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ACTIVITY RECORD FOR BILLING

Name :_____

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

BAH-00648103 IP5-00176754
Baby TATAVARTHI JANAKI SAHASRA
08-12-2013 12 Y 7 M 14 D (F)
Dr. SANDHYA VADDADI

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
22/07/26	9:30 Hrs	ER	ONCOLOGY	

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
22/07/2024	CBP, RBS	73472	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
22/7	infusion pump	11:30 Am	4pm	9716293	Veena.

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
22/7/26	chemotherapy	(1)	9716296	Veena

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : 22/7/26 Time : Prepared By : Veena

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Veena	Dayshift Oncology		

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	2			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record				
6	Doctors progress sheets	1			
7	Nursing plan of care and handover sheets	2			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
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	Anaestesia 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-e 1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Extra	6.			
	Total No. of Pages	25			

Signature and Date :
22/2/26

(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

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 : IP5-00176754 **Admit Date** : 22-Jul-2026 **Admit Time** : 09:03 AM **UHID** : BAH-00648103

Patient Details :

Patient Name	: Baby TATAVARTHI JANAKI SAHASRA	**Age**	: 12 Y 7 M 14 D
Guardian	: Mr TATAPARTI SSN MURTY	**DOB**	: 08-12-2013
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: PLOT NO - 50 , ARUNA ENCLAVE, TIRIMALAGIRI Trimulgherry Hyderabad Telangana INDIA 500015	**Phone No**	: 9014456795/ 8885680969
		E-mail	: NOMAIL@GMAIL.COM

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 TATAPARTI SSN MURTY **Relationship** : Father

Contact Address : PLOT NO - 50 , ARUNA ENCLAVE, TIRIMALAGIRI Trimulgherry Hyderabad Telangana INDIA 500015 **Phone No** : 9014456795 / 8885680969

Signature

Doctor Details :

Doctor Name : Dr. SANDHYA VADDADI **Specialisation** : HEMATO ONCOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : STATE BANK OF INDIA

BAH-00648103 IP5-00176754
Baby TATAVARTHI JANAKI SAHASRA
08-12-2013 12 Y 7 M 14 D (F)
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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: .....

Name of the Doctor: .....

Date & Time: 22/7/26 @ 12pm

BAH-00648103 IP5-00176754
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DISCHARGE CRITERIA – ONCOLOGY

Discharge to:

☐ HDU / Step down ICU ☑ Ward ☐ Outside Facility ☐ Others: .....

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

☑ Completion of chemotherapy, with no debilitating side effects.

☐ Resolution of febrile episode, with no fever>24hrs and Absolute Neutrophil count (ANC)> 500cells/mm3.

☐ Admitted patients - Once the admitting problem gets resolved or made a plan to manage further on out-patient basis.

Signature of the Doctor: .....

Name of the Doctor : .....

Date & Time: 22/2/16 @6PM

BAH-00648103 IP5-00176754
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08-12-2013 12 Y 7 M 14 D (F)
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PROGRESS NOTES AND DOCTOR'S ORDER

wt - 41.8 kg

Date & Time	Progress Notes	Doctor's Order
22/7/26	C/S/B Resident / Dr. Balaji	
	O - K/c/o B-cell ALL	
	Came for Chemotheraphy	
	c/o - mild cold	
	O/E) Child Afebrile,	
	CFT < 3sec	
	pulses - well felt	plan -
	vitals	
	HR - 117 bpm	1) Admit in Day care
	Temp - 98.4°F	2) CBP, RBS
	Bp - 113/62 (71)	3) Inj ondansetron 6mg IBD
	RR - 20 b/min	4) T. DOMPERIDONE 10mg TID
	SpO2 - 100% RA	
	S/E) RS - BAE (+)	N/B Abhishek
	CVS - S1S2 (+)	
	P/A - Soft	
		Dr. Balaji

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

BAH-00648103 IP5-00176754
Baby TATAVARTHI JANAKI SAHASRA
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RESULT SHEET

Date	22/11/26					
Time	10AM					
Hb	11.6					
PCV	34.6					
RBC	3.68					
WBC	10.32					
N/L	82/14					
Platelets	2.88					
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						

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DRUG CHART

Date of Admission: 22/7/26............. 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 / 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 ....

Baby TATAVARTHI JANAKI SAHASRA
08-12-2013 12 Y 7 M 14 D (F)
Dr. SANDHYA VADDADI

REGULAR PRESCRIPTIONS

Weight. 42.4 kg Ward. .....

