

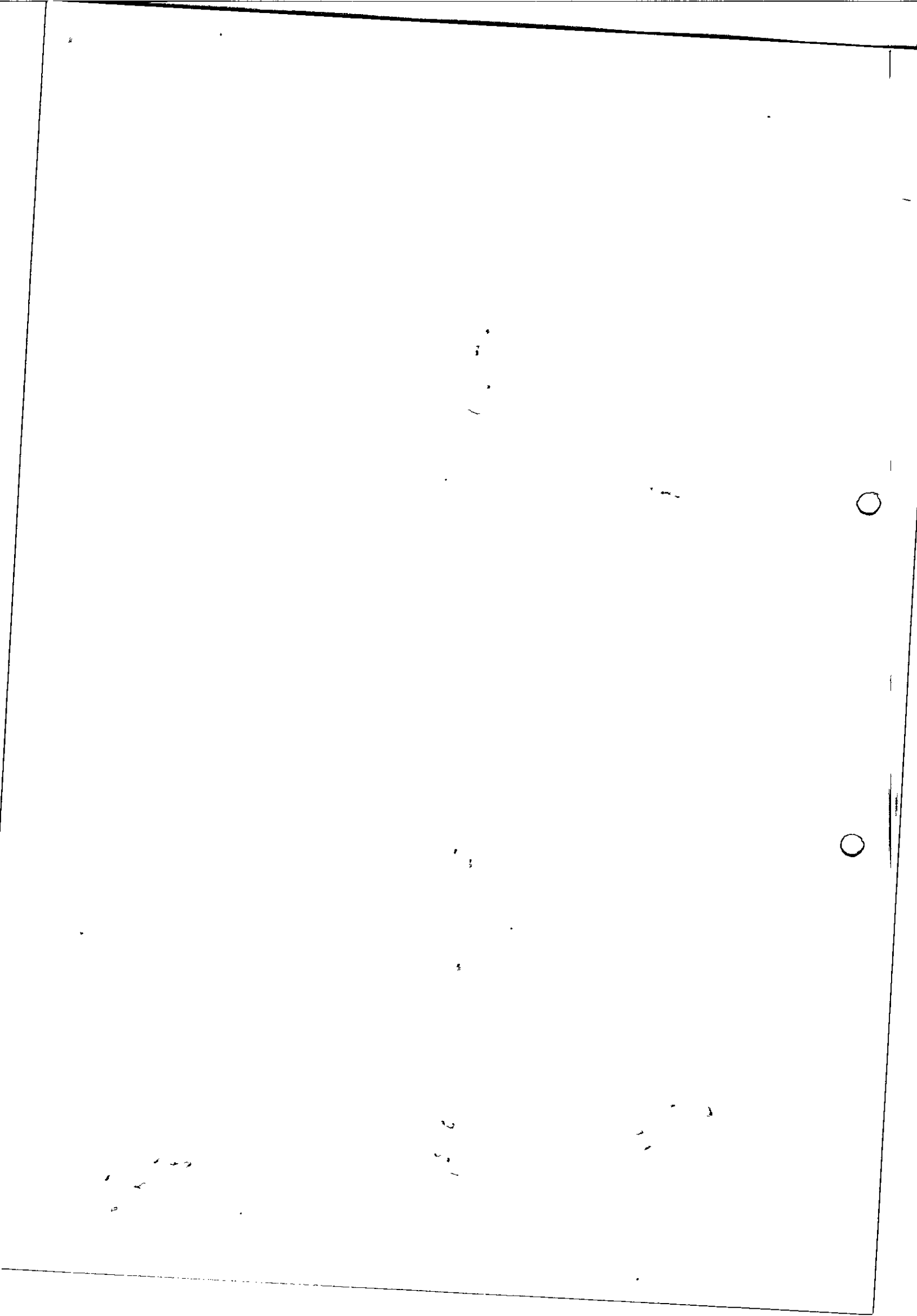
HNH-00015521 IP26-00006407
 Baby Of K SWATHI
 20-05-2026 0 Y 0 M 3 D (F)
 Dr. SPANDANA PASUPULETI



DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	1			
7	Nursing plan of care and handover sheets	2			
8	Consultation sheet				
9	General consent for treatment				
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia & post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record				
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart				
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale				
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	<i>Billing</i> <i>ok</i>	1			
	Total No. of Pages	<u>19</u>			

Signature and Date : 23/05/26
[Signature]



