2/2
F.C

Rainbow® Children's Hospital
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DISCHARGE SUMMARY

Name	Baby G.HANSIKA	**UHID**	BAH-00333789
Father/Guardian	Mr G.SHIVA PRASAD	**Age/Gender**	9 Y 10 M 28 D/ Female
Address	~, Ashok Nagar, Hyderabad, Telangana, INDIA, 500020		
IP No	IP26-00006845	**Admission Date**	14-07-2026
Ref Doctor	Self.		
Discharge Date	17.07.2026		

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

DIAGNOSIS	ICD CODE
ENTEROCOLITIS WITH DEHYDRATION	

History: Baby G.HANSIKA is a 9 Y 10 M 28 D , old girl presented with history of multiple loose stools associated with multiple episodes of non bilious, non projectile vomiting and fever since 1 day, headache & generalized body pains since 1 day, prior to admission. For the above complaints she was admitted at Rainbow Children's Hospital - for further management.

Examination: She was afebrile, maintaining saturations at room air. Her heart rate was 145/min, blood pressure was 103/73 mmHg and RR - 34/min. On examination Signs of

Name	Baby G.HANSIKA	UHID	BAH-00333789
IP No	IP26-00006845	Admission Date	14-07-2026

dehydration like dry oral mucosa, sunken eyes and reduced skin turgor were present. On auscultation of chest, air entry was bilaterally equal with normal heart sounds and there was no murmur. Abdomen was soft, tender without organomegaly. On neurological examination, she was conscious & alert. Pupils were bilaterally equal & reacting to light. There were no focal neurological deficits.

Weight on admission: 26 kilo grams.

Investigations: Enclosed reports.

VBG showed pH of 7.37, pCO2 of 32.8 mmHg, pO2 of 52 mmHg, HCO3 of 19.5 mmol/L and BE of -6.6 mmol/L.

Initial hemogram showed Hemoglobin of 13.3 gm%, White Blood Cell count of 11450 cells/cumm, platelet count of 3.21 lakhs/cumm and C-Reactive Protein of 214 mg/l. Complete urine examination was normal.

Ultrasound abdomen shows

* Submucosal wall thickening involving transverse, descending and sigmoid colon with increased bowel wall vascularity, suggestive of colitis - likely infective.
* Minimal free fluid in the pelvic peritoneal cavity.
* Few lower mesentery nodes.

Management: She was admitted in the ward and started on intra venous fluids and In venous antibiotics. She was treated symptomatically with antiemetics, antacids and antipyretics.

She was regularly monitored for her loose stool frequency and hydration status. Her loose stools and other symptoms settled gradually with the above line of management..

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

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

Name	Baby G.HANSIKA	**UHID**	BAH-00333789
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Medications given during hospital stay:
Injection. Esmoprazole
Injection. Ceftriaxone
Injection. Ondansetron
Pro-GG sachet
Syp. Zinconia

Advice:
* Diet as advised.

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Tab. TAXIM (Cefixime-200mg)	1/2 -0- 1/2	8am - 8pm (after food)	For 5 days.
2	Syrup. ONDEM (Ondansetron – 5ml/2mg)	7 ml	Max 3 times/day (30 mins before food)	SOS for vomiting
3	Pro-GG sachet	1 sachet	twice daily	for 3 days
4	Syrup Zinconia	5ml	at bedtime	for 13 days
5	Nasoclear nasal drops, 2 drops in each nostril **SOS** for nose block			

Plan: To collect final blood culture report on followup

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 8ml 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.

Name	Baby G.HANSIKA	**UHID**	BAH-00333789
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Review consultation with Dr. ANIKET ANIL PARASHAR on Monday (20.07.2026) at Himayatnagar in OPD with prior appointment **(Review consultation will be charged)**.

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

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

Registrar/Resident/C.M.O

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

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006845 **Admit Date** : 14-Jul-2026 **Admit Time** : 11:49 PM **UHID** : BAH-00333789

Patient Details :

Patient Name	: Baby G.HANSIKA	**Age**	: 9 Y 10 M 28 D
Guardian	: Mr G.SHIVA PRASAD	**DOB**	: 17-08-2016
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: ~ Ashok Nagar Hyderabad Telangana INDIA 500020	**Phone No**	: 9848553446
		E-mail	: spgaruda@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER02 **Ward Name** : GF -EMERGENCY

Room No : ER02 **Admission Type** : First Visit

Contact Details :

Name : Mr G.SHIVA PRASAD **Relationship** : Father

Contact Address : ~ Ashok Nagar Hyderabad Telangana INDIA 500020 **Phone No** : 9848553446

Signature

Doctor Details :

Doctor Name : Dr. ANIKET ANIL PARASHAR **Specialisation** : GENERAL PEDIATRICS

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

Co-Consultant :

Payment Details :

Deposit Amount : 25000.00

Payment Mode : Cash **Payor Name** : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name: ------ BAH-00333789 Baby G.HANSIKA IP26-00006845 ----------

UHID No : -- 17-08-2016 9 Y 10 M 28 D (F) Dr. ANIKET ANIL PARASHAR -------- Consultant : ---------- Dept : pediatric

Date of Adr : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
15/7/26	12:2AM	ER	2nd Floor	

Cross Consultation Visit

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

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INVESTIGATIONS

Date	Investigations	Order No.	Sign
15/7/26	CRP		
	CRP	11742	
	VBG	11741	[illegible]
15/7/26	CUE	11747	Sne
	cross checked done by Sneha		
15/7	Blood C/S	11755	[illegible]
15/7	USG abd	8537	[illegible]
	cross checked done by Supriya		

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MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
15/7	Infusion pump	1 Am	16/7/26 @ 2pm	3900	Sneha

Cross checked done by Sneha

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PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
15/7/26	IV placement	1	13893	
15/7/26	NHA	1	14035	

cross checked done by Supriya

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

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PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00333789 IP26-00006845
Baby G.HANSIKA
17-08-2016 9 Y 10 M 28 D (F)
Dr. ANIKET ANIL PARASHAR

Patient Name : HANSIKA/9y

Patient ID# :

Consultant :

Final Diagnosis :

Pediatric ... y & Physical Examination

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17-08-2016 9 Y 10 M 28 D (F)
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Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

Loose stools since yesterday night
& vomiting ~~since~~ since morning
3/ fever since yesterday
& Headache since yesterday

History of present illness :

Child was apparently asymptomatic till yesterday night after which she had fever which was moderate grade responding to oral paracetamol

Vomiting started in the morning initially non-bilious non-projectile 15 episodes/day later had greenish vomiting

Loose stools started yesterday which were 15-16 episodes of sticky yellowish. Loose stools

Headache since yesterday generalized.

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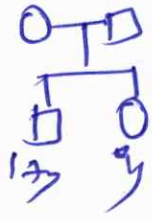
atric Multiorgan History & Physical Examination

P any previous investigation or treatment)

Birth & Neonatal History :

Term | AGA | 3.46 | CIAB



Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

None

Immunization History :

IAP schedule - Up-to-date

Pediatric M[...]xamination

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Anthropometry

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

Weight (kgs) 26 kg (Centile ________)

On Examination :

Temperature : ________ Pulse Rate: ________ Description ________

B.P. ________ SPO2 96 % at RA

Resp. rate and type of breathing : [illegible]

dry tongue

Rash ________ dry oral mucosa

Lymphadenopathy ________ Sunken eyes.

Oedema : ________

Respiratory system :

Inspection (any s/o distress) : ________

Air entry & breath sounds : BLE-ACE⊕

Any addes sounds : ________

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

Cardiovasclular System :

Inspection of procordium : ________

Heart Sounds : S1 S2 ⊕

Any murmur : ________

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

Per Abdomen :

Inspection ________

Palpation : P/A Soft

Ausculation : ________

Spine: ________ External Genitelia : ________

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

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 :

Δ Acute Gastroenteritis
↓ dehydration

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17-08-2016 9 Y 10 M 28 D (F)
Dr. ANIKET ANIL PARASHAR

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

IV fluids
IV Antibiotics

Desired goals of the treatment :

Loose stools subsidence

Planned Labs :

CBP
CRP
VBG
CUE
Blood C/S - collect
Extra plain - 1
USG Abdomen - T/y
i/b Ampm

Planned Management :

- Inj. CEFTRIAXONE 1.3gm IV BD
- Inj. ESOMEPRAZOLE 25 mg IV OD
- Inj. ONDANSETRON 4mg IV TID
- IV PLASMALYTE 25ml bolus
  ↓
  PLASMALYTE @ 60ml
- NPO (overnight)

i/b Ampm

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

Doctor's Signature Name [signature] Dr. ANIKET PARASHAR Reg. No: 08568 Date 14/7/26 Time

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/7/26 12 AM	S/B Dr. Aniket	P/c
	AGE ē dehydration	
		- IV PLASMALYTE 250ml bolus over 1 hour ↓
	Sunken eyes ⊕	
	dry oral mucosa ⊕	
	C/o Pain Abdomen	IV PLASMALYTE @60ml
	CVS - S1 S2 ⊕	- cf ONDANSETRON
	RS - BL - AE ⊕	ESOMOPRAZOLE
	P/A - soft	- w/f dehydration
	Conscious.	
15/7/26 7 AM	S/B Dr. Sneha	
	AGE ē dehydration	P/c
	C/o loose stools	- cf PLASMALYTE @60ml
	CVS - S1 S2 ⊕	
	RS - BL - AE ⊕	- cf ONDANSETRON
	P/A - soft	- w/f dehydration
	Conscious	- If CRP +ve ↓ send Blood C/S
	CRP - 214	- send Blood C/S
		IBS NB Sneha

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/07/2026 9:30am	S/B Dr. Aniket	
	AGE c dehydration ? Enterocolitis	
	2-3 episodes of loose stools	Plan
	nausea (+)	1) Ct ceftriaxone
	chest clear	2) Trace blood c/s, CUE
	P/A soft	3) USG Abdomen now
	oral intake - poor	4) Monitor vitals
		5) Ct IV fluids
		6) If persistent fever spikes, send stool c/s
		N/B Dr. Aniket
		[signature]

Dr. ANIKET PARASHAR Regd. No. 85568

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/7/26	C/S/13.	
2pm	Δ: Enterocolitis c̄ dehydration.	
	Last spike @ 2:50 AM (100.5°F).	Adv
		• Ct Inj CEFTRIAXONE.
	Nausea (+).	• Ct IVF → reassess if oral acceptance improves
	Oral acceptance - fair	• (f) Blood C&S.
	U/S] passed.	• TPR/I&O c - Inform SOS.
	o/e	
	vitally stable.	
	s/e	
	wnl.	
15/7/26.	S/B Dr-Aniket	
5:30pm	c/o	Adv.
	2 loose stools	• Ct Inj CEFTRIAXONE
	Nausea (+).	• Improve orals
	oral acceptance - poor	• (f) Blood C&S
		[VBG, CBP, CRP with n/p]
	o/e vitally stable.	
	s/e wnl.	
		Dr. D. Aniket
		D.B Amarnath @ 5pm

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/s/by Dr Anusha	
18/7/26. 8:30AM	AGE ī dehydrat Enterocolitis.	
	loose stools - ① once - minimal amnt.	
	vomiting - No.	Cannula - (N)
	fever - No (yesterday)	
	hydration - good	Plan
		- ct iv fluid
	vital stable	
		- Next prick VBG, CBP, CRP
	S/E	
	P/A soft	- ct Antibiotics
	non tend	
		- Enhance orals
		- (T) B/c/s
	Af	NIB Mounika

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/26 9:45 AM	S/B Dr. Aniket	
	Enterocolitis c dehydration.	
	No fever : 1 day.	
	No vomitings / loose motions	Adv.
	No fresh complaints	· (T) Blood c&s
		· Ct ceftriaxone
	O/E vitally stable.	· Improve orals.
		· Discharge (SOS) if culture is (-ve)
	S/E wnl.	Fu in 5days.
		· Continue probiotics & Zinc.
		N.B Amaytha @ 10AM
		Dr Anirudh
16/7/26 2pm	S/B Dr. Archana / Dr. Naipunya	
	Enterocolitis c dehydration	
	Afebrile	Adv.
	No vomitings / loose motions.	· Ct ceftriaxone.
	No fresh complaints	· Improve orals
		· Discharge c/m
	O/E vitally stable	· (T) Blood c&s
	S/E wnl.	NB @ 2PM

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/26 5.30pm	S/B Dr. Aniket →	
	Oral acceptance - improved.	Adv
		Soft diet only
	O/E	Ct ceftriaxone
	vitally stable.	Ct rest same.
		NB Sm[illegible] 5.30
		Dr. Aniket P

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/o/c. Dr. Subashi / Dr. Thanvi	
17/07/26 7AM	ENTEROCOLITIS with dehydration	
	Afebrile	
	No vomiting / Loose stools	
	No fresh concerns	
	O/E: Vitals: stable	
	Hydration - good	
		Adv
		- Inj Ceftriaxone
		- Trace Blood c/s
		- Monitor vitals and inform S/R
		Subashi
		NB - Supriya 7:40am @17/7/26

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/6 10Am	c/s/B Dr Aniket	
	Enterocolitis c Dehydration	
	Loose stool ↓	Plan
	Vomiting ↓	1) D/C Today
		F/Up Monday
	Oral intake - fair	
		2) Oral Cefixime - x 5 day
	Vitals Stable	SOS - Order
		Ct - Pro GG
		Zincovit
		(signature)

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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DRUG CHART

Date of Admission: 15/7/16 Drug Allergies: Nil ☐ 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 : T. PARACETAMOL				Date / Time	15/7 3:50 PM
Dose	Route	Frequency	Start Date		
500mg	Oral	SOS/6H	15/7		
Doctor's Signature		Valid Period	Pharm.		
Additional Instructions: 9 1/2 tablet					

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

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

Verified by Dr. Dhakshayani

VERIFIED BY : Name Signature

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Baby G.HANSIKA
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Dr. ANIKET ANIL PARASHAR

REGULAR PRESCRIPTIONS

Weight. 26 kg Ward.

Verified by Dr. Dhakshayani

DRUG : Inj CEFTRIAXONE

Dose	Route	Frequency	Start Date	Date/Time	15/7	16/7	17/7
1.3gm	IV	BD	15/7	6Am	2Am [signature]	[signature]	[signature]
				6Pm	[signature]	[signature]	

Name & Signature of the Doctor Starting the Drugs: B. Saeyle [signature]

Additional Instructions:

Daily Doctor's Endorsement by a Sign [signature]

Verified by Dr. Dhakshayani

DRUG : Inj. ESMOPRAZOLE

Dose	Route	Frequency	Start Date	Date/Time	15/7	16/7	17/7
25mg	IV	OD	15/7	6Am	1:47Pm [signature]	[signature]	[signature]

Name & Signature of the Doctor Starting the Drugs: B. Saeyle [signature]

Additional Instructions:

Daily Doctor's Endorsement by a Sign [signature]

Verified by Dhakshayani

DRUG : Inj. ONDANSETRON

Dose	Route	Frequency	Start Date	Date/Time	15/7	16/7	17/7
4mg	IV	TID	15/7	6Am	1:49Pm [signature]	[signature]	[signature]
				2Pm	[signature]	[signature]	
				10Pm	[signature]	[signature]	

Name & Signature of the Doctor Starting the Drugs: B. Saeyle [signature]

Additional Instructions:

Daily Doctor's Endorsement by a Sign [signature]

DRUG : Pro-GG sachets.

Dose	Route	Frequency	Start Date	Date/Time	16/7	17/7
1 sachet	PO	BD.	16/7	6Am	Y	[signature]
				6Pm	4:50Pm [signature]	

Name & Signature of the Doctor Starting the Drugs: [signature]

Additional Instructions:

Daily Doctor's Endorsement by a Sign

BAH-00333789 IP26-00006845
Baby G.HANSIKA
17-08-2016 9 Y 10 M 28 D (F)
Dr. ANIKET ANIL PARASHAR

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Your Right to a Safe Delivery

Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG : Syp ZINCONIA				Date ▸ Time ▾ 16/7
Dose 5ml	Route PO	Frequency H/S	Start Dt. 16/7	
Name & Signature of the Doctor Starting the Drugs:				10pm
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 ....

Patient Sticker

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Your Right to a Safe Delivery

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				

Signature

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Weight. 26/9 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.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
15/7	12:30 AM	PLASMALYTE	@250 ml over 2 hrs	IV		

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

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I.V. FLUIDS CHART

Weight. 26kg Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
15/7	1:30 AM	PLASMALYTE	IV	60 ml/hr			16/7-		

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

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RESULT SHEET

Date	15/7/26					
Time						
Hb	13.3					
PCV	37.8					
RBC	4.55					
WBC	11.45					
N/L	85.3/7.4					
Platelets	321					
CRP	214					
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						

(P.T.O)

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 : Blood C/S -)

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

Patient Sti

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SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 15/1/26 Time:	1:11 AM	2 AM	3:50 AM	5 AM	6 AM
Doctor / Nurse / Family Concern?					

Temperature (F)

104 103 102 101 100 99 98 97 96 95 94

99.4°F 99.5°F 100.5°F Given calpol T. 98.3° 98.5°F

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

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

107 (80) 68 103 (40) 65

Note: BP does not score in early warning scoring

Heart Rate (Number)	125bpm			128bpm	

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

70 60 50 40 30 20 10

Resp Rate (Number)	99			29bpm	
Resp Distress: Mod/ Severe / None / Mild					
Receiving O_2(l/min) O_2Saturations (%)	100%			100%	
Conscious Level: Normal / Altered					
GCS *					
TOTAL SCORE Number of shaded boxes	0			0	
Pain Score	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.

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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)

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Baby G.HANSIKA
17-08-2016 9 Y 10 M 28 D (F)
Dr. ANIKET ANIL PARASHAR

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SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 15/7 Time: 10am 3pm 6pm 10 PM 2 AM 6 AM

Doctor / Nurse / Family Concern?

Temperature (F): 98.6°F, 98.6°F, 98.2°F, 98.8°F, 98.1°F, 98.3°F

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

Note: BP does not score in early warning scoring

Heart Rate (Number): 108b/m, 102b/m, 114b/m, 113b/m, 110b/m, 114b/m

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

Resp Rate (Number): 22b/m, 24b/m, 25b/m, 24b/m, 24b/m, 23b/m

Resp Distress	Mod/ Severe / None / Mild					
Receiving O_2(l/min) O_2Saturations (%)		99%	99%	100%	100%	99%	99%
Conscious Level	Normal / Altered					
GCS *				15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes		0	0	0	0	0	0
Pain Score		0	0	0	0	0	0
Observer's Initials							

ACTIONS NB: Scores 3 should be recorded overleaf	
Score 1	: Continue normal observation by staff nurse
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Baby G.HANSIKA
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SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 16/7 Time:	10AM	2pm	6pm	10pm	2 AM	6 AM
Doctor / Nurse / Family Concern?						
Temperature (F) (scale 94–104)	98.3F	97.3F	97.6F	98.4F	97.4F	97.6F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190)	111/69 (75)	106/68 (77)	101/60 (72)	103/70 (70)	101/68 (76)	104/69 (81)
Heart Rate (Number)	114b/m	109b/m	102b/m	113b/m	106b/m	116b/m
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)						
Resp Rate (Number)	28b/m	25b/m	23b/m	25b/m	26b/m	26b/m
Resp Distress: Mod/ Severe						
Resp Distress: None / Mild						
Receiving O_2(l/min)						
O_2Saturations (%)	100%	98%	99%	99%	99%	99%
Conscious Level: Normal						
Conscious Level: Altered						
GCS *					15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Note: BP does not score in early warning scoring

ACTIONS

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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.

