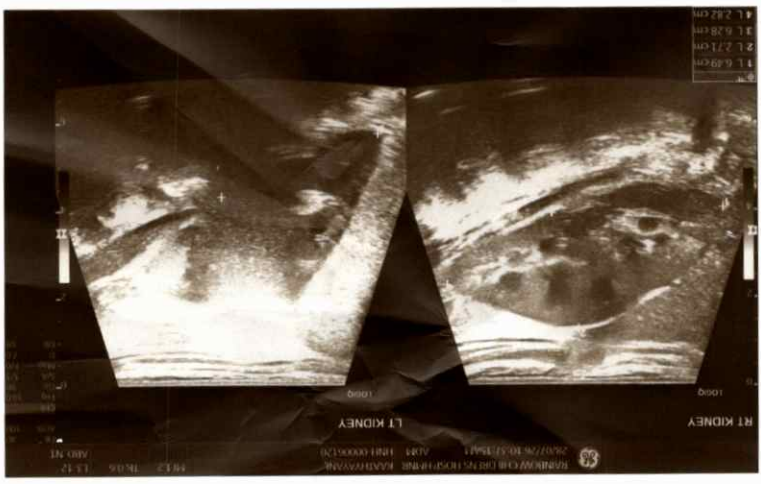
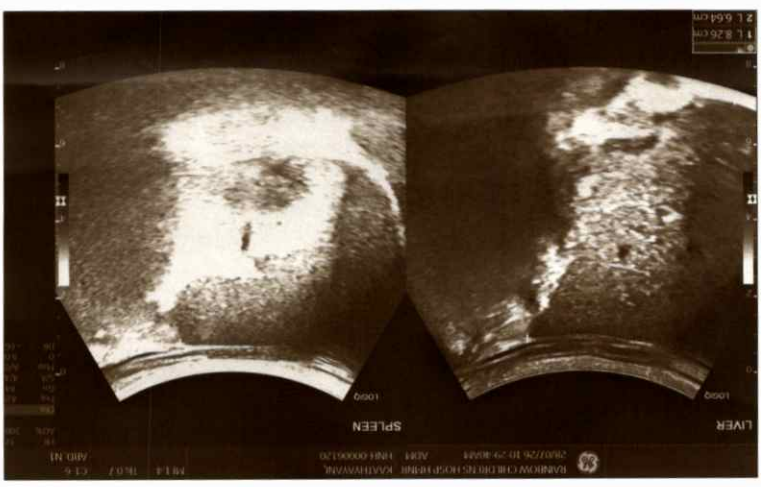
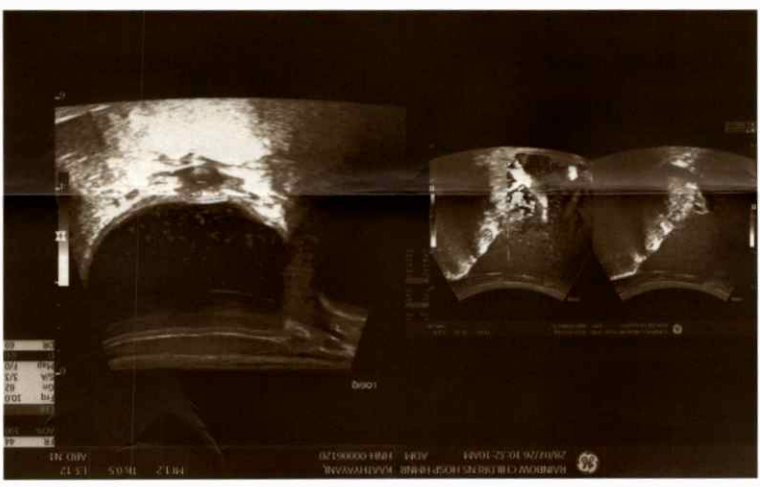
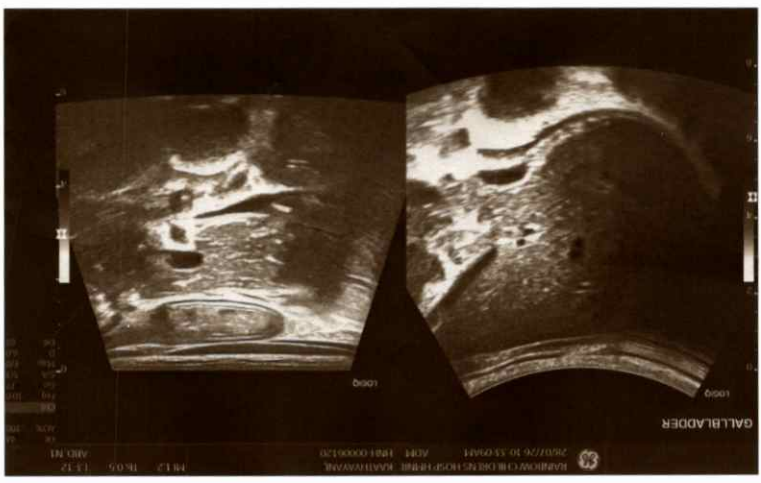
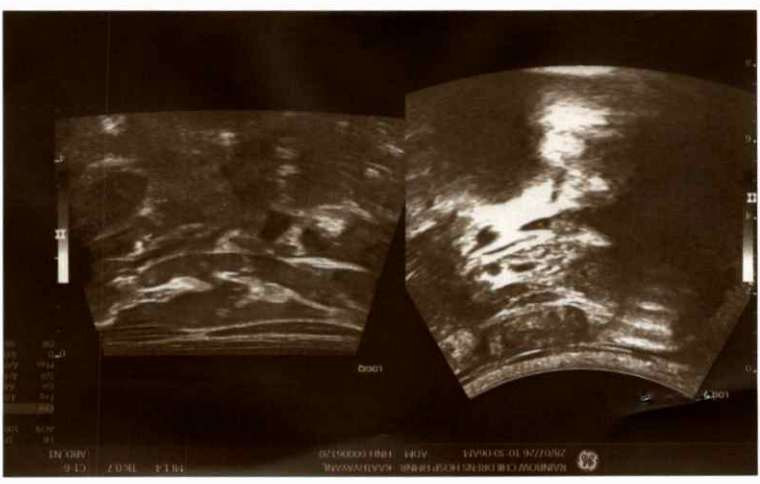

RT KIDNEY
LT KIDNEY


LIVER
SPLEEN




GALLBLADDER



Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006971 **Admit Date** : 28-Jul-2026 **Admit Time** : 02:27 AM **UHID** : HNH-00006120

Patient Details :

Patient Name	: Baby KAATHYAYANI GOUD	**Age**	: 1 Y 7 M 12 D
Guardian	: Mr OMPRAKASH GOUD	**DOB**	: 16-12-2024 01:00 AM
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 13-6-458/12 GAYATRI NAGAR KARWAN HYDERABAD Karwan Hyderabad Telangana INDIA 500006	**Phone No**	: 8897894567/ 9381092821
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : ER01 **Ward Name** : GF -EMERGENCY

Room No : ER01 **Admission Type** : First Visit

Contact Details :

Name : Mr OMPRAKASH GOUD, **Relationship** : Father

Contact Address : 13-6-458/12 GAYATRI NAGAR KARWAN HYDERABAD Karwan Hyderabad Telangana INDIA 500006 **Phone No** : 8897894567

Signature

Doctor Details :

Doctor Name : Dr. SINDHURA MUNUKUNTLA **Specialisation** : GENERAL PEDIATRICS

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

Co-Consultant :

Payment Details :

Deposit Amount : 10000.00

Payment Mode : DC/CC Card **Payor Name** : FAMILY HEALTH PLAN INSURANCE TPA LTD

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 28/7/25 Time of arrival : 1:05AM

Chief Complaints: c/o stomach pain since 2 hours back loose motions x 4 days vomiting episode RBS: .....

Height : ..... Weight : 9.18kg BMI : ..... Head Circumference (<2 years) .....

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: .....

If yes , identify .....

Pain Screening: ☑ Yes ☐ No If Yes, Pain Score: 6 Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker

☐ Character Acute ☐ Location stomach pain ☐ 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 : @ 1:07AM .....

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

Time	Nursing Notes
1:07 AM	Assess the patient condition monitor the vital sign

Samples collected by: /

Samples sent by : / Apurba

Time:

Time: / 2:50 AM

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: 122 b/m BP: 82/68 (74) mmHg CFT: NIA	Shift - out from ER to: 2nd floor (218)
RR: 22 b/m SPO_2 : 98%	Time of Shift - out: 3:18 AM
GCS: 15/15 Temperature : 98.7	Handover given to: Sandhya (Nurse's Name)
Pain Score:	
Repeat RBS (if applicable): NIA	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

IV placement done

Name of the Nurse : Shirisha

Signature of the Nurse : Sd

Date & Time : 28/7/26 @ 1:12 AM

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00006120 IP26-00006971 Baby KAATHYAYANI GOUD 16-12-2024 1 Y 7 M 12 D (F) Dr. SINDHURA MUNUKUNTLA	28/7/26 @ 2:27 PM	28/7/26 @ 3:18 AM
	Transfer Ordered by Dr. Pranav	Reason for Transfer Admission
From Unit ~~GR~~	To Unit ward (21F)	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File 15-1	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Shirisha	Dr. Pranav

Patient & Clinical Records Received by : Sr. Sandhya 28/7/26

Date & Time of Patient Received : @ 3:30 am

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

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

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ACTIVITY RECORD FOR BILLING

HNH-00006120 IP26-00006971
Name Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA
UHID

---------- Consultant : ---------- Dept : pediatrics

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/7/26	3:18 AM	ER	ward	

Cross Consultation Visit

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

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
15-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

INVESTIGATIONS

Date	Investigations	Order No.	Sign
28/7/24	CBP, CRP, Blood c/s, Creatinine, VBG	12761	
		Cross check done by Sr-Sandhya	
28/7/24	USG Abdomen	9236	Auf

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
28/7/26	Infusion Pump	28/7/26 @3:35 am.	29/8/6 @ 7:30pm	17600	Sandhya

Cross check done.

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
28/7/26	IV placement	1	17595	
28/7/26	NHA	1	7716	

cross check done

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow®
Children's
Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

Patient Name : _____

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examinati

Name : B/o Kavya

Informant Mother Reliability Y

Chief Presenting Complaints & Duration (Chronologically): c/o Fever - 4 days ago ~~for 1 day~~ for 3 days

c/o Loose stool :: 4 day

c/o Pain on Urination :: 4 day

c/o Dull activity & Poor Oral intake :: 2 day

c/o Vomiting :: 1 day

History of present illness :

Child brought with

c/o Fever - 4 days ago for 3 day → High grade.

c/o Loose stool :: 4 day

Multiple episode / day - Watery, Slimy - mucus

Foul smelling, Non blood stain

c/o Pain on Urination :: 4 day

On & off pain, No c/o Pre frequency

c/o Dull activity & Poor Oral intake :: 2 day

c/o Vomiting :: 1 day, Non bilious / Non projectile

No c/o Cold / Cough

CVE on 23/7

Pus cells → 35-40

Lowcocytes → 27

Blood → +

RBC → 8-10

CSE on 25/7 (contd)

Pus - 4-6 c/hpf

Starch - +

Fat - +

No RBC / ova / cyst

→ Stool C/S - Negative

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

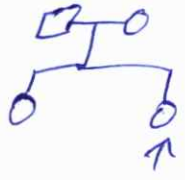
Pediatric Multiorgan History & Physical Examination

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

N/

Birth & Neonatal History :

FT / AGA / CIAB



Birth & Socio Economic History :

About Father :

About Mother : Upper middle class

Any additional Information :

Developmental History :

Immunization History :

Upto date

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
15-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

Pediatric Multiorgan History & Physical Exami

Anthropometry

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

Weight (kgs) 9.2 kg (Centile _____)

On Examination :

Temperature : 98°F Pulse Rate: 122/min Description _____

B.P. 82/68 (74) mm/Hg SPO2 97% at _____

Resp. rate and type of breathing : 24/min

Rash Signs of Dehydration - Sunken eyes, delay skin tent, Dry lips / oral mucosa

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

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

Any addes sounds : Clear

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : $S_1 S_2$ (+)

Any murmur : _____

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

Per Abdomen :

Inspection (N)

Palpation : Soft

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examinatio

Central Nervous System :

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

Cranial Nerves : WNL

Motor System :

Nutrition :

Tone : Power

Co-ordinator : WNL

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars

Sensory System :

WNL

Bladder / Bowel :

Clinical Summary & Diagnostic :

AFI - D4 - Urinary Tract Infection c
Acute Gastroenteritis c Dehydration

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Shock

Desired goals of the treatment :

H-D stability

Planned Labs :

VBG

CBP, CRP, creatinine

Blood C/S

+1 extra plain

catheter sample [CUE, Urine C/S] sent on OPD basis

NCB shisirwo

Planned Management :

Inj Ceftriaxone

Inj Amikacin

Inj Ondem / Inj Esomeprazole

IVF

Pro GG / 2kD

USG Abdomen KUB - T/m

NCB shisirwo

Please fill up the following details

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

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No. 66970

Doctor's Signature Name _____ Date 28/7/24 Time _____

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/7 8AM	C/S/B Dr. Pranav / Dr. Sushanth	
	UTI c	
	Acute GE c Dehydration	
	Fever - x Vomiting - ↓ Pain on Urination - x	Plan 1) Trace take 2) Inj Ceftriaxone Inj Amikacin 3) Inj Ondem Inj Esomeprazole
	O/E Child asleep Vitals stable R-S - B/L AE @ P/A - Soft	4) IVF - 2/3 rd @ 5) USG Abdomen / KUB - Today. 6) Monitor Vitals
		Pharm
		noted by sr. Sandhya 28/7/26.

Docu. No. : RCH /FRM / CLINICAL / 088

(P.T.O)

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/7/24 10AM.	C/C/B Dr. Sindhura D- Acute GE / UTI - Febrile ⇒ High grade - 103.5°F. - NB c/o vomiting. - O/E - vitals stable. S/E - P/A - SNT, NT. BS(+).	Plan - Ct. Ceftriaxone Amikacin. - Trace blood d/s, urine d/s. - USG Abdomen/KUB today. - Ct. Ecosprazole / ondansetron / Zinc drops / Pro Gg drops. NB- Medicines @ 11AM.

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No: 66970

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/7/26	c/s/b Dr. Varun / Dr. Naipunya.	
2 PM	Δ - Acute GE / ? UTI.	
	- High grade fever spikes persistent.	
	- Oral intake - Fair.	
	O/E - vitals stable.	Plan
		- Ct. Ceftriaxone Amikacin.
	S/E - P/A - Soft, NT.	
		- Trace blood c/s / Urine c/s.
		- Ct. Esomeprazole / ondansetron / zinc / pro GI drops.
		NB-Moulali @ 2:13 pm

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD (F)
16-12-2024 1 Y 7 M 12 D
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/7/26 6:30pm	MHS Dr. Sindhura	
	? UTI	
	- high grade spikes (+)	
	- no fresh c/o	
	- oral intake : fair	
	O/E	Plan
	vitals : stable	1) trace Blood c/s & urine c/s
	s/E - P/A - soft	2) plan discharge after reports
		3) ct. antibiotics
		4) Rest ct as per Rx chart
	Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970	[signature]
		5) monitor vitals
		Noted by [signature]

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/7/26 7:30am	W/B Dr. Dharani	
	UTI	
	- fever spikes (+)	
	- no fresh c/o	
	- oral intake : fair	
	O/E	
	vitals : stable	Plan
	S/E - (N)	1) trace blood c/s
		urine c/s
		2) plan discharge
		after reports
		3) ct. antibiotics
	(signature)	4) stop IVF
		5) monitor vitals
		NB Sneha @ 7:30am

Docu. No. : RCH /FRM / CLINICAL / 088

(P.T.O)

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

NURSING CARE RECORD

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Date: 27/7/24

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	3Am No 8Am	Assess the pt condition. Monitor vitals in record. Maintain I/o chart. Provide the comfortable position. medication Give as per as doctor order.	3Am No 8Am	Assessed the pt condition. Monitored vitals & recorded. Maintained I/o chart. Provided the comfortable position. medication given as per as doctor order.	→ Pt is stable. → Vitals normal	→ Monitor vitals. → Maintain I/o chart.	Sneha

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD (F)
16-12-2024 1 Y 7 M 12 D
Dr. SINDHURA MUNUKUNTLA

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: 28/7/26

Goals:
- ☐ ... Relieve Pain & Discomfort
- ☐ Maintain Fluid Balance
- ☐ Improve Activity Tolerance
- ☐ Maintain Good Nutritional Status
- ☐ Maintain Skin Integrity
- ☐ Mai...
- ☐ Prevent Infection
- ☐ Meet Elimination Needs
- ☐ Ensure Safety
- ☐ Early Ambulation Reduce Anxiety
- ☐ Patient & Family Education
- ☐ Identify Potential Complications
- ☐ Any Others. Specify: AKI ... PUJ

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM to 2PM	→ Assess the general condition of pt. → Monitor vitals → Maintain I/O chart. → Administer medication.	8AM to 2PM	→ Assessed the general → Monitored vitals. → Maintained vitals → Administered medication.	Pt is stable.	Re-assess vitals	[signature]
Afternoon	2pm to 8pm	→ Assess the general condition of pt → monitor vitals → Maintain I/O chart → T/blood C/S → urine. C/S	2pm to 8pm	→ Assess the general condition of pt → Monitor vitals → Maintain I/O chart → USG. Abdomen done. → urine C/S	pt is a stable.	Re-assess the vitals.	Madhuri
Night	8pm to 8am	→ Assess the patient general condition → monitor vitals → Administer medication as per doctor's orders.	8pm to 8am	→ Assessed the patient general condition → monitored vitals → Administered medications as per doctor's orders.	Patient is stable	Rechecked vitals	[signature]

Patient Sticker
HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD (F)
16-12-2024 1 Y 7 M 12 D
Dr. SINDHURA MUNUKUNTLA

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: AGE & UTI			Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify:			
	Surgery / Procedure:			Post OP Day:			
BACKGROUND	Date / Shift	27/7 N1	28/7 M6	28/7/26 E2	28/7/26 N1		
	Medical Condition (Any special condition to be noted):			–	–		
	Diet:	Soft	Soft	soft	soft		
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	–	–	–	–		
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.2°F	98.4°F	98.5°F	98.3°F		
	Res:	28b/m	28b/m	29b/m	29b/m		
	SpO_2:	98%	99%	99%	99%		
	Pulse:	112	115b/m	113b/m	112b/m		
	BP:	96/59	98/58	98/69	100/70		
	LOC:	–	–	–	–		
	Fall Risk Score:	–	–	–	–		
	Pain Score:	0	"0"	"0"	"0"		
	Skin Integrity	–	Good	good	Good.		
Recommendations	Safety Needs:	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	–	–	–	–		
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	–	–	–	–		
	Critical Lab Test / Values:	–	–	–	–		
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	–	–	–	–		
Post Operative Procedure Special Orders:		–	–	–	–		
Handed Over By Name :		Snehu	Mounika	Madhavi	Sandhya		
Signature / ID :		4(0)605	[signature]	[signature]	[signature]		
Date:		28/7	28/7/26	28/7/26	29/7/26		
Time:		8Am	2PM.	8pm	8am.		
Taken Over By Name :		Mounika	Madhavi	Sandhya			
Signature / ID :		[signature]	[signature]	[signature]			
Date:		28/7	28/7/26	28/7/26			
Time:		8AM	8pm	8pm.			

Docu. No. : RCH /FRM / CLINICAL / 097

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

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

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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	☐ 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:							

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
15-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

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MEDICATION RECONCILIATION FORM

Drug Allergies: NKA ☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ~~ER~~ Shifted to: ward

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	Z & D Drop	1ml	PO	OD	27/7	☒ C ☐ DC
2	ENTEROGERMINA	1 vial	PO	BD	27/7	☐ 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. pranav

Date & Time : 28/7/26 @ 2:24 PM

Nurse Name & Signature: Shirisha

Date & Time : 28/7/26 @ 3:18 AM

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

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

wt 9.18 kgs

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : B/O Kavya Age : .... **Gender:** ☐ Male ☐ Female

Date : 28/7/26 Time of Arrival : 1:01 AM

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: 97.8F PR: 122b/M BP: 82/68(74) mm Hg RR: 24b/M SpO_2: 98%

Chief Complaints: c/o stomach pain since 2 hours loose motions x 1 day vomiting 1 episode

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

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

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

* CTAS - Canadian Triage and Acuity Scale

[signature]
Signature of Parent / Guardian

Triage Completion Time : ....

