

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	800	Assess the baby monitor the vls administer of the medication as cut	800	Assessed the baby monitored the vls administered medicine maintaining rio chart.	administered medicine	Reassessed the patient good	[signature]
Afternoon				DAY			
Night	8PM to 8am	→ Assess the patient general condition → monitor vitals → plasmalyte 20ml/hr to continue → maintain I/O chart	8PM to 8am	→ Assessed the patient general condition → monitored vitals → maintained I/O → Administered medications as per orders.	Patient is stable	Rechecked vitals	[signature]

HNH-00009736 IP26-00006830
Master MAKADIA YEDHANT KUMAR
21-03-2025 1 Y 3 M 23 D (M)
Dr. ANIKET ANIL PARASHAR

NURSING CARE RECORD

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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

Rainbow® Children's Hospital
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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

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: Seizure.				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift	13/7 Night	13/7 N1	14/7 Night	14/7 N1		
	Medical Condition (Any special condition to be noted):	Fever	—	—	—		
	Diet:	—	—	—	—		
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	—	—	—	—		
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.0 F	98.5 F	98.2 F	98.1 F		
	Res:	32/m	32/m	32/m	32/m		
	SpO_2:	100 %	99 %	99 %	98 %		
	Pulse:	132/m	120/m	122/m	124/m		
	BP:	89/54	99/62	89/52	99/64		
	LOC:	—	—	—	—		
	Fall Risk Score:	—	—	—	—		
	Pain Score:	—	—	—	—		
	Skin Integrity	—	—	—	—		
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	—	—	—	—		
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	—	—	—	—		
	Critical Lab Test / Values:	—	—	—	—		
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	—	—	—	—		
Post Operative Procedure Special Orders:		wt due	—	—	—		
Handed Over By Name :		[illegible]	[illegible]	[illegible]	[illegible]		
Signature / ID :		[illegible]	[illegible]	[illegible]	[illegible]		
Date:		13/7	14/7	13/7	14/7		
Time:		8 PM	8 AM	8 PM	8 AM		
Taken Over By Name :		[illegible]	[illegible]	[illegible]			
Signature / ID :		[illegible]	[illegible]	[illegible]			
Date:		13/7	14/7	14/7			
Time:		8 PM	8 AM	[illegible]			

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NURSING SHIFT HAND OVER FORM

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

Pati

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 13/	DATE 14/3	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1			
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1			
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
	Total		12	12			

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

	Bed in low position		✓	✓			
	Call device within reach		✓	✓			
	Wheels Locked		✓	✓			
	Room free of clutter		✓	✓			
	Adequate lighting		✓	✓			
	Wheel chair support		X	X			
	Other Intervention(s) Specify		X	1			
	Nurse's Name:						
	Signature:						
	Date:		21/3	14/3			
	Time:		6	8			

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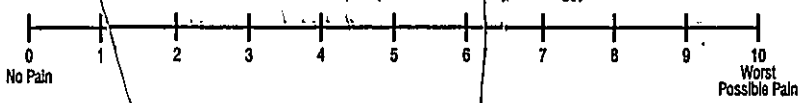
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
13/7	8pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	
13/7	10Pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
14/7	2Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
14/7	8Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
14/7/26	8pm	0/10	NA	☑ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☐ Yes ☐ No	ND	
14/7	10Pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
15/7	2Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
15/7	6Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

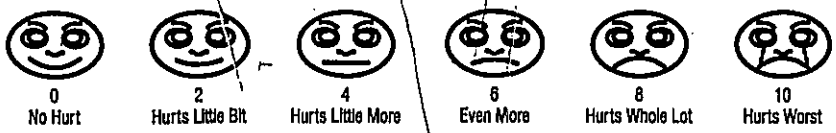
Re-assessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years



FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	13/7 DAY-1			14/7 DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0	0				
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	0	0	NA	0	0	NA				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	0	0	NA	0	0	NA				
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	0	0	NA	0	0	NA				
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	0	0	NA	0	0	NA				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	0	0	NA	0	0	NA				
			Signature of the Nurse										

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

Patient

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CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

Patient Sticker 1Y3M

220

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 13/7/26 Time: 11:25Am

Weight: 8.6kg Centile: 65th

Height: — Centile: —

Inference: underweight Child

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

Diet Recommendations: Soft high calcium diet

Re-Assesment: Avoid spicy, Chilled & outside foods

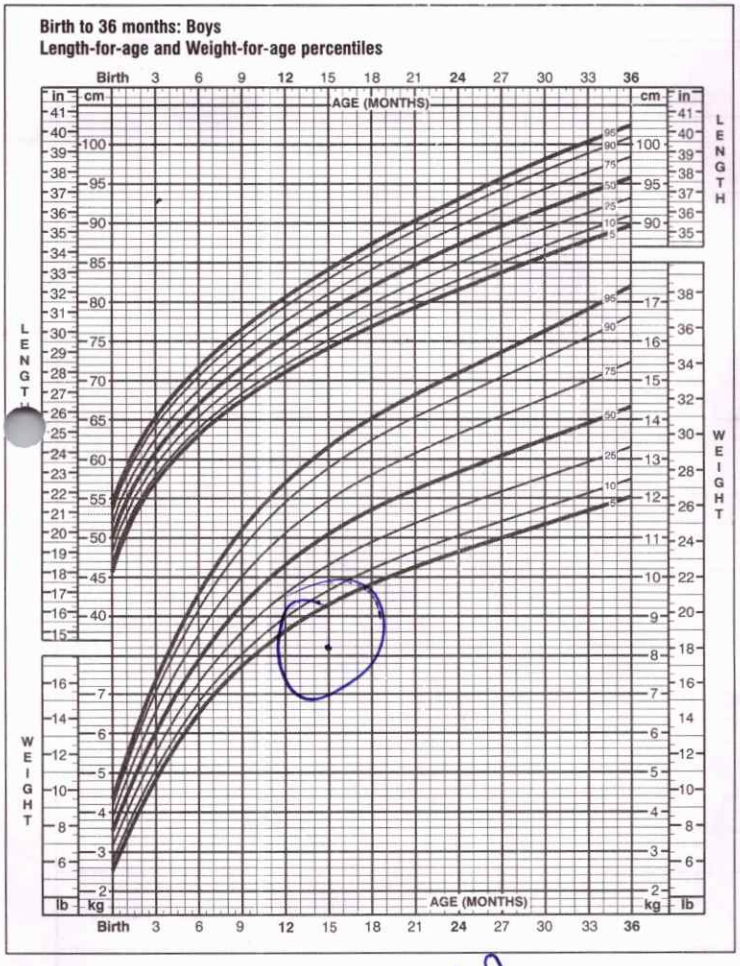
Food Allergies: ND Veg/Non-veg Non-veg

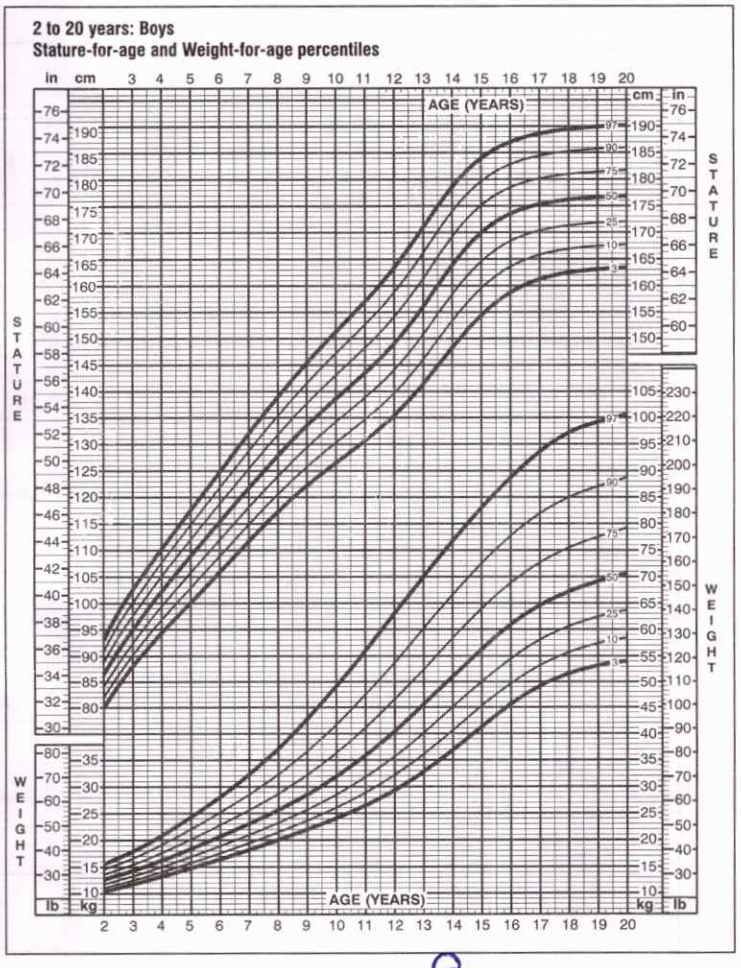
Diagnosis: Simple febrile seizures

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Kavitha

GROWTH CHART (BOYS)





Dietician's Name Sathvika-G Dietician's Signature

Daily Notes:

HNH-00009736 IP26-00006830
Master MAKADIA YEDHANT KUMAR
21-03-2025 1 Y 3 M 22 D (M)
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Wt-8.6kg RBS-139 mg/dl

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Yedhand Age : 1y6m **Gender:** ☑ Male ☐ Female

Date : 13/7/26 Time of Arrival : 6:45Am

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: 98.1°F PR: 138 BP: RR: 35 SpO_2: 100%

Chief Complaints: C/O Fever since Yesterday

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

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

INITIAL PHYSIOLOGICAL STATUS
☑ Stable
☐ Unstable :
- ☐ Not – Life - Threatening
- ☐ Life – Threatening

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

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

Signature of Parent / Guardian

* CTAS - Canadian Triage and Acuity Scale

Triage Completion Time : 6:48Am

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Apurba

Signature of Triage Nurse :

Date & Time : 13/7/26 @ 6:48pm

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 13/8/26 Time of arrival : 6:45 Am

Chief Complaints: Fever since yesterday. RBS: .....

Height : ..... Weight : ..... BMI : ..... 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
tick below fall risk intervention directly

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With ..... Family .....

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

Time of Initial assessment completed by ER Nurse : 6:50 Am .....

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

Time	Nursing Notes
	Assessed the patient condition
	vital checked.

Samples collected by: /

Samples sent by : / Apurba.

Time:

Time: / 7:40 Pm

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: 142 BP: ..... CFT: —	Shift - out from ER to: ICU
RR: 29 SPO_2 : 98	Time of Shift - out: 8:30 A.m
GCS: 15/15 Temperature : 9	Handover given to: .....
Pain Score:	(Nurse's Name)
Repeat RBS (if applicable): N.C	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

.....

Name of the Nurse : Anupam Signature of the Nurse : A. 12

Date & Time : 13/7/26

PATIENT TRANSFER FORM

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00009736 IP26-00006830 Master MAKADIA YEDHANT KUMAR 21-03-2025 1 Y 3 M 22 D (M) Dr. ANIKET ANIL PARASHAR	13/7/26	13/7/26
	Transfer Ordered by Dr: Tanvi	Reason for Transfer Admission
From Unit ER	To Unit 220	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 of Person Ordered Transfer
Dr. Tanvi	Anupam

Patient & Clinical Records Received by :

Date & Time of Patient Received : Sneha 13/7/26 9Am

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

Rainbow Childrens Hospital-Himayatnagar

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Master MAKADIA YEDHANT KUMAR**	**Age :**	**1 Y 3 M 22 D**
IP No:	**IP26-00006830**	**Sex:**	**Male**
Consultant:	**Dr. ANIKET ANIL PARASHAR**	**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: Deepesh.

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: Deepesh.

Name: DEEPESH
Relationship: Father.
Date: 13/7/26 Time: 7:30 AM
Witness Name:
Witness Signature:

Patient Address:

14-09-833 jummerath bazer opp lalbhavan hyderbad Jiaguda Hyderabad Telangana INDIA 500006

HNH-00009736 IP26-00006830
Master MAKADIA YEDHANT KUMAR
21-03-2026 1 Y 3 M 22 D (M)
Dr. ANIKET ANIL PARASHAR

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BILLING POLICY

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

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

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

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

MODE OF PAYMENT & REFUNDS

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

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

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

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.
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