HNH-00007083 IP26-00006697
Baby KIANA RATHI
10-12-2024 1 Y 6 M 20 D (F)
Dr. MANJIT KUMAR

Rainbow® Children's Hospital
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DEFICIENCY CHECK LIST OF CASE SHEET

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

Signature and Date : 1/7/25

(P.T.O)

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital

BirthRight by Rainbow

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 : IP26-00006697 **Admit Date** : 30-Jun-2026 **Admit Time** : 03:09 PM **UHID** : HNH-00007083

Patient Details :

Patient Name	: Baby KIANA RATHI	**Age**	: 1 Y 6 M 20 D
Guardian	: SHUBHAN RATHI	**DOB**	: 10-12-2024 01:00 AM
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 15-7-297 Begum Bazar Hyderabad Telangana INDIA 500012	**Phone No**	: 8019673456/ 8099137844
		E-mail	: ankitha.bajaj1@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 : SHUBHAN RATHI **Relationship** : Father

Contact Address : 15-7-297 Begum Bazar Hyderabad Telangana INDIA 500012 **Phone No** : 8019673456

Ankitha

Signature

Doctor Details :

Doctor Name : Dr. MANJIT KUMAR **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : Dr Manjit Kumar **Phone No** : 9866105609

Co-Consultant : Dr. PRITESH NAGAR

Payment Details :

Deposit Amount : 25000.00

Payment Mode : DC/CC Card **Payor Name** : SELFPAY

DISCHARGE SUMMARY

Name	Baby KIANA RATHI	**UHID**	HNH-00007083
Father/Guardian	SHUBHAN RATHI	**Age/Gender**	1 Y 6 M 20 D/ Female
Address	15-7-297, Begum Bazar, Hyderabad, Telangana, INDIA, 500012		
IP No	IP26-00006697	**Admission Date**	30-06-2026
Ref Doctor	Dr Manjit Kumar		
Discharge Date	01.07.2026		

Consultant:
Dr. MANJIT KUMAR
GENERAL PEADIATRICS
04126

Co-Consultant:
Dr. PRITESH NAGAR
MBBS MD
Medical Registration No. 47184

DIAGNOSIS	ICD CODE
ACCIDENTAL INGESTION OF HYDROCARBON (PAINT THINNER)	

History: Baby KIANA RATHI , 1 Y 6 M 20 D , old girl presented with the alleged

Name	Baby KIANA RATHI	UHID	HNH-00007083
IP No	IP26-00006697	Admission Date	30-06-2026

Base line investigations sent , showed normal , Chest x ray done after 6 hours of ingestion also normal .

She remained hemodynamically stable during the hospital stay . She improved with the above line of management and is being discharged with the following advice.

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

Medication during hospital stay:
Injection. Esmoprazole
Nasoclear pure hale mist spray

Advice:
* Diet as advised.

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	NEXPRO SACHET (10MG)	1 SACHET	7am (before breakfast)	For 3 days
2	NEBULISATION with 3% NS	1 respule	8TH hourly	For 2 days
3	Nasoclear nasal drops, 2 drops in each nostril **SOS** for nose block			

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 3 ml after food as and whenever

Name	Baby KIANA RATHI	**UHID**	HNH-00007083
IP No	IP26-00006697	**Admission Date**	30-06-2026

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

Registrar/Resident/C.M.O

Dr. MANJIT KUMAR
GENERAL PEADIATRICS
04126

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ACTIVITY RECORD FOR BILLING

HNH-00007083 IP26-00006697
Baby KIANA RATHI
10-12-2024 1 Y 6 M 20 D (F)
Dr. MANJIT KUMAR

Name: ---------- ----------

UHID No : ---- -------- Consultant : ---------- Dept : ----------

Date of Admission : ---------- Time : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
30/6/26	3:40pm	ER	310	A.D

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
30/6/26	CBP, [redacted]	10630	
	LFT	7808	
30/6/26	X-ray Chest	7808	
	Cont check for		
		1/7/26	
		9:30 AM	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
30/6	Infusion pum	4:30pm	9Am 1/7/20	9571	[illegible]

as checked by [illegible] 1/7/20

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
30/6/26	IV placement	(1)	9558	
30/6/26 (6pm)	NHA	(1)	9590	

cross checked by Dr 1/7/26

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow® Children's Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : HNH-00007083 IP26-00005697
Baby KIANA RATHI
10-12-2024 1 Y 6 M 20 D (F)
Dr. MANJIT KUMAR

Patient ID# :

Consultant :

Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

- C/o alleged h/o accidental Ingestion of paint thinner @ around 1pm

History of present illness :

→ child presented with c/o alleged h/o accidental Ingestion of paint thinner (? Hydrocarbon) @ around 1pm @ home while playing

→ No h/o vomitings / cough / cold.

→ No h/o fever / loose stools.

Pediatric Multiorgan History & Physical Examination

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

—

Birth & Neonatal History :

O/D

Birth & Socio Economic History :

About Father : Not significant

About Mother :

Any additional Information :

Developmental History :

Appropriate

Immunization History : Upto date.

Anthropometry

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

Weight (kgs) 10 kg. (Centile _____)

On Examination :

Temperature : Afebrile. Pulse Rate: 118/min Description _____

B.P. _____ SPO2 98%. at _____

Resp. rate and type of breathing : No tachypnea.

Rash –

Lymphadenopathy –

Oedema : –

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L AE (+).

Any addes sounds : B/L NVBS (+)

Relevant data from outside (Chest X-Ray, ABG, etc.,) No adde soonds

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1 S2

Any murmur : No

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

Per Abdomen :

Inspection _____

Palpation : Soft, Not distended

Ausculation : No organomegaly.

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves :

(WNL)

Motor System :

Nutrition : (WNL)

Tone : Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

(WNL)

DTR **Superficials :**

Plantars

Sensory System :

(WNL)

Bladder / Bowel :

Clinical Summary & Diagnostic :

accidental Ingestion of Hydrocarbon.

Preventive aspects of the treatment :

To prevent Resp. failure.

Desired goals of the treatment :

Planned Labs :

CBP
CFT
1 Extra sample.

Planned Management :

Tab → CBP
· CFT ·
– IV fluid DNS 30 ml/h. (2/3)
– Inj PANTOP 80MG.
– Inj ONDANSETRON (SOS)
– NPO till further order.
– Monitor vitals

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

Dr. Pampa Mukherjee
Consultant Obstetrics and Gynecology
Reg. No: 63599

Doctor's Signature Name _____ Date _____ Time _____

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Dr. MANJIT KUMAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/12 Sp	C/S/B Dr. Pritesh Si	
	Accidental Ingestion of Hydrocarbon	Plan
		1) NBM for 4-6 hours as cayed Till 7pm
	Occ Cough	2) Ct. Inj Ondem (SOS)
	No Vomiting	Inj Esomeprazole
	No Loose stool	
	Child asleep	3) Trace labs
	Vitals stable	
	Afebrile	4) W/f Warning Sign
	R-S - B/L AE @, clear	• Vomiting / Abd pain / Loose stool
	P/A - Soft	• Persistent Cough
		5) If no complaint Clear liquids after 7pm
		6) Nasoclear Parehale Wash tds
		7) Chest X ray - Now
		8) Monitor Vitals
		Dr. Pampana Priyadarshini Consultant Obstetrics and Gynecology Reg. No: 63596
	Dr. PRITESH NAGAR Reg. No: 47184	noted by Dr Sandhya 30/12/24

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10-12-2024
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6:30PM	S/B. Dr. Manjit Kumar.	
	clinically stable active / alert no vomiting no dehydration CFT < 2"	ct IVF NPO till 7PM
		noted by Dr. Sandhya 6:30PM

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GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/12/24 7AM	c/s/o Dr. Vinay / Dr. Sudarsha Accidental ingestion of paint thinner - Slept well overnight. - No fever, vomiting / loose stools. c/e- vitals stable. s/e- CNS.	Plan - Allow orally. - Ct. meds as per Rx chart. - Probable D/c today

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/o/c. Dr. Patel	
01/02/26 9:30AM	Accidental Ingestion of paint thinner	
	Afebrile / cough ® No fresh concern	
	O/E: Vitals Stable (Hydration: good) CC: free	
	S/E: NAD RS: BCAB ®. clear	
	Oral Lanzol Hyperneb R/A 24 hr	Adv - (IV fluids - ~~stop~~) - Inj Granopeazole - Supportive care - Monitor vitals and Intake SV - discharge after d/w Dr. Manjit - D/S today.

Dr. PRITESH [illegible] R
Reg. No: 47184

HNH-00007083 IP26-00006697
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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ 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: B10

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. Anusha

Date & Time : 30/6/24 @ 2:20 PM

Nurse Name & Signature: Anupam

Date & Time : 30/6/24 @ 2:20 PM

HNH-00007083 IP26-00006697
Baby KIANA RATHI
10-12-2024 1 Y 6 M 20 D (F)
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310 -> 306

RESULT SHEET

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Date	30/6/26					
Time						
Hb	11.8					
PCV	33.4					
RBC	4.48					
WBC	11.39					
N/L	25/68					
Platelets	343					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP	195					
SGPT	19					
SGOT	41					
T.Bill/Conj	0.5/0.1					
T.Protein	7.7					
S.Albumin	4.7					
S.Globulin	3					
A/G Ratio	1.5					
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.,) : .....

HNH-00007083 IP26-00006697
Baby KIANA RATHI
10-12-2024 1 Y 6 M 20 D (F)
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Patient

CLINICAL / 125

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

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

Date : 30/6/26 Time: 6pm 7pm 10pm 2Am 6pm

Doctor / Nurse / Family Concern?

Temperature (F)

104 103 102 101 100 99 98 97 96 95 94

98.1°F 98.4°F 97.6°F 97.2°F 98.6°F

Heart Rate (bpm)

and

Blood Pressure (mmHg) *

Note:
BP does not score in early warning scoring

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

Heart Rate (Number) 140b/m 140b/m 138b/m 140b/m 130b/m

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

70 60 50 40 30 20 10

Resp Rate (Number) 30b/m 30b/m 30b/m 40b/m 30b/m

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

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

Pt HNH-00007083 IP26-00006697
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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 :**						
30/6/26	02:00 pm											
	03:00 pm											
	04:00 pm	DNS	NPO	30	NA			NA			0	
	05:00 pm		NPO	30								
	06:00 pm		NPO	30								
	07:00 pm		NPO	30								
Total Intake :						**Total Output :** U – M –						
30/6/26	08:00 pm		Milk	30								
	09:00 pm			30								
	10:00 pm	DNS	Milk	30				NA			0	
	11:00 pm			30	NA							
	12:00 am			30								
	01:00 am		Milk	30								
Total Intake :						**Total Output :** U – M –						
1/7/26	02:00 am			30								
	03:00 am			30								
	04:00 am	DNS	Milk	30				NA			0	
	05:00 am			30	NA							
	06:00 am		Milk	30								
	07:00 am			30								
Total Intake :						**Total Output :** U – M –						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

		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							
1/7/26	08:00 am			30								
	09:00 am			30								
	10:00 am	DNS		STOP	NA				NA		0	
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :** U-					M-	
1/7/26	02:00 pm											
	03:00 pm											
	04:00 pm										0	
	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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BRADEN 'Q' SCALE

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					Date : 30/12/26	1/1/26	1/1/26	
					Time : 6PM	10PM	M5	
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	1	4	
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	3	4	
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	3	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	28	27	28	
				Evaluator's Name	[illegible]	[illegible]	[illegible]	

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Risk Score	Category	Action	**Support Surfaces** (**Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

HNH-00007083 IP26-00006697
Baby KIANA RATHI
10-12-2024 1 Y 6 M 20 D (F)
Dr. MANJIT KUMAR

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		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					
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		NA	NA	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					
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					
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	Nr	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 : .....

Signature of Ward In Charge :

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

Patient Sticker

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CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
BACKGROUND	Area / Shift Time	30/6/26 Evng	1/7/26 N	1/7/26 M			
	Medical Condition (Any special condition to be noted):	—	—	—			
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.3 f	98.2 f	98.4 F			
	Res:	34b/m	40b/m	40b/m			
	SpO_2:	99%	99%	99%			
	Pulse:	140b/m	140b/m	142b/m			
	BP:	—	—	—			
	Fall Risk Score:	—	—	—			
	Pain Score:	—	—	—			
Recommendations	Safety Needs:	yes	Yes	yes			
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	—	—	—			
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	—	—	—			
Post Operative Procedure Special Orders:		—	—	—			
Handed Over By Name :		Sandhya	Anu	Mounika			
Signature :							
Date:		30/6/26	1/7/26	1/7/26			
Time:		8pm	8AM	8PM			
Taken Over By Name :		Apoorva	Mounika				
Signature :							
Date:		30/6/26	1/7/26				
Time:		8pm	8AM				

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

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DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG : Inj ONDANSETRON				Date / Time
Dose: 2mg	Route: IV	Frequency: SOS	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

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

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

Signat

VERIFIED BY : Name .....

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Baby KIANA RATHI
10-12-2024 1 Y 6 M 20 D (F)
Dr. MANJIT KUMAR

REGULAR PRESCRIPTIONS

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

DRUG : 17 2SMUPICHSOLE

Dose	Route	Frequency	Start Date
10mg	iv	OD	30/6

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 30/6 1/7/26

DRUG : NASOCLEAR PUREHALE NASAL SPRAY

Dose	Route	Frequency	Start Da
2 Puff	P/N	4th July	30/6

Name & Signature of the Doctor Starting the Drugs: Ranav

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 30/6 1/7

12AM X
5
4AM X
8AM X
12pm X
4pm
8pm

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

Patient Sticker

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.	

Signature .....

VERIFIED BY : Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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Baby KIANA RATHI
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I.V. FLUIDS CHART

Weight. ..... 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
30/6/26	3pm	IV fluid DNS. (2/3 M)	iv	30ml/h					

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

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00007083 IP26-00006697 Baby KIANA RATHI 10-12-2024 1 Y 6 M 20 D (F) Dr. MANJIT KUMAR	30/6/26 @	30/6/26 @ 4:30P
	Transfer Ordered by Dr. Anusha.	Reason for Transfer Admission
From Unit ER	To Unit 310	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 18	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
Anupam	Dr Anusha.

Patient & Clinical Records Received by : Sr. Sandhya

Date & Time of Patient Received : 30/6/26 4:30pm

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

Patient Sticker

Kiana
1Y6M

102 -> 310

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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 30/6/26 Time: 6pm

Weight: 10.6kg Centile: 25th

Height: — Centile: —

Inference: underweight child

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

Diet Recommendations: N.P.O till further advice

Re-Assesment:

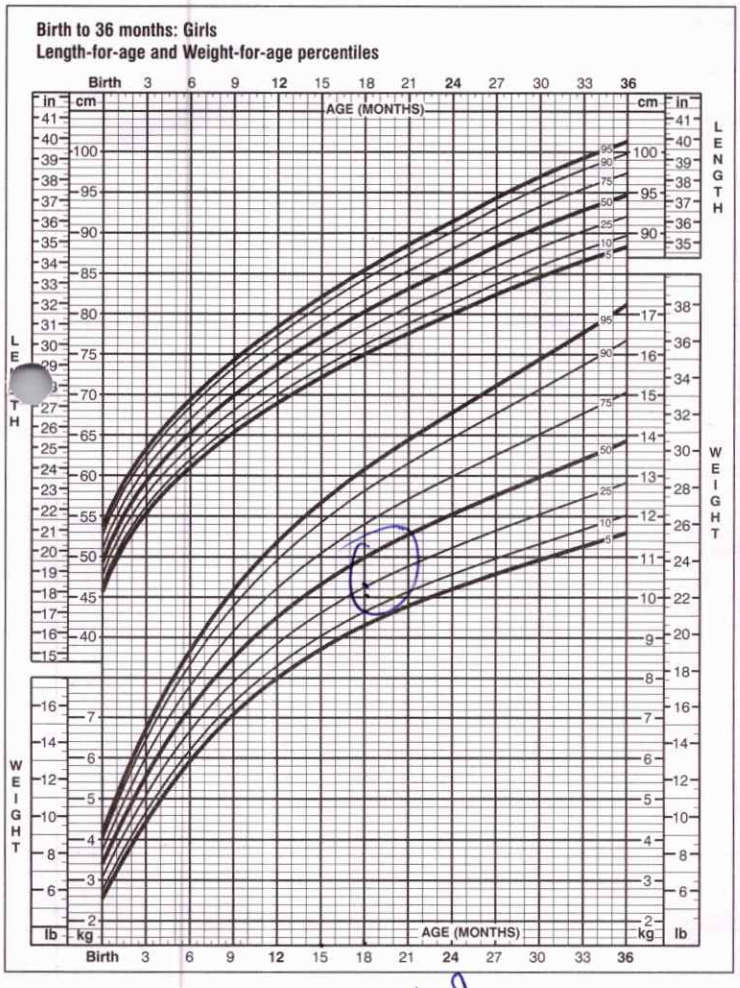
Food Allergies: NO Veg/Non-veg veg

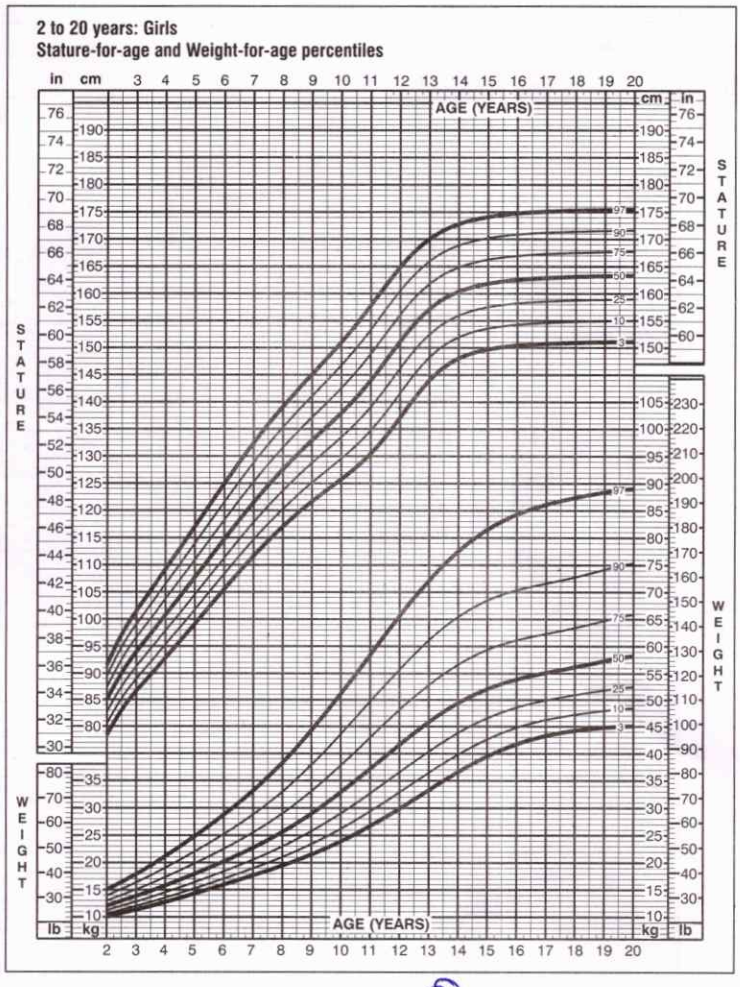
Diagnosis: Accidental ingestion of Hydrocarbon

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature:

GROWTH CHART (GIRLS)





Dietician's Name Sathwika.G

Dietician's Signature

Daily Notes:

HNH-00007083 IP26-00006697
Baby KIANA RATHI
10-12-2024 1 Y 6 M 20 D (F)
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10.6 kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Kiana Age : 1Y **Gender:** ☐ Male ☐ Female

Date : 30/6/26 Time of Arrival : 1:50pm

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: 98.8 PR: 124 BP: RR: SpO_2: 98%

Chief Complaints: Neckpain eating mod pain.

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

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

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

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

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

Signature of Parent / Guardian

* CTAS - Canadian Triage and Acuity Scale

Triage Completion Time : 1:52 p.m

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 : AmPam

Signature of Triage Nurse :

Date & Time : 30/6/26 @ 2:00 PM

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

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 30/6/24 Time of arrival : 1:50

Chief Complaints: Abdominal pain vomiting since yesterday RBS: .....

Height : ..... Weight : 10.8 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 : 2:00pm

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

Time	Nursing Notes
	Assessed the Patient conditio
	vital checked

Samples collected by: /

Samples sent by : / Apmhen

Time: /

Time: / 2100 Hrs

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: 124 BP: CFT:	Shift - out from ER to: ICU
RR: 25 SPO_2 : 99	Time of Shift - out: 3:40
GCS: Temperature : 98.7	Handover given to: Sandhya
Pain Score: 1	(Nurse's Name)
Repeat RBS (if applicable): NO	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

.....

Name of the Nurse : Ampan

Signature of the Nurse : A.M

Date & Time : 30/6/26

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, BirthRight by Rainbow

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 KIANA RATHI**	**Age :**	**1 Y 6 M 20 D**
IP No:	**IP26-00006697**	**Sex:**	**Female**
Consultant:	**Dr. MANJIT KUMAR**	**Ward/Bed No:**	**GF -EMERGENCY/ER01**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

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

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

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

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

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

Signature of Patient/Relative:

Name: Ankitha Rathi
Relationship: Mother
Date: 30-6-26 Time: 15.16 pm.
Witness Name:
Witness Signature:

Patient Address:
15-7-297 Begum Bazar Hyderabad
Telangana INDIA 500012

HNH-00007083 IP26-00006697
Baby KIANA RATHI
10-12-2024 1 Y 6 M 20 D (F)
Dr. MANJIT KUMAR

Rainbow® Children's Hospital | BirthRight BY RAINBOW HOSPITALS Your Right to a Safe Delivery | 25 years

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 / Demand draft or online payment.
- In 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 30% extra.
- Patient Government ID proof is mandatory to submit during the admission.
- TPA processing charges Rs.500 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

INTERIM BILLING

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 enquire 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.5,000/- will be refund through NEFT in three Bank working days.

Ankitha

Name & signature of Patient/Attendant

Sumedha Mane

(Signature of Admission Desk executive)

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