Communicable Disease Triage Screening

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

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

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

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☑ No

   If yes, State Location: ....

2. Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☑ No

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

☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough

☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

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

☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.

☐ The patient should be given a surgical mask immediately, if not already wearing one.

☐ Both patient and triage staff should perform hand hygiene.

☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Shirisha

Signature of Triage Nurse : [signature]

Date & Time : 28/7/26 @ 1:03 AM

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

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

Patient Sticke

/ 125

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

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

Date : 28/12 Time: 4am- 7am

Doctor / Nurse / Family Concern?

Temperature (F)
104 103 102 101 100 99 98 97 96 95 94
98.2°F 98.7°F

Heart Rate (bpm) and Blood Pressure (mmHg) *
190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

Note: BP does not score in early warning scoring

Heart Rate (Number): 135b/m 132b/m

Resp. Rate (bpm) (Over 1 Minute) *
70 60 50 40 30 20 10

Resp Rate (Number): 25b/m 22b/m

Resp Distress	Mod/ Severe		
	None / Mild		
Receiving O_2(l/min) O_2Saturations (%)		99%	99%
Conscious Level	Normal		
	Altered		
GCS *		14/15	15/15
TOTAL SCORE Number of shaded boxes		0	0
Pain Score		0	0
Observer's Initials		G	G

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

Patient Sticker

125

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

Pratiksha Rainbow Children's Hospital
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Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date 28/7/26.. Time:	10Am	2pm	6 pm	10pm	2am	6am
Doctor / Nurse / Family Concern?						
Temperature (F)	97.5F	98.2F	98.4F	97.6F	98.2F	98.6F
Heart Rate (bpm) and Blood Pressure (mmHg) *	120	125	120	130	128	110
Heart Rate (Number)	120b/m	125b/m	120b/m	130b/m	128b/m	110b/m
Resp. Rate (bpm) (Over 1 Minute) *	30	33	30	30	30	28
Resp Rate (Number)	30b/m	33b/m	30b/m	30b/m	30b/m	28b/m
Resp Distress: Mod/ Severe / None / Mild						
Receiving O_2(l/min) O_2Saturations (%)	99%	99%	100%	99%	99%	99%
Conscious Level: Normal / Altered						
GCS *	14/15	14/15	14/15	14/15	14/15	14/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials						

Note: BP does not score in early warning scoring

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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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)

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

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FLUID CHART

Sheet No. : 1

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	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		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										0	Sm
	03:00 am										0	
	04:00 am										0	
28/1	05:00 am			25ml							0	
	06:00 am	DNS		25ml		NA		NA			0	
	07:00 am			25ml							0	
Total Intake : Taken						Total Output :				U - M -		

Total 24 hrs. Intake		Total 24 hrs. Output	U - M -

ER

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

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
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FLUID CHART

Sheet No. : 2

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
28/7	08:00 am			25ml								
	09:00 am			25ml						✓		
	10:00 am	DNS	Jelly	25ml			0				0	
	11:00 am		Milk	25ml		NA		NA				
	12:00 pm		H2O	25ml								
	01:00 pm											
Total Intake :								**Total Output :** U-1 M-				
28/7	02:00 pm			25ml								
	03:00 pm		Milk	25ml						✓		
	04:00 pm	DNS	Milk	25ml			?				?	Nadia
	05:00 pm		H2O	25ml		NA		NA		✓		
	06:00 pm		Jelly	25ml								
	07:00 pm		J	25ml						✓		
Total Intake :								**Total Output :** U-3 M-0				
28/7	08:00 pm			25ml								
	09:00 pm		Jelly	25ml						✓		
	10:00 pm	DNS	H2O	25ml			0				0	
	11:00 pm			25ml		NA		NA				
	12:00 am			25ml						✓		
	01:00 am			25ml								
Total Intake : Taken								**Total Output :** U-2 M-				
29/7	02:00 am			25ml								
	03:00 am		H2O	25ml								
	04:00 am	DNS		25ml			0				0	
	05:00 am		+	25ml		NA		NA				
	06:00 am		Alb	25ml								
	07:00 am			25ml								
Total Intake : Taken								**Total Output :** U- M-				

Total 24 hrs. Intake		Total 24 hrs. Output	

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DRUG CHART

Date of Admission: 28/7/26 Drug Allergies: NKA ☐ 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 : CALPOL DROPS				Date / Time
Dose 1·3ml	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions: 1ml = 100 mg				

DRUG : Syp CROCIN-DS				Date / Time
Dose 3ml	Route PO	Frequency SOS	Start Date 28/7	
Doctor's Signature Pharm		Valid Period	Pharm.	
Additional Instructions: If T > 100°F				

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

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

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

REGULAR PRESCRIPTIONS

Weight. 9.2 kg Ward. .....

DRUG : Inj CEFTRIAXONE

Dose	Route	Frequency	Start Date
900mg	IV	Once Daily	28/7

Name & Signature of the Doctor Starting the Drugs: Pharm

Additional Instructions: 100mg/kg IV over 2 hour

Daily Doctor's Endorsement by a Sign

Date / Time: 28/7/24 — 3:40 pm — 3Am

DRUG : Inj AMIKACIN

Dose	Route	Frequency	Start Date
140mg	IV	Once Daily	28/7

Name & Signature of the Doctor Starting the Drugs: Pharm

Additional Instructions: 15mg/kg

Daily Doctor's Endorsement by a Sign

Date / Time: 28/7/24 — 4Am

DRUG : Inj ESOMEPRAZOLE

Dose	Route	Frequency	Start Date
10mg	IV	Once Daily	28/7

Name & Signature of the Doctor Starting the Drugs: Pharm

Additional Instructions: 1mg/kg

Daily Doctor's Endorsement by a Sign

Date / Time: 28/7/24 — 6Am

DRUG : Inj ONDANSETRON

Dose	Route	Frequency	Start Date
2mg	IV	TID	28/7

Name & Signature of the Doctor Starting the Drugs: Pharm

Additional Instructions: 0.2mg/kg

Daily Doctor's Endorsement by a Sign

Date / Time: 28/7/24 — 6Am — 2pm — 10pm

HNH-00006120 IP26-00006971
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Sheet No: .....

REGULAR PRESCRIPTIONS

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

DRUG : Z & D Drops

Dose	Route	Frequency	Start Dt.
1ml	Po	once daily	28/7

Name & Signature of the Doctor Starting the Drugs: Pranav

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 28/7 29/7

10Am Asf

DRUG : PRO-GG Drops

Dose	Route	Frequency	Start Dt.
15 drops	Po	BD	28/7

Name & Signature of the Doctor Starting the Drugs: Pranav

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 28/7 29/7

3:43

6Am Gm Gm

6Pm Nadh

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time:

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time:

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

(P.T.O.)

Patient Sticker

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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

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

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

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

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

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
15-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

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

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

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

Signature .....

Name .....

VERIFIED BY

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

I.V. FLUIDS CHART

Weight. ....9.2 kg.... Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
28/7	3 AM	IVF - DNS (2/3rd m)	IV	25					

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

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
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RESULT SHEET

Date	28/7/26					
Time						
Hb	12.0					
PCV	33.4					
RBC	4.74					
WBC	11.59					
N/L	63.3/29.5					
Platelets	369					
CRP	5.0					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine	0.2					
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	23/7/26	28/7/26				
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells	35-40	Loaded				
CUE - RBC Cells	8-10	20-25				
CUE / Lucocyte -	present	present				
Protein →	Present	present				
Nitrate →	Negative	positive				
Blood →	present					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : 28/7/26 Blood C/S →

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
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Patient S

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 28/7	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4				
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1	.				
Gender	Male	2					
	Female	1	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					
	Outpatient Area	1	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		✓				
	Call device within reach		✓				
	Wheels Locked		✓				
	Room free of clutter		✓				
	Adequate lighting		✓				
	Wheel chair support		X				
	Other Intervention(s) Specify		X				
	Nurse's Name:		Sneha				
	Signature:		Sy				
	Date:		29/7				
	Time:		8Am				

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BRADEN 'Q' SCALE

				Date : / Time :	28/7 8AM	28/7 10AM	8/7 2pm	
Mobility	[illegible] immobile: Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	3	4	4	
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	
				TOTAL SCORE	27	28	28	
				Evaluator's Name	[illegible]	[illegible]	[illegible]	

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

Docu. No. : RCH /FRM / CLINICAL / 119

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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16-12-2024 1 Y 7 M 12 D (F)
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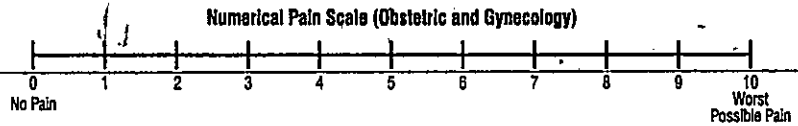
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
28/7	4Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sn
28/7	8Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sneha
28/7	10AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☐ Yes ☑ No	NA	[signature]
28/7	2pm			☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
28/7/26	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent- continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 27/1			DAY-2 28/1			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0				
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			NA	NA	NA	NA				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA	NA	NA	NA				
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			NA	NA	NA	NA				
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			NA	NA	NA	NA				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			NA	NA	NA	NA				
		Signature of the Nurse				Sneha	MJ	Al	CH				

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

Signature of Shift In Charge :
Signature : Sneha Name : Sneha

Signature of Ward In Charge :
Signature : Balarani Name : Balarani

Patient Sticker

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
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CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital

BirthRight by Rainbow

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby KAATHYAYANI GOUD**	**Age :**	**1 Y 7 M 12 D**
IP No:	**IP26-00006971**	**Sex:**	**Female**
Consultant:	**Dr. SINDHURA MUNUKUNTLA**	**Ward/Bed No:**	**GF -EMERGENCY/ER01**

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

Patient, be deemed advisable or necessary.

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

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

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

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

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature: .....)
3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name: Madikuda Omprakash Goud

Relationship: father

Date: 28/07/26 Time: 23 30 PM

Witness Name:

Witness Signature:

Patient Address:

13-6-458/12 GAYATRI NAGAR
KARWAN HYDERABAD Karwan
Hyderabad Telangana INDIA 500006

HNH-00006120 IP26-00006971
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BILLING POLICY

- Billing cycle: - With effective from 1st January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 12 PM, room rent will be charge for half day extra & post 6 pm, it will be charge for full day. Less than 24 hours stay will be considered as one day.
- As per the GOI guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Card 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

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

...NT OR PATIENT ATTENDANT
(TPA / INSURANCE / AROGYA BHADRATA / CORPORATE)

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 28/12/26

I have attended the financial counseling desk / billing desk and understood the approximate expected costs of treatment. I clearly understand and agree that the hospital would bill as per its (hospital's) existing terms and conditions or MOU with my TPA/ Insurance Company/ Corporate /Arogya Bhadrata Scheme.

In case my claim is rejected by my TPA / Insurance Company / Corporate / Arogya Bhadrata Scheme at any point of time, i.e. before admission, during admission, during discharge or post discharge when hospital bill claim is submitted, I promise to settle the claim with the hospital. I understand and agree that there are certain TPA / Insurance Company / Corporate / Arogya Bhadrata Scheme Non - Coverable billing components which have to be paid totally by me like the following.

Registration charges, Insurance Processing fee, Medical Record Charges, MLC Charges, Tax Collected at Source (TCS), Dietician Consultation, F&B charges. Luxury Tax, Pharmacy and Consumables Non Medicals like Gloves, Masks, Draw Sheets, Diapers / Koochees, Intrafix, Q-Syte, Venflon, Sterilium, Splint, Gowns, Stockings, etc, Investigations like HIV, HbsAg, Pre Anesthesia Checkup (PAC), all Genetic Investigations, Double Occupancy, Vaccination Charges etc, instruments like Laparoscope, Thoracoscope, Harmonic, N-Seal, Morcellator, Cobulator, C-Arm, Micro Debrider, Medetronic Drill, Mann Mann Drill, Neuro Microscope, Neuro Endoscope, Endoscope etc, Maternity related like, Anti D, Muhurtham, Welt Baby Charges, Epidural, Entonox, Tubectomy etc. Any other facility used / treatment / investigation done which is not related to the present ailment is not covered.

I promise to clear my medical / non-medical bill dues during admission on daily basis or as and when applicable or whenever called for.

Mandatory Documents to be submitted for cashless process (Corporate Policy)

1. Employee ID Card.
2. Employee Government ID Proof (PAN /Aadhaar Card / Passport / Voter ID).
3. Patient TPA / Insurance Health Card or E-Card.
4. Patient Government ID Proof (PAN /Aadhaar Card / Passport / Voter ID / Birth Certificate)

Mandatory Documents to be submitted for cashless process (Individual Policy)

1. Proposer's ID Proof.
2. Patient TPA / Insurance Health Card or E-Card.
3. Patient Government ID Proof (PAN / Aadhaar Card / Passport / Voter ID / Birth Certificate)

Name of the Patient: Kaathyayani Goud Date & Time of Admission: 2:30 AM

Name of the Parent / Guardian: Nadikuda Omprakash Mobile Number: 8897894567

Parent Aadhaar Card Number: .....

Signature & Relation Father

Docu. No. : RCHBH /FRM / GENERAL / 476

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD (F)
16-12-2024 1 Y 7 M 12 D
Dr. SINDHURA MUNUKUNTLA

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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UNDERTAKING OF INSURANCE PATIENT/ CREDIT PATIENT FOR ADVANCE PAYMENT

To

The Management,

Rainbow Children's Hospital, Himayat Nagar,

Hyderabad - 500029.

Sub:- **Undertaking of Insurance Patient for Advance Payment.**

I Mr./Mrs./Ms. Omprakash Goud (Father/ Mother/ Other _____) of Master/ Baby/ Baby of/ Mrs. / Ms. Kaathyayani Goud was bought to your hospital on Emergency basis on 28/7/26 at 2:30 PM approximate charges deposit details were explained by the front office executive on duty.

As I have cashless insurance so I have to pay 10K as a caution deposit at the time of admission. If there will be any difference amount after getting the approval I'll pay that amount at the time discharge.

Thanking You

Signature

Name:- Nandikuda Omprakash Goud

Ph. No.:- 8897894567

HNH-00006120 IP26-00006971
Baby KAATHYAYANI GOUD
16-12-2024 1 Y 7 M 12 D (F)
Dr. SINDHURA MUNUKUNTLA

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Rainbow® Children's Hospital
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Your Right to a Safe Delivery

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 28/7/26 Time: 8:45 am

Weight: 9.2 kg Centile: < 5th

Height: — Centile: —

Inference: Underweight child.

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

Diet Recommendations: Soft and bland diet with high fiber diet with liquids

Re-Assesment: NO Junk, Spicy food.

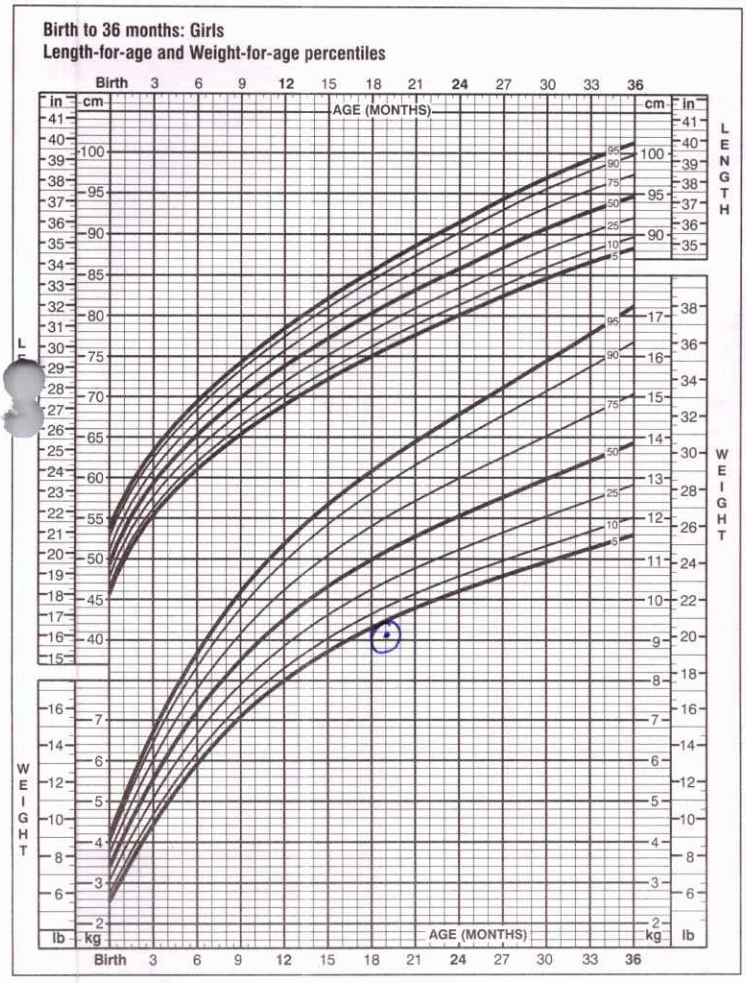
Food Allergies: NO Veg/Non-veg Non Veg

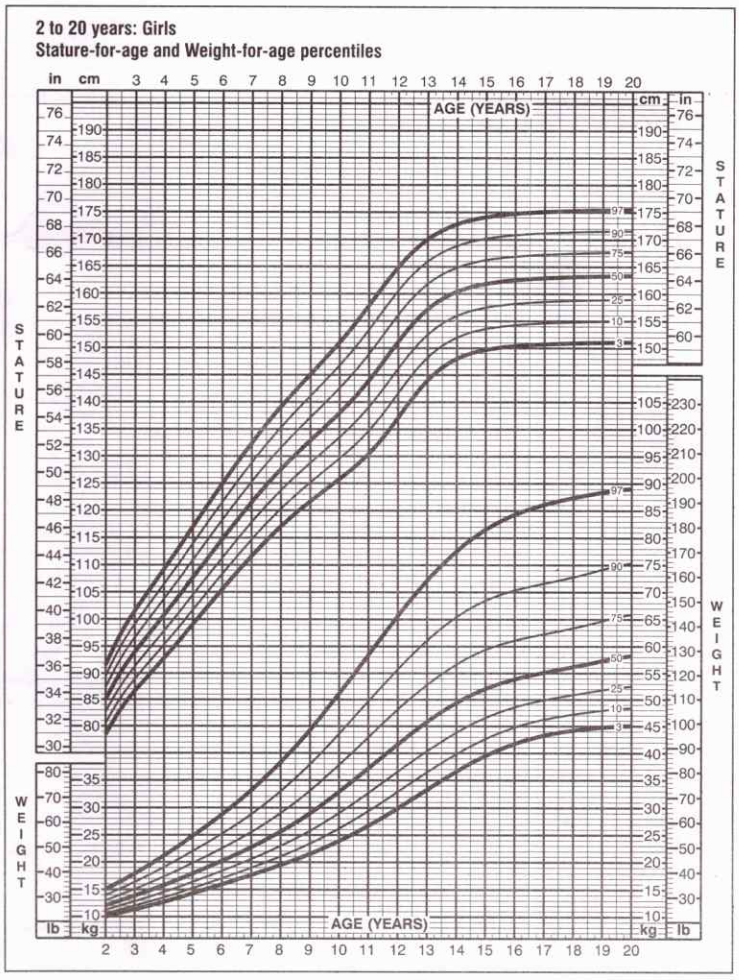
Diagnosis: Acute GE ? dehy ? UTI

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature:

GROWTH CHART (GIRLS)





Dietician's Name Syeda Sabiya Zaheen

Dietician's Signature Sabiya