DRUG : Inj. ONDANSETRON

Dose	Route	Frequency	Start Date
6mg	IV	BD	22/7/16

Name & Signature of the Doctor Starting the Drugs: Dr. Balaji

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date →	22/7															
Time →	11:30am															
	6am Veer Raja															
	6pm															

DRUG : Tab. DOMPERIDONE

Dose	Route	Frequency	Start Date
10mg	PO	TID	22/7/16

Name & Signature of the Doctor Starting the Drugs: Dr. Balaji

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date →	22/7															
Time →	6am X															
	2pm															
	10pm															

DRUG : Tab. METFORMIN

Dose	Route	Frequency	Start Date
250mg	PO	BD	22/7/16

Name & Signature of the Doctor Starting the Drugs: DR Balaji

Additional Instructions: AFTER food

Daily Doctor's Endorsement by a Sign

Date →	22/7															
Time →	6am X															
	8pm															

DRUG : Tab. AMLODIPINE

Dose	Route	Frequency	Start Date
5mg	PO	OD	22/7/16

Name & Signature of the Doctor Starting the Drugs: Dr. Balaji

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date →	22/7															
Time →																
	2pm															

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Signature .....

VERIFIED BY : Name .....

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Baby TATAVARTHI JANAKI SAHASRA
08-12-2013 12 Y 7 M 14 D (F)
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I.V. FLUIDS CHART

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

		Composition of I.V. Fluid (…sion, 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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FLUID CHART

Sheet No. : (1)

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

Date	Time	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
22/7/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am			150ml						150ml		
	12:00 pm	HW	100ml	60ml								Cleaned
	01:00 pm			60ml								
Total Intake : 270 ml.						**Total Output :** 150 ml						
	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	

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FLUID CHART

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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**	

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 9:40Am Mode of Arrival: By mother Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: N/o allergy reaction

Body Weight: 48.8 Kg

Height: ..... cm

Past Medical History: Obtained From ☐ Patient ☐ Family Member ☐ Medical Record ☐ Other (specify) .....

Past Medical History	Past Surgical History	Previous Hospital Admission
NA	NA	NA

Family History: Healthy family

Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☑ No

yes please list, ...

Was the child's birth normal? ☑ Yes ☐ No If No, please describe problems: .....

.....

Are the child's immunization up to date? ☑ Yes ☐ No

Current Medication: ☑ None ☐ Yes, If Yes, fill reconciliation form

Observations: Weight: 48.8 kg Length: ..... Head Circumference (< 2 years): .....

Temp.: 98.6F HR: 93bpm RR: 20bpm BP: 100/60 (71) mmHg

Pain Score: ..... Specify Site: ..... (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☑ Yes ☐ No Score: 8 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

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

Character of Pain ..... Location ..... Frequency ..... Duration .....

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 ☐ Special Feeding Method

☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

If Yes Consultant Notified: ..... (Date/Time): .....

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

Social History: Lives With ..... parents .....

Siblings in household ☑ Yes ☐ No (if yes How Many?) ..... Brother .....

All Information Obtained From ☐ Patient ☑ Mother ☐ Father ☐ Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☑ Yes ☐ No Waste Disposal Explained: ☑ Yes ☐ No

Infusion Pump : ☑ Yes ☐ No Hand hygiene Explained: ☑ Yes ☐ No ☐ Others

Patient Rights & Responsibilities: ☑ Yes ☐ No

Information given to ..... parents .....

Nurse Signature: .....

Nurse Name: ..... Cleona .....

Date: 22/7/26 .....

Time: 10 A.M. .....

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CONSENT FOR CHEMOTHERAPY

Patient Name : Janaki Sahasra Age : 12y Gender : Male ☐ Female ☐

UHID No : BAH-00648103 Department : OPD Date : 22/7/26

Type of Chemotherapy : Intravenous

The type of reactions, nature of the major risks and complications arising from the treatment despite precautions has been explained to me. These can include Bone Marrow depression with subsequent infections, bleeding, nausea, vomiting, diarrhea, mouth ulcers, alopecia, fever, phlebitis, ulceration at the site of injection organ injuries etc.

The doctor have explained to me about the benefits and alternative for this procedure that n/a

I understand that no promise of cure or freedom from risk can be given. During the course of treatment I will report any symptoms if they become bothersome.

I have read the above and have no further questions about the treatment to be given.

Patient Attendant :

Signature : Lakshmi Prasanna

Name :

Relationship with Patient: mother

Date & Time : 22/7/26 @ 11:30am

Witness :

Signature : Lakshmi Prasanna

Name :

Date & Time : 22/7/26 @ 11:30 Am

Doctor (who is taking the consent):

Signature :

Name : Saravan

Date & Time : 22/7/26 11:30AM