

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	Anaesthesia 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	1			
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Billing	1			
	Others	5			
	Total No. of Pages	24			

ADMISSION SHEET
Registration Details :


Admission No : IP26-00006684

Admit Date : 29-Jun-2026

Admit Time : 01:41 PM UHID : BAH-00659688

Patient Details :

Patient Name : Baby Of PRIYANKA AGARWAL

Age : 0 Y 0 M 6 D

Guardian : Mr AKSHATH AGARWAL

DOB : 23-06-2026 11:33 AM

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : H NO 16-45, ROAD NO 4, SRI KRISHNA
NAGAR COLONY Dilsukhnagar Colony
Hyderabad Telangana INDIA 500060

Phone No : 9700700300/ 9700700370

E-mail : AKSHAT_300@YAHOO.COM

Admission Details :

Bed Type : DAY CARE

Bed No : ER01

Ward Name : GF -EMERGENCY

Room No : ER01

Admission Type : First Visit

Contact Details :

Name : Mr AKSHATH AGARWAL

Relationship : Father

Contact Address : H NO 16-45, ROAD NO 4, SRI KRISHNA
NAGAR COLONY Dilsukhnagar Colony
Hyderabad Telangana INDIA 500060

Phone No : 9700700300 / 9700700370



Signature

Doctor Details :

Doctor Name : Dr. PRITESH NAGAR

Specialisation : GENERAL PEDIATRICS

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 25000.00

Payment Mode : DC/CC Card

Payor Name : SELFPAY

ACTIVITY RECORD

BAH-00659688 IP26-00006684
Baby Of PRIYANKA AGARWAL
23-06-2026 0 Y 0 M 6 D (M)
Dr. PRITESH NAGAR

Name: -----

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

Date of Admission: 29/06/26 Time: 1:41 pm Date of Discharge: ----- Time: -----

Room / Bed No: 2nd floor Ward: 215 Suggested Billable bed type: -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<u>29/6/26</u>	<u>2 pm</u>	<u>ER</u>	<u>2nd floor/215</u>	<u>[Signature]</u>

Cross Consultation Visit

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

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10



PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : _____

BAH-00659668 IP26-00006684
Baby Of PRIYANKA AGARWAL
23-06-2026 0 Y 0 M 6 D (M)
Dr. PRITESH NAGAR

Patient ID# : _____



Consultant : _____

Final Diagnosis : _____



Pediatric Multiorgan History & Ph

Name : TS6 Piyanka Agarwal Age/Sex 6d/male

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

Yellowish discoloration of eyes and
body x 2 days

History of present illness :

Yellowish discoloration of eyes and
body x 2 days

Full term (37w+9d) / NVD / B.Wt 2.6 kg /
Male ID#

Day of life - 6 days

T.Wt - 2.3 kg (↓ 300 gm)

wt. loss - 11.5%

DOB:- 23/06/26 11:33 AM

TLB → Head (15.8)
Chest (16.8)

OAG & MBR, Normal

Pediatric Multiorgan History & Physical Examination

BAH-00659688 IP26-00006684
Baby Of PRIYANKA AGARWAL
23-06-2026 0 Y 0 M 6 D (M)
Dr. PRITESH NAQAR



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

Birth & Neonatal History :

Full term / WVD / TS. wts = 2.6kg / Male / IDM
(37w + 9d)

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Immunization History :



Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 2.3 kg (Centile _____)

On Examination :

Temperature : 98.5 Pulse Rate: _____ Description _____

B.P. _____ SPO2 94% @ RA at _____

Resp. rate and type of breathing : _____

Normal

Rash _____

Lymphadenopathy Icterus ⊕

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BIACV. Clear

Any addles sounds : _____

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1S2 ⊕

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Soft Abdomen

Ausculation : _____

Spine: _____ External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

BAH-00659688 IP26-00006684
Baby Of PRIYANKA AGARWAL
23-06-2026 0 Y 0 M 6 D (M)
Dr. PRITESH NAGAR



Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

Cranial Nerves : _____

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

Neonatal (type 6 bilirubinemia)

Pediatric Multiorgan History & Physical Examination

BAH-00659688 IP26-00006684
 Baby Of PRIYANKA AGARWAL
 23-06-2026 0 Y 0 M 6 D (M)
 Dr. PRITESH NAGAR



Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

Planned Management :

- DSPT
 (Double surface phototherapy)
 with eyes and genitalia covered
 - DSF fls keeping 2nd hourly
 - Newborn warm care
 Note by Dr. Pritesh

Please fill up the following details

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

Doctor's Signature Name

(Signature)

Dr. Pritesh Nagar
 Consultant
 Neonatology

Date

22/6/26

Time

8pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/6/26 3pm	S/B Dr. Sneha ANNJ	Plan - CF DSPT
	CVJ - Suck @ PI - BLI - ALFA	- DBF + Burping 2nd
	PIA - Low CTA Good.	- + VITAMIN - D ₃
29/6/26 8:30pm	S/B Dr. Pritesh NNJ	Plan
	Eutermic C/T/A - Good	- Cont DSPT.
	Vitals - Stable.	- DBF + Formula feed (20-25cc) for burping
	RL / NAD PIA	- Lactational Counseling - SBR @ 12:00pm tomorrow
		- Cont Vit - D ₃ drops - Monitor vitals
		N/B priyanka.

Pritesh Nagar
 Consultant Pediatrician & Intensivist
 Reg. No. 47184



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6 7am	HLB ps. marin NNJ on esp T feeds ✓ weird ✓ steels ✓ ote exotherm YTH: good bf: flat mem (F) milals: stable	Plan 1) send SBR at 12pm today 2) ut esp T 3) ut - int D₃ drops 4) ventilation counselling 5) DBF + formulated (20-25 ml) 6) monitor milals

Date & Time	Progress Notes	Doctor's Order
20/9 9:30 am	<u>SBP R. P. B. B. B.</u> <u>NP1</u> - on DSPT - feeds ✓ - urine ✓ - stools ✓ <u>alt</u> entonic YTLA: good	<u>Plan</u> 1) send SBP now. 2) ct DSPT till SBP report. 3) DBF + formula feed (20-25 ml)
		Dr. Pritesh Nagar Consultant Pediatrician & Intensivist Reg. No: 47184

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

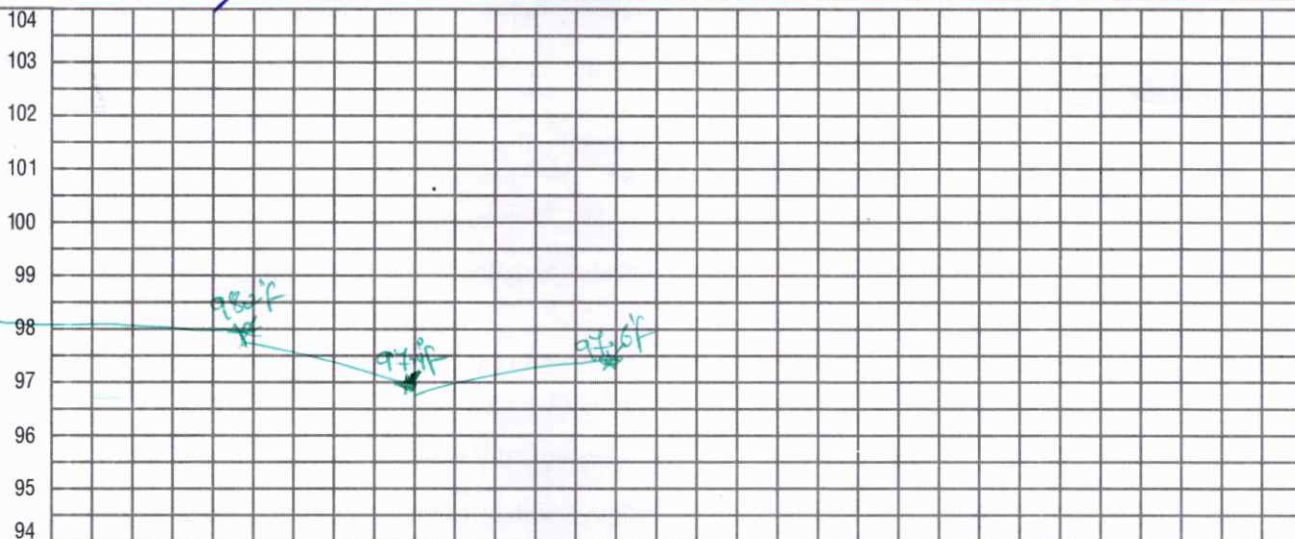
INFANT (<1 year) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 26/6 Time: 10:02 20:00 6:00

Doctor/Nurse/Family Concern?

Temperature
(°F)

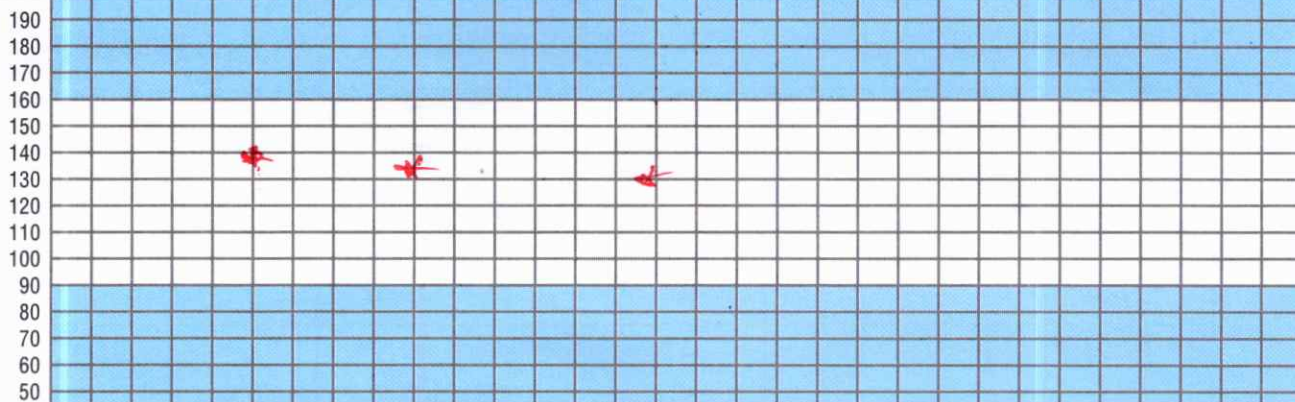


Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

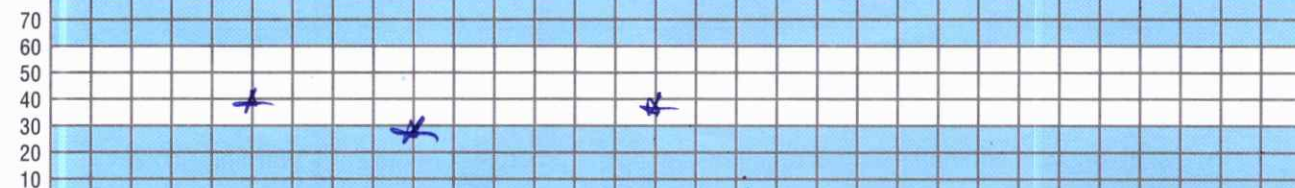
Note:
BP does not score
in early
warning scoring



Heart Rate (Number)

140bpm 132bpm 140bpm

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



Resp Rate (Number)

40bpm 30bpm 40bpm

Resp Mod/ Severe
Distress None / Mild

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

99% 100% 100%

Conscious Level
Normal Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0 0 0
0 0 0
0 0 0

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :			Total Output :								
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
	Total Intake :			Total Output :								
29/6/26	08:00 pm											
	09:00 pm	DEF										
	10:00 pm											
	11:00 pm	DEF										
	12:00 am	DEF										
	01:00 am											
	Total Intake :			Total Output :								
30/6/26	02:00 am											
	03:00 am	DEF										
	04:00 am											
	05:00 am	DEF										
	06:00 am											
	07:00 am	DEF										
	Total Intake :			Total Output :								
Total 24 hrs. Intake			Total 24 hrs. Output									

Patient Sticker

FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

BAH-00659688 IP26-00006684
 Baby Of PRIYANKA AGARWAL
 23-06-2026 0 Y 0 M 6 D (M)
 Dr. PRITESH NAGAR



NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Date:

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	8 AM	Assess the baby about the vitals wound care continue Rgt	8 AM	Assess the baby about the vitals wound care continue Rgt	wound care	Reassess the baby Vitals & Rgt	Dr. P

Patient Sticker

NURSING CARE RECORD



Date: 30.6.20

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 Baby condition → monitor the vitals → maintain I/O chart → DBP + FP every			→ baby is stable	→ rechecked vitals	Sohan
Afternoon							
Night							

BAH-00659688 IP26-00006684
 Baby Of PRIYANKA AGARWAL
 23-06-2026 O Y O M 6 D (M)
 Dr. PRITESH NAGAR

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Surgery / Procedure:		Post OP Day:					
BACKGROUND	Date	Shift	2/6					
	Medical Condition (Any special condition to be noted):		DM					
	Diet:		DL					
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:	98.6					
		Res:	12					
		SpO ₂ :	100					
		Pulse:	120					
		BP:	—					
		LOC:	—					
		Fall Risk Score:	—					
Pain Score:		—						
Skin Integrity		—						
Recommendations	Safety Needs:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:		—					
	Others Specify:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:		—					
	Critical Lab Test / Values:		—					
	Other Special Orders / Medications:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ADL (Dependent / Non Dependent):								
Post Operative Procedure Special Orders:		Repeat ASK						
Handed Over By Name :		Ch						
Signature / ID :		Ch						
Date:		2/6						
Time:		12:00						
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
	Surgery / Procedure:		Post OP Day:				
BACKGROUND	Date						
	Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:					
		Res:					
		SpO ₂ :					
		Pulse:					
		BP:					
		LOC:					
		Fall Risk Score:					
		Pain Score:					
		Skin Integrity					
	Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Physiotherapy:							
Others Specify:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Special Diet:							
Critical Lab Test / Values:							
Other Special Orders / Medications:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
PU Prophylaxis:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DVT Prophylaxis:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

BRADEN 'Q' SCALE

					Date : 30/6/2026			
					Time : 8:00			
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.	2			
"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.	1			
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	3			
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	3			
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4			
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4			
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			
TOTAL SCORE					21			
Evaluator's Name					ll			

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



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

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 Hospital's Verbal Order Policy.

SOS / PRN (As Required Medication)

[illegible]



Weight. Ward.

Page: 2/4

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.

[illegible]

1P28-00006684

23-06-2026

0YOMBD (M)

Dr. PRITESH NAGAR

Weight. Ward.

[illegible]

VERIFIED BY : Name Signature



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: NICU Shifted to: 215 / Lachhmi

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. Shashank

Date & Time: 29/06/26 @ 1:40 PM

Nurse Name & Signature: Atanu

Date & Time: 29/06/26 @ 2 PM

10/1/74
 10/2/74
 10/3/74
 10/4/74
 10/5/74
 10/6/74
 10/7/74
 10/8/74
 10/9/74
 10/10/74
 10/11/74
 10/12/74
 10/13/74
 10/14/74
 10/15/74
 10/16/74
 10/17/74
 10/18/74
 10/19/74
 10/20/74
 10/21/74
 10/22/74
 10/23/74
 10/24/74
 10/25/74
 10/26/74
 10/27/74
 10/28/74
 10/29/74
 10/30/74
 10/31/74

DATE	DESCRIPTION	AMOUNT	BALANCE
10/1/74			
10/2/74			
10/3/74			
10/4/74			
10/5/74			
10/6/74			
10/7/74			
10/8/74			
10/9/74			
10/10/74			
10/11/74			
10/12/74			
10/13/74			
10/14/74			
10/15/74			
10/16/74			
10/17/74			
10/18/74			
10/19/74			
10/20/74			
10/21/74			
10/22/74			
10/23/74			
10/24/74			
10/25/74			
10/26/74			
10/27/74			
10/28/74			
10/29/74			
10/30/74			
10/31/74			

10/31/74
 11/1/74
 11/2/74
 11/3/74
 11/4/74
 11/5/74
 11/6/74
 11/7/74
 11/8/74
 11/9/74
 11/10/74
 11/11/74
 11/12/74
 11/13/74
 11/14/74
 11/15/74
 11/16/74
 11/17/74
 11/18/74
 11/19/74
 11/20/74
 11/21/74
 11/22/74
 11/23/74
 11/24/74
 11/25/74
 11/26/74
 11/27/74
 11/28/74
 11/29/74
 11/30/74

CONSENT FOR FORMULA FEEDS



Patient Name : Age : Gender : ☒ Male ☐ Female

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

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

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

29/6/26 I hereby give consent for formula feed for my child. Doctors have explained me

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

Patient Attendant :

Signature :

Name :

Relationship with Patient:

Date & Time :

Witness :

Signature : Sis. Priganka

Name : Priganka

Date & Time : 29/6/26

Doctor (who is taking the consent) :

Signature : Dr. Naipunya

Name : Dr. Naipunya

Date & Time : 29/6/26



డబ్బా పాలు పట్టించుటకు సమ్మతి పత్రం

రోగి పేరు : వయస్సు : లింగం పు ☐ స్త్రీ ☐

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

తేదీ

నేను శ్రీ/శ్రీమతి వయస్సు సంవత్సరాలు

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

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

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

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము



wt - 2.6 kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : B/o priyanka agarwal Age : 6 days Gender: ☒ Male ☐ Female

Date : 29/06/26 Time of Arrival : 1:30 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: 98.2 PR: 132/beat BP: _____ RR: 42/beat SpO₂: 99%

Chief Complaints: 40 yellow with discoloration.

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance	Work of Breathing	☒ Stable
☒ Normal	☒ Normal	☐ Unstable :
☐ Sick Looking	☐ Increased	☐ Not - Life - Threatening
☒ Normal	☐ Decreased	☐ Life - Threatening
☐ Abnormal	☐ Gasping / Apnea	
☐ Bleeding		

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 : 1:32 PM

Communicable Disease Triage Screening

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

- Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
- Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
- 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

- 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: _____
- 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 : Atanu

Signature of Triage Nurse :

Date & Time : 29/06/26 @ 1:32 PM



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 29/06/26 Time of arrival: 1:34PM

Chief Complaints: elo yellow wisk discoloration. RBS:

Height: Weight: 2.6kg BMI: Head Circumference (<2 years)

Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:

If yes, identify

Pain Screening: ☐ Yes ☒ No If Yes, Pain Score: 10' 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: 1:34PM

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

BAH-00659688 IP26-00006684
 Baby Of PRIYANKA AGARWAL
 23-06-2026 0 Y 0 M 6 D (M)
 Dr. PRITESH NAGAR



Time	Nursing Notes
	Assessed the Patient Condition.
	monitor vitals Done

Samples collected by: /

Time: /

Samples sent by : /

Time: /

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: 125b/min BP: CFT: RR: 43b/min SPO ₂ : 94% GCS: Temperature : 98.5°F Pain Score: Repeat RBS (if applicable):	Shift - out from ER to: 202 Am / 215 Time of Shift - out: 2pm Handover given to: Dr. Prakash (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

Name of the Nurse : Atanu

Signature of the Nurse :

Date & Time : 20/06/2026 11:34pm

PATIENT TRANSFER FORM

BAH-00659688 IP26-00006684 Baby Of PRIYANKA AGARWAL 23-06-2026 0 Y 0 M 6 D (M) Dr. PRITESH NAGAR 		Date & Time of Admission 29/06/26 @	Date & Time of Transfer Order 29/06/26 @
		Transfer Ordered by Dr. Shasank	Reason for Transfer Admission.
From Unit ER	To Unit	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 10	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 Atanu / [Signature]		Name of Person Ordered Transfer Dr. Shasank.	
Patient & Clinical Records Received by : Priyanka			
Date & Time of Patient Received : 29/6/26 @ 2pm.			

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

GENERAL CONSENT FOR TREATMENT

Patient Name: Baby Of PRIYANKA AGARWAL **Age :** 0 Y 0 M 6 D
IP No: IP26-00006684 **Sex:** Male
Consultant: Dr. PRITESH NAGAR **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 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.

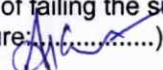
"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process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

insurance. 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:

Akshat

Relationship:

Father

Date:

Time:

Witness Name:

Witness Signature:

Patient Address:

H NO 16-45, ROAD NO 4, SRI KRISHNA
NAGAR COLONY Dilsukhnagar Colony
Hyderabad Telangana INDIA 500060

BAH-00659688 IP26-00006684
 Baby Of PRIYANKA AGARWAL
 23-06-2026 0 Y 0 M 6 D (M)
 Dr. PRITESH NAGAR



COUNSELLING SHEET

hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State
 Housing Board Himayatnagar, Hyderabad- 500029

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

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

	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	
DOCTORS CHARGES				CROSS CONSULTATION CONSUMABLES BLOOD PRODUCTS OXYGEN	PHONES ARE NOT ALLOWED IN PICU(PHOTOGRAPHY AND VIDEOGRAPHY STRICTLY PROHIBITED) VISITING HOURS 04:00pm TO 05:00pm.
NURSING CHARGES		DLX - 19,300		HFNC / VENTILATOR / C PAP / HFO / NIV / NIV-C PAP EQUIPMENT	IN ICU EITHER MOTHER OR FATHER ALLOWED(NO VISITORS)
DIET CHARGES				PROCEDURE NEBULISATION	OUTSIDE FOOD AND MEDICATION NOT ALLOWED
TOTAL	13,350	DLX 17250		MRD, DRUG ADMINISTRATION, INSURANCE PROCESSING FEE (IF ANY)	
PATIENT NAME				AGE/SEX	
UHID			INSURANCE NAME	Cash	


 ATTENDENT SIGNATURE

CAUTION
 DEPOSIT
 50K
 25K


 COUNSELLING PERSON SIGNATURE

DSP T - 5500 - 5000
 4500 - 5500
 opted for - DLX -

BAH-00659688 IP26-00006684
Baby Of PRIYANKA AGARWAL
23-06-2026 0 Y 0 M 6 D (M)
Dr. PRITESH NAGAR



BILLING POLICY

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

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

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

MODE OF PAYMENT & REFUNDS

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

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

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

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

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

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

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

CIN: U85110 TG1998 PTC029914

email : info@rainbowhospitals.in

www.rainbowhospitals.in

DISCHARGE SUMMARY

Name	Baby Of PRIYANKA AGARWAL	UHID	BAH-00659688
Father/Guardian	Mr AKSHATH AGARWAL	Age/Gender	0 Y 0 M 6 D/ Male
Address	H NO 16-45, ROAD NO 4, SRI KRISHNA NAGAR COLONY, Dilsukhnagar Colony, Hyderabad, Telangana, INDIA, 500060		
IP No	IP26-00006684	Admission Date	29-06-2026
Ref Doctor	Self		
Discharge Date	30.06.2026		

Consultant:

Dr. PRITESH NAGAR

MBBS MD

Medical Registration No. 47184

DIAGNOSIS	ICD CODE
NEONATAL HYPERBILIRUBINEMIA	

History: Baby Of PRIYANKA AGARWAL is a 0 Y 0 M 6 D old baby boy presented with history of yellowish discolouration of skin and eyes since 2 days prior to admission. For the above complaints, he was investigated on OPD basis (Transcutaneous bilirubin was 16.8 mg/dl). In view of hyperbilirubinemia, he was admitted to Rainbow Children's Hospital, Himayatnagar for further management.

Birth history: Baby Of PRIYANKA AGARWAL is a term (37weeks + 4days) Male baby delivered to a G4A2L2 mother by Spontaneous vaginal delivery on 23-06-

Name	Baby Of PRIYANKA AGARWAL	UHID	BAH-00659688
IP No	IP26-00006684	Admission Date	29-06-2026

2026 at 11:33am with birth weight of 2.6 kgs in Rainbow Children's Hospital, Banjara Hills, Hyderabad. Baby cried immediately after birth. Apgar scores were 9/10 at 1 min, 10/10 at 5 min. Injection. Vitamin K 1mg IM was given after delivery. Delayed cord clamping done. Fetal presentation was Vertex.

Examination: He was euthermic, euvoletic & maintaining saturations at room air. Heart Rate- 132/min and Respiratory Rate -38 /min. Icterus was present. Chest was clear with normal heart sounds. Abdomen was soft without organomegaly. Cry, tone, activity and newborn reflexes were normal. There were no obvious external congenital anomalies.

Weight on admission : 2.3 kilo grams.

Weight at discharge : 2.32 kilo grams.

Investigations: Enclosed reports.

Management: He was admitted in ward. His transcutaneous bilirubin on admission (done on OP basis) was 16.8 mg/dl. He was started on double surface phototherapy. Baby was continued on demand breast feeds + measured feeds. Repeat serum bilirubin at 7 days of life was 7.1 mg/dl with indirect fraction of 7.0 mg/dl. This doesn't fall in phototherapy range. Hence phototherapy was stopped.

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

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

New born screening advanced / Newborn screening-4: To be done on

Name	Baby Of PRIYANKA AGARWAL	UHID	BAH-00659688
IP No	IP26-00006684	Admission Date	29-06-2026

follow up.

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

Advice:

Warmth care.

Exclusive breast feeding.

Continue direct breast feeds + measured feeds as advised.

Burping after each feed.

Monitor urine output.

Immunization to be given as per schedule.

Vitamin D3 Drops (1ml/800IU) 0.5ml once daily till further advice.

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

Plan:

- 1. Newborn screening advanced / Newborn screening-4 test report on followup.**
- 2. Serum bilirubin to be done on followup.**

Review consultation with Dr. PRITESH NAGAR on Thursday(02.07.2026) in OPD at Himayatnagar with prior appointment **(Review consultation will be charged).**

Review back to Hospital:

If baby is not feeding continuously for > 6 hours, If breathing fast, Fever or poor activity or lethargy, Bluish discolouration of lips, Increase in jaundice, Abnormal movements occurs.

The content of the patient discharge summary, medication, food & drug

Name	Baby Of PRIYANKA AGARWAL	UHID	BAH-00659688
IP No	IP26-00006684	Admission Date	29-06-2026

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. PRITESH NAGAR
MBBS MD
Medical Registration No. 47184