

**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 : IP5-00174597 Admit Date : 01-Jun-2026 Admit Time : 12:30 PM UHID : CUV-00162031

Patient Details :

Patient Name : Master MURARI POORNA PRAGNA SUHANSH Age : 1 Y 7 M 29 D
Guardian : Mr RAVI TEJA MURARI DOB : 03-10-2024 04:12 PM
Gender : Male Religion :
Occupation : Martial Status : Single
Address (H) : H NO 1-121, KALAVAKURU ROAD Phone No : 9030543163/ 6304707647
DHAMAVARIPALEM, Addanki Prakasam E-mail : NA@GMAIL.COM
Andhra Pradesh INDIA 523201

Admission Details :

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

Contact Details :

Name : Mr RAVI TEJA MURARI Relationship : Father
Contact Address : H NO 1-121, KALAVAKURU ROAD Phone No : 9030543163 / 6304707647
DHAMAVARIPALEM, Addanki Prakasam Andhra Pradesh INDIA 523201


Signature

Doctor Details :

Doctor Name : Dr. NALLA ANURAAG REDDY Specialisation : HEMATO ONCOLOGY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 0.90
Payor Name : SELFPAY


ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ Consultant: _____ Dept : _____

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

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Master MURARI POORNA PRAGNA (M)
03-10-2024 1 Y 7 M 29 D
Dr. NALLA ANURAG REDDY



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/6/26	1:15pm	ER	oncology	B

Cross Consultation Visit

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
01/06	IV Placement	①	7611	Samsheer
1/6	IVIG [W]	①	9637838	Ding

ANY OTHER INFORMATION

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Date : 1/6/26 Time : 5pm Prepared By : Ueeng

Staff Nurse Ueeng	Shift / Ward morning duty Oncology	Billing Assistant	Billing Supervisor
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CUV-00162031 IP5-00174597
Master MURARI POORNA PRAGNA
03-10-2024 1 Y 7 M 29 D (M)
Dr. NALLA ANURAAG REDDY



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 Diarrohea 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: A

Name of the Doctor: Dr. Soavani

Date & Time: 11/6/26 @ 1:30pm

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Master MURARI POORNA PRAGNA
03-10-2024 1 Y 7 M 29 D (M)
Dr. NALLA ANURAG REDDY



DISCHARGE CRITERIA – ONCOLOGY

Discharge to:

- HDU / Step down ICU Ward Outside Facility Others: *Home*

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: *[Signature]*


Name of the Doctor : *Dr. Sparan*

Date & Time: *1/6/26 @ 5pm*



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		wt 6.83 kg
01/10/24		
12:30 PM	<p>Post BMT - (9 months)</p> <p>Case - SCID for IVIG.</p> <p>(IVIG Received 6 weeks ago.) (on 17/4/26)</p>	<p>plan</p> <p>Day care Admissions Dr. Anurag</p>
		1) IVIG 5gm over 6 hours
	Vitals: SpO ₂ - 98% - RA	2) inj. Anal stat
	HR - 116/min	
	BP Temp - 116/66 (72)	3) inj. Hydrocortisone stat.
	BP Temp - 98°F	
	No Fever, cough, cold	
	MS Shravan 16/10/26	(Dr. N. Reddy)

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 Master MURARI POORNA PRAGNA
 03-10-2024 1 Y 7 M 29 D (M)
 Dr. NALLA ANURAAG REDDY




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: 1/6/26 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

6.83 kg

REGULAR PRESCRIPTIONS

Weight. 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 :				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																					
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																					



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
01/06/26	3pm	inj. IVIG	5gm (100ml) over 6 hours.	IV	N.P.S	Dr. N.P.S Soman
			0.5 ml/kg/hr ↓ 60 mins			Dr. N.P.S Soman
			1 ml/kg/hr ↓ 60 mins			Dr. N.P.S Soman
			2 ml/kg/hr ↓ 60 mins			Dr. N.P.S Soman
			Remaining 4 ml/kg/hr.			Dr. N.P.S Soman
01/06/26	3pm	inj. AMIL	0.1 ml	IV	N.P.S	Dr. N.P.S Soman
01/06/26	3pm	inj. HYDROCORTISONE	5mg	IV	N.P.S	Dr. N.P.S Soman

