


ACTIVITY RECORD FOR BILLING

Name : **KOH-00296691** IP5-00174695
Baby SANNIDHANAM CHAITRA
22-04-2022 4 Y 1 M 12 D (F)
Dr. SIRISHA RANI

UHID N:  Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/6/26	1:35 pm	ER	+2L(0)	Rit

Cross Consultation Visit

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

ADMISSION SHEET

Registration Details :



Admission No : IP5-00174695

Admit Date : 03-Jun-2026

Admit Time : 12:31 PM UHID : KOH-00296691

Patient Details :

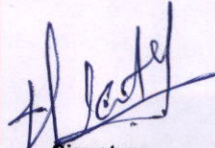
Patient Name : Baby SANNIDHANAM CHAITRA LATHIKAA Age : 4 Y 1 M 12 D
Guardian : Mr SANNIDHANAM SRIKANTH DOB : 22-04-2022
Gender : Female Religion :
Occupation : Martial Status : Single
Address (H) : FLAT NO 406, SHAMBAVI RESIDENCY, SRI
RAM NAGAR COLONY Manikonda Hyderabad Phone No : 8897194477/ 9789841363
Telangana INDIA 500089 E-mail : sharmahema846@gmail.com

Admission Details :

Bed Type : GENERAL WARD Bed No : GW121 (D) Ward Name : 1F-GENERAL WARD I
Room No : GW121 (D) Admission Type : First Visit

Contact Details :

Name : Mr SANNIDHANAM SRIKANTH Relationship : Father
Contact Address : FLAT NO 406, SHAMBAVI RESIDENCY, SRI Phone No : 8897194477
RAM NAGAR COLONY Manikonda Hyderabad
Telangana INDIA 500089


Signature

Doctor Details :

Doctor Name : Dr. SIRISHA RANI Specialisation : HEMATO ONCOLOGY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : SELFPAY

KOH-00296691 IP5-00174695
 Baby SANNIDHANAM CHAITRA
 22-04-2022 4 Y 1 M 12 D (F)
 Dr. SIRISHA RANI



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Sirisha Rani

Date : 3/6/26

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

Start Time of Assessment : 1pm Weight : 14.65kg

Allergic History: _____

Chief Complaints: _____
Urination - Burning sensation } since today.
Pain while passing stool }
 K/4/10 B-cell ALL / CALLA positive /
 TEL-AML / CNS - Negative / Post
 induction - on steroid tapering / MRD
 negative / on consolidation

Pediatric Assessment Triangle

A Appearance - TICLS _____

B Breathing

- ↑ WOB
- ↓ WOB
- Normal
- Gasping / Apnea

C Circulation

- Normal
- Abnormal
 - Pallor
 - Cyanosis
 - Mottling
 - Bleeding

Initial Physiological Status: Stable Unstable

- Life Threatening
- Non Life Threatening

Any urgent interventions needed: Yes No
 If Yes _____

Significant Past History: _____

Medication History: 3/6/26: CBP → 6.1 → 0.65 → 170
18.6 23/55.4

Relevant Investigations: _____

Primary Assessment

Airway Open Maintainable Not Maintainable

Any urgent interventions needed: Yes No
 If Yes _____

Breathing

Rate: 24/min SpO₂ on FIO₂ 100% on RA

Rhythm: Regular


Retractions: Suprasternal ICR SCR
 Sternal Supraclavicular Nasal Flaring

Respiratory Noises: Stridor Wheezing Grunting

Air Entry: B/L AE (+)

Palpation Findings (If necessary) _____

Any urgent interventions needed: Yes No
 If Yes _____

Circulation  HR: 137am

BP: 98/54(63) mmHg

Pulse Volume: Central Peripheral

If in Shock: Compensated Hypotensive

Muffled Heart Sound: Yes No

Engorged Neck Veins: Yes No

CFT Central Peripheral

Murmurs: Yes No


Liver Span:

ECG:

Any Signs of Heart Failure: Yes No

Any urgent interventions needed: Yes No

If Yes

Disability  GCS: 15/15 AVPU:

Pupils: Responsive Non-Responsive


Size Right Left

Active Seizures: Yes No Sugars:

Signs of Neurological compromise

Any urgent interventions needed: Yes No

If Yes

Exposure  Temp.: 97.3°F

Any Rash: Yes No,

If yes describe the rash

Active bleed

Lacerations Abrasions bruises

Describe:

Any urgent interventions needed: Yes No

If Yes

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

Secondary Assessment: Head to toe examination with positive findings:

Labs Planned:

CBP - done on OPD basis

CVE } to send today

Urine c/s }


Treatment Planned:

• PRBC transfusion

• Ibuprofen

Need for Oxygen: Yes No if yes Low Flow High Flow PPV

Final Diagnosis with possible Differential Diagnosis (If necessary):

Assessment done by
 Name of the Doctor: Dr. Ramya
 Signature: 
 Date & Time: 3/6/26 ; 1:06 pm.

Sr. Doctor on Duty (If necessary)
 Name of the Sr. Doctor:
 Signature:
 Date & Time:

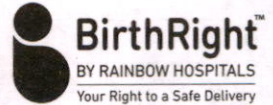
Charita Lallata

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6/26 3pm	Dr Asandlye Abull Acl completed Amelisation Day 7 post Day 29 cycle	
	no fever / vomiting	(P) → PRBC now send urine c/s
	as RH R/D	→ start Zmax w/iron sulfate
	(M)	q/c after PRBC R/V on 6/6/26 C BP in OP
		R/V SOS if any fever
		[Signature] Asandlye 3/6/26

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Patient



MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER Shifted to: 121 (0)

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	Syp. Ceramixure	5ml	PO	BD	} 3/6/26	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2	Syp. levipril	3ml	PO	BD		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
3	Syp lacosamide	3.5ml	PO	BD		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
4	Syp. Colamen	5ml	PO	BD		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
5	Syp. Moltel	5ml	PO	OD		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
6	Teb Amlodi (2.5mg)	1/2 teb	PO	BD		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
7	Syp lobetas	5ml	PO	OD		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
8	Teb Lenzol.	17teb	PO	OD		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
9	Syp. GMP	2ml	PO	OD		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Ranya

Date & Time: 3/6/26 1:35 pm

Nurse Name & Signature: Pooja

Date & Time: 3/6/26 @ 1:35 pm



DRUG CHART

Date of Admission: 3/6/25 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:																						

VERIFIED BY: Name Signature



REGULAR PRESCRIPTIONS

Weight. 14.65 kg ~~15 kg~~ Ward.

DRUG : <u>Tab Voriconazole</u>				Date Time																	
Dose <u>1/2 tab</u>	Route <u>PO</u>	Frequency <u>Q24H</u>	Start Date <u>3/6/26</u>																		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Ravi</u>																					
Additional Instructions: <u>1 tab = 200mg</u>																					
Daily Doctor's Endorsement by a Sign																					
DRUG :				Date Time																	
Dose	Route	Frequency	Start Date																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG :				Date Time																	
Dose	Route	Frequency	Start Date																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG :				Date Time																	
Dose	Route	Frequency	Start Date																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					



Weight. Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
3/6/26		PRBC transfusion	225 ml over 4-5 hrs	IV	R	
3/6/26		Ivj AVIL	0.3ml	IV	R	
3/6/26		Ivj HYDROCORTISONE	30mg	IV	R	

VERIFIED BY : Name Signature

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RESULT SHEET

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

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FLUID CHART

Sheet No. :

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

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

FLUID CHART

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

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

Total 24 hrs. Intake

Total 24 hrs. Output

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

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

THE HUMPTY DUMPTY SCALE 3/6/26

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3				
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1				
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1				
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1				
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1				
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1				
TOTAL			60				

Intervention : -Fall Risk : Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

Bed in low position	Yes				
Call device within reach	Yes				
Wheels Locked	Yes				
Room free of clutter	Yes				
Adequate Lighting	Yes				
Wheel Chair Support	Yes				
Other Intervention(s) Specify	Yes				
Nurse's Name :		poorika			
Signature :		[Signature]			
Date :		3/6/26			
Time :		12:36 pm			



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sirisha Rani Department: paediatric Date of Admission: 3/6/26

SITUATION	Diagnosis: <u>All</u>		Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:							
	Area		/							
BACKGROUND	Shift Time	<u>ER 1:50 pm</u>	/							
	Medical Condition (Any special condition to be noted):	<u>NA</u>	/							
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Vital Signs:	Temp:	<u>97.3F</u>	/						
		Res:	<u>20b/min</u>	/						
		SpO ₂ :	<u>100%</u>	/						
		Pulse:	<u>89b/min</u>	/						
		BP:	<u>98/54</u>	/						
		Fall Risk Score:	<u>10</u>	/						
	Pain Score:	<u>0</u>	/							
Recommendations	Safety Needs:	<u>4M</u>	/							
	Physiotherapy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Others Specify:	<u>NA</u>	/							
	Special Diet:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Other Special Orders / Medications:	<u>NA</u>	/							
Post Operative Procedure Special Orders:		<u>NA</u>	/							
Handed Over By Name :		<u>Pooja</u>	/							
Signature :		<u>[Signature]</u>	/							
Date:		<u>3/6/26</u>	/							
Time:		<u>1:50 pm</u>	/							
Taken Over By Name :		<u>Pooja</u>	/							
Signature :		<u>[Signature]</u>	/							
Date:		<u>3/6</u>	/							
Time:		<u>2pm</u>	/							

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
BACKGROUND	Area							
	Shift Time							
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
		Fall Risk Score:						
Pain Score:								
Recommendations	Safety Needs:							
	Physiotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Others Specify:							
	Special Diet:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Other Special Orders / Medications:							
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature :								
Date:								
Time:								
Taken Over By Name :								
Signature :								
Date:								
Time:								



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/6/26	12:36 pm	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	R
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Re-assessment Frequency:

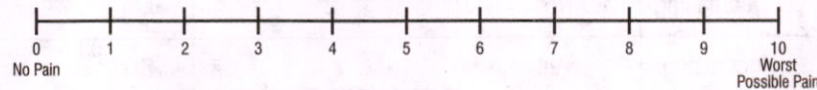
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

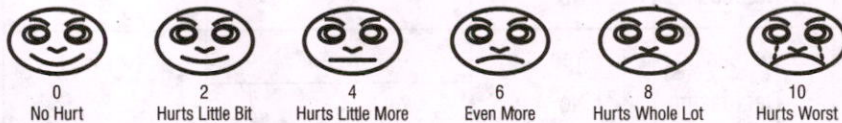
Numerical Pain Scale (Obstetric and Gynecology)



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



CONSENT FOR BLOOD TRANSFUSION



Name: Age: Gender: Male Female
UHID.No : Date:

- Type of Blood Product:**
- | | | |
|--|---|---|
| <input type="checkbox"/> Fresh Frozen Plasma | <input type="checkbox"/> Packed Red Blood Cells | <input type="checkbox"/> Random Donor Platelets |
| <input type="checkbox"/> Cryoprecipitate | <input type="checkbox"/> Single Donor Platelet | <input type="checkbox"/> Whole Blood |
| <input type="checkbox"/> Albumin | <input type="checkbox"/> Red Blood Cell | <input type="checkbox"/> Others |

I 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):	Doctor (Who is talking the consent)
Signature: <i>S. Hemalatha</i>	Signature: <i>A. Sawani</i>
Name: <i>S. Hemalatha</i>	Name: <i>Sawani</i>
Date & Time: <i>03/06/26 - 4:55pm</i>	Date & Time:

Witness
Signature:
Name:
Date & Time:

రక్త మార్పిడి కొరకు ఆంగ్లీకార పత్రము

రోగి పేరు: వయస్సు: లింగము పురుషుడు స్త్రీ

UHID. సంఖ్య: తేదీ:

రక్త ఉత్పత్తి రకాలు: తాజా ఘనీభవించిన ప్లాస్మా ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు Random Donor Platelets

క్రయో ప్రెసిపిటేట్ ఒకే దాత ఫ్లేటిలాట్స్ Whole Blood

మొత్తం రక్తం ఎర్ర రక్త కణం ఇతరులు.....

నేను ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో ఆర్డీబీ అయి

ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి ఆంగ్లీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హాప్ ఐ బి యాంటీ బిడిస్, హైపటైటిస్ బి సర్వేస్ యాంటిజెన్, హైపటైటిస్ యాంటిబిడిస్, మలేరియా మరియు సిస్టిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణయాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్ సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు 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 ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ప్లెస్ ప్రోజెన్ ప్లాస్మా, క్రయో ప్రెసిపిటేట్ మొదలైనవి) నా ఆంగ్లీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటొనైంట్) సాక్షి

సంతకము సంతకం

పేరు పేరు

తేదీ మరియు సమయము తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు