

VIH-00206415 IP-00060594
Master MANI KARTHIK CHAUHAN
16-05-2013 13 Y 1 M 20 D (M)
Dr. SANDHYA VADDADI

ACTIVITY RECORD FOR BILLING

Name: -----

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

Date of Admission : 6/2 Time : ----- Date of Discharge : ----- Time : -----

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<u>6/2</u>	<u>11.45PM</u>	<u>ER</u>	<u>Picu</u>	<u>Me</u>
<u>7/7/26</u>	<u>11.30AM</u>	<u>Picu</u>	<u>106 1st floor</u>	<u>N-18</u>

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	<u>Dr. Pranjakta</u>	<u>9/2/26</u>	<u>3059473</u>	<u>[Signature]</u>
2.	<u>Dr. Pranjakta</u>	<u>10/2/26</u>	<u>3059793</u>	
3.	<u>Cross checked by [Signature] 10/2/26</u>			
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS			
Date	Investigations	Order No.	Sign
6/7/26	CBP	26022620	Bunker
	Cross check by Bx. NBS 7/7/26 @ 11 AM		
8/7	ANA Panel	26022701	[Signature]
8/7	CBP	2602270	[Signature]
	Cross checked by Coapang 9/7 @ 2 AM		
9/7/26	RBS @ 6:30 AM 147 mg/dl	26022883	[Signature]
	CBP	26022884	[Signature]
9/7	(HBSAG), Anti HIV, Anti HCV, Creatinine, urea, Ccr, Cg, DCT, Retic count, S/G, CFT, CRP, GSR,	26022926	[Signature]
	CUG, spot protein, Creatinine Ratio	26022940	[Signature]
	Cross checked by Coapang 9/7 @ 11 PM		
10/7	CBP	26023007	[Signature]
	Cross checked by [Signature] 10/7/26		

Date _____

Investigations

Order No.

Sign

61712

CBP

26022620

Brinkley

Cross check by Ro. N.B 7/7/26 @ 11 AM

~~2/2~~

ANA Panel

2602270



8/2

CRP

26022750

7

gross chiled by cooling at 20°C

9/3/26

RBS @ 6:30 AM 147 mg/dl

260 27883



CBP

26029884



9/7

(HB3AG), $\text{Al}^{\circ} \text{H}16$, $\text{Al}^{\circ} \text{ECV}$ &

creatinine, urea, ccr, Cr

৯৬০২২৭২৬

[Signature]

OCF, Retention, S/G, CFF

CAP, ESR

CUG, stop protein

Coabine Radio

126022940



Gross checked by Company 9/7 @ 11PM

10/7

CBP

26023007



Cross checked by ~~for~~ 10/17/26

[illegible]

Name of Equipment

Connecting Time

Disconnecting Time

Order No.

Signature

61712.6

Invasive monitor

11:45 PM

3098246

309

6/11/26

Invasive monitor

11:45 PM

7/7/26
11:30 AM

3098246

Bunli

7/126

Infusion pump

1:20 Am

HH28
11.30 AM

3098252

Bucks

Cross Check by Bo. ~~Alt~~ HTHZ @ 11 AM

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
6/2	IV Displacement	1	3098256	Acc
7/12/6	IVIG Infusion	1	3098258	Bul
<i>cash check by BO. N/A 7/17/26 @ 11AM</i>				

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
	<i>0/2/26 @ 11AM</i>		

Name	Master MANI KARTHIK CHAUHAN	UHID	VIH-00206415
Father/Guardian	Mr SRINIVAS	Age/Gender	13 Y 1 M 24 D/Male
Address	HNO-14-64/2/4/2 SAI NAGAR , NAGARAM ROAD, Husnabad, Karimnagar, Telangana, INDIA, 505467		
IP No	IP-00060594	Admission Date	06-07-2026
Ref Doctor	Dr J Shravan Kumar	Discharge Date	10-07-2026

DISCHARGE SUMMARY

Consultant: Dr. SANDHYA VADDADI,
MBBS, MD Paediatrics, FNB PEDIATRIC HAEMATO-ONCOLOGY
CONSULTANT PEDIATRIC HAEMATO-ONCOLOGIST
& PEDIATRICIAN
71664

**Diagnosis: Known case of Immune thrombocytopenic purpura
Systemic lupus erythematosus**

History: Master MANI KARTHIK CHAUHAN is a 13 Y 1 M 24 D boy presented with history of petechial rashes over the upper limb & neck region since 2 days. For the above complaints, he was investigated and treated at referral center, but in view of persistence of symptoms, he was referred to Rainbow Children's Hospital for further management.

Past History: Child was admitted at Rainbow Children's Hospital on 30.06.2026 with similar episode for which 20 grams IVlg transfusion was given.

Outside Investigations : Complete blood picture done on 06.07.2026 showed hemoglobin 14.9 gm%, white blood cells count of 13,700 cells/cumm, platelet count of 10,000 cells/cumm.

Name	Master MANI KARTHIK CHAUHAN	UHID	VIH-00206415
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Examination: He was afebrile, maintaining saturations at room air. Heart rate- 110/min, blood pressure - 110/70 mmHg and respiratory rate 20/min. Petechial rashes present over upper limb and neck. On auscultation of chest, air entry was bilaterally equal with normal heart sounds and there was no murmur. Abdomen was soft without organomegaly. Bowel sounds were heard. Neurologically, he was conscious and oriented. Examination of other systems including spine was normal.

Weight on admission : 79 kgs.

Investigations: Enclosed.

Management: He was admitted in the ward and total IVIG of 20 grams infusion under close monitoring was given. No adverse reactions were noted. Child was continued on oral steroids.

His complete blood picture showed hemoglobin 13.6 gm%, white blood cells count of 14,620 cells/cumm, platelet count of 18,000 cells/cumm. Anti DS-DNA was reactive.

Consultation with Dr. Prajakta Dekate, Consultant Rheumatologist, was done who advised further investigations to evaluate SLE and further course of treatment decided on review of reports.

His vitals were regularly monitored. His symptoms gradually reduced. Repeat hemogram done on 10.07.2026 - showed 13.7 gm%, white blood cells count of 17,860 cells/cumm, platelet count of 50,000 cells/cumm. He remained hemodynamically stable during the hospital stay and is being discharged with the following advice.

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

Name	Master MANI KARTHIK CHAUHAN	UHID	VIH-00206415
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Advice:

1. Diet as advised.
2. Tablet Omnacortil (20mg)

8 AM	8 PM	Duration
2 tablets	1&1/2 tablet	10-07-26 to 14-07-26
2 tablets	1 tablet	15-07-26 to 19-07-26
2 tablets	1/2 tablet	20-07-26 to 24-07-26
2 tablets	----	25-07-26 to 29-07-26

3. Tablet Pantoprazole (40mg) 1 tablet, 12th hourly (1/2 hour before food) for 20 days.
4. Vitamin-D sachet 60K IU, 1 sachet weekly once for 10 weeks.
5. Tablet HCQ (200mg) 1 tablet once daily till further advice.
6. Tablet Folvite (5mg) 1 tablet once daily till further advice.
7. Tablet Shelcal (500mg) 1 tablet once daily for 2 months.
8. Injection Romiplastim (250mcg) subcutaneously on 14.07.2026 & 21.07.2026.
9. Kindly consult Dr. Sandhya Vaddadi, Consultant Pediatric Hemato-oncologist & Pediatrician, after 7 days in OPD with prior appointment (This consultation will be charged).
10. Kindly consult Dr. Prajakta Dekate, Consultant Rheumatologist, after one week in OPD with ultrasound abdomen, chest x-ray PA view, Ophthalmologist screening, T3, T4, TSH, lipid profile, TB screening report with prior appointment (This consultation will be charged).

In case of Fever:

Tablet Paracetamol (625mg), 1 tablet (if needed) if fever more than 99.6°F (maximum 4-6 hourly).

Name	Master MANI KARTHIK CHAUHAN	UHID	VIH-00206415
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In case of any bleeding manifestations:

Tablet Tranexamic Acid (500mg) 1 tablet, maximum 8th hourly.

To take appointment for OPD consultation at Rainbow Children's Hospital, just dial one number 1800-2122 (between 8 a.m. to 8 p.m.) (or) log on to www.rainbowhospitals.in

Now booking appointments is much easy, download Rainbow Application for Free from Google play store.

In Case of Emergency Contact 040-42462200, Extn: 2010 (or) 7337357870 for increasing breathing difficulty, dullness or high fever.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctorin the language that I understand and I have understood the same.

Name :

Signature :

Relationship with patient :

This summary has been explained by :

Summary prepared by: Dr. Shivam

DEO : MD Younus Pasha



Registrar/Resident/C.M.O

Dr. SANDHYA VADDADI,

MBBS, MD Paediatrics, FNB PEDIATRIC HAEMATO-ONCOLOGY

CONSULTANT PEDIATRIC HAEMATO-ONCOLOGIST

& PEDIATRICIAN

71664

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040-42462200, Ext 2000,2001,2002,



INSURANCE COPY

PatientName : Master MANI KARTHIK CHAUHAN Inpatient No. : IP-00060594
Age/Gender : 13 Y 1 M 20 D/ Male Admit Date : 06-07-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :06-07-2026 22:50	
HEMOGLOBIN (Colorimetry)	13.6	g/dL	13 - 16
RBC COUNT (DC detection method)	4.46	10 ¹² /L	L 4.5 - 5.3
PCV/HCT (Calculated)	37.1	VOL%	36 - 51
MCV (Calculated)	83.3	fL	79 - 98
MCH (Calculated)	30.4	pg/cells	25 - 35
MCHC (Calculated)	36.5	g/dL	H 32 - 36
RDW-CV (Calculated)	13.5	%	11.5 - 14
PLATELET COUNT (DC Detection Method)	20	10 ⁹ /L	L 150 - 450
MPV (Calculated)	10.2	fL	H 6.5 - 10
WBC COUNT (DC Detection Method)	14.62	10 ⁹ /L	H 4.5 - 13
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	70	%	H 34 - 64
LYMPHOCYTES (Microscopy, Leishman stain)	20	%	L 25 - 45
MONOCYTES (Microscopy, Leishman stain)	09	%	4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	01	%	1 - 4

PERIPHERAL SMEAR (Microscopy, Leishman stain) RBC - NORMOCYTIC / NORMOCHROMIC
WBC - LEUCOCYTOSIS
PLATELETS - SEVERE THROMBOCYTOPENIA

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

COMPLETE BLOOD PICTURE (Specimen : BLOOD)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :08-07-2026 06:13	
HEMOGLOBIN (Colorimetry)	14.1	g/dL	13 - 16
RBC COUNT (DC detection method)	4.65	10 ¹² /L	4.5 - 5.3
PCV/HCT (Calculated)	39.1	VOL%	36 - 51
MCV (Calculated)	84.2	fL	79 - 98
MCH (Calculated)	30.3	pg/cells	25 - 35
MCHC (Calculated)	36.0	g/dL	32 - 36
RDW-CV (Calculated)	13.6	%	11.5 - 14
PLATELET COUNT (DC Detection Method)	25	10 ⁹ /L	L 150 - 450
MPV (Calculated)	9.8	fL	6.5 - 10
WBC COUNT (DC Detection Method)	14.47	10 ⁹ /L	H 4.5 - 13

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040-42462200, Ext 2000,2001,2002,

PatientName	: Master MANI KARTHIK CHAUHAN	Inpatient No.	: IP-00060594
Age/Gender	: 13 Y 1 M 22 D/ Male	Admit Date	: 06-07-2026
Ward/Bed	: N 0 GF-EMERGENCY/ ER 101	Discharge Date	:
Investigation	Result	Unit	Biological Reference Interval
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	77	%	H 34 - 64
LYMPHOCYTES (Microscopy, Leishman stain)	13	%	L 25 - 45
MONOCYTES (Microscopy, Leishman stain)	09	%	4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	01	%	1 - 4
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC - NORMOCYTIC / NORMOCHROMIC WBC - LEUCOCYTOSIS PLATELETS - REDUCED		

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

COMPLETE BLOOD PICTURE (Specimen : BLOOD)**TEST RESULT STATUS : REPORT AUTHORISED**

Order Date :09-07-2026 06:30

HEMOGLOBIN (Colorimetry)	14.0	g/dL	13 - 16
RBC COUNT (DC detection method)	4.60	10 ¹² /L	4.5 - 5.3
PCV/HCT (Calculated)	38.7	VOL%	36 - 51
MCV (Calculated)	84.2	fL	79 - 98
MCH (Calculated)	30.5	pg/cells	25 - 35
MCHC (Calculated)	36.2	g/dL	H 32 - 36
RDW-CV (Calculated)	13.4	%	11.5 - 14
PLATELET COUNT (DC Detection Method)	30	10 ⁹ /L	L 150 - 450
MPV (Calculated)	10.5	fL	H 6.5 - 10
WBC COUNT (DC Detection Method)	16.78	10 ⁹ /L	H 4.5 - 13

Differential Count

NEUTROPHILS (Microscopy, Leishman stain)	84	%	H 34 - 64
LYMPHOCYTES (Microscopy, Leishman stain)	12	%	L 25 - 45
MONOCYTES (Microscopy, Leishman stain)	03	%	L 4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	01	%	1 - 4

PERIPHERAL SMEAR (Microscopy, Leishman stain) RBC - NORMOCYTIC / NORMOCHROMIC
WBC - NEUTROPHILIC LEUCOCYTOSIS
PLATELETS -REDUCED

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356



MC-7373

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PatientName : Master MANI KARTHIK CHAUHAN
Age/Gender : 13 Y 1 M 23 D/ Male
Ward/Bed : N 0 GF-EMERGENCY/ ER 101

Inpatient No. : IP-00060594
Admit Date : 06-07-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
C3 QUANTITATION (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED Order Date :09-07-2026 12:31	
C3 QUANTITATION (Rate Nephelometry)	81.6	mg/dl	L 90 - 180

Dr. RANGANATHAN N. IYER, MD FRCPATH DNB DPB

CONSULTANT MICROBIOLOGIST, Reg No : 64038

Investigation	Result	Unit	Biological Reference Interval
C4 QUANTITATION (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED Order Date :09-07-2026 12:31	
C4 QUANTITATION (Rate Nephelometry)	11.9	mg/dl	10 - 40

Dr. RANGANATHAN N. IYER, MD FRCPATH DNB DPB

CONSULTANT MICROBIOLOGIST, Reg No : 64038

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040-42462200, Ext 2000,2001,2002,

PatientName	: Master MANI KARTHIK CHAUHAN	Inpatient No.	: IP-00060594
Age/Gender	: 13 Y 1 M 23 D/ Male	Admit Date	: 06-07-2026
Ward/Bed	: N 0 GF-EMERGENCY/ ER 101	Discharge Date	:
Investigation	Result	Unit	Biological Reference Interval
C REACTIVE PROTEIN (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :09-07-2026 12:31	
CRP (Immunoturbidimetry)	1.0	mg/L	<10



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

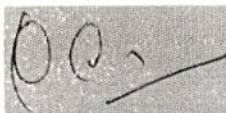
investigation	Result	Unit	Biological Reference Interval
CREATININE (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :09-07-2026 12:31	
CREATININE (Enzymatic)	0.8	mg/dl	0.5 - 1.1



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
DIRECT COOMBS TEST (Specimen : BLOOD)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :09-07-2026 12:31	
DIRECT COOMBS TEST	POSITIVE {2+}		



Dr. SUREKHA DEVI ALLANKI, SENIOR CONSULTANT, TRANSFUSION

CONSULTANT,

Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :09-07-2026 12:31	
SODIUM (Direct ISE)	136	mmol/L	134 - 143
POTASSIUM (Direct ISE)	4.2	mmol/L	3.7 - 5
CHLORIDE (Direct ISE)	97	mmol/L	L 98 - 108



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
ERYTHROCYTE SEDIMENTATION RATE (Specimen : BLOOD)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :09-07-2026 12:31	

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PatientName : Master MANI KARTHIK CHAUHAN
Age/Gender : 13 Y 1 M 23 D/ Male
Ward/Bed : N 0 GF-EMERGENCY/ ER 101

Inpatient No. : IP-00060594
Admit Date : 06-07-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
ESR	10	mm/1st hour	UPTO 10

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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LIVER FUNCTION TEST (Specimen : SERUM)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :09-07-2026 12:31

TOTAL BILIRUBIN (Azobilirubin)	0.8	mg/dl	<1.3
CONJUGATED BILIRUBIN (Spectrophotometric)	0.1	mg/dl	<0.3
UNCONJUGATED BILIRUBIN (Spectrophotometric)	0.7	mg/dl	<1.1
SGOT (AST) (Kinetic with P5P)	25	U/L	15 - 40
SGPT (ALT) (Kinetic with P5P)	51	U/L	H 10 - 45
ALKALINE PHOSPHATASE (pNPP/AMP buffer)	217	U/L	130 - 525
PROTEIN (Biuret method)	6.9	g/dL	6.3 - 8.6
ALBUMIN (Bromocresol Green)	3.4	g/dL	L 3.7 - 5.6
GLOBULIN (Calculated)	3.5	g/dL	1.6 - 3.5
A/G RATIO (Calculated)	0.9		L 1.4 - 3.4

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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RETICULOCYTE COUNT (Specimen : BLOOD)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :09-07-2026 12:31

RETICULOCYTE COUNT (Microscopy, New methylene blue stain)	1.5	%	1 - 3
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Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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UREA (Specimen : SERUM)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :09-07-2026 12:31

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PatientName	: Master MANI KARTHIK CHAUHAN	Inpatient No.	: IP-00060594
Age/Gender	: 13 Y 1 M 23 D/ Male	Admit Date	: 06-07-2026
Ward/Bed	: N 0 GF-EMERGENCY/ ER 101	Discharge Date	:

Investigation	Result	Unit	Biological Reference Interval
UREA (Kinetic, Urease)	46.3	mg/dl	H 15 - 38

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
COMPLETE URINE EXAMINATION (Specimen : URINE)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :09-07-2026 15:25

PHYSICAL

COLOUR (Visual Examination)	PALE YELLOW	
APPEARANCE (Gross Examination)	CLEAR	
pH (Double pH indicator)	7.0	5 - 8.5
SPECIFIC GRAVITY (PKA Reaction)	1.020	1.005 - 1.030
SEDIMENT (Gross Examination)	NIL	NIL

CHEMICAL

PROTEIN (Protein error of pH indicator)	NIL	NIL
GLUCOSE (GOD POD method)	NIL	NIL
KETONE BODIES (Acetoacetic acid reaction)	NEGATIVE	NEGATIVE

BILE SALTS (Hay's Sulfur Test)	ABSENT	ABSENT
BILE PIGMENTS (Diazo reaction)	ABSENT	ABSENT
NITRITE (Reflectance Photometry)	NEGATIVE	NEGATIVE
BLOOD (Peroxidase reaction)	ABSENT	ABSENT
LEUCOCYTES (Esterase reaction)	NEGATIVE	NEGATIVE

MICROSCOPY

PUS CELLS	4-5	HPF	L 0 - 5
EPITHELIAL CELLS	3-5	HPF	L 0 - 5
RBCS.	NIL	HPF	0 - 2

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
SPOT PROTEIN / CREATIINE RATIO (Specimen : URINE)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :09-07-2026 15:25

SPOT PROTEIN	0.6	mg/dl	
SPOT CREATININE (Modified Jaffe Kinetic)	34.8	mg/dl	24 - 392

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040-42462200, Ext 2000,2001,2002,



PatientName	: Master MANI KARTHIK CHAUHAN	Inpatient No.	: IP-00060594
Age/Gender	: 13 Y 1 M 23 D/ Male	Admit Date	: 06-07-2026
Ward/Bed	: N 0 GF-EMERGENCY/ ER 101	Discharge Date	:
Investigation	Result	Unit	Biological Reference Interval
RATIO	0.02		

Res Liche

Dr. RASHIDA MAHREEN, MBBS,MD

CONSULTANT BIOCHEMIST, Reg No : HMC13081

Investigation	Result	Unit	Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :10-07-2026 06:32	
HEMOGLOBIN (Colorimetry)	13.7	g/dL	13 - 16
RBC COUNT (DC detection method)	4.43	10 ¹² /L	L 4.5 - 5.3
PCV/HCT (Calculated)	37.5	VOL%	36 - 51
MCV (Calculated)	84.5	fL	79 - 98
MCH (Calculated)	31.0	pg/cells	25 - 35
MCHC (Calculated)	36.6	g/dL	H 32 - 36
RDW-CV (Calculated)	13.7	%	11.5 - 14
PLATELET COUNT (DC Detection Method)	50	10 ⁹ /L	L 150 - 450
MPV (Calculated)	10.8	fL	H 6.5 - 10
WBC COUNT (DC Detection Method)	17.86	10 ⁹ /L	H 4.5 - 13
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	80	%	H 34 - 64
LYMPHOCYTES (Microscopy, Leishman stain)	15	%	L 25 - 45
MONOCYTES (Microscopy, Leishman stain)	04	%	4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	01	%	1 - 4
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC - NORMOCYTIC / NORMOCHROMIC WBC - NEUTROPHILIC LEUCOCYTOSIS PLATELETS - SEVERE THROMBOCYTOPENIA		

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Laboratory Report

Patient Name	Master MANI KARTHIK CHAUHAN	Patient Ph. No	8008767701
Age	13 Y 1 M 23 D	Requisition No	VI26022701
Gender	Male	Collected on	07-07-2026 05:18 PM
IP / Bill No.	IP-00060594	Received on	07-07-2026 05:25 PM
UHID No.	VIH-00206415	Reported on	
Ref Doctor	Dr. SANDHYA VADDADI	Ward/Bed No	N 1F-FIRST FLOOR / SR 106

ANTI NUCLEAR ANTIBODY PANEL (Specimen :SERUM)

RESULT

TEST RESULT STATUS : REPORT ENTERED

Anti Nuclear Antibody (ANA) Profile - Immuno Blot.

nRNP/Sm *	Negative
Sm *	Negative
SS-A *	Negative
Ro-52 *	Negative
SS-B *	Negative
Scl-70 *	Negative
PM – SCL (PW) *	Negative
Jo-1 *	Negative
CENP B *	Negative
PCNA *	Negative
Nucleosomes *	Negative
Histones *	Negative
Ribosomal-P Protein (PO) *	Negative
AMA-M2(M2) *	Negative

ANA WITH TITRE

1 : 40 Result : Reactive.

Laboratory Report

Patient Name	Master MANI KARTHIK CHAUHAN	Patient Ph. No	8008767701
Age	13 Y 1 M 23 D	Requisition No	VI26022701
Gender	Male	Collected on	07-07-2026 05:18 PM
IP / Bill No.	IP-00060594	Received on	07-07-2026 05:25 PM
UHID No.	VIH-00206415	Reported on	
Ref Doctor	Dr. SANDHYA VADDADI	Ward/Bed No	N 1F-FIRST FLOOR / SR 106

Grading / Intensity : (1+)

1 : 80 Result : Reactive.

Grading / Intensity : (1+)

1 : 160 Result : Reactive.

Grading / Intensity : (1+)

Pattern : Coarse speckled)

Methodology :IFA

ANTI DS-DNA.

1 : 10 Result : Reactive.

1 : 20 Result : Reactive.

Methodology : IFA.

Kindly await for further diution.

..... End of the Report



MC-7373

Laboratory Report

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BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name	Master MANI KARTHIK CHAUHAN	Patient Ph. No	8008767701
Age	13 Y 1 M 23 D	Requisition No	VI26022926
Gender	Male	Collected on	09-07-2026 12:51 PM
IP / Bill No.	IP-00060594	Received on	09-07-2026 01:09 PM
UHID No.	VIH-00206415	Reported on	09-07-2026 07:21 PM
Ref Doctor	Dr. SANDHYA VADDADI	Ward/Bed No	N 1F-FIRST FLOOR / SR 106

ANTI HCV ANTIBODIES (Specimen :SERUM)

RESULT

TEST RESULT STATUS : REPORT AUTHORISED

REPORT : NON REACTIVE

METHODOLOGY: ENHANCED CHEMILUMINESCENCE

Dr. VIJENDRA KAWLE MD DNS

(CONSULTANT MICROBIOLOGIST)

Dr. RANGANATHAN N. IYER MD FRCPATH DNB DPB

(CONSULTANT MICROBIOLOGIST)

..... End of the Report



Laboratory Report

Patient Name	Master MANI KARTHIK CHAUHAN	Patient Ph. No	8008767701
Age	13 Y 1 M 23 D	Requisition No	VI26022926
Gender	Male	Collected on	09-07-2026 12:51 PM
IP / Bill No.	IP-00060594	Received on	09-07-2026 01:09 PM
UHID No.	VIH-00206415	Reported on	09-07-2026 07:21 PM
Ref Doctor	Dr. SANDHYA VADDADI	Ward/Bed No	N 1F-FIRST FLOOR / SR 106

ANTI HIV (I & II) ANTIBODIES (Specimen :SERUM)

RESULT

TEST RESULT STATUS : REPORT AUTHORISED

REPORT : NON REACTIVE
METHODOLOGY: ENHANCED CHEMILUMINISCENCE

Dr. VIJENDRA KAWLE MD DNS
(CONSULTANT MICROBIOLOGIST)

Dr. RANGANATHAN N. IYER MD FRCPATH DNB DPB
(CONSULTANT MICROBIOLOGIST)

..... End of the Report



MC-7373

Laboratory Report

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Patient Name	Master MANI KARTHIK CHAUHAN	Patient Ph. No	8008767701
Age	13 Y 1 M 23 D	Requisition No	VI26022926
Gender	Male	Collected on	09-07-2026 12:51 PM
IP / Bill No.	IP-00060594	Received on	09-07-2026 01:09 PM
UHID No.	VIH-00206415	Reported on	09-07-2026 07:21 PM
Ref Doctor	Dr. SANDHYA VADDADI	Ward/Bed No	N 1F-FIRST FLOOR / SR 106

HEPATITIS B SURFACE ANTIGEN (HBSAG) (Specimen :SERUM)**RESULT**

TEST RESULT STATUS : REPORT AUTHORISED

RESULT - NOT DETECTED

METHODOLOGY: ENHANCED CHEMILUMINISCENCE

Dr. VIJENDRA KAWLE MD DNS
(CONSULTANT MICROBIOLOGIST)

Dr. RANGANATHAN N. IYER MD FRCPATH DNB DPB
(CONSULTANT MICROBIOLOGIST)

..... End of the Report

DEFICIENCY CHECK LIST OF MEDICAL CASE SHEET

VIH-00206415

IP-00060594

Master MANI KARTHIK CHAUHAN

16-05-2013

13 Y 1 M 23 D

(M)

Patient Name

Dr. SANDHYA VADDADI

IP.No:

Ward:



DOA:

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Sl.No	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	1	—	—	
2	Discharge Summary	3	—	—	
3	Nursing Initial assessment form	1	—	—	
4	Patient Transfer Forms	2	—	—	
5	In-patient Medical Record	3	—	—	
6	Doctors Progress Sheets	4	—	—	
7	Nurses Progress notes	6	—	—	
8	Consultation Sheets	2	—	—	
9	General Consent for Treatment	1	—	—	
10	Consent for Surgery				
	Consent for Blood Transfusion	1	—	—	
12	Consent for Chemotherapy				
13	Consent for High Risk				
14	Consent for Restraint				
15	DAMA Consent				
16	Consent for Special Procedure				
17	Consent for Radiological Investigations				
18	Consent for HIV Test				
19	Anaesthesia consent form				
20	Anaesthesia notes (Pre Anaesthesia & Post)				
21	Pre Operative checklist				
22	Surgical safety Checklist				
23	Operation Theatre notes				
24	Nurses Clinical Presentation				
25	TPR & BP chart	4	—	—	
26	Intake and Output chart (fluid Chart)	2	—	—	
	Drug Chart (Regular prescription)	84	—	—	
28	Daily Investigation sheet				
29	Investigation Values (Result Sheet)	1	—	—	
30	Nebulization Chart				
31	Diabetic chart				
32	Nutritional Review chart	1	—	—	
33	MLC form (in case of MLC)				
34	Patient Education Form				
	Numbly - dumpy	3	—	—	
	pain Assessment	2	—	—	
	Thrombophlebitis	2	—	—	
	Braden Score	2	—	—	
	Dthers	12	—	—	
	Total No. of Pages	57			

Noted by
Beromika
10/7/26
@12pm

Signature and Date :

ERROR LOG

LOCATION: - NICU / PICU / HDU / OT / GENERAL WARD

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

ADMISSION SHEET

Registration Details :



Admission No : IP-00060594

Admit Date : 06-Jul-2026

Admit Time : 10:30 PM UHID : VIH-00206415

Patient Details :

Patient Name : Master MANI KARTHIK CHAUHAN

Age : 13 Y 1 M 20 D

Guardian : Mr SRINIVAS

DOB : 16-05-2013

Gender : Male

Religion :

Occupation :

Martial Status :

Address (H) : HNO-14-64/2/4/2 SAI NAGAR , NAGARAM
ROAD Husnabad Karimnagar Telangana
INDIA 505467

Phone No : 8008767701

E-mail : NA@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD

Bed No : ER 101

Ward Name : N 0 GF-EMERGENCY

Room No : ER 101

Admission Type : First Visit

Contact Details :

Name : Mr SRINIVAS

Relationship : Father

Contact Address : HNO-14-64/2/4/2 SAI NAGAR , NAGARAM
ROAD Husnabad Karimnagar Telangana INDIA
505467

Phone No : 8008767701 / 9848850442



Signature

Doctor Details :

Doctor Name : Dr. SANDHYA VADDADI

Specialisation : HEMATO ONCOLOGY

Referral Doctor : Dr J Shravan Kumar

Phone No : 8125251010

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : ICICI LOMBARD GENERAL
INSURANCE CO LTD

Patient Name : Mast. MANI KARTHIK CHAUHAN UHID : VIH-00206415 IPD : IP-00060594 Gender : Male
Age : 13 Y 1 M 20 D

VIH-00206415 IP-00060594
Master MANI KARTHIK CHAUHAN
16-05-2013 13 Y 1 M 20 D (M)
Dr. SANDHYA VADDADI



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wt - 79 kg

EMERGENCY TRIAGE FORM

Patient's Name : Mst. Mani Karthik Age : 13y Gender : ☒ Male ☐ Female

Date : 6/7/26 Time of Arrival : 2.10.00 PM

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

Source of Information : ☒ Parents ☐ Others (Specify) :

Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 97.3° PR: 110b/m BP: 107/66 (70) RR: 20b/m SpO₂: 97%

Chief Complaints: Rash since 7 days

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 of Parent / Guardian : N. Vijaya Lakshmi
Triage Completion Time : 10.05 PM

Communicable Disease Triage Screening

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

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

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

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☒ No
If yes, State Location:
- Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☒ No

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

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

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

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Bro. Sangay

Signature of Triage Nurse : Sangay

Date & Time : 6/7/26 @ 10.05 PM

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

Patient Name : Mast. MANI KARTHIK CHAUHAN UHID : VIH-00206415 IPD : IP-00060594 Gender : Male
Age : 13 Y 1 M 20 D

VIH-00206415 IP-00060594
Master MANI KARTHIK CHAUHAN
16-05-2013 13 Y 1 M 20 D (M)
Dr. SANDHYA VADDADI



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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 6/7/26 Time of arrival : 10.06 PM
Chief Complaints : Rash since 7 days RBS :
Height : Weight : 79 kg BMI : Head Circumference (<2 years)
Allergies : ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other :
If yes, identify :
Pain Screening : ☒ Yes ☐ No If Yes, Pain Score : 0 Pain Tool Used : ☐ N Pass ☐ FLACC ☒ Wong Baker
☐ Character ☐ Location ☐ Frequency ☐ Duration

RISK FOR FALL:

- ☐ If patient is < 6 years
tick below fall risk intervention directly
☒ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months

☐ Yes ☒ No

Ambulatory Aids:

- Wheelchair
- Uses furniture for support

☐ Yes ☐ No
☐ Yes ☐ No

Gait/Transferring:

- Bedrest / immobile
- Weak
- Impaired

☐ Yes ☐ No
☐ Yes ☐ No
☐ 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?) 1 sister

Time of Initial assessment completed by ER Nurse : 10.10 PM

Patient Name : Mast. MANI KARTHIK CHAUHAN UHID : VIH-00206415 IPD : IP-00060594 Gender : Male
Age : 13 Y 1 M 20 D

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

Time	Nursing Notes
10 PM	Pt came TO ER.
10:05 PM	Pt vitals checked and Records done.
10:10 PM	Dr. Shirkar seen the Pt advice Admission.
10:15 PM	Pt admission process done.
10:20 PM	Pt IV placement done and sample sent to lab.
11:45 PM	Pt shifted ER TO PICU

Samples collected by: Sis. mogisha
Samples sent by:

Time: 10.20 PM

Time: 10.25 PM

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: 110b/m BP: 110/70mmHg CFT: 234 RR: 20b/m SPO ₂ : 98% GCS: 15 Temperature: 97.3 F. Pain Score: 0 Repeat RBS (if applicable):	Shift - out from ER to: <u>PICU</u> Time of Shift - out: <u>11:45 PM</u> Handover given to: <u>Sis. Jagaraj</u> (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

Dr cannulation

Name of the Nurse : Bmo Sanyal

Signature of the Nurse : Sanyal

Date & Time : 6/7/22 @ 11:45 PM

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00206415 IP-00060594 Master MANI KARTHIK CHAUHAN 18-05-2013 13 Y 1 M 20 D (M) Dr. SANDHYA VADDADI 		Date & Time of Admission 6/7/26 @ 10:30 PM	Date & Time of Transfer Order 7/7/26 @ 11:35 am
		Transfer Ordered by Dr. Sandhya Vaddadi	Reason for Transfer Stabak WIG Transfer
From Unit P1EU	To Unit 1st floor - 106		Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File 43	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.	D - w 10 ml		2
2.	D8y 5%		3
3.	2%		2
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Dr. Nandishwar		Name of Person Ordered Transfer Dr. Sandhya Vaddadi	
Patient & Clinical Records Received by : Dr. Beenuka			
Date & Time of Patient Received : 7/7/26 @ 11:40 AM			

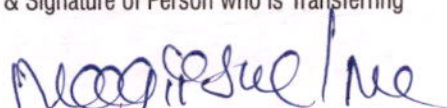
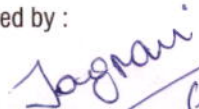
If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00206415 IP-00060594 Master MANI KARTHIK CHAUHAN 16-05-2013 13 Y 1 M 20 D (M) Dr. SANDHYA VADDADI 		Date & Time of Admission 6/7/26 @ 10.30 PM	Date & Time of Transfer Order 6/7/26 @ 11.45 PM
		Transfer Ordered by Dr. Vishwas	Reason for Transfer Admission
From Unit ER	To Unit	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 28	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 Dr. Vishwas	
Patient & Clinical Records Received by :  6/7/26 @ 11.45 PM			
Date & Time of Patient Received :			

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



Nursing General Admission Assessment Form For Pediatrics

Diagnosis: JTP

Arrival Time: 11:35 AM Mode of Arrival: By walking Admitting From: ☐ ER ☐ OPD ☐ Direct PICU

Allergy / Adverse Reaction Nil Body Weight: 79 Kg

Height: 110 cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>Nil Yes</u>	<u>Nil</u>	<u>Yes</u>

Family History: Nil

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: 79 kg Length: Head Circumference (< 2 years):

Temp: 98.6°C HR: 100 b/m RR: 20 b/m BP: 110/70

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

Fall Risk Assessment: ☒ Yes ☐ No Score: 9 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 27) (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 Nil Location Nil Frequency Nil Duration Nil

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: h.u.l (Date/Time): h.u.l

Social History: Lives With Parents

Siblings in household ☒ Yes ☐ No (if yes How Many?) one sister

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 Parents

Nurse's Name: Beamanika Date: 07/07/26 Time: 11:50AM

Bea
Signature



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PEDIATRIC IN-PATIENT MEDICAL RECORD

VIH-00206415 IP-00060594
Master MANI KARTHIK CHAUHAN
16-05-2013 13 Y 1 M 20 D (M)
Dr. SANDHYA VADDADI



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

C/o petechial rash over upper limbs, neck region
since 2 days.

History of present illness :

Child brought by parents with
c/o petechial rash over hands and neck region
since yesterday

↓

consulted out of hospital
investigated

↓

6/7/26

HB: 14.9

WBC - 5.14

WBC - 13,200

H⁺ - 83%

L⁺ - 13%

plt - 10,000 (normal)

↓

admitted in ward for further mgt

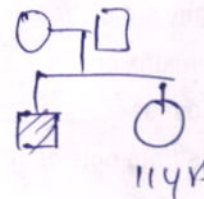


Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Term/ 2.7kg/ 100cm/ no NICU stays.



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Appropriate for age in all 4 domains.

Immunization History :

Received up to date



paediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____
Weight (kgs)) 9.9 kg (Centile _____)

On Examination :

Temperature : _____ Pulse Rate : _____ B.P. _____ SPO2 _____

Resp. rate and type of breathing : _____

Rash Detected rash (+) - Over upper limbs, neck region

Lymphadenopathy _____

Oedema : (-)

Allergies (if any): (-)

Respiratory System :

Inspection (any s/o distress) : (N)

Air entry & breath sounds : B/LAE (+)

Any added sounds : NO.

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

Cardiovascular System :

Inspection of precordium : (N)

Heart Sounds : S1S2 (+)

Any murmur : NO.

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : _____

Per Abdomen :

Inspection : (N)

Palpation : Soft

Auscultation : R/L (+)

Spine : (N) External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score :

11/15

Cranial Nerves :

intact

Motor System:

Nutriton :

Tone:

Power

Co-ordinator :

Posture :

Involuntary Movements :

NO

Reflexes : +

DTR +2

Superficials: +

Plantars

flexor

Sensory System : +

Bladder / Bowel :

NO incontinence

Clinical Summary & Diagnostic:

ITP.



Continuing Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

To prevent complications

Desired goals of the treatment: _____

To treat the underlying cause

Planned Labs:

CBD,

1 extra plain @
for ANA Profile

Planned Management

→ IV fluid
→ IVIG 200mg over 10 hrs

→ PMS ROPAMIDOL (TM)
→ 200 mg

→ Continue oral
amoxicillin.

noted by. Dr. Sanyal

Signature of the Doctor: _____

Name of the Doctor: _____

Date & Time: 06/7/16 - 11 PM

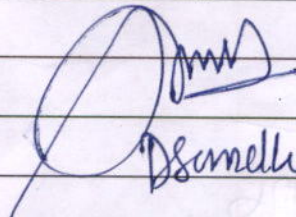
Signature of the Consultant: _____

Name of the Consultant: _____

Date & Time: _____

Date & Time	Progress Notes	Doctor's Order
7/26: 2:00PM	<u>9/B Resident:</u> <u>IC/O ITP.</u> o/e, Baby alert, Euthermic, Pink Sple.	
	obs - 812 ⊕ Ps - BAE ⊕, P/A - soft.	<u>Adv.</u> <u>- CR</u>
	→ <u>D/L (AD)</u> after Sandra's morn round.	(Dnherm)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7 4pm	S/b Mamellyc Δ-Acute ITP partial/all sustained response to steroid no net bleed by Comprostim gun <u>6/7/26</u>	CBMA-② Br → ②P → G Omnacortil → Tranexa → Rpt CBP T/m → face-ANA profile → Rheumatology R/v  Dr. Sandhya Vaddadi
		Noted by manisha 7/7/26 @8pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26 7 am	slb aslanellu Acute ITP no acute issues no acet bleed taking feeds	Autoimmune disorder (P) → ct Ommacoxil → ct suppressive care → trace ANA profile → RPT CRP RBS } T/m
8/7/26 12:45 PM	CD/WD Dr. Prajatta (Rheumat) Adx -DO ESR, CRP, UFT, RFT, C3, C4, DCP, Rebio, HIV, HbsAg, HCV Immunoglobulin profile - Hold Uric Protein creatinine Rebio	T/m (Hold) after ANA report



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/2026 8:20 AM	Acute <u>IIP</u> ? Autoimmune → No fresh lesions (bleeding sites) No fevers orally tolerating	C/D/W / updated to Dr. Sandhya G.
		<u>Plan</u>
(Anti dsDNA +ve) - verbal	CVS - S/S CNS - NAD RS - SLAET PA - soft.	- Dr. Prajakta VC @ Physical - Tree official (ANA report) Continue - T. Prednisolone. - Inj. fronex - Send all the samples as per Dr. Prajakta CRP, ESR, LFT, C3, C4, RFT. PCT, Re Hct HIV, Hbs Ag, HCV, <u>UP</u> creatin Immunoglob
	noted by Beenuka 9/7/26 @ 2pm	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7 4pm	Sb Rosamellyc Acute RP (2° to autoimmune disorder) ANA +ve dsDNA +ve in w. no acute crown CRP RFT PKM	→ to start tapering steroid from 70mg (P) Tab OMNACORTIL (20 mg) 1 — 1 — 1 10/7 to 14/7 1 — 1 15/7 to 19/7 1 — nil (20/7 to 23/7) 1/2 — nil (24/7 to 27/7) CT G-Pan D CT T. Sheldal. Inj POMIPLOSTIM 250 mcg SC on 14/7 & 21/7 Rpt CBP Tm → Dic if well for Propalete RLV Tm
	Noted by Benrika 10/7/28 @12pm	

Date & Time	Progress Notes	Doctor's Order
10/7/26	D/w Mr. Sandhya mem Performed Reports.	
Mitchwaia	1) Adv plan d/c today 2) Mr. prajaktha mem R/u Tod	
		noted by Beronika 10/7/26 @12pm



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CONSULTATION FORM

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Doctor Name : Dr. Prajakta Dekate.
Date : 9/07/26. Hour :

Hospital :

Type of Referral : ☐ Emergency (within one hr.)

Referred for : ☐ Opinion ☐ Co-Management

☐ Urgent (within 6 hrs.) ☐ Non Urgent (within 24 hrs.)

☐ Transfer of care

Date : Time : By :

Reason for Consultant : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

M.D.

Report of Findings and Recommendations :

13yr / Boy.

Presented with Patechire over right arm & trunk 2 weeks back, ↓
pHs upto 11,000, diagnosed with acute ITP, received 1V1G 20gm.

Started with Tab. Omnacort 40mg/day.

Two days later presented with similar symptoms,

Admitted on 6th July, pHs ↓ → received 1V1G 20gm.

No h/o recurrent fever / Photosensitivity / ~~oral ulcers~~
other rashes / complaints.

also significant Past 1 family history.

h/o recurrent oral ulcers.

Consultant :

Name : Signature : Date & Time :

NOTE : If more space is required use another consultation sheet as continuation

SE: Afebrile, Vital stable.
Patachiae over right arm ext.
Mtx + No swelling/tenderness.
Slio + NAD.

Imp: ? Evolving
SLE associated
Acute IRP.

Imve CBC: Hb + 14 | TMC + 16,780 | Plt + 21,000. (L) (post 10/19)
LDH + 341.

ANA: 1:640 homogeneous pattern + (reactive).
Antibds DNA +ve.

Advice

- ①. LFT, KFT.
- ②. Urine R/M, Urine Spot Protein Creatinine Ratio.
- ③. Complement C3, C4.
- ④. Immunoglobulin Profile.
- ⑤. HBs Ag, HCV, HIV.
- ⑥. ENA Profile
- ⑦. DCT.

Plan: Continue same tx at present.
To be reviewed with reports clin.

Signature



CONSULTATION FORM

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Doctor Name : Dr. Prajakta Dekte
Date : 10/07/26 Hour :

Hospital :

Type of Referral : ☐ Emergency (within one hr.)

Referred for : ☐ Opinion ☐ Co-Management

☐ Urgent (within 6 hrs.) ☐ Non Urgent (within 24 hrs.)

☐ Transfer of care

Date : Time : By :

Reason for Consultant : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

M.D.

Report of Findings and Recommendations :

Cx of Acute ITP.

ANA 1:640 homogeneous pattern +ve.

Antids DNA 1:20 +ve.

C3 marginally low.

DCt 2+ve.

Thrombocytopenia (Severe) ± Platelets. No active bleeding.

No Proteinuria.

ENA Profile.

Imps Lupus associated Immune Thrombocytopenia ±
Positive DCt ± low Complement ± Positive Antids DNA.
No proteinuria.

Consultant :

Name : Signature : Date & Time :

NOTE : If more space is required use another consultation sheet as continuation

Please to start Hcp, & MMF.

Rx,
- Tab. Hcg 2000mg once a day.
- Tab. Foliate 5mg once a day.

$\left. \begin{array}{l} \text{shops} \times 1 \text{ ————— } 1 \\ \uparrow \\ \text{shops} \times 1/2 \text{ ————— } 1/2 \\ \uparrow \\ \text{shops} \times 1/2 \text{ ————— } 0 \end{array} \right\} - \text{Lab. MMT (PCA) strong}$

- Lab. Amusement along (2) $\frac{1}{2} \times 5 \text{ days}$

$$\begin{array}{ccc} \text{shops} \times 0 & \xrightarrow{\quad} & (2) \\ \uparrow & & \\ \text{shops} \times r_1 & \xrightarrow{\quad} & (2) \\ \uparrow & & \\ \text{shops} \times (1) & \xrightarrow{\quad} & (2) \end{array}$$

- Classified assets 60,000/0 once a week towards
- 1st. Pan 40 Bd Br-

- 1 lb. Pan 40 Bd Br.

- Lab. Pan 40 SD BR-
Huang TB screening.
Chest xray PA view.
USG abdomen.
T3, T4, TSH
lipid profile.

D! Jyoti



NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA: 6/7/26	Diagnosis: I+P	Surgery / Procedures: —		
	Allergies: Nil		Post OP Day: —		
	Date:	6/7/26			
	Area	CR	PIU	PIU	
	Shift Time	pick (N)	Alert	Night	
	Diet:	Normal		Normal Diet	
	Ventilation (RA, NP, NIV, VENTI)	RA		RA	
INVASIVE LINES	1.			IUCV	
	2.	—			
	3.				
	4.				
ASSESSMENT	Infusions / Transfusions	—		IUIg 20gm/over 10hrs 20ml/hr	
	PU Prophylaxis	—		—	
	DVT Prophylaxis	—		—	
	Vitals	BP	107/68 (75/44)		105/67 (73)
		PR	116b/min		84b/min
		RR	20b/min		20b/min
		SpO ₂	98%		99%
		Temp	97.3°f		98.6°f
	Pain Score	0		0	
	LOC (Alert, Conscious, Confusion, Unconscious)	conscious		Alert	
	Skin Integrity (Intact / Bedsore / Any other condition)	Intact		Intact	
	Restraints If any	Physical	—		—
		Chemical	—		—
Fall Risk (Vulnerable Y/N) if yes score	9		9		
(Ambulation, walking, moving with assistance, bed ridden)	—		walking		
ADL (Dependent / Non-Dependent)	Dependent		Dependent		
Critical Lab Test / Values (If any)	—		—		

Note: RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Date:	6/7/24		
	Area	Shift Time		DTCK 8pm-8Am
	Ordered / Planned	CBS ANA Profile INJ IVIG 20gm over 10 days		→ IVIG 20gm Infusion → allow orally → Continue Same
	Due	All @ DM		ANA Profile
	Reports Pending	—		ANA Profile
	Referrals (If any)	—		—
	Remarks (Special Interventions like, Drainage tube flushing etc.)	—		—
Handed Over By Name :		Bro. Sayag		Sr. Jagrani
Signature :		SL		Jag
Date:		6/7/26		7/7/26
Time:		11.45pm		8Am
Taken Over By Name :		Sr. Jagrani		Bro. N.S.
Signature :		Jag		Bro. N.S.
Date:		6/7/26		7/7/26
Time:		11:45pm		8AM



3

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA:	6/7/26	Diagnosis:		Surgery / Procedures:	
	Allergies:	No			Post OP Day:	
	Date:	7/7/26				
	Area		PICU			
	Shift Time		8AM-2PM			
	Diet:		ORAL			
INVASIVE LINES	Ventilation (RA, NP, NIV, VENTI)		1x cannula			
	1.					
	2.					
	3.					
	4.					
ASSESSMENT	Infusions / Transfusions		1x IV			
	PU Prophylaxis		-			
	DVT Prophylaxis		-			
	Vitals	BP		105/75/60		
		PR		102		
		RR		20b/min		
		SpO ₂		98%		
		Temp		98.6-F		
	Pain Score		0			
	LOC (Alert, Conscious, Confusion, Unconscious)		Alert			
	Skin Integrity (Intact / Bedsores / Any other condition)		Intact			
	Restrains If any	Physical		-		
		Chemical		-		
	Fall Risk (Vulnerable Y/N) if yes score		-			
(Ambulation, walking, moving with assistance, bed ridden)		walking				
ADL (Dependent / Non-Dependent)		Dependent				
Critical Lab Test / Values (If any)		-				

Note: RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Date:	7/7/26		
	Area	Shift Time PICU 8AM - 2PM		
	Ordered / Planned			
	Due			
	Reports Pending			
	Referrals (If any)			
	Remarks (Special Interventions like, Drainage tube flushing etc.)			
	Handed Over By Name :	B. N. S.		
Signature :	B. N. S.			
Date:	7/7/26			
Time:	8			
Taken Over By Name :				
Signature :				
Date:				
Time:				



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: ITP (Immune Thrombocytopenia)	Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify: Nil					
	Surgery / Procedure: Nil	Post OP Day: Nil					
BACKGROUND	Date	7/7/26	7/7/26	7/7/26	8/7/26	8/7/26	9/7/26
	Shift	Morning	E	N	M	E	N
	Medical Condition (Any special condition to be noted):	Nil	Nil	Nil	SI	Nil	Nil
	Diet:	Soft diet	S-diet	Soft diet	S-diet	S-diet	S-diet
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA	RA	RA
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp: 98.6°F	Temp: 98.6°F	Temp: 98.3°F	Temp: 98.6°F	Temp: 98.6°F	Temp: 98.6°F
	Res:	19 blm	22 blm	24 blm	25 blm	22 blm	24 blm
	SpO ₂ :	99%	100%	98%	98%	99%	100%
	Pulse:	90 blm	100 blm	103 blm	101 blm	95 blm	96 blm
	BP:	112/72	114/78 (63)	120/80 (60)	126/80 (60)	112/72	108/60 (60)
	LOC:	conscious	conscious	conscious	conscious	conscious	conscious
	Fall Risk Score:	8	8	8	8	8	8
	Pain Score:	0	0	0	0	0	0
	Skin Integrity	Intact	Intact	Intact	Intact	Intact	Intact
	Safety Needs:	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
	Physiotherapy:	Nil	Nil	Nil	SI	Nil	Nil
	Others Specify:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Special Diet:	S-diet	S-diet	S-diet	S-diet	S-diet	Nil	
Recommendations	Critical Lab Test / Values:	Nil	Nil	Nil	Nil	Nil	Nil
	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):	dependent	dependent	dependent	depende	depende	Dependent
	Post Operative Procedure Special Orders:	Nil	Nil	Nil	Nil	Nil	Nil
	Handed Over By Name :	Beenuka	manisha	manisha	Andu	Beenuka	Subham
Signature / ID :	2018727	2018727	2018727	2018727	2018727	2018727	
Date:	7/7/26	7/7/26	8/7/26	8/7/26	8/7/26	9/7/26	
Time:	@ 2pm	@ 8pm	@ 2pm	@ 2pm	@ 8pm	@ 8 AM	
Taken Over By Name :	manisha	manisha	Andu	Beenuka	Subham	Beenuka	
Signature / ID :	2018727	2018727	2018727	2018727	2018727	2018727	
Date:	7/7/26	7/7/26	8/7/26	8/7/26	8/7/26	9/7/26	
Time:	@ 2pm	@ 8pm	@ 8 AM	@ 2pm	8pm	@ 8 AM	



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: ITP		Any Infection: ☐ Yes ☒ No ☐ Not Known		
	Surgery / Procedure: Nil		If Yes Specify: Nil		
		Post OP Day: Nil			
BACKGROUND	Date	9/7	9/7	9/7/26	10/7
	Shift	M	E	Night	M
	Medical Condition (Any special condition to be noted):	Nil	Nil	Nil	Nil
	Diet:	S.diet	S.diet	S.diet	S.diet
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp: 98.6	Temp: 98.6°F	Temp: 97.4°F	Temp: 98.6°F
	Res:	20b/m	25b/m	20b/m	20b/m
	SpO ₂ :	98%	99%	98%	99%
	Pulse:	106b/m	103b/m	98b/m	100b/m
	BP:	96/66/74	100/78	117/80	112/72
	LOC:	conscious	conscious	conscious	conscious
	Fall Risk Score:	8	8	8	8
	Pain Score:	0	0	0	0
	Skin Integrity	Intact	Intact	Intact	Intact
	Safety Needs:	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
	Physiotherapy:	Nil	Nil	Nil	Nil
Others Specify:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Special Diet:	Nil	Nil	S.diet	Nil	
Critical Lab Test / Values:	Nil	Nil	Nil	Nil	
Other Special Orders / Medications:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
PU Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
DVT Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ADL (Dependent / Non Dependent):	dependent	dependent	dependent	dependent	
Post Operative Procedure Special Orders:		Nil	Nil	Nil	Nil
Handed Over By Name :		Benonika	Anitha	Subham	Benonika
Signature / ID :		[Signature]	[Signature]	[Signature]	[Signature]
Date:		9/7/26	9/7/26	10/7	10/7
Time:		@ 2pm	@ 8pm	@ 8am	@ 12pm
Taken Over By Name :		Anitha	Subham	Benonika	
Signature / ID :		[Signature]	[Signature]	[Signature]	
Date:		9/7/26	9/7/26	10/7	
Time:		@ 2pm	@ 8pm	@ 8am	

VIH-00206415 IP-00060594
 Master MANI KARTHIK CHAUHAN
 18-05-2013 13 Y 1 M 20 D (M)
 Dr. SANDHYA VADDADI



NURSING CARE RECORD

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Date: 7/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night		=> Assessment => vitals => I/O chart		=> Assessed the child condition => monitor vitals are recorded => I/O chart 6 hourly	=> Inj IV 10 20mg over 10th hour	PT is stable	 7/7/26 08:00

VIH-00206415 IP-00060594
Master MANI KARTHIK CHAUHAN
16-05-2013 13 Y 1 M 21 D (M)
Dr. SANDHYA VADDADI



NURSING CARE RECORD

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BirthRight
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Your Right to a Safe Delivery

Date: 7/7/26

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... <u>Nil</u> | | | | |

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM	Assessed the Baby condition - vital check - monitor vitals	8AM	Assessed the Baby condition - Baby oral allowed - I to check 6hr hr	- Baby stable - vitals normal	input out put good	<u>Manisha</u> <u>7/7/26</u>
Afternoon	3pm	- maintain good nutritional status		- oral intake is good	- provided soft diet	- patient is stable	manisha 7/7/26 @8pm
Night	8pm	→ prevent infection	10:30 pm	→ Administered medications as per drug chart	→ to prevent infection	→ patient is stable	CI manisha



NURSING CARE RECORD

Date: 8/7/26

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	9:00	Maintain aseptic technique	9:00	- maintained aseptic technique	- prevent from Infection	- patient is stable	Indu G2pm 8/7/26
	1:00	- Ensure safety	1:00	- side rails kept up	- prevent from falls risk	- no fresh complaints	
Afternoon	3:00	- provide Comfortable position	3:00	- provided Comfortable position	- to reduce discomfort	- patient is stable	Bennika 9:30pm 8/7/26
	7:00	- Ensure safety	7:00	- side rails kept up	- prevent from falls risk		
Night	9pm	Maintain Aseptic technique ensure safety	11pm	Maintain Aseptic technique side rails kept up	prevent from infection. prevent from fall Risk.	patient is stable No fresh complaints	Subha 9/7 8Am



NURSING CARE RECORD

Date: 9/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning		→ Maintain good Nutritional status		→ To Oral Intake is good	→ To oral Provided soft diet	Patient is stable	Beronika 9/7 @ 2pm
Afternoon	5pm	→ Maintain personal Hygiene		→ Educate about personal hygiene	→ To prevent infection	→ patient is stable	Amitha 9/7 @ 8pm
	5pm	→ Ensure Safety		→ To side rails kept up	→ To prevent falls risk		
Night	9pm	→ Maintain good nutritional status	9pm	→ oral intake is good	→ To Provided by soft diet	→ patient is stable	Subh 10/7 @ 8am

NURSING CARE RECORD

Date: 10/7/20

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning				Discharge note Doctor came for rounds and advice for discharge.			
Afternoon							
Night							

Noted by
 Beomika
 10/7
 @12pm

Patient Sticker

NURSING CARE RECORD



Date:

Goals

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

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

WELL'S CRITERIA FOR ASSESSING DVT

NOTE: Assign a score of 1 if 'YES' in parameter 1 to 9 and Assign a score of -2 if 'YES' in parameter No 10

S.No	Assessment Criteria	Score	Date: 27/7	Date: 28/7	Date: 9/07	Date: 10/07	Date:	Date:
			Time: 6 AM	Time: 6 AM	Time: 6 AM	Time: 6 AM	Time:	Time:
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	1	0	0	0	0		
2	Bedridden recently >3 days or major surgery within four weeks	1	0	0	0	0		
3	Calf swelling >3cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	1	0	0	0	0		
4	Collateral (non varicose) superficial veins present (Assess for both legs)	1	0	0	0	0		
5	Entire leg swollen (Assess for both legs)	1	0	0	0	0		
6	Localized tenderness along the deep venous system (Assess for both legs)	1	0	0	0	0		
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	1	0	0	0	0		
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	1	0	0	0	0		
9	Previously documented DVT (Assess for both legs)	1	0	0	0	0		
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs)/ Co-morbidity like ESLD /Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction.	-2	0	0	0	0		
Total Score			0	0	0	0		
Signature of the Nurse			Subh	Subh	Subh	Subh		

Intervention: Nil

High Risk = >2 Score

Moderate Risk = 1-2 Score

Low Risk = <1 Score

Note : Daily assessment shall be carried out once every 24 hours and documented

VIH-00206415 IP-00060594
Master MANI KARTHIK CHAUHAN
16-05-2013 13 Y 1 M 20 D (M)
Dr. SANDHYA VADDADI



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

BirthRight
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Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			6/7	7/7	7/7	7/7	7/7
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1	1	1	1	1	1
Gender	Male	2	2	2	2	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	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	1	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	2	2	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	1	1	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	1	1	1	1
Total			9	9	9	9	9

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 up		✓	✓	✓	✓	✓
Other Intervention(s) Specify		✓	✓	✓	✓	✓
Nurse's Name:		Nurse	Nurse	Nurse	Nurse	Nurse
Signature:		Nurse	Nurse	Nurse	Nurse	Nurse
Date:		6/7	7/7	7/7	7/7	7/7
Time:		10:30 pm	6 am	12 pm	2	3 pm



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	7/7	8/8	8/8	8/8	9/7
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1	1	1	1	1	1
Gender	Male	2	2	2	2	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	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	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	2	2	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	1	1	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	2	1		1	
	Other Medications / None	1	2	1	1	1	1
Total			8	8	8	8	8

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		✓	✓	✓	✓	✓
Other Intervention(s) Specify		✓	✓	✓	✓	✓
Nurse's Name:		Mani	Ardu	Ardu	Sukhan	Banika
Signature:		Mani	Ardu	Ardu	Sukhan	Banika
Date:		7/7	8/8	8/8	9/7	9/7
Time:		11pm	9am	5pm	11pm	2pm

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					
	13 years old and above	1	1	1	1		
Gender	Male	2	2	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	1	1		
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	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	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	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	1	1		
Total			8	8	8		

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		✗	✗	✗		
Other Intervention(s) Specify		✓	✓	✓		
Nurse's Name:		Amelia	Subh	Ravish		
Signature:		Amelia	Subh	Ravish		
Date:		9/7	10/7	10/7		
Time:		8pm	4am	7am		

CHECKLIST FOR THROMBOPHLEBITIS

Ref. No. F / HW / QC / THROM / 07

Ward :

Date : Time :

S.No	SITE OBSERVATION	STAGE / ACTION	SCORE	I.P. No. 812						REMARKS
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 cord pyrexia	Advanced Stage of thrombophlebitis / Initiate treatment Re site Cannula	5							

NOTE : Phlebitis > 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 :

VIH-00206415 IP-00060594
Master MANI KARTHIK CHAUHAN
16-05-2013 13 Y 1 M 22 D (M)
Dr. SANDHYA VADDADI



CHECKLIST FOR THROMBOPHLEBITIS

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S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 8/7			9/7 DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0				
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			-	-	-	-				
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 cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-	-	-				
Signature of the Nurse						<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>				

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 : *[Signature]* Name : *Kalpana*

Signature of Ward In Charge :

Signature : *[Signature]* Name : *Elizabeth*



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/2	10:30 PM	-	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	-	Me
21/2/26	6 PM	-	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	-	Jeej
11/2/26	2 PM	0	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	-	NK
7/7/26	3 PM	0	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	manisha
7/7	11 PM	0	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Q
8/2	10 AM	0	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Indu
8/2	6 PM	0	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Indu
8/7	11 PM	0	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Gay
9/7/26	2 PM	0	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Bmit
9/7/26	8 PM	0	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Aneel

Re-assessment Frequency:

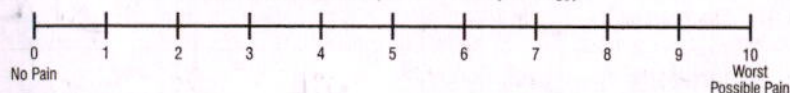
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

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

Numerical Pain Scale (Obstetric and Gynecology)



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, SaO₂	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

Wong - Baker (Pediatrics) Above 7 Years





2

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
10/7/26	11pm	0	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Subham
				☐ 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		
				☐ 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:

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



BRADEN 'Q' SCALE

					Date :	6/11/13	7/12/13	3/17/13	7/17/13
					Time :	7:45 AM	2 PM	3 PM	11 PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	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	4	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	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	4	
FRICITION-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	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 of 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	4	4	3	
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	4	
TOTAL SCORE					28	28	28	22	
Evaluator's Name					ML	Jag	ML	ML	

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

BRADEN 'Q' SCALE

				Date :	8/2	8/2		
				Time :	10:00	6pm		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4		
'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	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		
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		
FRICITION-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		
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	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		
TOTAL SCORE					20	24		
Evaluator's Name					2	6		

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

GENERAL CONSENT FOR TREATMENT

Patient Name: Master MANI KARTHIK CHAUHAN

Age : 13 Y 1 M 20 D

IP No: IP-00060594

Sex: Male

Consultant: Dr. SANDHYA VADDADI

Ward/Bed No: N 0 GF-EMERGENCY/ER 101

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

Patient, be deemed advisable or necessary.

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

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

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

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

Note:

1 We do not allow use of medication brought from outside by the patient.

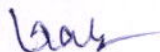
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.

(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:

L. Krishan Nayak

Relationship:

Grand Father

Date:

06-07-26

Time:

10-40 PM

Witness Name:



Witness Signature:



Patient Address:

HNO-14-64/2/4/2 SAI NAGAR ,
NAGARAM ROAD Husnabad
Karimnagar Telangana INDIA 505467

CONSENT FOR ADMISSION IN PEDIATRIC INTENSIVE CARE UNIT



Name: Mr. Kartvik Chauhan Age: 13y Gender: Male ☒ Female ☐
UHID.No: 206415 Date: 6/7/26
I Mr. Vijaya Laxmi S/O, D/o, W/o, Dr. D. Srinivas hereby
declare that our patient Master/Baby who is related to me as daughter
is getting admitted in the Pediatric Intensive Care Unit of Rainbow Children's Hospital on

The doctors have explained to me in a language understood by me that my child has following health related issues :

ITP

The doctors have clearly explained to me that my patient Master / Baby during his / her stay in the Pediatric Intensive Care Unit may undergo various medical and surgical procedures like airway management, mechanical ventilation, Central Line Insertion, Peripherally Inserted Central Catheter Line and arterial line placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is implied that I give consent for various invasive procedure to save the life of my child.

I understand that a sick child in Pediatric Intensive Care Unit has life threatening medical conditions.

I understand that when a child is sick in the Pediatric Intensive Care Unit with multiple medical and surgical procedures performed upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of infections, bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child Master / Baby : Kartvik Chauhan in the Pediatric Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved from various procedures, high risk medications and infections in the Pediatric Intensive Care Unit and treat him/her with all necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant :

Signature: Mr. Vijaya Laxmi
Name: Mr. Vijaya Laxmi
Relationship with Patient: Mother & son
Date & Time: 6/7/2026 11:30pm

Witness :

Signature:
Name:
Date & Time:

Doctor (who is taking the consent) :

Signature: Dr. Biswaja
Name: Dr. Biswaja
Date & Time: 6/7/26 @ 11:30pm

**పిల్లల ఇంటెన్సివ్ కేర్ యూనిట్ లో
అడ్మిషన్ కొరకు సమ్మతి**

రోగి పేరు వయస్సు లింగం ☐ పు ☐ స్త్రీ

యు.హెచ్.ఐ.డి
నేను s/o. d/o. w/o.

..... అనే బాలుడు / బాలిక యొక్క చికిత్స మేరకు రెయిన్ బో పిల్లల అనుపత్తి లోని పిల్లల ఇంటెన్సివ్ కేర్ యూనిట్
తేదీ నాడు పూర్తి సమ్మతితో చేర్చితిని.

మా బాలుడి / బాలిక లో ఈ కింద తెలిపిన ఆరోగ్య సమస్యల గురించి విద్య నిపుణుడు నాకు అర్థమగు భాషలో వివరించితిరి.

రెయిన్ బో చిల్డ్రన్స్ హాస్పిటల్ లోని పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో చేరించి బిడ్డకు ఆరోగ్య సంబంధిత సమస్యలు ఉన్నాయని వైద్యులు నాకు అర్థమయ్యే భాషలో వివరించారు. రోగి పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో ఉన్న సమయంలో అతను వివిధ వైద్య మరియు శస్త్ర చికిత్సలకు లోనవుతారని వైద్యులు నాకు స్పష్టంగా వివరించారు. ఎయిర్ వే మేనేజ్ మెంట్, మెకానికల్ వెంటిలేషన్, బొడ్డు ధమని కాథెటర్, బొడ్డు సిర మరియు ధమనుల కాథెటర్ వంటి. పెరిఫెరల్ ఇన్ఫర్మ్ చేయబడిన సెంట్రల్ కాథెటర్ లైన్ మరియు ఆర్థోరీ లైన్ ప్లేస్ మెంట్స్, ఛాతీ డ్రైయిన్ లేదా పెరిటోనియల్ డ్రైయిన్ ఇన్ఫర్మ్ మొదలైనవి.

అటువంటి ప్రక్రియలు చేస్తున్నప్పుడు నాకు సమాచారం ఇవ్వబడుతుందని మరియు దీనికి ప్రత్యేక సమ్మతి ఉంటుందని వైద్యులు నాకు చెప్పారు. ఏదేమైనప్పటికీ, ఏదైనా ప్రాణాంతక అత్యవసర పరిస్థితుల్లో సమాచారం తీసుకోవడానికి సమయం లేకపోతే నా బిడ్డ ప్రాణాన్ని కాపాడేందుకు ఇతర వైద్య ప్రక్రియలకు నేను సమ్మతి ఇస్తున్నాను.

పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో అనారోగ్యంతో ఉన్న పిల్లవాడికి ప్రాణాంతకమైన వైద్య పరిస్థితులు ఉన్నాయని అర్థం చేసుకోవడమైనది.

ఒక బిడ్డ అనారోగ్యంతో పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో ఉన్నప్పుడు అతని/ఆమెపై నిర్వహించబడు అనేక వైద్య మరియు శస్త్రచికిత్సా విధానాలతో ఈ అధిక ప్రమాదకరమైన విధానాల వల్ల సంభవించు నష్టాలు మరియు అధిక ప్రమాదకరమైన మందుల రూపంలో అంటువ్యాధులు, రక్తస్రావం, శ్వాసపరమైన, చర్మం మరియు ఇతర కణజాల నష్టం మొదలైనవి కలగవచ్చు డాక్టర్లు నాకు బాగా అర్థమయ్యే భాషలో వివరించారు.

మా బాలుడు / బాలిక ను ఇంటెన్సివ్ కేర్ యూనిట్ (పి.ఐ.సి.యు) లో చేర్చుకొని అవసరమయ్యే వైద్యం చేయుటకు నేను వైద్య బృందానికి నా సమ్మతి ధృవపరుస్తున్నాను.

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

CONSENT FOR BLOOD TRANSFUSION

Name: MAST. MANIKARTHIK CHAUHAN Age: 134r Gender: Male ☒ Female ☐
 UHID.No : 206415 Date: 7/7/26

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 IVIG

I N. Vijaya Laxmi 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

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the 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): Signature: <u>N. Vijaya Laxmi</u> Name: <u>N. Vijaya Laxmi</u> Date & Time: <u>7/7/2026 at 12 Am</u>	Doctor (Who is talking the consent) Signature: <u>[Signature]</u> Name: <u>[Signature]</u> Date & Time: <u>7/7/26 at 12 Am</u>
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Witness
 Signature:
 Name:
 Date & Time:

రక్త మార్పిడి కొరకు అంగీకార పత్రము

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 స్టేటిలెట్స్ | ☐ Whole Blood |
| ☐ మొత్తం రక్తం | ☐ ఎర్ర రక్త కణం | ☐ ఇతరులు..... |

నేను ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడివై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హెచ్ బి యాంటీ బిడీస్, హైపటెటిస్ బి సర్వేస్ యాంటిజెన్, హైపటెటిస్ యాంటిబిడీస్, మలేరియా మరియు సిప్టిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణీత కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతివర్కలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలెత్తవచ్చు 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, ప్లెస్ ప్రోజెన్ 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

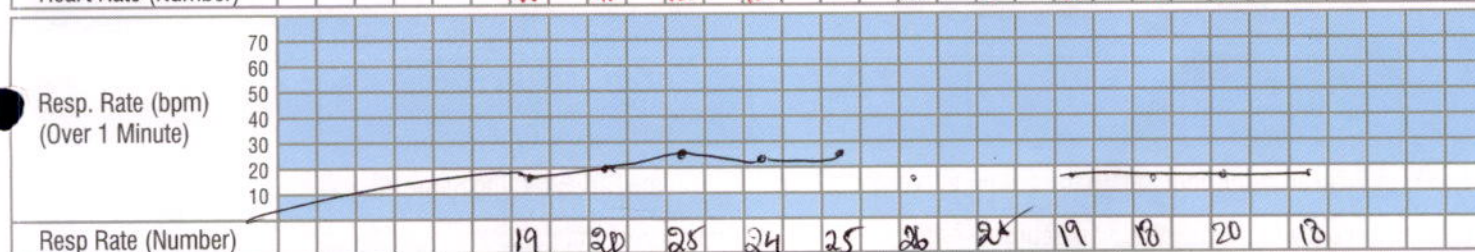
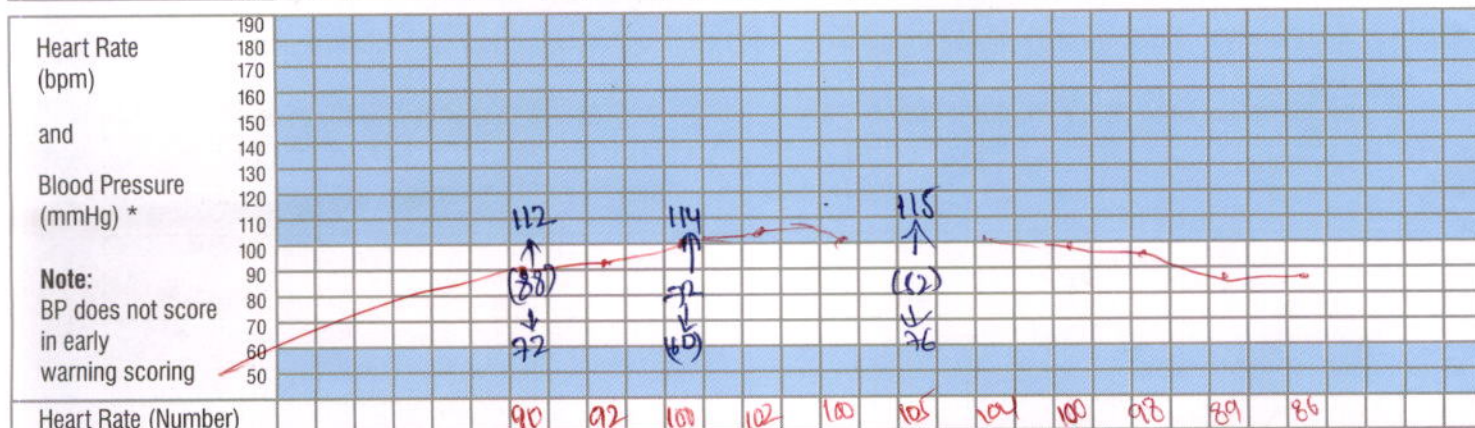
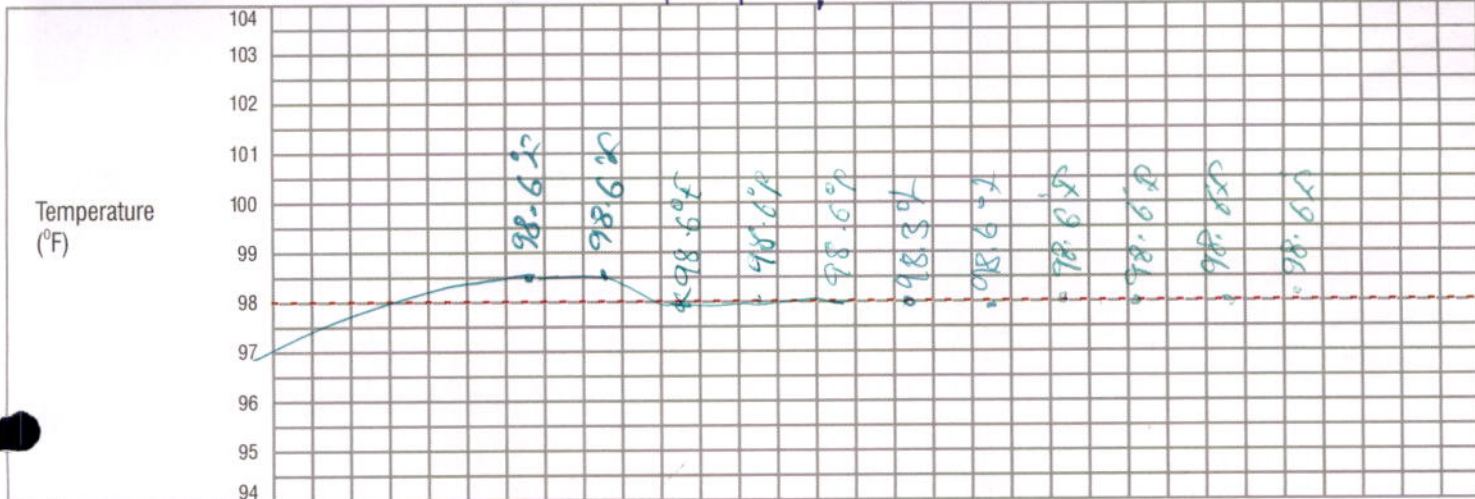


TEENAGE (12 + years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 27/12/16 Time: 12 2 3 5 7 9 11 1 3 5 7
Doctor / Nurse / Family Concern? Pm Pm pm pm pm pm pm Am Am Am Am



Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)		
O ₂ Saturations (%)	98	99
Conscious Level	N	N
GCS *	15	15
TOTAL SCORE		
Number of shaded boxes	0	0
Pain Score	0	0
Observer's Initials	B	B

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.

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)

VIH-00206415 IP-00060594
Master MANI KARTHIK CHAUHAN
16-05-2013 13 Y 1 M 21 D (M)
Dr. SANDHYA VADDADI



Doc. No. : RCH/ FRM / CLINICAL / 127

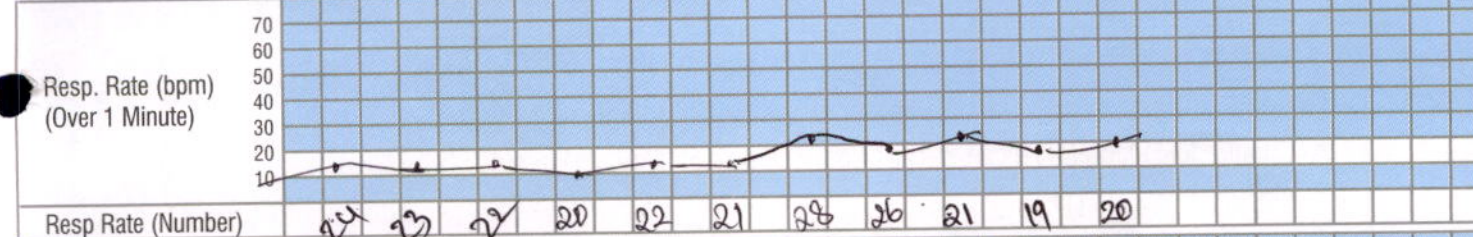
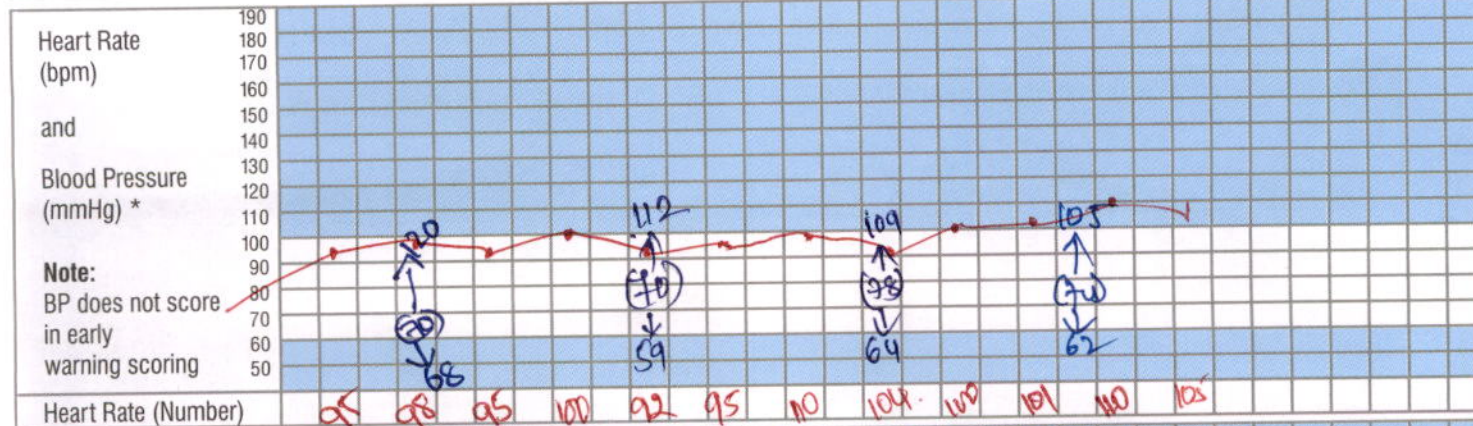
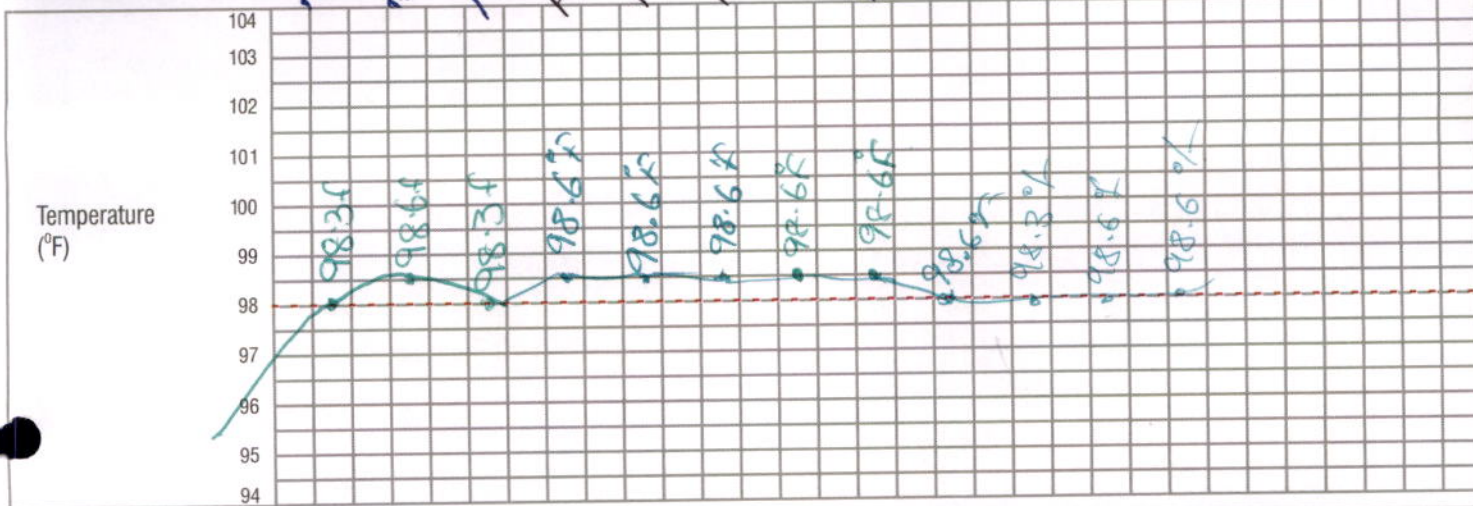
TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 16/05/2013 Time: 11:30 AM
Doctor / Nurse / Family Concern? Dr. Sandhya Vaddadi



Resp Distress	Mod/ Severe None / Mild										
		N	N	N	N	N	N	N	H	N	H
Receiving O ₂ (l/min)											
O ₂ Saturations (%)		98	97	98	100	98	99	100	99	99	97
Conscious Level	Normal / Altered	N	N	N	N	N	N	N	N	N	N
GCS *		15	15	15	15	15	15	15	15	15	15

TOTAL SCORE											
Number of shaded boxes	0	0	0	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0	0	0	0
Observer's Initials	Dr. Sandhya Vaddadi	Dr. Sandhya Vaddadi	Dr. Sandhya Vaddadi	Dr. Sandhya Vaddadi	Dr. Sandhya Vaddadi	Dr. Sandhya Vaddadi	Dr. Sandhya Vaddadi	Dr. Sandhya Vaddadi	Dr. Sandhya Vaddadi	Dr. Sandhya Vaddadi	Dr. Sandhya Vaddadi

ACTIONS	
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.

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.

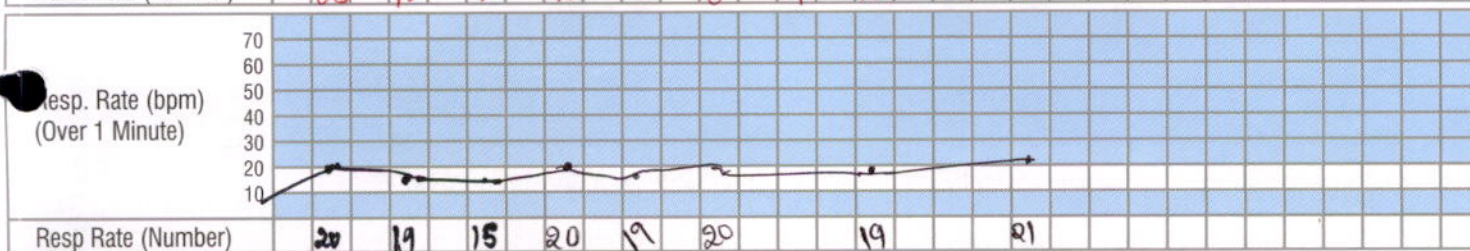
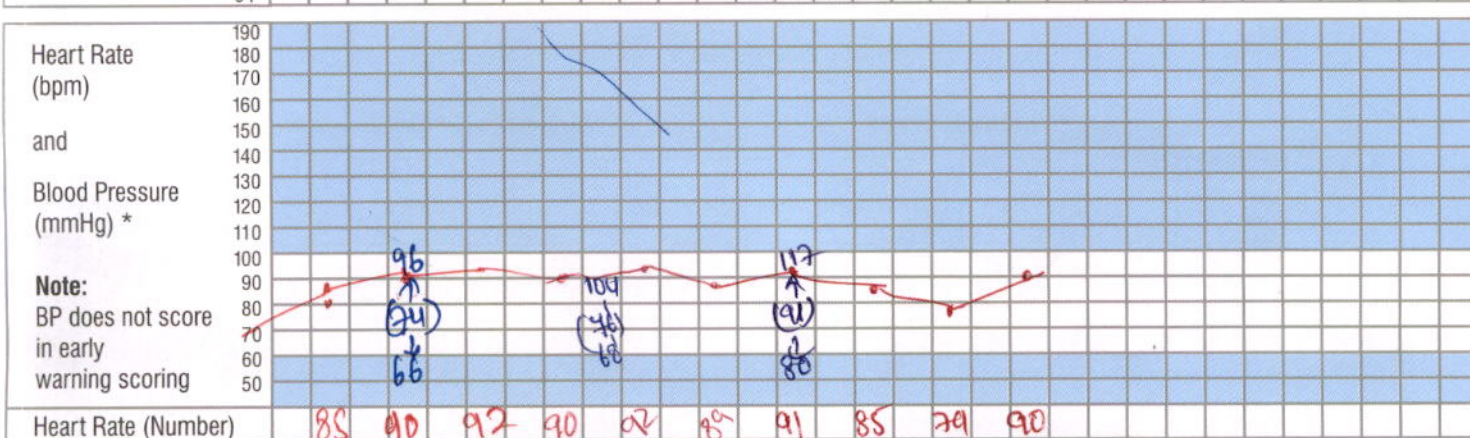
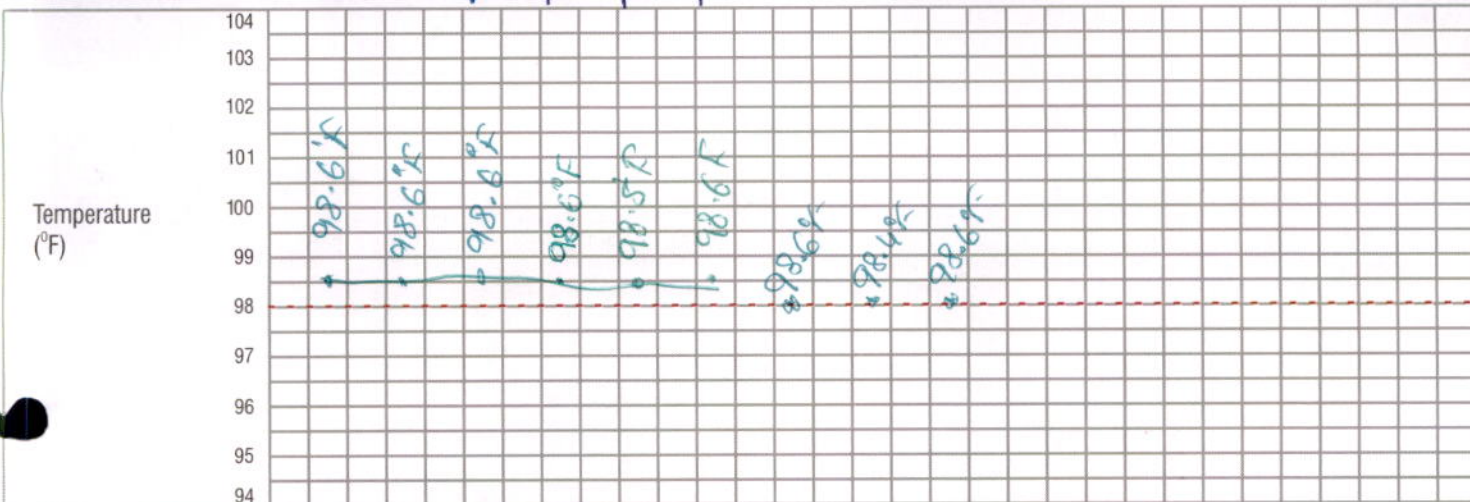
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B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's 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)



TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 09/07/26 Time: 9 11 1 3 5 7 10 1 4 7
Doctor / Nurse / Family Concern? am am pm pm pm pm pm am am pm



Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		
Conscious Level	Normal	
	Altered	
GCS *		

TOTAL SCORE	
Number of shaded boxes	
Pain Score	
Observer's Initials	

ACTIONS	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
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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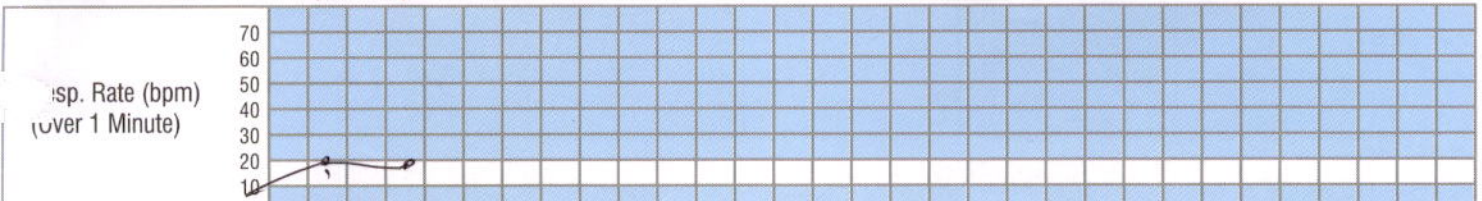
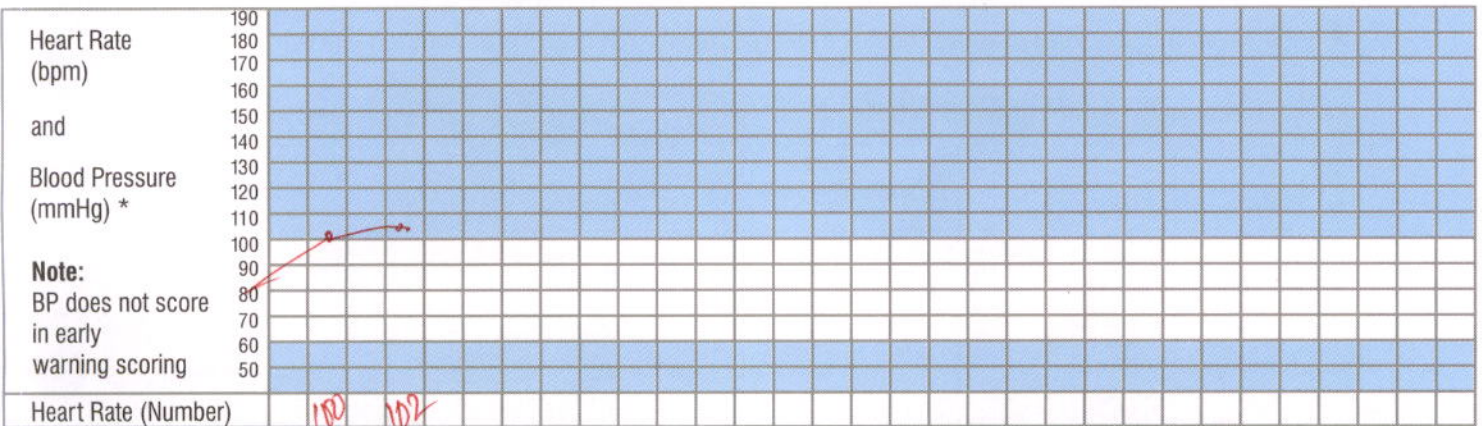
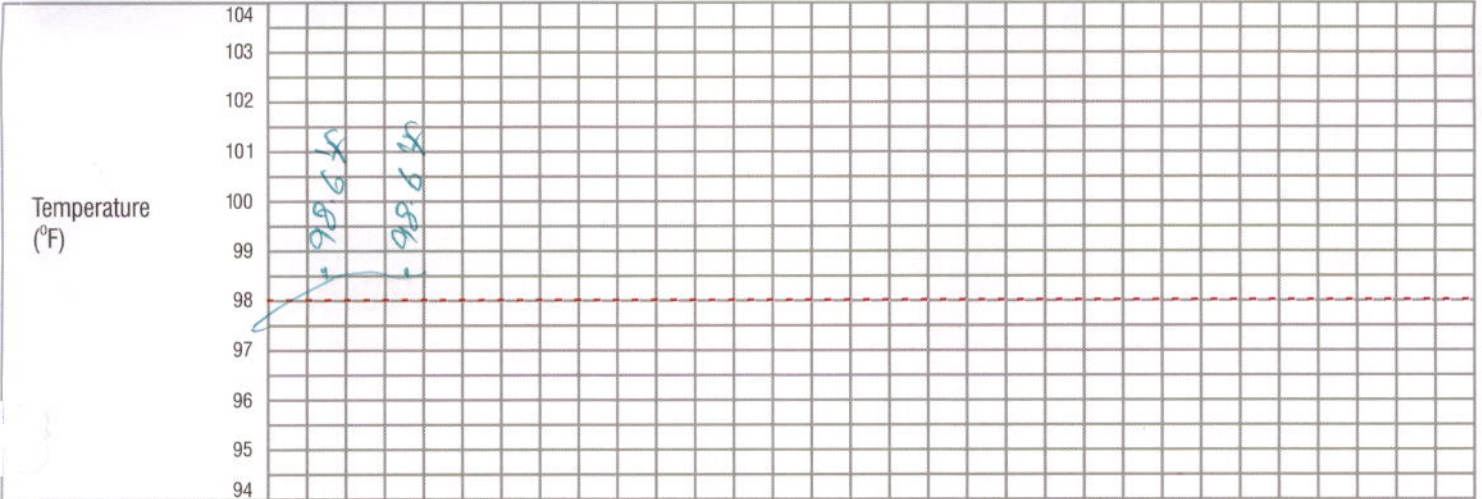


TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/7/17 Time: 9 11

Doctor / Nurse / Family Concern? am am



Resp Rate (Number) 20 20

Resp Distress	Mod/ Severe	None / Mild
<u>N</u>	<u>N</u>	<u>N</u>

Receiving O ₂ (l/min)	O ₂ Saturations (%)
<u>01</u>	<u>100</u>

Conscious Level	Normal	Altered
<u>N</u>	<u>N</u>	<u>N</u>

GCS * 15 15

TOTAL SCORE	Number of shaded boxes	Pain Score	Observer's Initials
	<u>0</u>	<u>0</u>	<u>B B</u>

ACTIONS

NB: Scores 3 should be recorded overleaf

Score 1	: Continue normal observation by staff nurse
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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.

*Noted by
Brij
10/7
@ 12pm*

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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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)



FLUID CHART

Sheet No.: ①

7/7/26

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										
7/7/26	08:00 am														
	09:00 am														
	10:00 am														
	11:00 am														
	12:00 pm														
	01:00 pm	Rice water													
Total Intake :						Total Output :									
7/7/26	02:00 pm		Rice												
	03:00 pm		water												
	04:00 pm									✓					
	05:00 pm										0				
	06:00 pm														
	07:00 pm									✓	1				
Total Intake :						Total Output :									
7/7	08:00 pm		Rice												
	09:00 pm		water							✓					
	10:00 pm														
	11:00 pm														
	12:00 am									✓					
	01:00 am									✓					
Total Intake :						Total Output :									
7/7	02:00 am														
	03:00 am		water							✓					
	04:00 am														
	05:00 am														
	06:00 am									✓					
	07:00 am														
Total Intake :						Total Output :									
Total 24 hrs. Intake													Total 24 hrs. Output		6 times

VIH-00206415 IP-00060594
 Master MANI KARTHIK CHAUHAN
 16-05-2013 13 Y 1 M 22 D (M)
 Dr. SANDHYA VADDADI



FLUID CHART

Sheet No. : ②

9/7/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
9/7/26	08:00 am											Benadine 9/7 @ 1pm	
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
9/7/26	02:00 pm											manisha 9/7/26 @ 8pm	
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
9/7	08:00 pm											Gan 9/7 @ 1pm	
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
10/7	02:00 am											Suta 10/7 @ 8AM	
	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 7 times

FLUID CHART

Sheet No. : 4

10/7/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
10/7	08:00 am											10/7 @ 12pm Benavise
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											10/7 @ 12pm Benavise
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											10/7 @ 12pm Benavise
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											10/7 @ 12pm Benavise
	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									



MEDICATION RECONCILIATION FORM

Drug Allergies: N/A

☒ 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: ICU

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						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Vishwajit

Date & Time: 6/12/2013 10:10 AM

Nurse Name & Signature: Nagisha

Date & Time: 6/12/2013 @ 10:10 AM



DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG :				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:				

Signature
VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 200 lb Ward. 114

Acid

DRUG :				Date
				Time
Dose	Route	Frequency	Start Date	
500mg	PO	PRN	6/2/16	6/2/16 9H
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : TAB OMNACORIL				Date
				Time
Dose	Route	Frequency	Start Date	
10mg	PO	12 HRS	6/2/16	6/2/16 9H
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : TAB. PANTOPRAZOLE				Date
				Time
Dose	Route	Frequency	Start Date	
40mg	PO	once daily	6/2	6/2 9H 10H
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : TAB SHELLCAL				Date
				Time
Dose	Route	Frequency	Start Date	
500mg	PO	OD	7/2	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

VIH-00206415 IP-00080584
Master MANI KARTHIK CHAUHAN
16-05-2013 13 Y 1 M 20 D (M)
Dr. SANDHYA VADDADI

I.P. No.

Sheet No.

Wards

Weight (kg)

PICC 79kg

REGULAR PRESCRIPTIONS

DRUG :	Dose	Route	Frequency	Start Dt.	Date Time
T. SHELICAL	500mg	P/O	ONCE DAILY	9/7	9/7 9AM
Name & Signature of the Doctor starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign.					

DRUG :	Dose	Route	Frequency	Start Dt.	Date Time
Tab TRANEXA	500mg	P/O	ONCE DAILY	9/7	9/7
Name & Signature of the Doctor starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign.					

DRUG :	Dose	Route	Frequency	Start Dt.	Date Time
TAB OMNACORTIL	1TAB	PO	8th	10/7	10/7 6AM
Name & Signature of the Doctor starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign.					

DRUG :	Dose	Route	Frequency	Start Dt.	Date Time
TAB. TRANEXEMIC	500mg	PO	1 st 12 hly	9/7	10/7 10AM
Name & Signature of the Doctor starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign.					

VIH-00206415 IP-00080594
 Master MANI KARTHIK CHAUHAN
 16-05-2013 13 Y 1 M 20 D (M)
 Dr. SANDHYA VADDADI



I.P. No.	Sheet No.	Wards	Weight (kg)
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REGULAR PRESCRIPTIONS

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.																			

(N)

Dr. Rishika
Clinical Pharmacologist



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

Signature

Name

VERIFIED

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
		INS. ROMP				
6/7/26		INS. ROMP 200 mg	s/c	L.		
		INT. IVIG	20 gm over 10 hrs			
7/7/26	1.20 PM		0.5 ml/hr 15 min IV	L	Jagmani	Chit
7/7/26	1.35		1 ml/hr 15 min IV	L	Jagmani	Chit
7/7/26	1.55		2 ml/hr 15 min IV	L	Jagmani	Chit
7/7/26	2.10		4 ml/hr 15 min IV	L	Jagmani	Chit
7/7/26	2.25		8 ml/hr 15 min IV	L	Jagmani	Chit
			20 ml/hr over IV	L	Not	Chit

Remaining Hour

SANDHYA VADDADI

Weight. Ward.

[illegible]



RESULT SHEET

Date	6/7/26	9/7	10/7			
Time	9.50pm	6.30	6.32AM			
Hb	13.6	14.0	13.7			
PCV	37.1	38.7	37.5			
RBC	4.46	4.60	4.43			
WBC	14.62	16.78	17.86			
N/L	70.4/19.7	88.5/11.7	82.6/12.0			
Platelets	18	21	50			
CRP		1.0				
ESR		10				
PCT						
RBS						
Na		136				
K		4.2				
Cl		97				
Ca/Mg						
Phosphate						
Urea		46.3				
Creatinine		0.8				
ALP		217				
SGPT		51				
SGOT		25				
T.Bill/Conj		0.8 < 0.1				
T.Protein		6.9				
S.Albumin		3.4				
S.Globulin		3.5				
A/G Ratio		0.9				
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