Signature

VERIFIED BY: Name



MEDICATION RECONCILIATION FORM

Drug Allergies: NO 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: oncology

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	TAB. OMNIGRETEL	2.5mg	PO	8H 24H	01/6/24	<input type="checkbox"/> C <input type="checkbox"/> DC
2	SYP. ZOVIRAX	0.5ml	PO	8H 8H	01/6/24	<input type="checkbox"/> C <input type="checkbox"/> DC
3	SYP. LEVFLORANIN	3ml	PO	24H	01/6/24	<input type="checkbox"/> C <input type="checkbox"/> DC
4	TAB. LISINAZID 50mg	1 tablet	PO	24H	01/6/24	<input type="checkbox"/> C <input type="checkbox"/> DC
5	T. BENADON 1.2	1.2 tab	PO	24H	01/6/24	<input type="checkbox"/> C <input type="checkbox"/> DC
6	SYP. BACTRIM	1.25ml - 1-1.25ml	PO	12H SAR/SUN	01/6/24	<input type="checkbox"/> C <input type="checkbox"/> DC
7	SYP. LEMPILL	0.5-0.7 - 0.5ml	PO	12H	01/6/24	<input type="checkbox"/> C <input type="checkbox"/> DC
8	T. ENVAS 2.5mg	1/2	PO	24H	01/6/24	<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 : Dr. Anurag Reddy

Date & Time : 01/26/24 1pm

Nurse Name & Signature: Bhavana B

Date & Time : 01/26/24 1:15pm

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)

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 Dr. NALLA ANURAAAG REDDY



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.

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									100ml			
	03:00 pm				16ml								
	04:00 pm	420	50ml		16ml								
	05:00 pm				16ml								
	06:00 pm	420	50ml		16ml								
	07:00 pm				16ml					100ml			
Total Intake : 196ml						Total Output : 200ml							
	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

Patient Sticker

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

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Master MURARI POORNA PRAGNA
03-10-2024 1 Y 7 M 29 D (M)
Dr. NALLA ANURAAG REDDY

Name: Age: 14 Gender: Male Female
UHID.No : Date: 1/6



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

I, P. Hema 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 Explained

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>P. Hema</u>	Signature: <u>[Signature]</u>
Name: <u>Pusala Hema</u>	Name: <u>DR. SANDHYA</u>
Date & Time: <u>1/6 @ 3pm</u>	Date & Time: <u>1/6 @ 3pm</u>

Witness

Signature: [Signature]
Name: Pusala Hema
Date & Time: 1/6 @ 3pm

రక్త మార్పిడి కొరకు అంగీకార పత్రము

రోగి పేరు: వయస్సు: లింగము పురుషుడు స్త్రీ
UHID. సంఖ్య: తేదీ:

- రక్త ఉత్పత్తి రకాలు:**
- | | | |
|---|---|--|
| <input type="checkbox"/> తాజా ఘనీభవించిన ప్లాస్మా | <input type="checkbox"/> ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు | <input checked="" type="checkbox"/> Random Donor Platelets |
| <input type="checkbox"/> క్రయో ప్రెసిపిటేట్ | <input type="checkbox"/> ఒకే ధాత ప్లేటిలెట్స్ | <input type="checkbox"/> Whole Blood |
| <input type="checkbox"/> మొత్తం రక్తం | <input type="checkbox"/> ఎర్ర రక్త కణం | <input type="checkbox"/> ఇతరులు..... |

నేను ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. ధాత రక్తాన్ని హెచ్ బి వి యాంటీ బడిస్, హైపటైటిస్ బి సర్వైస్ యాంటిజన్, హైపటైటిస్ యాంటిబడిస్, మలేరియా మరియు సిఫ్లిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణయ కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలెత్తవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు

పైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి చికిత్స చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. చికిత్స చేస్తున్న సమయంలో అన్ని రకముల రక్తమార్పిడులకు (మొత్తం రక్తం / లేదా రక్త ఉత్పత్తులు ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ప్లెష్ ఫ్రాజెన్ ప్లాస్మా, క్రయో ప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెండెంట్)	సాక్షి
సంతకము	సంతకం
పేరు	పేరు
తేదీ మరియు సమయము	తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)
సంతకము
పేరు