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :								**Total Output :**				
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :								**Total Output :**				
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am										0	
15/7	01:00 am	Plasmalyte	NPO	60ml			1				0	Sm
Total Intake :							0	**Total Output :**				
	02:00 am		1	60ml							0	
	03:00 am			60ml			loose				0	
	04:00 am		NPO	60ml			loose				0	
15/7	05:00 am			60ml							0	
	06:00 am			60ml							0	
	07:00 am			60ml							0	Sm
Total Intake :								**Total Output :**				

Total 24 hrs. Intake		Total 24 hrs. Output	

Docu. No. : RCH /FRM / CLINICAL / 092

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FLUID CHART

Sheet No. : 2

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
15/7	08:00 am	Plasmalyte	Tablet ORS	60ml		NA	Loose			✓	0	
	09:00 am			60ml								
	10:00 am			60ml				NA				
	11:00 am			60 ml								
	12:00 pm			60 ml			Loose			✓		
	01:00 pm			60 ml	✓							
Total Intake : Taken						**Total Output :** U- 2 M- 2						
15/7	02:00 pm	Plasmalyte	Rice + H2O	60ml		NA	loose	NA		✓	0	
	03:00 pm			60ml								
	04:00 pm			60ml						✓		
	05:00 pm			60ml								
	06:00 pm			60ml						✓		
	07:00 pm			60ml								
Total Intake : Taken						**Total Output :** M-1 U-2						
15/7/26	08:00 pm	Plasmalyte	Rice + H2O	60ml		NA		NA		✓	0	
	09:00 pm			60ml						✓		
	10:00 pm			60ml						✓		
	11:00 am			60ml								
	12:00 am			60ml								
	01:00 am			60ml								
Total Intake : Taken						**Total Output :** U- M-						
16/7/26	02:00 am	Plasmalyte	H2O	60ml		NA				✓	0	
	03:00 am			60ml								
	04:00 am			60ml						✓		
	05:00 am			60ml								
	06:00 am			60ml								
	07:00 am			60ml								
Total Intake : Taken						**Total Output :** U- M-						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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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							
16/7	08:00 am			60ml								
	09:00 am		Jelly	60ml								
	10:00 am	Fluids		60ml								
	11:00 am			30ml								
	12:00 pm			30ml								
	01:00 pm		Soup	30ml								
Total Intake :						**Total Output :**						
16/7	02:00 pm											
	03:00 pm											
	04:00 pm		Rice +									
	05:00 pm											
	06:00 pm		H2O									
	07:00 pm											
Total Intake :						**Total Output :**						
16/7/26	08:00 pm											
	09:00 pm		Rice +									
	10:00 pm											
	11:00 pm		H2O									
	12:00 am											
	01:00 am											
Total Intake : Taken						**Total Output :**						
17/7/26	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am		Soup									
Total Intake : Taken						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
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	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

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

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Baby G.HANSIKA
17-08-2016 9 Y 10 M 28 D (F)
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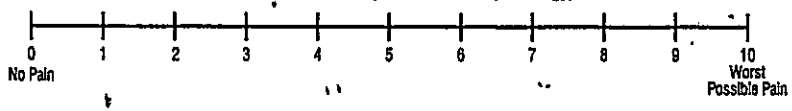
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
15/7	12Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
15/7	3Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
15/7	8Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
15/7/26	10am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
15/7/26	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
15/7/26	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
16/7/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
16A	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
16/7	8Pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
16/7/26	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	

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	DAY-1 M	DAY-1 E	DAY-1 N (18/7)	DAY-2 M (15/7)	DAY-2 E	DAY-2 N	DAY-3 M (16/7)	DAY-3 E	DAY-3 N	Remarks
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			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			NA	NA	NA	NA	0	NA	NA	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA	NA	NA	NA	0	NA	NA	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			NA	NA	NA.	NA	0	NA	NA	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			NA	NA	NA	NA	0	NA	NA	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			NA	NA	NA	NA	0	NA	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 : Srekha

Signature of Ward In Charge :

Signature : Balarani Name : Balarani

Docu. No. : RCH /FRM / CLINICAL / 137

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CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

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NURSING CARE RECORD

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Date: 14/7/28

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				EP			
Afternoon							
Night	8pm 8pm	Assess the Pt condition. monitor vitals & record. maintain I/O chart. Provide the comfortable position. medication give as per as doctor order	8pm 8pm	Assessed the Pt condition. monitored vitals & recorded maintained I/O chart. Provided the comfortable position. medication given as per as doctors order	→ Pt is stable. → Vitals normal.	→ Monitor vitals → Maintain I/O Clean	Sn Sn

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NURSING CARE RECORD

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Date: 15/7/26

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	8am 2pm	- Assess the Pt Condition - Monitor vitals - Maintain I/O Chart - Medication Given as per drug chart	8am 2pm	- Assessed the Pt Condition - Monitored vitals - Maintained I/O Chart - Medication Given as per drug chart	Pt is Stable	Re checked vitals	Mow M
Afternoon	2pm 8pm	-Assess the pt. condition -Monitor vitals & record -Maintain I/o chart -Give Medication as prescribed by doctor	2pm 8pm	-Assessed the pt. condition -Monitored vitals & records -Maintained I/o chart -Given medication as prescribed by doctor.	patient is Stable now	Re-checked vitals	
Night	8pm 8am	→ Assess the patient condition → monitor vitals → plasmalyte @ 60ml/hr to cont. → Administer medications as per orders.	8pm 8am	→ Assessed the patient condition → monitored vitals → Administered medications as Per doctor's orders.	Patient is stable	Rechecked vitals	

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NURSING CARE RECORD

Date: 16/7

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 to 2Pm	Assess the baby Comfort the vitals administer Medication Monitor I/O		Assessed the baby Comfort vitals administer Medication Monitored I/O	[illegible]	Reassess the Pt [illegible]	[illegible]
Afternoon	2Pm to 8Pm	Assess the Pt condition. Monitor vital signs. Maintain I/O chart. Provide the comfortable position. Medication given as Per as doctor order	2Pm to 8Pm	Assessed the Pt condition. Monitored vital signs. Maintained I/O. Provided the comfortable position. Medication given as Per as doctor order	→ Pt is stable. → vitals normal.	→ monitor vitals. → maintain I/O chart.	[signature]
Night	8PM to 8am	→ Assess the patient general condition → Monitor vitals → Administer medication as Per doctor's orders.	8PM to 8am	→ Assessed the patient general condition → Monitored vitals → Administered medications as Per doctor's orders	Patient is stable	Rechecked vitals	[signature]

Patient Sticker

NURSING CARE RECORD

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Date: .....

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

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Patient

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: AG ē dehydration			Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify:			
	Surgery / Procedure:			Post OP Day:			
BACKGROUND	Date / Shift	14/7 N1	15/7/26 M6	15/7/26 E2	15/7/26 N8	16/7 2P	16/7 E2
	Medical Condition (Any special condition to be noted):			–	–	–	–
	Diet:	Soft	Soft	Soft	soft	–	–
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Ventilation (RA, NP, NIV, VENTI):	–	–	–	–	–	–
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Vital Signs: Temp:	98.2°F	98.6°F	97.8°F	98.3°F	98°F	98.2°F
	Res:	24b/m	24bb	24b/m	25b/m	20	20bm
	SpO_2:	99%	99%	100%	99%	100%	99%
	Pulse:	112	114bm	118bm	119b/m	102	99
	BP:	96/54	98/60	101/62	100/70	100/62	102/62
	LOC:	–	–	–	–	–	–
	Fall Risk Score:	–	–	–	–	–	–
	Pain Score:	0	–	–	–	–	–
	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 :		Srih	Mow	Priyanka	Sandhya	[illegible]	Sr
Signature / ID :		[signature] 20/6041	[signature]	[signature]	[signature]	[signature]	20/6051
Date:		15/7	15/7/26	15/7/26	16/7/26	16/7	16/7
Time:		8A	2pm	8pm	8am	2P	7Pm
Taken Over By Name :		Mow	Priyanka	Sandhya	[illegible]	Sr	Supriya
Signature / ID :		[signature]	[signature]	[signature]	[signature]	20/6051	[signature]
Date:		15/7/26	15/7/26	15/7/26	16/7	16/7	16/7/26
Time:		8am	2pm	8p	[illegible]	2Pm	8pm

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NG SHIFT HAND OVER FORM

SITUATION	Diagnosis: AGE					Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:	
	Surgery / Procedure:					Post OP Day:	
BACKGROUND	Date / Shift	16/7/16 N1					
	Medical Condition (Any special condition to be noted):	–					
	Diet:	Soft					
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	–					
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.1°F					
	Res:	26b/m					
	SpO_2:	100%					
	Pulse:	106					
	BP:	103/69					
	LOC:	–					
	Fall Risk Score:	–					
	Pain Score:	"0"					
	Skin Integrity	Good					
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	–					
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	–					
	Critical Lab Test / Values:	–					
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	–					
Post Operative Procedure Special Orders:		–					
Handed Over By Name :		Supriya					
Signature / ID :							
Date:		16/7/16					
Time:		8 AM					
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

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MEDICATION RECONCILIATION FORM

Drug Allergies: Nil ☐ 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: 2nd Floor (212)

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 [illegible]

Date & Time : 15/7/26 @ 12:15 pm

Nurse Name & Signature: [illegible]

Date & Time : 15/7/26 @ 12:20 pm

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

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wt- 26 kg

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EMERGENCY TRIAGE FORM

Patient's Name : Hansika Age : 8y **Gender:** ☐ Male ☐ Female

Date : 14/7/27 Time of Arrival : 11:30 Pm

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

Source of Information : ☐ Parents ☐ Others (Specify)

Mode of Arrival : ☐ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 100.1 PR: 145 BP: 103/73(85) RR: SpO$_2$: 98

Chief Complaints: C/o loose stools, fever since yesterday morning & vomiting

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.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 11:32 Pm

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 : Ammpom

Signature of Triage Nurse : A.P

Date & Time : 14/7/26 @ 11:25 Pm

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

BAH-00333789 IP26-00006845
Baby G.HANSIKA
17-08-2016 9 Y 10 M 28 D (F)
Dr. ANIKET ANIL PARASHAR

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 14/7/26 Time of arrival : ~~28/7~~ 11:30 pm

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

Height : ..... Weight : 16 kg 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 : 11:30 pm .....

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

Time	Nursing Notes
	Assessed the patient condition
	vital checked,
	Iv pacement done.

Samples collected by:

Samples sent by : vidya.

Time:

Time: 11:35pm

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
	Paracemol i.v.e.	Iv	250 ml		A.P

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 141 BP: 103/74 CFT: — RR: 21 SPO_2 : ..... GCS: 15/15 Temperature : 98 Pain Score: 0 Repeat RBS (if applicable): NO	Shift - out from ER to: ICU Time of Shift - out: 1:30 Am Handover given to: Sruthy (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

.....

Name of the Nurse : Anu Pavan

Signature of the Nurse : A.P

Date & Time : 14/7/26 @ 11:35pm

PATIENT TRANSFER FORM

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BAH-00333789 IP26-00006845 Baby G.HANSIKA 17-08-2016 9 Y 10 M 28 D (F) Dr. ANIKET ANIL PARASHAR	Date & Time of Admission 15/7/26 @	Date & Time of Transfer Order 15/7/26 @ 11:00Am
	Transfer Ordered by Dr. Sowmya	Reason for Transfer Admission
From Unit ER	To Unit 2nd. floor	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 19	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
[signature]	Dr. Sowmya

Patient & Clinical Records Received by : Sneha @ 1Am

Date & Time of Patient Received : 15/7/26

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

Docu. No. : RCH /FRM / CLINICAL / 102

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

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

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

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

MODE OF PAYMENT & REFUNDS

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

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

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

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

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

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

Rainbow Childrens Hospital-Himayatnagar

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby G.HANSIKA**	**Age :**	**9 Y 10 M 28 D**
IP No:	**IP26-00006845**	**Sex:**	**Female**
Consultant:	**Dr. ANIKET ANIL PARASHAR**	**Ward/Bed No:**	**GF -EMERGENCY/ER02**

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 to consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

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

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

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

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature.....)

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

Signature of Patient/Relative:

Name: Baby G.Hansika

Relationship: father

Date: 15/7/26 Time:

Patient Address:

~ Ashok Nagar Hyderabad Telangana INDIA 500020

Wittness Name:

Wittness Signature:

COUNSELLING SHEET

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

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BAH+00333789 IP28-00006845
Baby G.HANSIKA
17-08-2016 9 Y 10 M 28 D (F)
Dr. ANIKET ANIL PARASHAR

	TWIN SHARING / OBSERVATION(LDR) / SHARED WARD	PRIVATE / DELUXE ROOM	PICU / NICU / HDU	SEPARATED FROM TARIF	12 TO 12 NOON BILLING POLICY
BED CHARGES				PHARMACY ✓	
				INVESTIGATION ✓	
CONSULTATION CHARGES				CROSS CONSULTATION ✓	PHONES ARE NOT ALLOWED IN PICU(PHOTOGRAPHY AND VIDEOGRAPHY STRICTLY PROHIBITED)
				CONSUMABLES ✓	
CONSULTANT CHARGES				BLOOD PRODUCTS ✓	VISITING HOURS 04:00pm TO 05:00pm.
				OXYGEN ✓	
NURSING CHARGES				HFNC / VENTILATOR / C PAP / HFO / NIV / NIV-C PAP ✓	IN ICU EITHER MOTHER OR FATHER ALLOWED(NO VISITORS)
				EQUIPMENT / DSPT / SSPT / TSPT ✓	
DIET CHARGES				PROCEDURE ✓	OUTSIDE FOOD AND MEDICATION NOT ALLOWED
				NEBULISATION ✓	
TOTAL	13350 + GST	17250 + GST		MRD, DRUG ADMINISTRATION, INSURANCE PROCESSING FEE (IF ANY) ✓	

PATIENT NAME		AGE/SEX	
UHID		INSURANCE NAME	

G. Sivaprasad

ATTENDENT SIGNATURE

CAUTION DEPOSIT	25 K

Kiran

COUNSELLING PERSON SIGNATURE

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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 15/7/21 Time: 8:30 am

Weight: 26Kg Centile: 10th

Height: — Centile: —

Inference: Underweight child

RDA: — Calories: 1600 Kcal/day Protein: 28 g/day

Diet Recommendations: Gastrodiet can add :- ORS (WHO), Sago Water, Coconut Water, Rice [illegible]

Re-Assesment: Avoid :- Ragi, Milk, Egg, Oats, Sugar, Citrus.

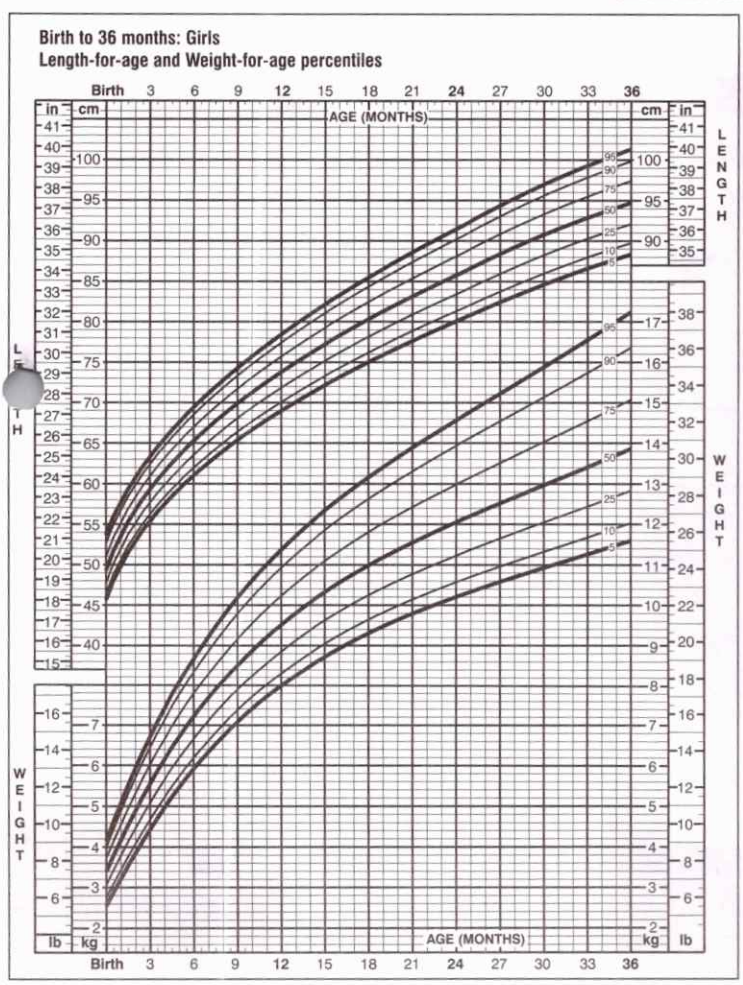
Food Allergies: NO Veg/Non-veg Veg.

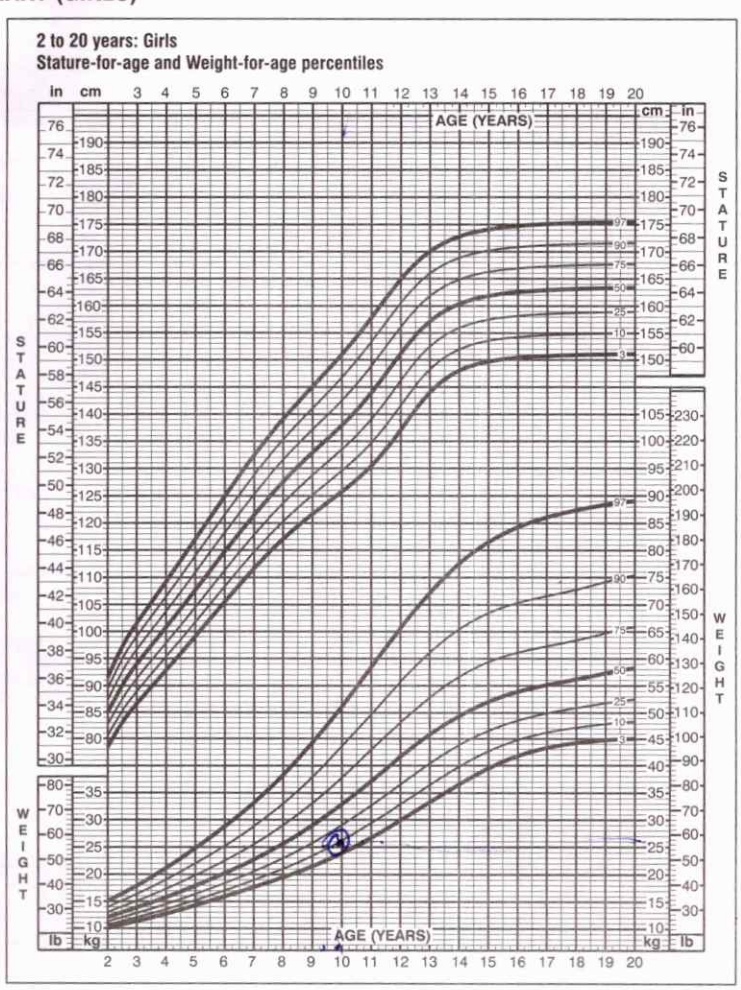
Diagnosis: Acute gastroenteritis & dehydration

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Sravanthi

GROWTH CHART (GIRLS)





Dietician's Name Syeda Sobiya Zaheer Dietician's Signature Sobiya

Daily Notes: