

ADMISSION SHEET

Registration Details :



Admission No : IP5-00173972 Admit Date : 18-May-2026 Admit Time : 01:45 PM UHID : BAH-00656586

Patient Details :

Patient Name : Master KANTHA PRIYANSHA Age : 7 Y 1 M 0 D
Guardian : Mr KANTHA JAIPAL DOB : 18-04-2019
Gender : Male Religion :
Occupation : Martial Status : Single
Address (H) : THE FIRST BY DSR, FLAT NO 2702, NEAR Phone No : 9885732514/ 7675998841
ARETE HOSPITAL Gachibowli Hyderabad E-mail : NOMAIL@GMAIL.COM
Telangana INDIA 500032

Admission Details :

Bed Type : PICU Bed No : PICU 222 Ward Name : 2F-PICU II
Room No : PICU 222 Admission Type : First Visit

Contact Details :

Name : Mr KANTHA JAIPAL Relationship : Father
Contact Address : THE FIRST BY DSR, FLAT NO 2702, NEAR Phone No : 9885732514
ARETE HOSPITAL Gachibowli Hyderabad
Telangana INDIA 500032

Mother
[Handwritten Signature]
Signature

Doctor Details :

Doctor Name : Dr. LEENATHA JAKKIDI Specialisation : PEDIATRIC ENDOCRINOLOGY
Referral Doctor : Self Phone No :
Co-Consultant : Dr. KAPIL BHAGWATRAO SACHANE

Payment Details :

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

18/5

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ Consultant: _____ Dept : _____
BAH-00656586 040265-043512
 Master PRIYANSHA
 18-04-2019 7 Y 1 M 0 D (M)
 Dr. LEENATHA JAKKIDI

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

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

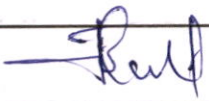
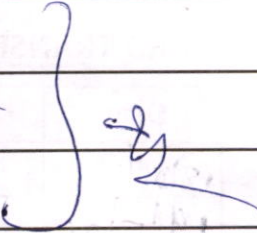
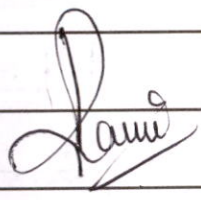
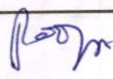
WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
18/05/20	1:20 pm	ER	PIW	Mushmal
19/5/26	12pm	PIW	311	ney

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	DR. Anurag	18/5	9614420	[Signature]
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

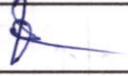
Date	Investigations	Order No.	Signature
18/5	Rbx - 452 mg/dl, VBC, ketoneu blood	OPD	
18/5	-BP, RPa -HbA1c, CRP Thyroid Profile -type-I diabetes Panel - I VBC	26050985	
19/5/26	RPa -ABG, RBS	26050689 26050688	
18/5/26	RBS, RBS, RBS	26050697	
19/5/26	RBS, RBS, RBS	26050703	
	RBS, RBS, RBS	26050707	
	RBS, RBS, RBS	26050708	
	RBS, RBS, RBS	26050711	
19/5/26	GRBS ⁽¹⁶⁵⁾ , GRBS ⁽²⁶³⁾ @ 4pm GRBS (263) pre dinner	26051061	Swarna
20/5/26	GRBS (151 mg/dl)	26051195	
20/5/26	GRBS (201 mg/dl)	26051196	

MEDICAL EQUIPMENT (WARD & ICU)

PROCEDURE

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
18/5	mv monitor				
	inf pump			9614092	
	Syr. pump		stop		
	Syr. pump	8pm			
19/5/26	Inv. monitor			9614046	
	Inf pump			9614046	
	Syr. pump		stop	9614749	Lau
	Syr. pump			9614749	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
18/5	W Placement	(1)	96A929	

ANY OTHER INFORMATION

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.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Ar per Rada Date : 18/05/20

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

Start Time of Assessment: 1:15 PM Weight: 22.8 kg

Allergic History: (-)

Chief Complaints:
c/o Increased frequency of
nocturnal voids = 5/day
polydipsia (+)
polyuria (+)
Vomiting - 2 days
wf loss = 1 month
(> 2kg loss)

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: klc/o LCH on treatment (Trametinib)

Relevant Investigations: H/o Diabetes in Father stopped 4 months ago.

Primary Assessment

Airway

Open
 Maintainable
 Not Maintainable

Any urgent interventions needed: Yes No
 If Yes

Breathing

Rate: 24/min SpO₂ on FiO₂ 99% @RA

Rhythm: regular

Retractions: Suprasternal ICR SCR
 Sternal Supraclavicular Nasal Flaring

Respiratory Noises: Stridor Wheezing Grunting

Air Entry: BAE (+)

Palpation Findings (if necessary)

Any urgent interventions needed: Yes No
 If Yes



Circulation

HR: 142/min

CFT Central <3 sec
 Peripheral

Any urgent interventions needed: Yes No

If Yes*

BP: 89/55 mmHg

Pulse Volume: Central <3 sec
 Peripheral

Murmurs: Yes No

Liver Span:

If in Shock: Compensated

Hypotensive

ECG:

Any Signs of Heart Failure: Yes No

Muffled Heart Sound: Yes No

Engorged Neck Veins: Yes No



Disability

GCS: AVPU: Alert

Any urgent interventions needed: Yes No

If Yes

Pupils: Responsive Non-Responsive
Size Right
 Left

Active Seizures: Yes No Sugars: 452mg/dl

Signs of Neurological compromise

Exposure



Temp.: 98°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:

Labs Planned: VBG

Blood ketones

Treatment Planned: 1) NS Bolus stat

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

Final Diagnosis with possible Differential Diagnosis (If necessary): Diabetic ketoacidosis

Assessment done by
Name of the Doctor: Joyashi

Sr. Doctor on Duty (If necessary)
Name of the Sr. Doctor: Dr. Kattuk

Signature: JM

Signature: Allet

Date & Time: 18/05/20

Date & Time: 18/05/20



PEDIATRIC INTENSIVE CARE ADMISSION RECORD

Date: 18/5/22 Time: 2pm

Patient Assessment Form:

Informant: Father Mother Other

Presenting Complaints / Chief Complaints :

Increased urination - for 7 days
Increased thirst - for 7 days
Significant weight loss since last 7-10 days
Vomiting 3 times 2 days back.
Lethargic since yesterday.

No history of fever, loose stool, cough, fast breathing, burping, icteric, pain abdomen

Past History (Including previous treatment and investigations) :

diagnosed in 2022.
- K1c10 Langerhans cell histiocytosis
Child was stopped on Trimeprazine 4 months back.
Follow up at Apollo Chennai.

Birth and Developmental History :

H/O multiple hospitalisation for chemotherapy
Term / Mck / bwt 2.3kg / born to G2P1
via LSCS (parent's choice), cried at-birth
Developmentally normal as per peer

Immunization History :

Immunised as per NIS.

H/O Allergy :

Not known.

Family History :

Father is diabetic.

localized diffuse sharp aching referred vague burning / soreness

Frequency: constant intermittent occasional

Pain Management done Yes No

Nutritional Evaluation:

Underweight

Current Medications:

INITIAL ASSESSMENT

RBS : 455 mg/dl Temperature : Weight (kg) : 22kg
Respiratory System Findings:
 Air Way: Open Maintainable Not Maintainable Intubated, If Intubated, size & position of ETT :
 Respiratory Examination Finding: (Air entry, breath sounds, s/o distress etc.): Respiratory Rate : 24/min
RR: 20/min
 SPO₂: 99% O by NC / FM / NRB mask / Oxyhood, at L / min
 Ventilatory Support: Yes No - Day # of Vent : Respiratory Efforts : Good
 Ventilatory Settings : Leak around ETT : - Delivered Vt : -
 ABG : - EtCO₂ : -

Provisional Diagnosis : w/d/o Langerhans cell histiocytosis & de novo DM
Moderate DKA.

Prism III score at 24 hrs of admission : Worse SOFA Score :

Referred Patient - Self Referral - Rainbow Patient "

Transferring Unit : Ward OT - Transported? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

Referring Consultant :

Admitting Consultant Dr. Leenatha Jakkid

Indication for PICU referral : DKA

PLAN OF CARE

Preventive aspects of the treatment : Shock, Metabolic acidosis

Desired goals of the treatment : Hemodynamic stability

PLANNED INVESTIGATIONS

CBP, RP2.
HA HbA1c.
urine c/s
urine UE.
Thyroid profile.
Type I diabetes panel I.
CRP.
Blood c/s
Blood ketones.

PLANNED MANAGEMENT

IV fluids as per DKA.
Insulin infusion.
Ceftriaxone 2g
Esomeprazole.

Final Diagnosis: w/d/o LCH with de novo DM with
Moderate DKA.

Doctor's Signature : [Signature]
 Name : Subha G. Das
 Date : 18/07/20
 Time : 2:20pm

Consultant's Signature : [Signature]
 Name : [Signature]
 Date : 19/07/20
 Time : [Signature]

Dr. Apil Bhagwatrao Achane
 Reg. No.: JSMC/FMR/19525



ADMISSION CRITERIA – PICU

Admission / Transfer from:

- Emergency Outpatient (OPD) Ward Operation Theater Others:

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

- All patients requiring mechanical ventilation;
- Patients with impending respiratory failure;
 - Upper airway obstruction;
 - Lower airway obstruction;
 - Alveolar disease; and
 - Unstable airway;
- All Paediatric patients after successful resuscitation;
- Comatose Patients;**
 - Meningitis, encephalitis; Hepatic encephalopathy; cerebral malaria;
 - Head injury; Poisonings; and Status epilepticus;
- All types of shock/hemodynamic instability:**
 - Septic shock;
 - Hypovolemic shock; (Bleeding emergencies such as gastrointestinal bleeding, bleeding diathesis, disseminated intravascular coagulation; Cardiogenic shock; myocarditis, cardiomyopathy, congenital heart disease; Neurogenic shock; and Multiple trauma;
- Cardiac arrhythmias after consulting with the treating consultant
- Hypertensive Emergencies;
- Severe acid base disorders;
- Severe electrolyte abnormalities;
- Diabetic ketoacidosis (Ph < 7.2, altered sensorium, hyperglycemia)
- Acute renal failure; Patients requiring acute hemodialysis, hemofiltration and peritoneal dialysis;
- Post-Operative Patients;**
 - Requiring ventilation;
 - Unstable patients; and
 - Post-operative patients after open heart surgery, neurosurgery, thoracic surgery and other patients after major general surgery with potential for respiratory/haemodynamic instability;
- Patients requiring nitric oxide therapy;
- Malignant hyperpyrexia;
- Acute hepatic failure
- Severe dehydration with mental status change;
- Asthma requiring hourly nebulization/getting tired with increasing oxygen requirement/mental status change.

“UNSTABLE” PATIENT IS DEFINED AS

- HR < 50 or > 160 per minute or more than upper normal limit according to age. BP < 90 systolic and < 50 diastolic an or requiring inotropic support. Arrhythmia or risk of sudden arrhythmia.
- Signs of peripheral poor perfusion or suspicion of any type of shock.
- Capillary refill time > 4seconds.
- Children Blood pressure (Syst.) < [70 + (2× age “Years”)].

Respiratory failure or high risk of failure or airway obstruction:

- Respiration rate < 5 per minute below the normal or > 10-15 per minute above the normal range for age.
- O2 Saturation < 90 % or need for O2 > 4 Litres per minute by normal face mask. Abnormal ABG: PH < 7.25, PaO2 < 60 torr, PaCO2 > 50 torr.
- Distress and risk of exhaustion
- Change of level of consciousness: GCS < 13.**
- Persistent oliguria with acidosis.**

Signature of the Doctor: [Signature] Name of the Doctor: Dr. Nandan Date & Time: 8/05/2026

BAH-00656586 IP5-00173972
Master KANTHA PRIYANSHA
18-04-2019 7 Y 1 M 0 D (M)
Dr. LEENATHA JAKKIDI



DISCHARGE CRITERIA – PICU

Discharge to:

- HDU / Step down ICU Ward Outside Facility Others:

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

- Stable hemodynamic parameters.
- Stable respiratory status (patient extubated with stable arterial blood gases) and airway patency at least for 24 hours with no respiratory distress needing continuous monitoring.
- Minimal oxygen requirements that do not exceed patient care unit guidelines.
- Intravenous inotropic support, vasodilators, and antiarrhythmic drugs are no longer required or, when applicable, low doses of these medications can be administered safely in otherwise stable patients in a designated patient care unit.
- Cardiac dysrhythmias are controlled.
- Neurologic stability with control of seizures.
- Removal of all hemodynamic monitoring catheters.
- Routine peritoneal or hemodialysis with resolution of critical illness not exceeding general patient care unit guidelines.
- Patients with mature artificial airways (tracheostomies) who no longer require excessive suctioning.

Signature of the Doctor:

Name of the Doctor :

Date & Time:

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 Mother KANTHA PRIYANSHA
 19-04-2019 7 Y 1 M 2 D (M)
 Dr. LEENATHA JAKKIDI



DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	2			
5	In-patient Medical record				
6	Doctors progress sheets	8			
7	Nursing plan of care and handover sheets	2 + 1 + 2			
8	Consultation sheet	1			
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation	1			
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	2			
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	1			
35	Intensive care unit (ICU Charts)	3			
36	Consent for Admission in PICU / NICU	1			
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list	1			
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note	1			
43	BP Monitoring chart				
44	RBS monitoring chart				
	<i>only others</i>	2			
		2 + 13 + 3			
	Total No. of Pages				

50

Signature and Date : 20/9/20 (P.T.O)

ERROR LOG

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

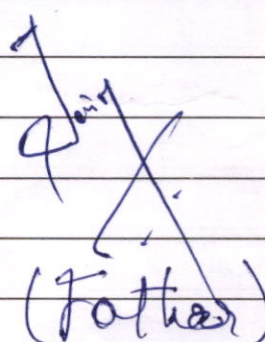
OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/5/26 2pm.	<p style="text-align: center;"><u>Counselling note</u></p>	
	<p style="text-align: center;"><u>Dr. Sandeep</u></p>	
	<p>Child is having high acid level due to diabetic ketoacidosis. Child is mostly having diabetes mellitus where there is insulin deficiency leading to high glucose & acid level. Child gets dly hydrated due to passage of large urine. We will start him on fluids & insulin infusion. Acid level will come down in 12-24 hrs. Child needs frequent blood sampling to see acid level. Leenatha ma'am (Endocrinologist) will come & see. As child stabilizes we will shift to subcutaneous insulin & start him feeds. Child needs ICU care till acid level comes to normal.</p>	
	<p style="text-align: center;">  (Father) </p>	<p style="text-align: right;">Subya</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/5/26 1:15 PM	Seen by Dr Leenatha Jakkidi	
	= ↑ Glucose	
	- DKA.	
	- pH = 7.23	} <u>DKA</u>
	RBS > 400	
	- Father - T2DM ^Δ sed @ 32 yrs	
	- Started on IV fluids -	
	→ PICU → Follow DKA protocol.	
		LJK
		Dr. LEENATHA JAKKIDI Reg. No: 72032



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/5/20 2:40 pm	<p>6/5/18 11/5/18 Randat W/O LCH. Moderate Δ: Acute DKA. De novo diabetic ketosis. HT loss since lat 10 days Polyuria x 7 days. Polydipsia x 7 days Vomiting 3 times 2 days back. Lethargic since yesterday No breathing No fever, look well, fast breathing, Child on room air. SpO₂: 100%. PR: 82/min RR: 25/min. BP:</p>	<p>Dr. Sandeep WT: 22 kg</p>
		<p>Plan:-</p>
		<p>① Start DKA fluid management.</p>
		<p>② Insulin infusion after 2hr. of iv fluids</p>
		<p>③ Secu 20g cannula</p>
		<p>④ CBP, RPE, HbA1c</p>
		<p>urine c/s Thyroid profile.</p>
		<p>CVE. Type I Diabetes panel?</p>
		<p>CRP. Blood c/s. Blood ketones.</p>
		<p>⑤ Ig Ceftriaxone</p>
		<p>⑥ Monitor urine output.</p>
		<p>⑦ ABG LQ 7pm.</p>
		<p>⑧ Dr. Anurag consultation</p>
	<p>Pupil: 2+ 2+ Tone: (N). PA: soft, NT.</p>	<p>noted by Mathew 18/5/20 2:40 pm</p>

BAH-00656586
 Master KANTHA PRIYANSHA
 18-04-2019 7 Y 1 M 0 D
 Dr. LEENATHA JAKKIDI (M)



RESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		Wt 22g.
	F.I. Correction (DKA)	
	Maintenance : 1540 ml / Day : 3080 ml over 48hr.	
	5% Correction : 1100 ml over 48hr.	
	Bolus : 220 ml.	
	Total fluid req : $\frac{3080 + 1100 - 220}{48}$	
	= 82 ml/hr.	
	<u>F.I. correction</u>	
	Maintenance : $1540 \times 2 = 3080$ ml over 48hr.	
	F.I. correction : 1540	
	Total fluid req = $\frac{3080 + 1540 - 220}{48}$	
	= 91 ml/hr.	



PROGRESS NOTES AND DOCTOR'S ORDER

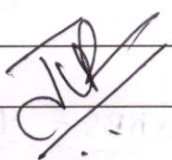
Date & Time	Progress Notes	Doctor's Order
18/05/2026 6PM	E/S/B PICU team	
	D: moderate DKA K/C/O LCH	Plan
	- on RA - Hemodynamically Stable	- cont. IV fluids as per advice.
	- NO fresh issues.	- cont. IV insulin infusion.
	- NO fever spikes. Lwt GRBS - 240mg/dl	- continue medications as per chart
		- send Blood c/s CUE Urine c/s
		- True thyroid profile HbA1c, T ₁ ? - 1 Diabetes Panel
		- ABG @ 7PM
		- GRBS q 1 hourly
		- Doc Admrag Noted by Mathew 18/5/26 @ 6:40P Nandana (Dr. Nandana)

BAH-00656586
 Master KANTHA PRIYANSHA
 18-04-2019 7 Y 1 M 0 D
 D. LEENATHA JAKKIDI (M)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/5/26 8PM	Moderate DKA K/C/O LCH.	c/d/w Dr. Leenatha <u>Plan</u>
	on room air Hemodynamically stable. no fresh issue	- Taziba 7units 1/c. 1unit/kg/hr. - continue IV insulin.
	ABG done.	- allow orally. - ABC (T/m) Noted by: Navaneetha 18/5/26 @ 8:10pm.
19/5/26 8:30AM	GRBS - 90 mg.	c/d/w Dr. Leenatha. <u>plan.</u> - Give ficsp 3units s/c. Noted by: Navaneetha 19/5/26 @ 8:35AM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order																		
19-5-26	Review																			
	Newly ^{sed} T1DM Mild DKA - resolved	1. Tresiba → 8 units at 8pm daily ✓																		
		2. Fiasp before BF/L/D qpm																		
		<table border="1"> <tr> <td><100</td> <td>4</td> <td>X</td> </tr> <tr> <td>>100</td> <td>5</td> <td>2</td> </tr> <tr> <td>>200</td> <td>6</td> <td>3</td> </tr> <tr> <td>>300</td> <td>7</td> <td>4</td> </tr> <tr> <td>>400</td> <td>8</td> <td>5</td> </tr> <tr> <td>>500</td> <td>9</td> <td>6</td> </tr> </table>	<100	4	X	>100	5	2	>200	6	3	>300	7	4	>400	8	5	>500	9	6
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>400	8	5																		
>500	9	6																		
<div style="border-left: 1px solid black; border-right: 1px solid black; border-bottom: 1px solid black; padding: 5px;"> <p>Monitor FBG Before lunch 4pm before dinner 2am</p> </div>																				
		Stop IV insulin after 45min of giving Fiasp																		
		Stop IV fluids at the same time.																		
<div style="border: 1px solid black; padding: 5px;"> <p>Free style libre sensor 2</p> </div>																				

Dr. LEENATHA JAKKIDI
 Reg. No: 72032

BAH-00656586 IP5-00173972
 Master KANTHA PRIYANSHA (M)
 18-04-2019 7 Y 1 M 0 D
 Dr. LEENATHA JAKKIDI



P16-2
 BEO-14



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/6/26	NOTATION REVISED	
9e	PBW: 224 K/C/O LCA - DICA	
	7am - CMD - METAWITAMIN - 3 loops / 145ml WB (PRISTINE - METAMM - BANGLA)	
	8am - 100-1814 / SMDU OOSA / UAMA / DHARA / OAN (100-120g or 120ml) (1:2) EGG - 1 @ CMD - 100	
	10am - PANNA - 50g @ BEANS - 100 (0:2) NON-VAN - 100g @ VAN - 2SERVIS (1:2:1)	
	1m - RICA - 100 (100ml COP) / OAN (ON) DHARA - 100ml 4m - CMD - METAWITAMIN - 3 loops / 145ml WB	
	6m - CHICKEN SOOP / CHICKEN GRILLER	
	7m - EGG - 1 OAN / DHARA / NON-1 @ VAN	
	BEDTIME - SPAN	

BROWNIE
 19/6/26
 9am

BAH-00656586 IP5-00173972
 Master KANTHA PRIYANSHA
 18-04-2019 7 Y 1 M 0 D (M)
 Dr. LEENATHA JAKKIDI



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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/05/26		
11Am	<p>dsib Dr. Kapil</p> <p>Δ New onset diabetes (? Type 1 dm)</p> <p>Kidney LCH ⊕</p> <p>O/E</p> <p>CVC - S1S2 ⊕</p> <p>R/S - B/L AE ⊕ clear</p> <p>P/A - soft (Not passed stools since admission)</p> <p>Bowel sounds ⊕</p> <p>Vital</p> <p>PR - 95bpm</p> <p>RR - 20bpm</p> <p>SpO2 - 99% R/A</p> <p>BP - 100/60</p> <p>Abx: Inj. cefmaxone - D2</p> <p>RTU's:</p> <p>1) Hypokalemia.</p>	<p>↳ S/P Tramton to e/c tramulin on sliding scale.</p> <p>Plan:</p> <p>① Cont. insulin regime as advised by Dr Leenath.</p> <p>② Shift to room.</p> <p>③ Dietician consult for diabetic diet.</p> <p>④ Remove one cannula, arterial line.</p>
		<p>noted by [Signature]</p> <p>19/05/26</p> <p>11:10AM</p> <p>Dr. Kapil Bhagwatrao Sachare</p> <p>Reg. No: TSMC/FMR/19525</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/5/16	Bed side counselling	Dr Kcpil
11 AM	condition of child explained to parents that	
	child is better. Acid level of child decreased.	
	child is on subcutaneous insulin. IV Insulin has	
	been stopped. Dietician review will be done.	
	Endocrinologist will see the child.	
	<u>XXX</u>	
	Father	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/5/26 11:20pm	<p><u>Shifting notes</u></p> <p>Δ: Langerhan cell histiocytosis. Denovo diabetic ketoacidosis.</p> <p>no issues. acidosis settled.</p> <p><u>OIC</u> child alert vitals stable</p> <p>HR - 100/min SpO₂ - 100% PV good</p>	<p><u>Plan.</u></p> <p>① Trace HbA1c ② CRBS monitoring as advised ③ Trace hyper diabetic panel. ④ Insulin as per sliding scale ⑤ monitor vitals Inform SOS</p> <p><i>Noted by venuse 19/5/26 @ 11:30pm.</i></p>
19/5/26 1 PM	<p>C/S/B - Recurred</p> <p>H/C/O - Langerhan cell histiocytosis now 2 - Denovo DKA</p>	<p><u>Plan</u></p> <p>- no fresh issues CRBS - before lunch - 3 night hemodynamically stable child alert/active/afebrile P/A - soft.</p> <p>→ continue Insulin as per sliding scale → CRBS monitoring as advised</p> <p>- Trace HGA, C., T-1 Diabetic panel - monitor vitals - Inform SOS</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/5/26 8:50 AM	<p><u>Seen by Resident:</u></p> <p>Δ: K/cfo LCH now with Demoro T1DM & moderate DKA (resolved)</p>	
HbA1c	<p>- cfo: 1 episode of hypoglycemia at night - 11-11:30pm</p> <p>- no symptoms as child was asleep</p> <p>- parents & child actively involved in insulin administration</p> <p>- passed urine - 5 times</p>	<p><u>Adv:</u></p> <p>1) (D) today</p>
	<p>O/E: alert</p> <p>stable vitals</p> <p>last RBS - 188 mg/dL.</p> <p>no dehydration</p> <p>S/E: NAD</p> <p>cannula - patent</p>	<p>Stable</p>



CROSS CONSULTATION FORM

Doctor Name : Dr. Anurag Reddy Date : 18/5/16 Time : 3pm

Diagnosis : LCH / Typ 1DM / Moderate DKA

Hospital : Relt. Baijer Hill

Type of Referral :

- Emergency
- Urgent
- Non Urgent

Referred for : Opinion Co-Management Transfer of care

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

Hematology opinion for Langerhan cell histiocytosis
Sphar
Signature:

Findings and Recommendations :

K/clo LCH. on Trameterib (MEK ⊕)
now admitted with New onset diabetes mellitus (moderate DKA)

F^M - 7.2
AG - 13.4
o/e - Serum - ⊕
vital - stable

P, RP₂ - awaited
RBC - 455 m/dl - 498 m/dl

Plan
1. Continue DKA management & ICU care

Consultant :

Name : Dr. Anurag Reddy Signature : [Signature] Date & Time : 18/5/16 @ 3pm

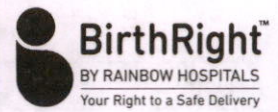
BAH-00656586 IP5-00173972

Master KANTHA PRIYANSHA

18-04-2019 7 Y 1 M 0 D (M)

Dr. LEENATHA JAKKIDI

anpha.



RESULT SHEET

Date	18/5/26	19/5/26			
Time	3PM	6AM			
Hb	13.8				
PCV	42.3				
RBC	5.66				
WBC	6,300				
N/L	39.4/55.9				
Platelets	3,59,000				
CRP	5				
ESR					
PCT					
RBS	4.25				
Na	136	137			
K	5	3.2			
Cl	105	112			
Ca/Mg					
Phosphate					
Urea	18	12			
Creatinine	0.9	0.5			
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	HbA1c				
N/L	Bicarbonate	6	15		

Date	18/5/26					
Time	10pm					
CUE - Alb						
CUE - Sugar	3+					
CUE - Ketones	4+					
CUE - PUS Cells	3-4					
CUE - RBC Cells	1-2					
CUE Leucocytes	⊖					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : Thyroid profile (18/05/2026)

T₃ - 54.02 ↓
T₄ - 5.55 ↓

Radiology : USG : TSH - 1.64

X-Ray :

ECHO : ketone dip stick - ++

CT :

MRI :

Others (ECG, Contrast Studies etc.) :

BAH-00656586 IP5-00173972
 Master KANTHA PRIYANSHA
 18-04-2019 7 Y 1 M 0 D (M)
 Dr. LEENATHA JAKKIDI



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: PICU

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						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input 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 : Jayar

Date & Time : 18/07/20 1:10pm

Nurse Name & Signature: Reshmi

Date & Time : 18/07/20 @ 1:25 pm



DRUG CHART

Date of Admission: 18/5/26 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 :				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. 22kg Ward. PW

VERIFIED

DRUG : INJ. CEFTRIAZONE				Date Time	18/5/2019
Dose	Route	Frequency	Start Date		
1.1g	IV	BD	18/05		
Name & Signature of the Doctor Starting the Drugs:				60m / [Signature]	
Additional Instructions:				Opn. Sub. [Signature]	
Daily Doctor's Endorsement by a Sign					

DRUG : INJ. ESOMEPRAZOLE				Date Time	
Dose	Route	Frequency	Start Date		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

VERIFIED

DRUG : INJ. ESOMEPRAZOLE				Date Time	18/5/2019
Dose	Route	Frequency	Start Date		
20mg	IV	OD	18/05		
Name & Signature of the Doctor Starting the Drugs:				60m / [Signature]	
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	
Start Date	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	Dose		Dose		Dose		Dose		Dose	
Start Date	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor	Dose		Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:	Dose		Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
18/5	8 PM	Inj TRESIBA	7units	s/c	KSR	Amber Rani
19/5	6AM	Inj-KCl 10ml + 100ml NS Potassium chloride		IV over 5hr	KSR	Amber Narmita
19/5	8AM	Syp POTICLOR	10ml	PO	(Hold) Narmita	
19/5	8:45AM	Inj. FIASP	3 units	SC	KSR	Subrata Venkela

VERIFIED BY: Name Signature

I.V. FLUIDS CHART

Weight. 22kg Ward. puw



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
18/5/24	2pm.	IVF 10% DNS if RBS < 150 BNS if RBS 150-250 NS if RBS > 250	iv.	82ml/hr 91ml/hr		make → venela	19/5		venela (@9:47AM) Subrata
18/5/24	2pm.	JNT INSULIN. 1ml in 30ml NS to make 1IU/ml	iv.	2.2ml/hr		make → venela	19/5		venela (@9:47AM) Subrata

Signature

VERIFIED BY : Name



311

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 20/5/26 Time: 9 AM

Weight: 22kg Centile: 50th

Height: 115cm Centile: 50th

Inference: well child

RDA: — Calories: 1500kcal/d Protein: 26g/d

Diet Recommendations: Diabetic diet

Re-Assessment: Avoid Spicy, Chilled & Outside foods

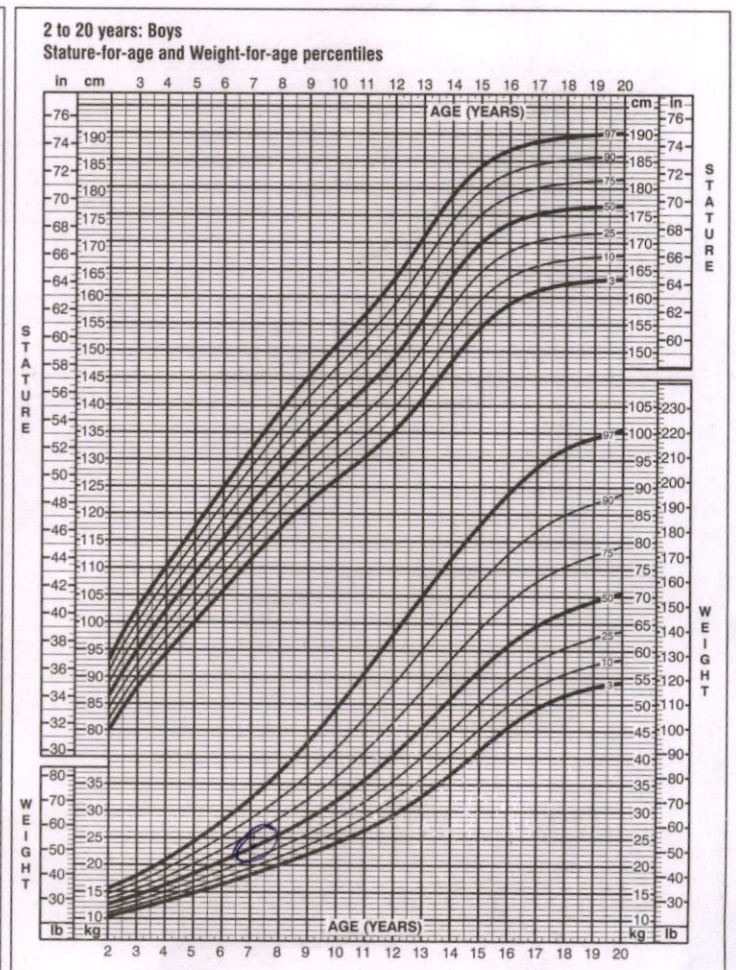
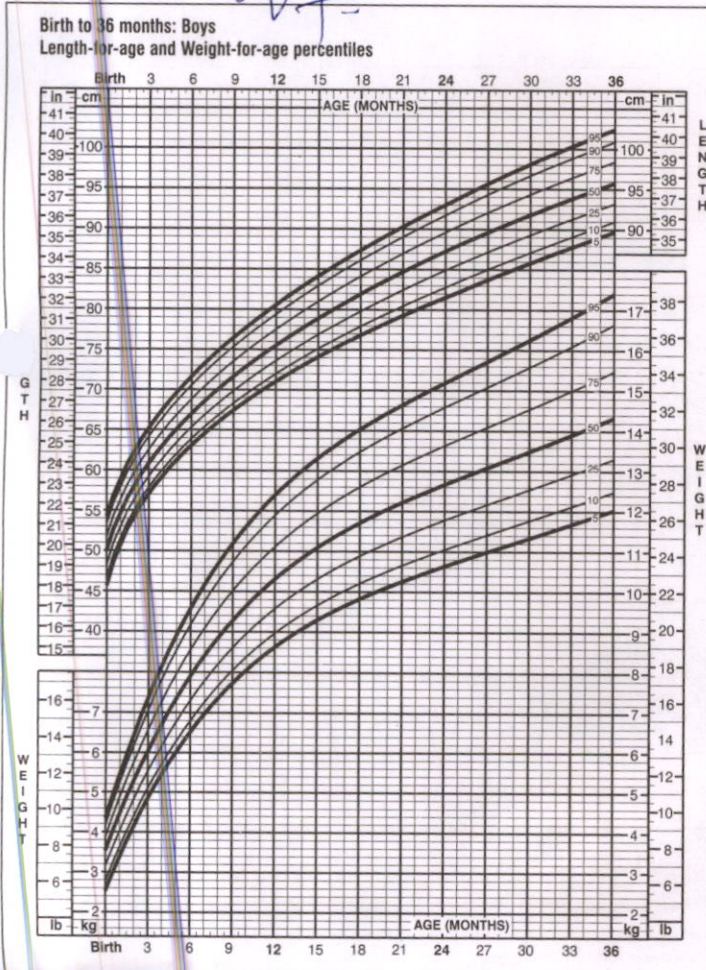
Food Allergies: NO Veg/Non-veg: NON-veg

Diagnosis: K/C/O LCH & bKA behav T1 D.M &

Nutritional Intervention - Oral Enteral Parenteral moderate bKA Resolved

Patient's Signature: *[Signature]*

GROWTH CHART (BOYS)



Dietician's Name: *Leena*

Dietician's Signature: *[Signature]*

