

ADMISSION SHEET
Registration Details :


Admission No : IP5-00174681 Admit Date : 03-Jun-2026 Admit Time : 09:07 AM UHID : BAH-00634009

Patient Details :

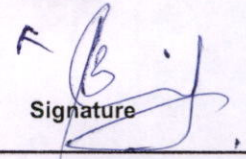
| | | | |
|--------------|---|----------------|--------------------------|
| Patient Name | : Baby DUNNA PURVI | Age | : 6 Y 2 M 24 D |
| Guardian | : Dr. DUNNA VENKATESH | DOB | : 10-03-2020 |
| Gender | : Female | Religion | : |
| Occupation | : | Martial Status | : Single |
| Address (H) | : H NO EWS 27 , NEAR 1st PHASE BUS STAND APHB Colony Moulali Hyderabad Telangana INDIA 500040 | Phone No | : 8801857437/ 7013639763 |
| | | E-mail | : BINDUSRI1986@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 | : Dr. DUNNA VENKATESH | Relationship | : Father |
| Contact Address | : H NO EWS 27 , NEAR 1st PHASE BUS STAND APHB Colony Moulali Hyderabad Telangana INDIA 500040 | Phone No | : 8801857434 / 7013639763 |


 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 | : SELFPAY |

ACTIVITY RECORD FOR BILLING



Name : _____

UHID No. : _____ IF _____ Patient: _____ Dept : _____

Date of Admission: _____ Discharge : _____ Time: _____

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

BAH-00634009 IP5-00174681
Baby DUNNA PURVI
10-03-2020 6 Y 2 M 24 D (F)
Dr. SIRISHA RANI

WARD TRANSFERS

| Date | Time | From | To | Signature of Nurse |
|------|---------|------|----------|--------------------|
| 3/6 | 9:30 am | ICU | oncology | Jay |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Cross Consultation Visit

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

BAH-00634009 IP5-00174681
Baby DUNNA PURVI
10-03-2020 6 Y 2 M 24 D (F)
Dr. SIRISHA RANI



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. Sarani*

Date & Time: *3/6/26 @ 9:30 AM*

BAH-J0634009 IP5-00174681
Baby DUNNA PURVI
10-03-2020 6 Y 2 M 24 D (F)
Dr. SIRISHA RANI



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: A

Name of the Doctor: DR Sravani

Date & Time: 3/6 @ 3pm

BAH-00634009 IP5-00174681
Baby DUNNA PURVI
10-03-2020 6 Y 2 M 24 D (F)
Dr. SIRISHA RANI

Patie



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|-------------|---|----------------|
| 3/6/20 | <u>Procedure Note</u> | |
| 12.40pm | child positioned, parts cleaned & draped, 22G needle inserted into L4-L5 space. CSF flow noted. Distal catheter connected. Needle removed. Sewn up. Observed. | |
| | | <u>None</u> |
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BAH-00634009 IP5-00174681
 Baby DUNNA PURVI
 10-03-2020 6 Y 2 M 24 D (F)
 Dr. SIRISHA RANI



RESULT SHEET

| | | | | | |
|---------------------|-------|--|--|--|--|
| Date | 3/6 | | | | |
| Time | 1PM | | | | |
| Hb | 12.6 | | | | |
| PCV | 37.1 | | | | |
| RBC | 4.06 | | | | |
| WBC | 3.69 | | | | |
| N/L | 37/31 | | | | |
| Platelets | 292 | | | | |
| 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: 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. 17.79. Ward. Oncohem

| | | | | | | | | | | | | | | | | | | | | |
|--|-----------|-----------|-------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| DRUG : <u>Luji- ONDANSETRON</u> | | | | Date Time | | | | | | | | | | | | | | | | |
| Dose | Route | Frequency | Start Date | | | | | | | | | | | | | | | | | |
| <u>3mg</u> | <u>IV</u> | <u>8H</u> | <u>03/6</u> | <u>6am</u> | | | | | | | | | | | | | | | | |
| Name & Signature of the Doctor Starting the Drugs: <u>N. Prathishu</u> | | | | | | | | | | | | | | | | | | | | |
| Additional Instructions: | | | | <u>BP</u> | | | | | | | | | | | | | | | | |
| 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. | |
|--------------------------------|------------|--|------------|--|------------|--|------------|--|
| | | | | | | | | |
| DRUG : | Dose | | Dose | | Dose | | Dose | |
| | Dr. Sign. | | Dr. Sign. | | Dr. Sign. | | Dr. Sign. | |
| Route | Dose | | Dose | | Dose | | Dose | |
| | Dr. Sign. | | Dr. Sign. | | Dr. