

ACTIVITY RECORD FOR BILLING

Name : **PHW-00110942** **IP5-00176251**
Master ANUMANDLA KARTHIK
05-01-2016 **11 Y 6 M 6 D**
Dr. NALLA ANURAAG REDDY (M)

UHID : 

Consultant: _____ Dept: _____

Date of Admission: _____ Date of Discharge: _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/7/26	10:40 am	ER	onco	

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
11/7/26	Blood & Tissue Bank Lumber punch Consent & Sedation	13	9697959	[Signature]

ANY OTHER INFORMATION

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.....

Date : 11/7/26

Time : 2PM

Prepared By :

Staff Nurse [Signature]	Shift / Ward ambulatory Sedation	Billing Assistant	Billing Supervisor
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Rainbow Children's Hospital - Banjara Hills
8-2-120/103/1,2,3,4 and 5, Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills, Hyderabad
Telangana, India, 500034.
TEL NO : +91-40-4466 5555
WEB : <https://rainbowhospitals.in>

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176251 Admit Date : 11-Jul-2026 Admit Time : 09:55 AM UHID : PHW-00110942

Patient Details :

Patient Name : Master ANUMANDLA KARTHIK REDDY Age : 11 Y 6 M 6 D
Guardian : Mr ANUMANDLA MADAN MOHAN REDDY DOB : 05-01-2015
Gender : Male Religion :
Occupation : Martial Status : Single
Address (H) : H.NO-3-112/8/A/4, BEERAPPA NAGAR Torur Phone No : 9949007332/ 8096505063
Warangal Telangana INDIA 506163 E-mail : na@gmail.com

Admission Details :

Bed Type : BASINET Bed No : CRDL HO DC 1-1 Ward Name : 1F-HEMATO-ONCOLOGY
Room No : CRDL HO DC 1-1 Admission Type : First Visit

Contact Details :

Name : Mr ANUMANDLA MADAN MOHAN Relationship : Father
Contact Address : H.NO-3-112/8/A/4, BEERAPPA NAGAR Torur Phone No : 9949007332 / 8096505063
Warangal Telangana INDIA 506163


Signature

Doctor Details :

Doctor Name : Dr. NALLA ANURAAG REDDY Specialisation : HEMATO ONCOLOGY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 4985.44
Payor Name : NIVA BUPA HEALTH INSURANCE COMPANY LTD

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Dr. NALLA ANURAG REDDY


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It takes a lot to treat the little.


BirthRight™
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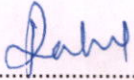
ADMISSION CRITERIA – ONCOLOGY

Admission / Transfer from:

☒ Emergency ☐ Outpatient (OPD) ☐ Ward ☐ Operation Theater ☐ Others:

Tick (✓) any of the following criteria requiring admission / transfer to ONCOLOGY

- ☐ For Chemotherapy-Day Care or IP Admission as per the Type of Chemotherapy
- ☐ Febrile Neutropenias (ANC <500 cells / mm³)
- ☐ Netropenic Enterocolitis
- ☐ Mucositis Induced Significant Diarrhea or Pain
- ☐ Neurological Complications (like Seizures, Bleeding, Thrombosis) that can arise while on Chemotherapy Treatment or at the Time of Presentation and also for other Systemic Problems like Pancreatitis during Chemotherapy
- ☐ Management of Oncological Emergencies
- ☐ Bleeding Problems (where it is indicated)
- ☐ Evaluation and Management of Severe Anemias
- ☐ Day Care Admissions for PRBC Transfusions
- ☐ Evaluation and Management of Sick Children who come with Hematological Problems like Severe Anemia like Autoimmune Hemolytic Anemia/ Bleeding/ Others
- ☐ Primary Immunodeficiency Disorders with Infections that Warrants Hospitalisation
- ☐ Management and Evaluation of Hemophagocytic LymphoHisticytosis
- ☐ Any Systemic Disorders with Significant Hematological issues like JRA / SLE with Secondary HLH

Signature of the Doctor: 

Name of the Doctor: M. Ramesh Kumar

Date & Time: 17/7 @ 10a

PHW-00110942 IP5-00176251
Master ANUMANDLA KARTHIK
05-01-2015 11 Y 6 M 6 D (M)
Dr. NALLA ANURAAG REDDY



DISCHARGE CRITERIA – ONCOLOGY

Discharge to:

☐ HDU / Step down ICU ☐ Ward ☐ Outside Facility ☐ Others:

Tick (✓) any of the following criteria requiring discharge / transfer from ONCOLOGY

- ☐ Completion of chemotherapy, with no debilitating side effects.
- ☐ Resolution of febrile episode, with no fever > 24hrs and Absolute Neutrophil count (ANC) > 500cells/mm³.
- ☐ Admitted patients - Once the admitting problem gets resolved or made a plan to manage further on out-patient basis.

Signature of the Doctor: _____

Name of the Doctor : _____

Date & Time: 11/7/26 @ 5pm



Date & Time	Progress Notes	Doctor's Order
11/07	Procedure notes	
com	1. Strict Aseptic Precautions cu 2. Sedation Lumbar puncture done IT. chemotherapy given Procedure is uneventful Plan HR - 120/min SpO₂ - 98% BP - 107/74/84	
		<i>[Signature]</i> Thakani

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor: Dr. Sandhya

Date: 11/7/26

Type of Admission: ☒ OPD ☐ ER ☐ Referral (if referral, Doctor's Name: _____)

Start Time of Assessment: 9:40 am

Weight: 40 kg

Allergic History: _____

Chief Complaints: B-cell ALL on intensive chemotherapy

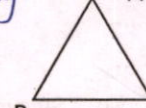
Came for LP procedure

NO H/O fever, cold, cough, vomiting.

looks stable.

Pediatric Assessment Triangle

A Appearance - TICLS



B

C Circulation

Breathing

☐ ↑ WOB

☐ ↓ WOB

☒ Normal

☐ Gasping / Apnea

☒ Normal

☐ Abnormal

— Pallor ☐

— Cyanosis ☐

— Mottling ☐

— Bleeding ☐

Initial Physiological Status: ☒ Stable ☐ Unstable

— Life Threatening ☐

— Non Life Threatening ☐

Any urgent interventions needed: ☐ Yes ☒ No

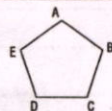
If Yes _____

Significant Past History: _____

Medication History: _____

Relevant Investigations: _____

Primary Assessment



Airway

☒ Open

☐ Maintainable

☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____

Breathing

Rate: 24/min

SpO₂ on FiO₂ 100% on RA

Rhythm: Regular

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR

☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: Bilateral

Palpation Findings (If necessary) _____

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____



Circulation

HR: 120/min

CFT ☐ Central
☐ PeripheralAny urgent interventions needed: ☐ Yes ☒ No

BP: 106/63 (71) mmHg

Pulse Volume: ☐ Central
☐ PeripheralIf in Shock: ☐ Compensated
☐ HypotensiveMuffled Heart Sound: ☐ Yes ☒ NoEngorged Neck Veins: ☐ Yes ☒ NoMurmurs: ☐ Yes ☒ No

Liver Span:

ECG:

Any Signs of Heart Failure: ☐ Yes ☒ No

If Yes



Disability

GCS: 15/15 AVPU:

Pupils: ☒ Responsive ☐ Non-Responsive ☐
Size ☐ Right
☐ LeftActive Seizures: ☐ Yes ☒ No Sugars:

Signs of Neurological compromise

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

Exposure



Temp.: 98-3°F

Any Rash: ☐ Yes ☒ No,

If yes describe the rash

Active bleed

Lacerations ☐ Abrasions ☐ bruises ☐

Describe:

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest
☐ Shock - Compensated ☐ Hypotensive ☐
☐ Cardiopulmonary Arrest ☒ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings:

Labs Planned:

CBP
NIB
Sagan
11/7/26

Treatment Planned:

LP
NPO to continue
IV fluidsNIB
Sagan
11/7/26Need for Oxygen: ☐ Yes ☒ No if yes Low Flow ☐High Flow ☐ PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): Bcell All for LP procedure

Assessment done by

Name of the Doctor: Dr. Ramya

Signature: br

Date & Time: 11/7/26, 10am

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor:

Signature:

Date & Time:

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RESULT SHEET

Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

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.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

DRUG CHART

Date of Admission: 11/7/20 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 :				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:				

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



REGULAR PRESCRIPTIONS

Weight. 40kg Ward.

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

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

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

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
11/07/25		RDP 30	3 units	Ivover 30min	Zu	
		Ini AVIL	act ml	IV		
11/07	11:30AM	Ini AVIL	1ml	IV	Zu	all
11/07	11:35AM	RDP 20	2 units	IV	Zu	
11/07	11pm	PRBC	1 unit	Ivover 4hrs	Zu	
11/07	12pm	Ini KETAMINE	20mg	IV	Zu	
11/07	12pm	Ini MIDAZOLAM	2mg	IV	Zu	
11/07	5pm	Ini LASIX	20mg	IV	Zu	

Weight. 40kg, Ward.

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05-01-2015 11 Y 6 M 6 D (M)
Dr. NALLA ANURAG REDDY



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:

Shifted to:

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Teb Septtran	1teb	PO	BD		☒ C ☐ DC
2	Teb Celamen	1teb	PO	OD	11/7/26	☒ C ☐ DC
3	Teb Zineovit	1teb	PO	OD		☒ 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. Ramya

Date & Time : 11/7/26 : 9:40 pm

Nurse Name & Signature : Sagar

Date & Time : 11/7/26 @ 10:10 am

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



Patient Sticker

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							



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.
3. 24 hrs. total to be entered in the kardex in RED.

		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												



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 10am Mode of Arrival: walking Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction No allergy

Body Weight: 40kg Kg

Height: cm

Past Medical History: Obtained From ☐ Patient ☒ Family Member ☐ Medical Record ☐ Other (specify)

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>NA</u>	<u>NA</u>	<u>ND</u>

Family History: No significant

Has the child or close family member had recent contact with a communicable disease? ☒ Yes ☐ No

If yes please list,

Was the child's birth normal? ☒ Yes ☐ No If No, please describe problems:

Are the child's immunization up to date? ☒ Yes ☐ No

Current Medication: ☐ None ☐ Yes, If Yes, fill reconciliation form

Observations: Weight: 40kg Length: Head Circumference (< 2 years):

Temp: 98.6 F HR: 112b/m RR: 28b/m BP: 100/60 (22)

Pain Score: 0 Specify Site: (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☐ Yes ☐ No Score: 1 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☐ Yes ☐ No If Yes, Pain Score: 0 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker

Character of Pain 0 Location NA Frequency NA Duration NA

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

☐ Special Feeding Method

☐ Feeding Problem

☐ Special diet

☐ No Abnormality Detected

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?)

All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach: ☒ Yes ☐ No Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump: ☒ Yes ☐ No Hand hygiene Explained: ☒ Yes ☐ No ☐ Others

Patient Rights & Responsibilities: ☐ Yes ☐ No

Information given to Mother

Nurse's Name: N. cum Date: 11/2/26 Time: 10am

ay
Signature

PHW-00110942 IP5-00176251
Master ANUMANDLA KARTHIK
05-01-2015 11 Y 6 M 6 D (M)
Dr. NALLA ANURAAG REDDY



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

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 11/2/26

Assessment: Patient having weakness

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
10am	→ Assess the patient General condition.	10:30am	→ Assessed the patient General condition.	Patient feel Better
11am	→ Maintain fluid Balance.	11:30am	→ Maintained fluid Balance	
12pm	→ Ensure Safety.	12:30pm	→ provided side rails.	
4pm	→ Administer medication as order	4:30pm	→ Given medications as order.	

Re-Assessment: Patient is active

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Sneha

Date & Time: 11/2/26 4pm

Patient Sticker

NURSING CARE RECORD


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Hospital**
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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

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:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

Patient



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Nalla anuraag Department: ER Date of Admission: 11/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known		
	<u>B cell ALL</u>		If Yes Specify:		
BACKGROUND	Area	<u>ER</u>	<u>OLD</u>		
	Shift Time	<u>10:40 am</u>	<u>2pm</u>		
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>		
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:	<u>98.3°</u>	<u>98.4°</u>	
		Res:	<u>24 b/m</u>	<u>20</u>	
		SpO ₂ :	<u>100%</u>	<u>100%</u>	
		Pulse:	<u>142 b/m</u>	<u>121 b/m</u>	
		BP:	<u>113/78</u>	<u>100/66</u>	
		Fall Risk Score:	<u>10</u>	<u>10</u>	
	Pain Score:	<u>0/10</u>	<u>0</u>		
	Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>	
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
Others Specify:		<u>yes</u>	<u>NA</u>		
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>		
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>		
Handed Over By Name :		<u>Shavane</u>	<u>Shavane</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>11/7/26</u>	<u>11/7/26</u>		
Time:		<u>10:40 am</u>	<u>2pm</u>		
Taken Over By Name :		<u>[Signature]</u>	<u>[Signature]</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>11/7/26</u>	<u>11/7/26</u>		
Time:		<u>11:17</u>	<u>11:17</u>		

PHW-00110942 IP5-00176251
Master ANUMANDLA KARTHIK
05-01-2016 11 Y 6 M 6 D (M)
Dr. NALLA ANURAG REDDY



LONG 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:							

PHW-00110942 IP5-00176251
Master ANUMANDLA KARTHIK
05-01-2015 11 Y 6 M 6 D (M)
Dr. NALLA ANURAAG REDDY

CONSENT FOR PROCEDURAL SEDATION

Authorization By: ☐ Patient ☒ Patient Attendant

I, the undersigned do hereby acknowledge the following:

- I have been made aware by the doctors in language known to me the details of sedation planned for the procedure
LP Umbilical Puncture.
- I have been made aware of the possible complications from the procedure of sedation as follows:
- Changes in heart rate, blood pressure, need for oxygen supplementation, allergic reactions, upper airway obstruction, laryngospasm, conversion to general anaesthesia
- I have been made aware that the sedation is being advised to relieve pain and anxiety during the procedure. It will help me remain calm, comfortable, and cooperative, allowing the procedure to be performed smoothly and safely.
- I have been clearly explained about the benefits, risk, and alternative of the sedation which is General Anaesthesia.
- I authorize Dr. Sirisharani and his / her team to perform the procedural sedation upon the patient / myself.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: Am
ie: A-Madon Madan Reddy
Relationship with patient: _____
Date & Time: 11/07/16

Witness:

Signature: Umy
Name: Umy
Date & Time: 11/7/16 @ 3:40 pm

Doctor (who is taking consent):

Signature: Li Name: T Parani Date: 11/07 Time: 3:40 P.M.

ప్రాసీజర్ల సెడేషన్కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, క్రింది విషయాలను అంగీకరిస్తున్నాను:

నాకు తెలిసిన భాషలో, వైద్యులు ఈ క్రింది ప్రాసీజర్కు ఇచ్చే సెడేషన్ గురించి పూర్తి వివరాలు నాకు తెలిపారు:

- సెడేషన్ వల్ల సంభవించగల సాధ్యమైన క్రింది సమస్యలు/ప్రమాదాలు గురించి నాకు తెలిపారు: గుండె వేగం మారడం, రక్తపోటు మారడం, ఆక్సిజన్ అవసరం, అలర్జిక్ ప్రతిచర్యలు, ఎగువ శ్వాసనాళ అడ్డంకి, లాలింజోస్టాసమ్, జనరల్ అనస్థీషియాగా మారాల్సిన అవకాశం.
- ప్రాసీజర్ సమయంలో నొప్పి, భయం, ఆందోళన తగ్గించేందుకు సెడేషన్ ఇవ్వడం అవసరం అని నాకు వివరించారు. ఇది ప్రాసీజర్ సజావుగా, సురక్షితంగా జరగడానికి సహాయపడుతుంది.
- సెడేషన్కు సంబంధించిన ప్రయోజనాలు, ప్రమాదాలు, ప్రత్యామ్నాయం (జనరల్ అనస్థీషియా) గురించి నాకు స్పష్టంగా వివరించారు.
- డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ ప్రాసీజర్ సెడేషన్ చేయడానికి నేను అనుమతిస్తున్నాను.
- పై సమాచారాన్ని నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ఉన్న ప్రశ్నలన్నీ, నాకు అర్థమయ్యే భాషలో సమాధానమిచ్చారు. ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సాక్షి:

సంతకం:

సంతకం:

పేరు:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

PHW-00110942 IP5-00176251
Master ANUMANDLA KARTHIK
05-01-2015 11 Y 6 M 6 D (M)
Dr. NALLA ANURAAG REDDY



CONSENT FOR SPECIAL PROCEDURES

Patient Name : Karthik Gender: ☒ Male ☐ Female
UHID No : Department : H. oncology Date : 11/07/2026
I S/D/W/O

Here by give consent for procedure of : Lumbarpuncture

For my patient, Named : KARTHIK

The doctors have clearly explained to me that the procedure has following possible complications:

Trauma, Headache Bleeding.

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

NA

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr. SANDHYA V

Patient Attendant :

Signature : Am

Name : Dr. Madan Mohan Reddy

Relationship with Patient: Father

Date & Time : 11/7/2026

Witness :

Signature : Chy

Name : Chy

Date & Time : 11/7/26 @ 3:40pm

Doctor (who is taking the consent) :

Signature : Li

Name : T. Parvathi

Date & Time : 11/07/26

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

.....

.....

.....

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు (అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

Moderate Sedation Flow-Sheet

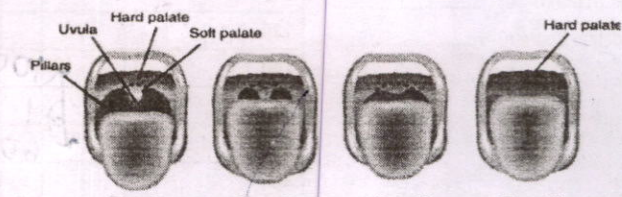
Immediate Pre-Sedation Assessment

B.P	P.R	R.R	Temp	SPO ₂	Pain Score	Weight
106/76	112/min	20	98.6°F	98%	1	14.1 kg

Diagnosis: ALL

Procedure: Lumbar Puncture

Comorbidities:

☐ Risk, benefits & alternatives discussed; ☐ Patient understand & elects to proceed ☐ Consents for procedure and sedation signed and dated ASA Physical Status ☒ ASA PS 1: Healthy Patient ☐ ASA PS 2: Mild Systemic Disease, no functional limitations ☐ ASA PS 3: Severe Systemic Disease, functional limitations ☐ ASA PS 4: Severe Systemic Disease, constant threat to life ☐ ASA PS 5: Moribund Patient unlikely to survive 24 hrs. ☐ ASA PS 6: A declared braindead patient whose organs are being removed for donor purposes ☐ E: Emergency procedure GCS: <u>15E4</u> <u>M6</u> <u>V5</u>	AIRWAY EVALUATION Mouth: ☐ Normal ☒ Loose Teeth ☐ Small Mouth ☐ Protruding Incisors ☐ Receding Lower Jaw ☐ Dentures Neck: ☒ Normal ☐ Decreased ROM ☐ Thyromental Distance Less Than 6 cm ☐ Short Neck  A Class I Class II Class III Class IV
☒ IV Site: Gauge:	Mallampati Class: ☒ I ☐ II ☐ III ☐ IV
Sedation Plan: <u>short sedation</u>	
Allergies:	

Monitoring of Patient Intra – Procedure

Procedure Monitoring

Heart Rate (HR), Respiratory Rate (RR), Oxygen Saturation (O₂ Sat) continuously monitored, and Level of Consciousness (LoC) to be monitored and recorded minimally every 15 minutes until 15 minutes after the last administration of any sedation, then every 30 minutes, then every 1 hour until stable. Respiratory status to be monitored continuously.

Level of Consciousness (LOC):

- ☒ A - Alert
☐ V - Verbally Responsive
☐ P - Painfully Responsive
☐ U - Unresponsive

TIME	BP	PR	RR	O ₂ Sat%	O ₂ Supplementation	Comments / Initials
Baseline	110/60 (2)	1016/m	266/m	100%		

Doctor Notes: Un Eventful

Time of transportation to post sedation care room: Day care LOC: alert

Doctor Name: A. K. Kaur Signature: [Signature]

3:50 pm

TOTAL ALDRETTE SCORE AT DISCHARGE =
(If 9 and more patient can discharge from post Sedation care unit)

Patient Discharge Time: 3:50 pm

Nurse Name: Ueeng

Date: 11/3/26 Time: 3:50 p

Consultant Name: Dr. Jirisha Rani

Stamp

Signature:

Signature: _____

CONSENT FOR BLOOD TRANSFUSION

PHW-00110942 IP5-00176251
Master ANUMANDLA KARTHIK
05-01-2015 11 Y 6 M 6 D (M)
Dr. NALLA ANURAAG REDDY



Name: Karthik Reddy Age: 11y Gender: Male ☒ Female ☐
UHID.No : PHW-00110942 Date: 11/7/26

Type of Blood Product: ☐ Fresh Frozen Plasma ☒ Packed Red Blood Cells ☐ Random Donor Platelets
☐ Cryoprecipitate ☒ Single Donor Platelet ☐ Whole Blood
☐ Albumin ☐ Red Blood Cell ☐ Others

I A. Madan Mohan Reddy hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immuno-deficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that Explained

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Doctor (Who is talking the consent)

Signature: Am Signature: Ahanusha

Name: A. Madan Mohan Reddy Name: Ahanusha

Date & Time 11/7/2026 @ 1:36pm Date & Time 11/7/26 @ 1:36pm

Witness

Signature: Chirag

Name: Chirag

Date & Time 11/7/26 @ 1:36pm

రోగి పేరు: వయస్సు: లింగము ☐ పురుషుడు ☐ స్త్రీ
UHID, సంఖ్య: తేదీ:

రక్త ఉత్పత్తి రకాలు:

- ☐ తాజా ఘనీభవించిన ప్లాస్మా ☐ ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు ☐ Random Donor Platelets
☐ క్రయోప్రెసిపిటేట్ ☐ ఒకే ధాత ఫ్లేటిలెట్స్ ☐ Whole Blood
☐ మొత్తం రక్తం ☐ ఎర్ర రక్త కణం ☐ ఇతరులు.....

నేను ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడి/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. ధాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడీస్, హైపటెటిస్ జి సర్ఫేస్ యాంటీజన్, హైపటెటిస్ యాంటీబడీస్, మలేరియా మరియు సిప్లిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణయ కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలితవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు

పైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి చికిత్స చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. చికిత్స చేస్తున్న సమయంలో అన్ని రకముల రక్తమార్పిడులకు (మొత్తం రక్తం / లేదా రక్త ఉత్పత్తులు ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ఫ్రెష్ ఫ్రాజెన్ ప్లాస్మా, క్రయోప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకం

పేరు

పేరు

తేదీ మరియు సమయము

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 11/7/26 Time: 1:36pm
Blood Group of the Patient: A+ve Blood Group on the Blood Bag: O+ve
Blood Bank Issue No: BAH98-01643/01620 Date of Collection: 10/7/26/8/7/26 Date of Expiry: 15/7/26/13/9/26
Date & Time of Starting Transfusion: 11/7/26 @ 1:36pm Planned duration of Transfusion: 3 minutes
Check for Correct Unit: ☒ Correct Patient: ☒
Blood products cross checked by: Nurse 1: Deena Nurse 2: Dinpa
Before starting transfusion vitals: Temp: 98.6f HR: 106b/m RR: 26b/m BP: 100/60 SpO₂: 100%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
11/7/26	15 Min	106b/m	98.6f	100/60	100%	No	No	No	No
	15 Min	96b/m	98.6f	96/56	100%	No	No	No	No
	30 Min	91b/m	98.6f	90/60/91	100%	No	No	No	No
	30 Min	93b/m	98.6f	93/56	100%	No	No	No	No
	30 Min	106b/m	98.6f	95/73	100%	No	No	No	No
	1 Hr	101b/m	98.6f	91/53	100%	No	No	No	No
	1 Hr	90b/m	97.6f	101/53	100%	No	No	No	No.

Comments:

Name of the Incharge-Nurse: [Signature] Name of the Nurse: [Signature]
Signature of the Incharge-Nurse: [Signature] Signature of the Nurse: [Signature]
Date & Time: 11/7/26 at 4pm Date & Time: 11/7/26 at 4pm

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2, Banjara Hills, Hyderabad, Telangana State Lic.No. 46/HD/TS/2018/BB/G		
PLATELET CONCENTRATE I.P. Qty. 58 ml. Prepared from Whole human blood collected in 63 ml. of C.P.D./ SAGM Solution.		
	HIV I & II/ HBsAG/ HCV - Non reactive VDRL - Non reactive MP - Negative NAT(HIV I & II/ HBsAG/ HCV)- Non reactive	
	Unit No.: BAH26-01643 Blood Group: O Rh Positive Collection Date: 10/Jul/2026 Expiry Date: 15/Jul/2026	
	1. Do Not Dispence Without Prescription. 2. Check Blood Group On Label & Recipient's Group And Name Before Administration. 3. Shake Gently Before Use. 4. Do Not Add Any Medication. 5. Use Immediately After Issue. 6. Use Sterile Transfusion Set With Filter. 7. Do Not Use If There Is Any Visible Evidence Of Deterioration Like Haemolysis Clotting Or Discoloration. 8. Store Continuously At 22° C - 24° C With Gentle Agitation.Or Below. 9. Administer Without Warming.	

Issue Label / CrossMatching Report	
Patient : MASTER.KARTHIK REDDY - Patient's Blood Group : A Rh Positive Hosp/Dr : Rainbow Childrens Hospital, dr sandhya UHID No.: PHW-00110942 Wd-Bed No.:	
Product : RDp Blood Group : O Rh Positive Issue Dt : 11/Jul/2026 Unit No.: BAH26-01643 Colln. Dt : 10/Jul/2026 XMatching Report: Group non Specific Exp. Dt : 15/Jul/2026 X-matched by: B.Abbhishek Issued By : B.Abbhishek	
Rainbow Hospital Blood Centre, Rainbow Childrens Hospital D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2, Banjara Hills, Hyderabad, Telangana State Lic.No. 46/HD/TS/2018/BB/G	

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2, Banjara Hills, Hyderabad, Telangana State Lic.No. 46/HD/TS/2018/BB/G		
PLATELET CONCENTRATE I.P. Qty. 55 ml. Prepared from Whole human blood collected in 63 ml. of C.P.D./ SAGM Solution.		
	HIV I & II/ HBsAG/ HCV - Non reactive VDRL - Non reactive MP - Negative NAT(HIV I & II/ HBsAG/ HCV)- Non reactive	
	Unit No.: BAH26-01620 Blood Group: O Rh Positive Collection Date: 08/Jul/2026 Expiry Date: 13/Jul/2026	
	1. Do Not Dispence Without Prescription. 2. Check Blood Group On Label & Recipient's Group And Name Before Administration. 3. Shake Gently Before Use. 4. Do Not Add Any Medication. 5. Use Immediately After Issue. 6. Use Sterile Transfusion Set With Filter. 7. Do Not Use If There Is Any Visible Evidence Of Deterioration Like Haemolysis Clotting C Gentle Ag 9. Admini	

Issue Label / CrossMatching Report	
Patient : MASTER.KARTHIK REDDY - Patient's Blood Group : A Rh Positive Hosp/Dr : Rainbow Childrens Hospital, dr sandhya UHID No.: PHW-00110942 Wd-Bed No.:	
Product : RDp Blood Group : O Rh Positive Issue Dt : 11/Jul/2026 Unit No.: BAH26-01620 Colln. Dt : 08/Jul/2026 XMatching Report: Group non Specific Exp. Dt : 13/Jul/2026 X-matched by: B.Abbhishek Issued By : B.Abbhishek	
Rainbow Hospital Blood Centre, Rainbow Childrens Hospital D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2, Banjara Hills, Hyderabad, Telangana State Lic.No. 46/HD/TS/2018/BB/G	

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2, Banjara Hills, Hyderabad, Telangana State Lic.No. 46/HD/TS/2018/BB/G		
LEUCO REDUCED BLOOD CELLS I.P Qty. 286 ml. Prepared from Whole human blood collected in 63 ml. of C.P.D.A. Solution.		
	HIV I & II/ HBsAG/ HCV - Non reactive VDRL - Non reactive MP - Negative NAT(HIV I & II/ HBsAG/ HCV)- Non reactive	
	Unit No.: BAH26-01565 Blood Group: A Rh Positive Collection Date: 30/Jun/2026 Expiry Date: 11/Aug/2026	
	1) Administer Without Warming. 2) Shake Gently Before Use. 3) Do Not Add Any Medication. 4) Check Blood Group on Label & Recipient's Group and Name Before Administration. 5) Use Sterile Transfusion Set Without Prescription. 7) Do Not Use if	