DISCHARGE SUMMARY

Name	Baby Of K SWATHI	UHID	HNH-00015521
Father/Guardian	Mr K. SAIKIRAN	Age/Gender	0 Y 0 M 3 D/ Female
Address	hno:4-30/2, ROAD NO-06 west gandhi nagar,nagaram, Nagaram, Hyderabad, Telangana, INDIA, 500083		
IP No	IP26-00006407	Admission Date	22-05-2026
Ref Doctor	Self.		
Discharge Date	23-05-2026		

Consultant:
Dr. SPANDANA PASUPULETI
MBBS, MRCPCH
30925

DIAGNOSIS	ICD CODE
TERM (37 weeks + 3 days)/AGA/BABY GIRL	
NEONATAL(UNCONJUGATED) HYPERBILIRUBINEMIA	

History: Baby Of K SWATHI is a 0 Y 0 M 3 D old baby girl presented with history of yellowish discolouration of skin and eyes since 1 day prior to admission. TCB was done which was 13.1mg/dl. In view of hyperbilirubinemia, she was admitted to Rainbow Children's Hospital, Himayatnagar for further

Name	Baby Of K SWATHI	UHID	HNH-00015521
IP No	IP26-00006407	Admission Date	22-05-2026

management.

Birth history: Baby Of K SWATHI is a term (37 weeks + 3 days) baby girl, delivered to a G2A1 mother by spontaneous vaginal delivery on 20.05.2026 at 02:45 pm with birth weight of 2.78 kgs in Rainbow Children's Hospital, Himayatnagar Hyderabad. Baby cried immediately after birth. Apgar scores were 9/10 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.

Examination: She was euthermic, euvolemic & maintaining saturations at room air. Heart Rate- 152/min and Respiratory Rate - 35/min. Icterus was present. Chest was clear with normal heart sounds. Abdomen was soft without organomegaly. Cry, tone, activity and newborn reflexes were normal. There were no obvious external congenital anomalies.

Weight on admission : 2.68 kilo grams.
Weight at discharge : 2.680 kilo grams.

Investigations: Enclosed.

Management: She was admitted in ward. Her transcutaneous bilirubin 13.1 mg/dl on admission (done on OP basis). She was started on double surface phototherapy. Baby was continued on demand breast feeds + measured feeds. Her last serum bilirubin on day 3 of life was 10.2 mg/dl with indirect fraction of 10.1 mg/dl. This does not come under phototherapy range, hence phototherapy stopped.

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

Name	Baby Of K SWATHI	UHID	HNH-00015521
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TEOAE (Transient Evoked Otoacoustic Emissions): Hearing test: to be done on follow-up.

New born screening advanced / Newborn screening-4: to be done on follow-up.

At the time of discharge : Baby was active, afebrile, hemodynamically stable, maintaining temperature, accepting & tolerating feeds well.

Advice:

Keep the baby clean & warm

Exclusive breast feeding

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.

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

Plan:

TEOAE (Transient Evoked Otoacoustic Emissions): Hearing test: to be done on follow-up.

New born screening advanced / Newborn screening-4: to be done on follow-up.

Review consultation with Dr. SPANDANA PASUPULETI on Monday (25.05.2026) in OPD at Himayatnagar with prior appointment (**Review consultation will be charged**).

Review back to Hospital: If baby is not feeding continuously for > 6 hours, If

Name	Baby Of K SWATHI	UHID	HNH-00015521
IP No	IP26-00006407	Admission Date	22-05-2026

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.


Parent/ Attender

In case of emergency contact number 9154865030 emergency pediatrician on duty.

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

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


Registrar/Resident/C.M.O

Dr. SPANDANA PASUPULETI
MBBS, MRCPCH
30925



ADMISSION SHEET

Registration Details :



Admission No : IP26-00006407 Admit Date : 22-May-2026 Admit Time : 05:39 PM UHID : HNH-00015521

Patient Details :

Patient Name : Baby Of K SWATHI Age : 0 Y 0 M 2 D
Guardian : Mr K. SAIKIRAN DOB : 20-05-2026 02:45 PM
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : hno:4-30/2, ROAD NO-06 west gandhi nagar,
nagaram Nagaram Hyderabad Telangana INDIA 500083 Phone No : 9573365750/ 9300992288
E-mail : swathikura92@gmail.com

Admission Details :

Bed Type : DAY CARE Bed No : ER01 Ward Name : GF -EMERGENCY
Room No : ER01 Admission Type : First Visit

Contact Details :

Name : Mr K. SAIKIRAN Relationship : Father
Contact Address : hno:4-30/2, ROAD NO-06 west gandhi nagar,
nagaram Nagaram Hyderabad Telangana INDIA 500083 Phone No : 9573365750 / 9300992288


Signature

Doctor Details :

Doctor Name : Dr. SPANDANA PASUPULETI Specialisation : NEONATOLOGY
Referral Doctor : Self. Phone No :
Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card Deposit Amount : 20000.00
Payor Name : SELFPAY

PATIENT TRANSFER FORM

HNH-00015521 IP26-00006407

Baby Of K SWATHI
20-05-2026 0 Y 0 M 2 D (F)
Dr. SPANDANA PASUPULETI



Date & Time of Admission <i>22/5/26 @ 5:40pm</i>		Date & Time of Transfer Order <i>22/5/26 @ 6pm</i>
Treating Consultant Name	Transfer Ordered by <i>Dr. prabhat</i>	Reason for Transfer <i>ADMISSION</i>
From Unit <i>ER</i>	To Unit <i>3rd floor (301)</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>251-</i>	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>		
Name & Signature of Person who is Transferring <i>Bhargavi</i>		Name of Person Ordered Transfer <i>Dr. prabhat</i>
Patient & Clinical Records Received by : <i>Maheshwari 22/5/26 @ 6:15pm</i>		
Date & Time of Patient Received :		

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


Unavailable Bed

Nurse not Available

Available Bed not ready

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Dr. SPANDANA PASUPULETI

ACTIV _____ **ING**

Name:  _____

UHID No : _____ IP No : _____ Consultant : _____ Dept : *pediatric*

Date of Admission : *22/5/26* Time : _____ Date of Discharge : _____ Time : _____

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

WARD TRANSFERS


Date	Time	From	To	Signature of Nurse
<i>22/5/26</i>	<i>6pm</i>	<i>ER</i>	<i>3rd floor (301)</i>	<i>Bhargavi</i>

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
22/5/26	(POCT)		
	fore head - 11.7mg/dl		
	chest - 13.1mg/dl.		
23/5/26	SBR	8676	

cross checked done by miralba

Ref.No. F/IN/PR/10



**Rainbow[®]
Children's
Hospital**

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

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Baby Of K SWATHI
20-05-2025 0 Y 0 M 2 D (F)
Dr. SPANDANA PASUPULETI



Patient Name : _____

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

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Baby Of K SWATHI
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Dr. SPANDANA PASUPULETI



Name : _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

cp Yellowish discoloration of skin.

History of present illness :

20L
cp Yellowish discoloration of skin
gradual onset, progressive,
involving B/c face.

T.Wt. 2.68kg
(100g ↓).

3.6% loss

TCB: Head 11.7
Chest 13.1

on DBF + FF.

M B G	B +
B B G	B +

Pediatric Multiorgan History & Physical Examination

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Dr. SPANDANA PASUPULETI



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

Multiple horizontal lines for writing past history.

Birth & Neonatal History :

~~NVD~~ / 37+3 WK / CIA B / 2.78 kg / 0+.

Birth & Socio Economic History :

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Up to date

Immunization History :

Up to date.



Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 2.68 kg (Centile _____)

On Examination :

Temperature : 98°F Pulse Rate: 152/min Description _____

B.P. _____ SPO2 98% at RA

Resp. rate and type of breathing : _____

Rash _____ Icterus extending to B/L High +

Lymphadenopathy _____

Oedema : _____

Respiratory system : B A +.

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any addes sounds : _____

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

Cardiovasclular System : S1S2+

Inspection of procordium : _____

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen : Soft

Inspection _____

Palpation : _____

Ausculation : _____

Spine: _____ External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

MNH-00015521 IP26-00006407
Baby Of K SWATHI
20-05-2028 0 Y 0 M 2 D (F)
Dr. SPANDANA PASUPULETI



Central Nervous System :

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

Cranial Nerves : _____

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

Neonatal Jaundice .

Pediatric Multiorgan History & Physical Examination

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Baby Of K SWATHI
20-05-2026 0 Y 0 M 2 D (F)
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Preventive aspects of the treatment :

Prevent BIND.

Desired goals of the treatment :

Treat ↓ jaundice.

Planned Labs :

^{advance.}
SBR, NBS t/m 6am

Plan OAE.

Planned Management :

1) DSPT = eyes & genitalia covered.

2) SBR, NBS t/m 6am

3) Lactation Consultation

4) DBF ~~FF~~ + FF = good bumps

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 _____ on
whose name the patient is being referred

Doctor's Signature Name _____ Date _____ Time _____



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/05/26	C/S/B. D. Sankubal D. Naeranya	
7 AM	Baby on DSPT	
	Euthemic	
	Vitals: stable	
	C/T/A Activity - good	
	S/S - NAD	
		Ade
		- Cont DSPT
		- Trau SBR
		- DSPT + RR fls burping
		- NTS cream care
	C/S/B. D. Tejaswi	Sankubal
	Euthemic	
	Vitals: Stable	
	C/T/A - good	
		Ade
		✓ Cont. DSPT
		✓ Trau SBR (d/s after report)
		✓ DSPT + RR fls burping
		✓ NTS cream care
		Dr Tejaswi
		NB Sankubal

Dr. S. TEJASWI REDDY
 Registration No. 54068

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Baby Of K SWATHI
20-05-2026 0 Y 0 M 2 D (F)
Dr. SPANDANA PASUPULETI



301

RESULT SHEET


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


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

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.) :

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 Baby Of K SWATHI
 20-05-2026 0 Y 0 M 2 D (F)
 Dr. SPANDANA PASUPULETI

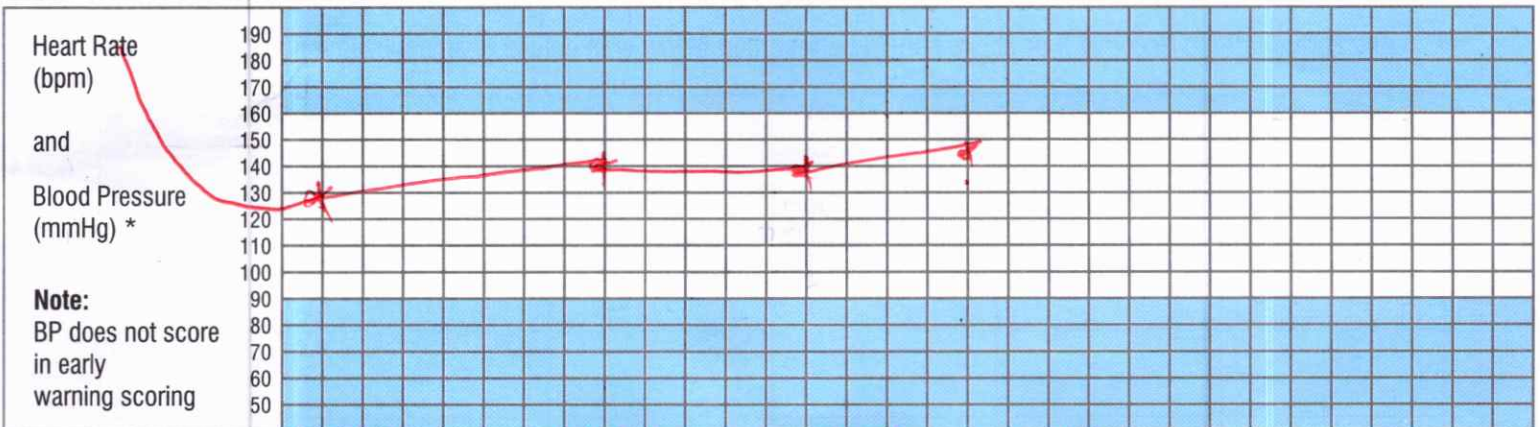
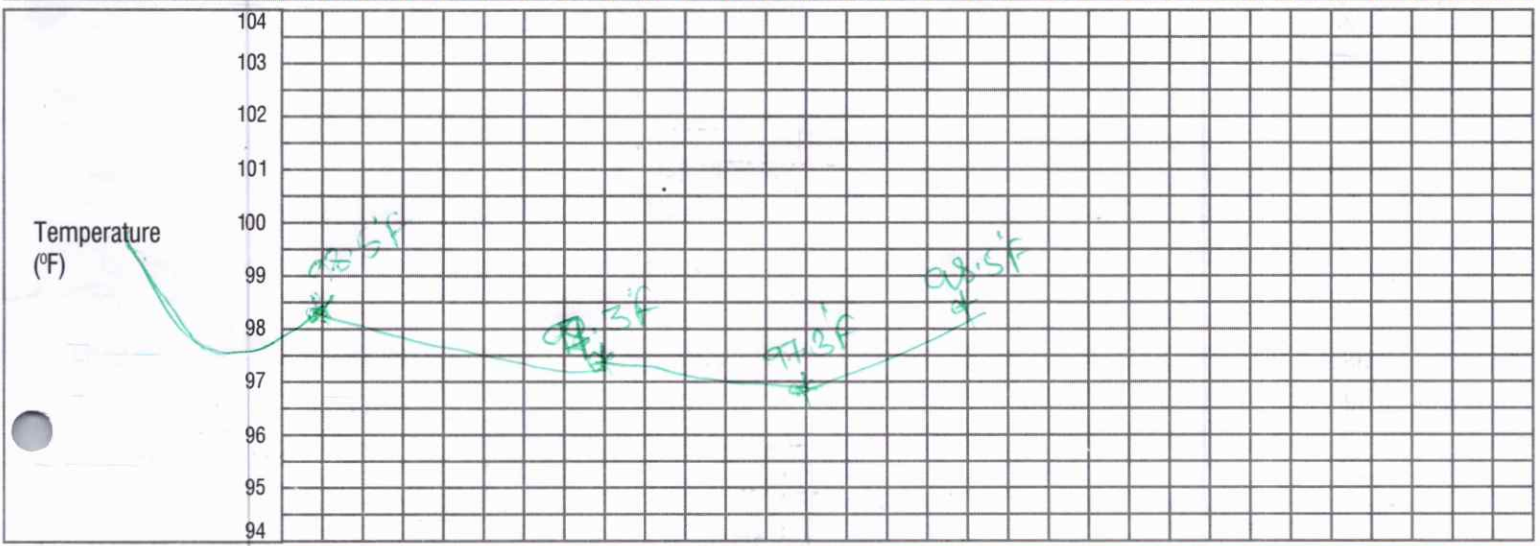
INFANT (<1 year)
 Children's Observation &
 Early Warning Scoring Chart

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

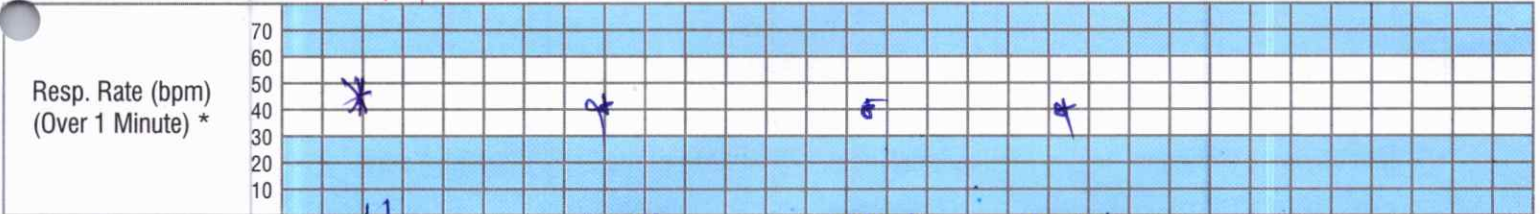
BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

WARNING SCORE: CHILDREN'S UNIT

Date: 22/5/24 Time: 6:00 pm 10 pm 2 am 6 am
 Doctor/Nurse/Family Concern?



Heart Rate (Number) 142b/m 143b/m 144b/m 145b/m



Resp Rate (Number) 45b/m 45b/m 43b/m 45b/m

Resp Distress: Mod/ Severe None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 99% 100% 99% 100%

Conscious Level: Normal Altered

GCS *

TOTAL SCORE
 Number of shaded boxes: 0 0 0 0
 Pain Score: 0 0 0 0
 Observer's Initials: [Signature] [Signature] [Signature] [Signature]

- ACTIONS**
- 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)

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 Baby Of K SWATHI

20-05-2026 0 Y 0 M 2 D (F)
 Patient Dr. SPANDANA PASUPULETI



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				
	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 :								
23/5/28	08:00 pm		DBF+FF			/								
	09:00 pm		DBF+FF			/								
	10:00 pm	o	DBF+FF			/	NA		NA				Ⓢ	
	11:00 pm		DBF			/								
	12:00 am		DBF			/								
	01:00 am		DBF			/								
Total Intake :						Total Output :								
23/5/28	02:00 am		DBF+FF			/								
	03:00 am		DBF+FF			/								
	04:00 am	o	DBF+FF			/	NA		NA				Ⓢ	
	05:00 am		DBF+FF			/								
	06:00 am		DBF+FF			/								
	07:00 am		DBF+FF			/								
Total Intake :						Total Output :								

Total 24 hrs. Intake

Total 24 hrs. Output

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FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
23/5/26			Mouth	I.V	N.G		✓			✓		
	08:00 am		DBF+FF									
	09:00 am											
	10:00 am	G	DBF+FF									MS
	11:00 am											
	12:00 pm		DBF+FF									
	01:00 pm											
Total Intake :					Total Output :							
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :					Total Output :							
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :					Total Output :							
Total 24 hrs. Intake					Total 24 hrs. Output							

HNH-00015521

IP26-00006407

Baby Of K SWATHI
20-05-2026

0 Y 0 M 2 D

(F)

Dr. SPANDANA PASUPULETI



BRADEN 'Q' SCALE



Date : 22/5/24 22/5/24 23/5/24
Time : 6p 10pm MC

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.	3	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	3	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	3	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.	3	4	4	
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."	3	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 of 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.	3	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	

TOTAL SCORE

23 28 28

Evaluator's Name

SR SR MS

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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-00015521 IP26-00006407
 Baby Of K SWATHI
 20-05-2026 0 Y 0 M 2 D (F)
 Dr. SPANDANA PASUPULETI



NURSING CARE RECORD

Date: 20/5/24

- 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	6pm	- Assess the Baby Condition - monitor vital signs - DBF + FF 2nd hourly		- Assess the Baby Condition - monitor vital signs - DBF + FF 2nd hourly	Baby stable	Rechecked vital	[Signature]
	8pm	- ct DSPT		- ct DSPT			
Afternoon							
Night	8pm	- Assess the baby condition - monitor the v/s - maintain the I/O	8pm	- Assess the baby condition - monitor the v/s - maintain the I/O	- Baby is stable	- Rechecked the v/s	[Signature]
	8am	- DBF + FF 2nd hourly	8am	- DBF + FF 2nd hourly - ct DSPT			

HNH-00015521 IP26-00006407
 Baby Of K SWATHI
 20-05-2026 0 Y 0 M 3 D (F)
 Dr. SPANDANA PASUPULETI



NURSING CARE RECORD



Date: 20/5/26

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	8 AM 2 PM	→ Assess the baby condition. → monitor the vitals. → maintain I/O chart. → DBF+FF give 2nd hourly. → plan discharge after SBR report.	8 AM 2 PM	→ Assessed the baby condition. → monitored the vitals. → maintained I/O chart. → DBF+FF given 2nd hourly. → planned discharge after SBR Report.	→ Baby is stable now	→ Reassessed the vitals	Maheshwari
Afternoon							
Night							

HNH-00015521 IP26-00006407

Baby Of K SWATHI
20-05-2026 0 Y 0 M 2 D (F)
Dr. SPANDANA PASUPULETI



Patient



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: NNJ	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date / Shift	22/5/26 G	22/5/26 N1	23/5 ng	/	/	
	Medical Condition (Any special condition to be noted):	—	—	—	/	/	
	Diet:	—	—	DBF+FF	/	/	
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	—	—	—	/	/	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	98.1°F	98.3°F	98.1°F	/	/
		Res:	16b/m	12b/m	16b/m	/	/
		SpO ₂ :	99%	99%	99%	/	/
		Pulse:	142b/m	132b/m	146b/m	/	/
		BP:	—	—	—	/	/
		LOC:	—	—	—	/	/
		Fall Risk Score:	—	'0'	'0'	/	/
Pain Score:	—	'0'	'0'	/	/		
Skin Integrity	—	Good	Good	/	/		
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	—	—	—	/	/	
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	—	—	DBF+FF	/	/	
	Critical Lab Test / Values:	—	—	—	/	/	
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
ADL (Dependent / Non Dependent):	—	—	—	/	/		
Post Operative Procedure Special Orders:		—	—	—	/	/	
Handed Over By Name :		Supandamahi					
Signature / ID :							
Date:		22/5/26	23/5/26	23/5/26	/	/	
Time:		8pm	8am	2pm	/	/	
Taken Over By Name :		Supandamahi					
Signature / ID :							
Date:		22/5/26	23/5	/	/	/	
Time:		8pm	8am	/	/	/	

Patient Sticker



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date	/	/	
	Shift							
	Medical Condition (Any special condition to be noted):							
	Diet:							
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):							
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
		LOC:						
		Fall Risk Score:						
Pain Score:								
Skin Integrity								
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:							
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:							
	Critical Lab Test / Values:							
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
PU Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
DVT Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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:								



REGULAR PRESCRIPTIONS

Weight: 2.68kg Ward.

DRUG : VIT D3 DROPS				Date Time
Dose	Route	Frequency	Start Date	
0.5ml	PO	OD	22/5/26	
Name & Signature of the Doctor Starting the Drugs: Dr. Prabhakar				
Additional Instructions: (800 IU/ml)				
Daily Doctor's Endorsement by a Sign				

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

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

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



Weight. Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

VERIFIED BY : Name Signature

HNH-00015521 IP26-00006407
 Baby Of K SWATHI
 20-05-2028 0 Y 0 M 2 D (F)
 Dr. SPANDANA PASUPULETI



MEDICATION RECONCILIATION FORM

Drug Allergies: N.P.I. 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: 3rd floor (301)

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						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Prabhat

Date & Time: 22/5/26 @ 5:40pm

Nurse Name & Signature: Bhargavi

Date & Time: 22/5/26 @ 5:45pm



wt - 2.68kg TCB? - head - 11.7mgd chest - 13.1mgd



EMERGENCY ROOM TRIAGE FORM

Patient's Name : blo. Swathi Age : 2 days Gender: Male Female

Date : 22/5/26 Time of Arrival : 5:30pm

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°F PR: 150b/m BP: RR: SpO₂: 98%

Chief Complaints: clo. yellowish discoloration of skin

INITIAL PHYSIOLOGICAL CATEGORIZATION			INITIAL PHYSIOLOGICAL STATUS	
Appearance	Circulation / Colour <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding	Work of Breathing	<input checked="" type="checkbox"/> Stable	
<input checked="" type="checkbox"/> Normal		<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased	<input type="checkbox"/> Unstable :	
<input type="checkbox"/> Sick Looking		<input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea	<input type="checkbox"/> Not - Life - Threatening <input type="checkbox"/> Life - Threatening	

Triage Classification	CTAS
<input type="checkbox"/> Level 1 : Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2 : EMERGENT : Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	<input type="checkbox"/> 30 min
<input checked="" type="checkbox"/> Level 4 : LESS URGENT : Significant illness but not life threatening	<input checked="" type="checkbox"/> 60 min
<input type="checkbox"/> Level 5 : NON - URGENT : May receive care when convenient	<input type="checkbox"/> 120 min

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

Signature of Parent / Guardian

* CTAS - Canadian Triage and Acuity Scale

Triage Completion Time :

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Bhargavi

Signature of Triage Nurse : [Signature]

Date & Time : 22/5/26 @ 5:32pm



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 22/5/26 Time of arrival : 5:34pm

Chief Complaints : no yellowish desquamation of skin RBS:

Height : Weight : 2.168kg 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 :

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

Time	Nursing Notes
5:36pm	Assess the pt condition monitor the vitals

Samples collected by: *[Signature]*
 Samples sent by : *[Signature]*

Time: *[Signature]*
 Time: *[Signature]*

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: <i>152b/m</i> BP: CFT: RR: SPO ₂ : <i>98%</i> GCS: Temperature: <i>98°F</i> Pain Score: Repeat RBS (if applicable):	Shift - out from ER to: <i>3rd floor (3rd)</i> Time of Shift - out: <i>6pm</i> Handover given to: (Nurse's Name)

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any):

Name of the Nurse : *Bhargava* Signature of the Nurse : *(B)*

Date & Time : *22/11/26 @ 5:38pm*

HNH-00015521
 Baby Of K SWATHI
 20-05-2026 0 Y 0 M 2 D (F)
 Dr. SPANDANA PASUPULETI

IP26-00006407

GENERAL CONSENT FOR TREATMENT

Pat: .THI Age: 0 Y 0 M 2 D
 IP No: IP26-00006407 Sex: Female
 Consultant: Dr. SPANDANA PASUPULETI 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".

No: 1 I 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:.....)

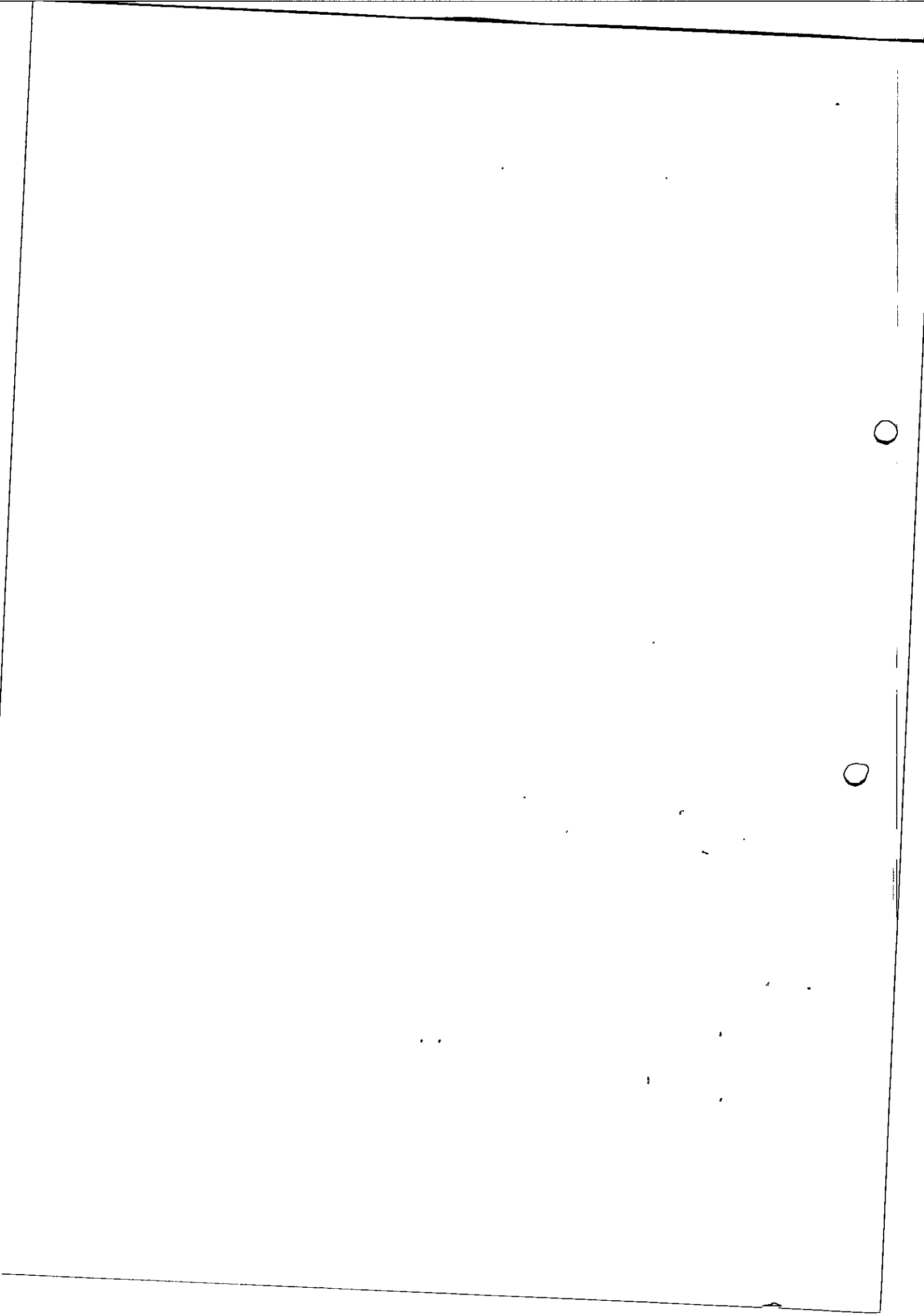
3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
 4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name: Sai Kiran
 Relationship: father
 Date: 24/5/26
 Witness Name: [Signature]
 Witness Signature: [Signature]

Patient Address:
 hno:4-30/2, ROAD NO-06 west gandhi nagar,nagaram Nagaram Hyderabad Telangana INDIA 500083

Time: 5:39 PM



HNH-00015521
Baby Of K SWATHI
20-05-2026
Dr. SPANDANA PASUPULETI
IP26-00006407
0 Y 0 M 2 D
(F)

BILLING POLICY

Billing cycle: - With effective from 1st January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 12 PM, room rent will be charge for half day extra & post 6 pm, it will be charge for full day. Less than 24 hours stay will be considered as one day.

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

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

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

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

MODE OF PAYMENT & REFUNDS

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

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

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

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

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

Corporate Office: 8-2-19/1/A, Daulet Arcade, Karvy Line, Road No.11, Banjara Hills, Hyderabad - 500 034.

Branches : BANJARA HILLS - T: 2233 4455 | VIKRAMPURI - T: 4246 2200 | KONDAPUR - T: 4246 2400 | MADHAPUR - T: 6464 2020 | KUKATPALLY - T: 4246 2300 | L B NAGAR - T: 7111 1333 | MARATHAHALLI, BENGALURU - T: +91 80 7111 2345 | BANNERGHATTA ROAD, BENGALURU - T: +91 80 2551 2345, HIMAYATNAGAR- T:- 40 48873000

