

BAH-00500689 IP5-00174451
 Master ALATHURU CHARITH
 15-03-2019 7 Y 2 M 13 D (M)
 Dr. SIRISHA RANI



ACTIVITY RECORD FOR BILLING

Name : _____

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

Date of Admission: _____ Time : _____ Date of Discharge : 28/5 Time: 4:30 PM

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<u>28/05/20</u>	<u>2:10 PM</u>	<u>CR</u>	<u>145</u>	<u>[Signature]</u>

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1				
2				
3		<u>[Signature]</u>		
4				
5				
6				
7				
8				
9				
10				

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
2/2/15	Blood test	①	9631632	[Signature]

ANY OTHER INFORMATION

.....
.....
.....
.....
.....
.....
.....

OK

Date : 28/5/15

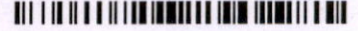
Time : 4:07

Prepared By : [Signature]

Staff Nurse [Signature]	Shift / Ward S/W	Billing Assistant	Billing Supervisor
----------------------------	---------------------	-------------------	--------------------

**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 : IP5-00174451 Admit Date : 28-May-2026 Admit Time : 01:21 PM UHID : BAH-00509689

Patient Details :

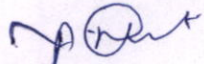
Patient Name : Master ALATHURU CHARITH KHUSHAL Age : 7 Y 2 M 13 D
Guardian : Mr DINESH ALATHURU DOB : 15-03-2019
Gender : Male Religion :
Occupation : Martial Status : Single
Address (H) : FLAT NO. 303,H NO 20-74/7, HILL VIEW Phone No : 9642358827/ 9581815729
RESIDENCY, GOUTHAM NAGAR,NEAR E-mail : na123@gmail.com
GOUTHAM NAGAR WATER TANK, Malkajgiri
Hyderabad INDIA 500047

Admission Details :

Bed Type : SHARED WARD Bed No : SW 145 Ward Name : 1F-VIBGYOR
Room No : SW 145 Admission Type : First Visit

Contact Details :

Name : Mr DINESH ALATHURU Relationship : Father
Contact Address : FLAT NO. 303,H NO 20-74/7, HILL VIEW Phone No : 9642358827 / 9581815729
RESIDENCY, GOUTHAM NAGAR,NEAR
GOUTHAM NAGAR WATER TANK, Malkajgiri
Hyderabad INDIA 500047


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 : MEDI ASSIST INSURANCE TPA PVT LTD



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Sirisha

Date 28/05/26

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

Start Time of Assessment:

Weight: 13.55kg

Allergic History:

Chief Complaints:

KfO Relapsed refractory
 Rhabdomyosarcoma
 involving neck of Bladder &
 Prostatic Urethra
 with Bladder Outlet obstruction
 Now for PRBC transfusion

Pediatric Assessment Triangle

A Appearance - TICLS

B Breathing

C Circulation

Normal
 Abnormal

Pallor
 Cyanosis
 Mottling
 Bleeding

↑ WOB
 ↓ WOB
 Normal
 Gasping / Apnea

Initial Physiological Status: Stable Unstable
 Life Threatening
 Non Life Threatening

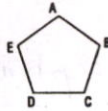
Any urgent interventions needed: Yes No
 If Yes

Significant Past History:

Medication History: On VIT chemotherapy

Relevant Investigations: D+IG post chemotherapy

Primary Assessment



Airway



Open
 Maintainable
 Not Maintainable

Any urgent interventions needed: Yes No
 If Yes

Breathing



Rate: 22/min SpO₂ on FiO₂ 98.1 @ RA
 Rhythm: regular
 Retractions: Suprasternal ICR SCR
 Sternal Supraclavicular Nasal Flaring
 Respiratory Noises: Stridor Wheezing Grunting
 Air Entry: BAE@, clear
 Palpation Findings (if necessary).....

Any urgent interventions needed: Yes No
 If Yes

Circulation

HR: 119/min

CFT Central > 3 sec Peripheral > 3 sec

Any urgent interventions needed: Yes No

BP: 115/70 mmHg

Murmurs: Yes No

Pulse Volume: Central > 3 sec Peripheral > 3 sec

Liver Span:

If in Shock: Compensated Hypotensive

ECG:

Muffled Heart Sound: Yes No

Any Signs of Heart Failure: Yes No

Engorged Neck Veins: Yes No

Disability

GCS: AVPU: Alert

Any urgent interventions needed: Yes No

Pupils: Responsive Non-Responsive

If Yes

Size: Right Left

Active Seizures: Yes No

Sugars:

Signs of Neurological compromise:

Exposure

Temp.: 98.0° P

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 N/B

Stem

Treatment Planned:

- Continue septran, Mouthcare,

Mouthwash, Mottel.

- PRBC Transfusion

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

Final Diagnosis with possible Differential Diagnosis (If necessary): PRBC Transfusion

Assessment done by

Name of the Doctor: Jaya Sn

Signature: JM

Date & Time: 28/05/26 @ 1:45 PM

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor:

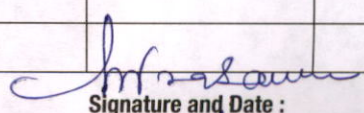
Signature:

Date & Time:

128B

DEFICIENCY CHECK LIST OF CASE SHEET

S.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				
12	Consent for chemotherapy	1			
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	1			
43	BP Monitoring chart				
44	RBS monitoring chart				
	Extra	6			
	Total No. of Pages	26			


 Signature and Date :

28/5/26

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

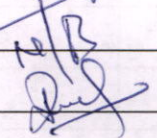
DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

BAH-00509689 IP5-00174451
 Master ALATHURU CHARITH
 15-03-2019 7 Y 2 M 13 D (M)
 Dr. SIRISHA RANI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Day care notes</u>	
28/05/26		
1:30 PM	K/fo Relapse refractory RMS	
	of Bladder neck &	
	Prostatic Urethra	
	Now for PRBC Transfusion	
		<u>Plan</u>
	O/E = child alert	1) Continue medications as advised.
	Resp } PIA } (M) CVS }	2) <u>PRBC Transfusion.</u>
	Vitals - stable	3) Monitor Vitals
		 <u>Dr. Jayashree</u>

BAH-00509689 IP5-00174451
 Master ALATHURU CHARITH
 15-03-2019 7 Y 2 M 13 D (M)
 Dr. SIRISHA RANI



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: Onw

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	Syrup SEPTRAW	4ml	PO	BD (Mon, wed, Fri)	27/5/26	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2	Syrup ZINCOVIT	5ml	PO	OD	27/5/26	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
3	Syrup CALCIMAX PLUS	5ml	PO	OD	27/5/26	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input 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

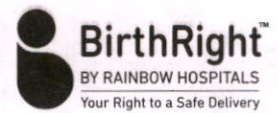
Doctor Name & Signature: Jaya Sri (Jsr)

Date & Time: 28/5/26 @ 1:30 PM

Nurse Name & Signature: T. sneha

Date & Time: 28/05 @ 2:10 PM

BAH-00509689 IP5-00174451
 Master ALATHURU CHARITH
 15-03-2019 7 Y 2 M 13 D (M)
 Dr. SIRISHA RANI



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					



DRUG CHART

Date of Admission: 28/05/20 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 : Syrup PARACETAMOL				Date Time																
Dose	Route	Frequency	Start Date																	
4ml	po	6th hrs	28/5																	
Doctor's Signature		Valid Period	Pharm.																	
Fajari		2 days	✓																	
Additional Instructions:																				
(5ml/240ms) If T > 100F																				

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 Signat



REGULAR PRESCRIPTIONS

Weight. 13.55kg Ward.

VERIFIED

DRUG : Inj ONDENSEYROW				Date Time	28/5
Dose	Route	Frequency	Start Date		
4mg	IV	12 th ly	28/5		
Name & Signature of the Doctor Starting the Drugs:				GAMAX	
Additional Instructions:				6pm ^{hmb} saw	
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					

✓



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
28/5	3:40pm	Inj AVIL	7mg	IV	Jayash	Krishna Sanyal
28/5	3:40pm	Inj HYDROCORTISONE	25mg	IV	Jayash	Krishna Sanyal
28/5	3:40pm	PRBC	1 unit over 6 hours	IV	Jayash	Krishna Sanyal
28/5	u.p.p.s	Inj LASIX	5mg	IV	A	Krishna Sanyal

Signature
VERIFIED BY: Name

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)



FLUID CHART

Sheet No. : 1

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

		Intake				Output					IV Site Thrombophlebitis 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							

BAH-00509689 IP5-00174451
 Master ALATHURU CHARITH
 15-03-2019 7 Y 2 M 13 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.
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

CONSENT FOR BLOOD TRANSFUSION



BAH-00509689 IP5-00174451
 Master ALATHURU CHARITH
 15-03-2019 7 Y 2 M 13 D (M)
 Dr. SIRISHA RANI

Name: Age: Gender: Male Female
 UHID.No : Date: 28/05/2026

- 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

Mr. Dinigh. K. 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: <u>Prin</u>	Signature: <u>Keerthi</u>
Name: <u>Poojima</u>	Name: <u>Keerthi</u>
Date & Time: <u>28/05/2026 @ 4pm</u>	Date & Time: <u>28/05/2026 Sirisha</u>

Witness

Signature: Indrshendu Sorn

Name: Indrshendu Sorn

Date & Time: 28-5-2026 @ 4pm

రోగి పేరు: వయస్సు: లింగము పురుషుడు స్త్రీ


UHID. సంఖ్య:

రక్త ఉత్పత్తి రకాలు:

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. 265 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.: BAH26-01202 Blood Group: O Rh Positive Collection Date: 17/May/2026 Expiry Date: 28/Jun/2026

1) Administer Without Warming. 2) Shake Gently Before Use. 3) Do Not Add Any Medication. 4) Check Blood Group on Label & Recipient's Group and Name Before Administration. 5) Use Sterile Transfusion Set 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 Compatible Cross Matched Blood Without Atypical Antibodies. 10) Blood should Be Used.

- Random Donor Platelets
- Whole Blood
- ఇతరులు.....

పపత్రిలో అడ్మిట్ అయి అంగీకారం తెలుపుతున్నాను. లేనియా మరియు సిప్లిస్ కి పరీక్షలో కనబడని అనేక క్షుత్తుల మార్పిడికి సంబంధించిన తెలెత్తవచ్చు అని నేను అర్థం

Issue Label / CrossMatching Report

Patient : **master a charith khushal .**
 Patient's Blood Group : O Rh Positive
 Hosp/Dr : Rainbow Childrens Hospital, DR. SIRISHA RANI
 UHID No.: BAH-00509689 Wd-Bed No.:

Product : LR-PRBC
 Blood Group : O Rh Positive Issue Dt : 28/May/2026
 Unit No.: **BAH26-01202** Colln. Dt : 17/May/2026
 XMatching Report: Compatible Exp. Dt : 28/Jun/2026
 X-matched by: MONOJ Issued By : MONOJ

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

చేస్తున్న డాక్టర్ ద్వారా నాకు రక్త ఉత్పత్తులు ప్యాక్ చేయబడిన నా అంగీకారము తెలుపుతున్నాను.

నేను ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా తరక్తాన్సిహెచ్ ఐ వి యాంటి లక్షణాలు లేవని పరీక్షించి బడిన ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదైన ప్రతిచర్యలు సోకే ప్రమాదం వుండే చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం

పైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు వివరించబడ్డాయి. చికిత్స చేస్తున్న సమయంలో ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్ నాకు పూర్తిగా అర్థమగు భాషలో నాకు న

సహాయకుడు(అటెండెంట్) సంతకము పేరు
 తేదీ మరియు సమయము
 వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)
 సంతకము పేరు

సాక్షి సంతకం పేరు
 తేదీ మరియు సమయము



BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 28/5/20 Time: 2:45 pm

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: 28/5/20 Planned duration of Transfusion: 2 hrs

Check for Correct Unit: Correct Patient:

Blood products cross checked by: Nurse 1: Krishnakumar Nurse 2: Sangeetha

Before starting transfusion vitals: Temp: 98.8 HR 112 RR: 28 BP: 102/62 SpO₂ 100

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
	15 Min	112	98.8	102/62	100	NA	NA	NA	NA
	15 Min	108	98.2	102/62	100	NA	NA	NA	NA
	30 Min	120	98.7	108/62	100	NA	NA	NA	NA
	30 Min	112	97.1	105/62	99	NA	NA	NA	NA
	30 Min	108	98.1	108/62	99	NA	NA	NA	NA
	1 Hr	102	98.4	112/76	99	NA	NA	NA	NA
	1 Hr								

Comments: Nil

Name of the Incharge-Nurse: Krishnakumar Name of the Nurse: Sangeetha

Signature of the Incharge-Nurse: Krishnakumar Signature of the Nurse: Sangeetha

Date & Time: 28/5/20 2:45 pm Date & Time: 28/5/20 2:45 pm