

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No. : _____ 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
21/07/20	11:45 a	ER.	One	Renuel.

Cross Consultation Visit

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

[illegible]

21/7

CRP (OP)

PROCEDURE

[illegible]

[illegible]

Date :

21 | 7

Time :

613

Prepared By :

Sanen

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor

Sonar

oncology

BAH-00657857 IPS-00176704
Master AALLA YAGNESH REDDY
07-08-2022 3 Y 11 M 14 D (M)
Dr. SIRISHA RANI



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	2			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record				
6	Doctors progress sheets	1			
7	Nursing plan of care and handover sheets	2			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion	1-1			
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Extra	5			
	Total No. of Pages	25			

Signature
Signature and Date :
21/7/24

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /

2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

ADMISSION SHEET

Registration Details :


Admission No : IP5-00176704 **Admit Date :** 21-Jul-2026 **Admit Time :** 11:32 AM **UHID :** BAH-00657857

Patient Details :

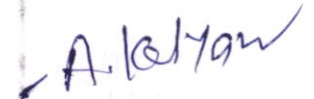
Patient Name :	Master AALLA YAGNESH REDDY	Age :	3 Y 11 M 14 D
Guardian :	Mr AALLA KALYAN	DOB :	07-08-2022
Gender :	Male	Religion :	
Occupation :		Marital Status :	Single
Address (H) :	SAISAMRATH SADAN FLAT -NO 102 OPP CHEST HOSPITAL KALYAN NAGAR S R Nagar Hyderabad Telangana INDIA 500038	Phone No :	6281143849/ 7386032178
		E-mail :	KALYANSAP401@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : HO DC 2 **Ward Name** : 1F-HEMATO-ONCOLOGY
Room No : HO DC 2 **Admission Type** : First Visit

Contact Details :

Name : Mr AALLA KALYAN **Relationship** : Father
Contact Address : SAISAMRATH SADAN FLAT -NO 102 OPP
 CHEST HOSPITAL KALYAN NAGAR S R Nagar
 Hyderabad Telangana INDIA 500038 **Phone No** : 6281143849 / 7386032178


 Signature

Doctor Details :

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

Payment Details :

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

BAH-00657857 IP5-00176704
Master AALLA YAGNESH REDDY
07-08-2022 3 Y 11 M 14 D (M)
Dr. SIRISHA RANI




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


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ADMISSION CRITERIA – ONCOLOGY

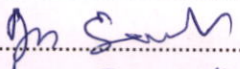
Admission / Transfer from:

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

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

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

Signature of the Doctor: 

Name of the Doctor: 

Date & Time: 

BAH-00657857 IP5-00176704
Master AALLA YAGNESH REDDY
07-08-2022 3 Y 11 M 14 D (M)
Dr. SIRISHA RANI

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DISCHARGE CRITERIA – ONCOLOGY

Discharge to:

☐ HDU / Step down ICU

☒ Ward

☐ Outside Facility

☐ Others:

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

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

Signature of the Doctor:

Name of the Doctor :

Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/9/26	cls/b Dr. Balaji (ER Resident) D - K/clo B-cell / CALLA tre Came for PRBC Transfusion cb mid cycle child - Alert, Afebrile pulmonary full Vitals HR - 132 bpm RR - 24 /min SpO₂ - 98% RA T - 98.2°F Bp - 101 / 65 (AC) mmHg SG: BAS (+) SIS (+) PLA - coh very hyp. clamped fate Syp Relat	Wt 16.5 kg plan 1) PRBC transfusion 2) Cyp. MERCAPTOPURINE (ml) ON 3) V. CRICOMATORE 4) SEPTICAN 5) Give Reptarctine 8x today 6) Vial monitoring 7) Inform son 8) 2g AVIL and 1g 9) 2g. CASSIX 10) DLS - today N.B Learn 0.155m CT Dr. Balaji Ms. Nishu 01/09/26 21/09/26 11:30 AM

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



DRUG CHART

Date of Admission: 21/02/26 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 : <u>Zy-ONDANSETRON</u>				Date Time															
Dose <u>2mg</u>	Route <u>Or</u>	Frequency <u>Sos</u>	Start Date <u>21/2/26</u>																
Doctor's Signature		Valid Period <u>24 hrs</u>	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:																			

BAH-00857857
Master AALLA YAGNESH REDDY
07-08-2022 3 Y 11 M 14 D (M)
Dr. SRISHA RANI

REGULAR PRESCRIPTIONS

Weight. 14.5 kgs Ward.

Drug				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : <u>inj Ceftriaxone</u>				Date Time <u>21/7</u>
Dose	Route	Frequency	Start Date	
<u>1 gram IV</u>	<u>OD</u>	<u>21/7</u>		
Name & Signature of the Doctor Starting the Drugs:				
<u>Ashwath</u>				
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				



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
21/7/20	1:30pm	24. AVIL	0.3 ml	ZV	[Signature]	Ueena Soham
21/7/20	1:30pm	PRBC	210 ml over 4-6 hrs	ZV	[Signature]	Ueena Soham
21/7/20	4:pm	24. LASIX	10 mg at midday	ZV	[Signature]	Ueena Soham
21/7/20		24. Cnsrx	10 mg after breakfast	ZV	[Signature]	(Held)

I.V. FLUIDS CHART

Weight. Ward.

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign

BAH-00857857 IP5-00178704
Master AALLA YAGNESH REDDY
07-08-2022 3 Y 11 M 14 D (M)
Dr. SIRISHA RANI



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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: ICU

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	Sup. AMOXICILLIN + CLAVULINIC.	4ml	PO	BD	20/8/22 8pm	☒ C ☐ DC
2	Sup. RELENT PLW	4ml	PO	BD	20/8/22 8pm	☒ C ☐ DC
3	Sup. SEPTRAN	5ml	PO	BD (on ready, 1st day 8/22)	20/8/22 8pm	☒ C ☐ DC
4	Sup. ZINCovit	5ml	PO	OD	20/8/22	☒ C ☐ DC
5	Sup. CALCIUM PLW	5ml	PO	OD	20/8/22	☒ 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. Sirisha Rani

Date & Time: 21/8/22, 12:40 pm

Nurse Name & Signature: Neeraj

Date & Time: 21/8/22 @ 11:40 am



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
21/7	11:15 AM	0/10	WB	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NO NO	Asced
21/7	7 PM	0/10	WA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NO C	Gaya 3
				☐ 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:

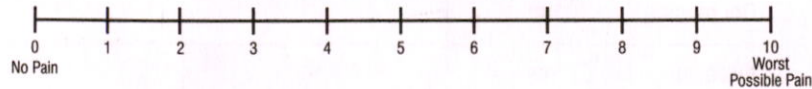
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, 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





①

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/7 Time: 12pm 4pm

Doctor / Nurse / Family Concern?

104		
103		
102		
101		
100		
99	98.2 F	98.4 F
98		
97		
96		
95		
94		

Heart Rate (bpm)	190	
	180	
	170	
	160	
	150	
	140	
	130	
	120	
	110	
	100	
	90	
	80	
	70	
	60	
	50	
Blood Pressure (mmHg) *	120	100
	110	
	100	
	90	
	80	
	70	
	60	
	50	
Note: BP does not score in early warning scoring	100	100
Heart Rate (Number)	24bpm	24bpm

70	
60	
50	
40	
30	
20	
10	
Resp. Rate (bpm) (Over 1 Minute) *	
Resp Rate (Number)	100%

Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)	95/95	95/95
Conscious Level	Normal	
	Altered	
GCS *	15/15	15/15

TOTAL SCORE	
Number of shaded boxes	0
Pain Score	0
Observer's Initials	8

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.

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)

BAH-00657857 IP5-00176704
Master AALLA YAGNESH REDDY
07-08-2022 3 Y 11 M 14 D (M)
Dr. SIRISHA RANI



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 Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
	Total Intake :						Total Output :						
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

BAH-00657857 IP5-00175704
Master AALLA YAGNESH REDDY
07-08-2022 3 Y 11 M 14 D (M)
Dr. SIRISHA RANI



FLUID CHART

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No. :

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

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



CONSENT FOR BLOOD TRANSFUSION

Name: Yagnesh Age: 34y Gender: Male ☒ Female ☐
UHID.No : 657857 Date: 21/2/2026

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 HAHA

I T. Triveni 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 Immunodeficiency 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 None

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: T. Triveni
Name: T. Triveni
Date & Time: 21/2 @ 11m

Doctor (Who is talking the consent)

Signature: Shankha
Name: Shankha
Date & Time: 21/2 @ 1:30m

Witness

Signature: [Signature]
Name: Son
Date & Time: 21/2 @ 1n



BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 21/7/26 Time: 12:45 pm

Blood Group of the Patient: B+ve Blood Group on the Blood Bag: B+ve

Blood Bank Issue No: BAH26-01674 Date of Collection: 12/7/26 Date of Expiry: 23/8/26

Date & Time of Starting Transfusion: 21/7/26 @ 12:45 pm Planned duration of Transfusion: 4 hr

Check for Correct Unit: ☒ Correct Patient: ☒

Blood products cross checked by: Nurse 1: Sonu Nurse 2: Sonith

Before starting transfusion vitals: Temp: 98.5 HR 110 RR: 20 BP: 100/60 SpO₂ 100%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
<u>21/7</u>	15 Min	<u>108</u>	<u>98.5</u>	<u>100/60</u>	<u>100%</u>	<u>No</u>	<u>No</u>	<u>No</u>	<u>No</u>
	15 Min	<u>96</u>	<u>98.5</u>	<u>99/60</u>	<u>100%</u>	<u>No</u>	<u>No</u>	<u>No</u>	<u>No</u>
	30 Min	<u>108</u>	<u>98.5</u>	<u>99/60</u>	<u>100%</u>	<u>No</u>	<u>No</u>	<u>No</u>	<u>No</u>
	30 Min	<u>100</u>	<u>98.5</u>	<u>100/60</u>	<u>100%</u>	<u>No</u>	<u>No</u>	<u>No</u>	<u>No</u>
	30 Min	<u>108</u>	<u>98.5</u>	<u>100/60</u>	<u>100%</u>	<u>No</u>	<u>No</u>	<u>No</u>	<u>No</u>
	1 Hr	<u>108</u>	<u>98.5</u>	<u>100/60</u>	<u>100%</u>	<u>No</u>	<u>No</u>	<u>No</u>	<u>No</u>
	1 Hr	<u>108</u>	<u>98.5</u>	<u>100/60</u>	<u>100%</u>	<u>No</u>	<u>No</u>	<u>No</u>	<u>No</u>

Comments: No Reaction

Name of the Incharge-Nurse: Sonith Name of the Nurse: Sonu

Signature of the Incharge-Nurse: [Signature] Signature of the Nurse: [Signature]

Date & Time: 21/7 @ 5 PM Date & Time: 21/7 @ 5 PM

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2,
Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

LEUCO REDUCED BLOOD CELLS I.P

Qty. 258 ml. Prepared from Whole human blood collected in 63 ml. of C.P.D.A. Solution.



Rh Positive

HIV I & II/ HBsAG/ HCV - Non reactive
VDRL - Non reactive
MP - Negative
NAT(HIV I & II/ HBsAG/ HCV)- Non reactive

Unit No. **BAH26-01674**
Blood Group: **B Rh Positive**
Collection Date: **12/Jul/2026**
Expiry Date: **23/Aug/2026**

Administer Without Warming. 2) Shake gently Before Use. 3) Do Not
Group and Name Before Administration. 4) Check Blood Group on Label & Recipient's
With Filter. 6) Do Not Dispense Without Prescription. 7) Do Not Use if
There is Any Visible Evidence. 8.) Store Between 2° C to 6° C 9)
Appropriate Cross Matched Blood Without Atypical

Issue Label / Cross Matching Report

Patient : **Mr. Alla Yagnesh -**

Patient's Blood Group : **B Rh Positive**

Hosp/Dr : **Rainbow Childrens Hospital, DR. SIRISHA RANI**

UHID No.: **BAH-00657857** Wd-Bed No.:

Product : **LR-PBC**

Blood Group : **B Rh Positive**

Unit No.: **BAH26-01674**

X-Matching Report: **Compatible**

X-matched by: **Premalatha**

Issue Dt : **21/Jul/2026**

Colln. Dt : **12/Jul/2026**

Exp. Dt : **23/Aug/2026**

Issued By : **Premalatha**

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital

D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road
No.2, Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G