Issue Label / CrossMatching Report	
Patient : MASTER.KARTHIK REDDY - Patient's Blood Group : A Rh Positive Hosp/Dr : Rainbow Childrens Hospital, dr sandhya UHID No.: PHW-00110942 Wd-Bed No.:	
Product : L.R-PRBC Blood Group : A Rh Positive Issue Dt : 11/Jul/2026 Unit No.: BAH26-01565 Colln. Dt : 30/Jun/2026 XMatching Report: Compatible Exp. Dt : 11/Aug/2026 X-matched by: B.Abbhishek Issued By : PILLEM	
Rainbow Hospital Blood Centre, Rainbow Childrens Hospital D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2, Banjara Hills, Hyderabad, Telangana State Lic.No. 46/HD/TS/2018/BB/G	

Patient S

PHW-00110042 IP5-00176251
 Master ANUMANDLA KARTHIK
 05-01-2015 11 Y 6 M 6 D (M)
 Dr. NALLA ANURAG REDDY

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 Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2				
	13 years old and above	1					
Gender	Male	2	2				
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1				
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1				
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1				
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1				
TOTAL			10				

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

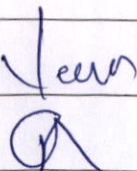
High Risk Humpty Dumpty Score = 12 or above

Bed in low position	YES					
Call device within reach	YES					
Wheels Locked	YES					
Room free of clutter	YES					
Adequate Lighting	YES					
Wheel Chair Support	No					
Other Intervention(s) Specify	No					
Nurse's Name :	Shashi					
Signature :	[Signature]					
Date :	11/7					
Time :	10 AM					

CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

Type of Line: ☐ PICC Line ☐ UAC ☐ UVC ☐ Other **Date of Initial Line Insertion:** **Duration of Central Line:**

- Always perform hand hygiene before accessing central line
- Use Sterile gloves for handling central line
- Clean the hub with antiseptic solution every time before & after it is accessed
- Consider – antibiotic via central line before removal of the line
- Inspect Central line in each shift for the following

Parameters	Date	Shift Time						
Can we remove Central Line today (Discuss in the clinical round)		11/2 2pm	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Evidence of any inflammation at insertion site (Redness / Swelling (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Blood at insertion site (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any peeling of dressing? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is dressing clean and dry? (If no inform the doctor)			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any leakage at insertion site? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there any obstruction to the infusion flow? (If yes inform the doctor)			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing intact and labelled properly			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Central line changed on								
Name of the Nurse			Jeeva					
Signature of the Nurse								

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Master ANUMANDLA KARTHIK
05-01-2015 11 Y 6 M 8 D (M)
Dr. NALLA ANURAG REDDY



BRADEN 'Q' SCALE

					Date : 11/7			
					Time : 10 AM			
Mobility	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			
"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			
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			
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			
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					24			
Evaluator's Name					Bhava			

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

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part -

Patient / Learner Literacy: ☒ Read ☐ Write ☒ Speak Willingness to Learn: ☒ Yes ☐ No Healthcare Literacy: ☐ Yes ☐ No

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
11/7	10AM	7	Infection control measures	M	1	0	1	1	-	Shavas

Part - III: CODES

Who was taught:	PT: Patient	F: Father	M: Mother	S: Spouse	Sn: Son	D: Daughter	C: Caregiver	O: Other (Specify)															
Learning Barriers:	<table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice	2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)	3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	
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2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)																			
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing																				
Teaching Tools Used:	A: Audio	D: Demonstration	V: Video	O: Oral	P: Printed																		
Mechanism/s to overcome barrier/s:	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify																				
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference																					
Understanding:	<table border="0"> <tr> <td>1. Verbalizes Understanding</td> <td>2. Demonstrates Understanding</td> <td>3. Needs Review</td> </tr> </table>								1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review												
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PHW-00110942 IP5-00176251
Master ANUMANDLA KARTHIK
05-01-2016 11 Y 6 M 6 D (M)
Dr. NALLA ANURAG REDDY



MULTI-DISCIPLINARY PLAN OF CARE FORM

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
11/7/26	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	B-cell ALL	hemodynamic stability	LP procedure	[Signature]	☐ Nursing ☐ Others:
11/7/26 10AM	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	B cell ALL	Hemodynamic stability	LP	Shavan	☐ Medical ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others: