Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176099 **Admit Date** : 08-Jul-2026 **Admit Time** : 10:48 AM **UHID** : BAH-00397366

Patient Details :

Patient Name	: Baby NAVYASREE	**Age**	: 14 Y 10 M 5 D
Guardian	: Mrs PRONEETHA	**DOB**	: 03-09-2011
Gender	: Female	**Religion**	: Hindu
Occupation	:	**Martial Status**	: Single
Address (H)	: PLOT NO 259,, MANGA PURAM COLONY, Old Alwal Bolaram Bazar Hyderabad Telangana INDIA 500010	**Phone No**	: 7032789690/ 8125227733
		E-mail	: proneethap@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER 04 **Ward Name** : 1B-EMERGENCY

Room No : ER 04 **Admission Type** : First Visit

Contact Details :

Name : Mrs PRONEETHA **Relationship** : MOTHER

Contact Address : PLOT NO 259,, MANGA PURAM COLONY, Old Alwal Bolaram Bazar Hyderabad Telangana INDIA 500010 **Phone No** : / 7032789690

Signature

Doctor Details :

Doctor Name : Dr. DR.V.V.R.SATYA PRASAD **Specialisation** : PEDIATRIC NEPHROLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant : Dr. SRUTHI BALLA/ Dr. JAPA AVINASH

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

BAH-00397366 IP5-00176099
Baby NAVYASREE
03-09-2011 14 Y 10 M 5 D (F)
Dr. DR.V.V.R.SATYA PRASAD

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Albumin. ~~BLOOD PRODUCTS~~ TRANSFUSION MONITORING FORM

Date: 8/7/26 Time: 11 AM

Blood Group of the Patient: — Blood Group on the Blood Bag: —

Blood Bank Issue No: — Date of Collection: — Date of Expiry: —

Date & Time of Starting Transfusion: 8/7 at 11:18 AM Planned duration of Transfusion: 4 hours

Check for Correct Unit: ☐ ✓ Correct Patient: ☒

Blood products cross checked by: Nurse 1: NR Ismail Nurse 2: NR Subnur

fore starting transfusion vitals: Temp: 98.1°F HR 98b/m RR: 24b/m BP: 110/68 (78) SpO_2 97% RA

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO_2	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
8/7/26	11:33 AM 15 Min	99b/m	98.3°F	113/64 (76)	98% RA	NO	NO	NO	NO
	11:53 AM 15 Min	102b/m	98.4°F	110/68	99%	NO	NO	NO	NO.
	12:23 pm 30 Min	105b/m	98.4°F	115/72	98%	NO	NO	NO	NO
	12:53 pm 30 Min	90b/m	98°F	115/68	99%	NO	NO	NO	NO
	1:23 pm 30 Min	89b/m	98.3°F	116/65	98%	NO	NO	NO	NO
	2:23 pm 1 Hr	92b/m	98.6°F	114/65	99%	NO	NO	NO	NO
	3:23 pm 1 Hr	98b/m	98.7°F	112/73	100%	NO	NO	NO	NO.

Comments: .....

.....

Name of the Incharge-Nurse: Samhy

Signature of the Incharge-Nurse:

Date & Time: 8/07 h

Name of the Nurse: Subnur

Signature of the Nurse: Subnur

Date & Time: 8/7/26 at 11:30 AM

Docu. No. : RCHBH./FRM / CLINICAL / 078

CONSENT FOR BLOOD TRANSFUSION

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Name: Baby Navyasree Age: 14y Gender: Male ☐ Female ☑

UHID.No : BAH- 00397366 Date: 8/7/26

Type of Blood Product:

☐ Fresh Frozen Plasma	☐ Packed Red Blood Cells	☐ Random Donor Platelets
☐ Cryoprecipitate	☐ Single Donor Platelet	☐ Whole Blood
☑ Albumin	☐ Red Blood Cell	☐ Others .....

I ..... 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 .....

Nil

.....

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: P.P

Name: Praneetha

Date & Time 08/07/2026, 11 AM

Doctor (Who is talking the consent)

Signature: Dr. Nandan

Name: Dr. Nandan

Date & Time 08/07/2026, 11 AM

Witness

Signature: B

Name: Bhavani

Date & Time 8/7/26 @ 11AM

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Baby. Navya Sree Age : 14yr **Gender:** ☐ Male ☑ Female

Date : 8/07/2026 Time of Arrival : 10:30 am Triage Completion Time : 10:40 am

Allergies: ☑ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): — ☐ Not known any drug Allergies

Source of Information : ☑ Parents ☐ Others (Specify) —

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing
☑ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS
☑ Stable
☐ Unstable :
☐ Not – Life - Threatening
☐ Life – Threatening

Initial Vital Signs: Temp: 98.4°F PR: 102/min BP: 111/79 (86) RR: 22/min SpO: 96%

Brief Complaints: Came for : Albumin Supplementation

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

Communicable Disease Triage Screening

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

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

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

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☐ No
   If yes, State Location: .....
2. Are your parents / close contacts at home 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 : Arun Sing

Signature of Triage Nurse : .....

Date & Time : 8/07/2026 at 10:40 am

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 8/7/26 Time of arrival : 10:40 am

Chief Complaints: Came for Albumin Transfusion RBS: N/A

Height : N/A Weight : 45.0kgs BMI : Head Circumference (<2 years) N/A

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: N/A

If yes , identify N/A

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

☐ Character Nil ☐ Location Nil ☐ Frequency N/A ☐ Duration

RISK FOR FALL:

☐ If patient is < 6 years
tick below fall risk intervention directly

☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☐ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☑ No
- Uses furniture for support ☐ Yes ☐ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☑ No
- Weak ☐ Yes ☐ No
- Impaired ☐ Yes ☐ No

Mental Status: Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

☐ Escort while ambulating
☐ Assist Patient
☐ Educate patient and family on fall precautions/prevention

Functional Screening: ☑ No Abnormalities Detected

☐ Mobility Problem
☐ Walking Problem
☐ Developmental Delay
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

Nutritional Screening: ☑ No Abnormalities Detected

☐ Underweight
☐ Overweight
☐ Feeding Problem
☐ Special diet
☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☑ No

If Yes Consultant Notified: N/A (Date/Time): N/A

Social History: Lives With family

Siblings in household ☐ Yes ☑ No (if yes How Many?) N/A

Cultural & Spiritual Needs: ☐ Yes ☑ No if Yes specify N/A Inform consultant for positive criteria.

Time of Initial assessment completed by ER Nurse : 10:42 AM

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

Time	Nursing Notes
	C/S/D Dr Nandan
	Iv placement done.
	Opfile Handover to mother

Samples collected by: NA. Time: NA

Samples sent by : Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Nil

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 102/m BP: 111/79(86) CFT: <2sec	Shift - out from ER to:
RR: 22b/m. SPO_2 : 96%	Time of Shift - out: ER Pay care
GCS: 15/15 Temperature : 98.4°F	Handover given to:
Pain Score: 0/10	(Nurse's Name)
Repeat RBS (if applicable): NA	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): Iv placement on Rt hand (22G)

Name of the Nurse : NR Subrun Signature of the Nurse :

Date & Time : 28/07 at 12:30 pm

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ACTIVITY RECORD FOR BILLING

Name :_____ BAH-00397366 IPS-00176099
Baby NAVYASREE
03-09-2011 14 Y 10 M 6 D (F)
Dr. DR.V.V.R.SATYA PRASAD

UHID No. : _____ IP No : _____ Dept : _____

Date of Admission: _____ Ti... _____ Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/7/26	—	ER	—	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
08/2/2018	CARDIAC MONITER	11:10AM		92970	Santhosh
8/2/18	INFUSION PUMP	11:10AM		92990	Santhosh

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
8/7/26	IC placement Albumin Prasfusion	(1)	92977.	

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Sathyaprasad sir Date : 08/07/2026

Type of Admission: ☐ OPD ☑ ER ☐ Referral (if referral, Doctor's Name: .....

Start Time of Assessment: 08/07/2026 Weight: 4.8 kg

Allergic History: NKDA

Chief Complaints:

H/o liver transplant
1 year of age
Now with AGN
↓
Now admitted for
Albumin transfusion

Pediatric Assessment Triangle

A Appearance - TICLS Normal

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 ☐

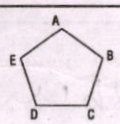
Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Significant Past History: H/o liver transplant at 1 year of age

Medication History: NKDA

Relevant Investigations: Serum Albumin - 1.6

Primary Assessment



Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☐ No
If Yes .....

Breathing

Rate: 22 br/min SpO_2 on FiO_2 100% RA

Rhythm: Normal

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: B/L AEE, clear

Palpation Findings (If necessary) .....

Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Circulation

HR: 92 b/m CFT Central <3 sec Peripheral <3 sec

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

BP: 110/70 mmHg

Pulse Volume: Central Good Peripheral Good

If in Shock: Compensated ..... Hypotensive .....

Muffled Heart Sound: ☐ Yes ☑ No

Engorged Neck Veins: ☐ Yes ☑ No

Murmurs: ☐ Yes ☑ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☑ No

Disability

GCS: 15/15 AVPU: A

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Pupils: Responsive ☑ Non-Responsive ☐

Size: Right 3 mm Left 3 mm

Active Seizures: ☐ Yes ☑ No Sugars: .....

Signs of Neurological compromise .....

—

Exposure

Temp.: 98.4°F

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Any Rash: ☐ Yes ☑ No,

If yes describe the rash —

Active bleed —

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: —

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: Normal

Labs Planned:

—

Treatment Planned:

- IV Albumin 1 vial
- IV Pantop

N.B. Albumin. 8/7/26 at 12:30pm

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

Final Diagnosis with possible Differential Diagnosis (If necessary): Post liver trans. ? Graft C MPGN

Assessment done by

Name of the Doctor: Dr. A. Dr. Nanda

Signature: Dr. A.

Date & Time: 08/07/2026, 11 AM

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: .....

Signature: .....

Date & Time: .....

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/16 3pm.	Seen by Dr. Satyaprasad sir	Plan: • Continue Albumin transfusions • Continue Mofcon, Omnocard, Tacrolimus. } as per plan • Discharge today • Rev on monday Dr Ramya

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

(P.T.O)

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

IP5-00176099
BAH-00397366 (F)
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DRUG CHART

Date of Admission: 08/07/2026 Drug Allergies: Nil ☐ 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 / 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

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REGULAR PRESCRIPTIONS

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

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

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Dr. DR.V.V.R.SATYA PRASAD

Weight. 48 Kg Ward. .....

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

VARIABLE DOSE DRUG : / Route / Start Date / Name & Signature of the Doctor / Additional Instructions:	Date▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
		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
08/07/26	11:18 AM	INJ. ALBUMIN (20.1.)	100ml over 4 hrs	IV	Nurse-A	Keerthee Bhavani
08/07/26	1:30 pm	INJ. LASIX	30 mg (midway)	IV	Nurse-A	Subhasri Bhavani
08/7/26	3:42 PM	INJ. LASIX	30mg (End way)	IV	Nurse-A	Renuka Pooja
08/7/26	11:15 AM	INJ. PANTOPRAZOLE	40mg	IV	Nurse-A	Keerthee Bhavani

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

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

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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: E.R ..... Shifted to: E.R admission (Day care

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.A., Dr. Nandan

Date & Time : 08/07/2026, 11 AM

Nurse Name & Signature: Subasri

Date & Time : 08/07 at 11 AM

BAH-00397366 IP5-00176099
Baby NAVYASREE
03-09-2011 14 Y 10 M 5 D (F)
Dr. DR.V.V.R.SATYA PRASAD

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RESULT SHEET

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

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

Culture and Sensitivities : .....

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Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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FLUID CHART

Sheet No. : 01

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							
8/7/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am	Albumin		25ml	-	—	—	—	-	[illegible]	0	Submitted
	12:00 pm	Albumin		25ml	—	—	—	-	-	200ml	0	Submitted
	01:00 pm	Albumin		25ml	—	—	passed	—	—	[illegible]	0	Submitted
Total Intake :				75ml		Total Output :				500ml		
8/7/26	02:00 pm	Albumin		25 ml	—	—	passed	—	—	150ml	0	Renuka
	03:00 pm	Albumin		25 ml	—	-	passed	—	—	200ml	0	Renuka
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :				50ml		Total Output :				750ml		
	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	100 ml	Total 24 hrs. Output	1250 ml

Patient Sticker

FLUID CHART

Rainbow® Children's Hospital
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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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			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**	

H-00397366 IP5-00176099
by NAVYASREE
09-2011 14 Y 10 M 5 D (F)
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THE HUMPTY DUMPTY SCALE 8/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2				
	13 years old and above	1					
Gender	Male	2					
	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		9				

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

	Bed in low position		Yes				
	Call device within reach		Yes				
	Wheels Locked		Yes				
	Room free of clutter		Yes				
	Adequate Lighting		Yes				
	Wheel Chair Support		NO				
	Other Intervention(s) Specify		NO				
	Nurse's Name :		Sagari				
	Signature :						
	Date :		8/7				
	Time :		11:10 Am				

Docu. No. RCHBH / FRM / CLINICAL / 005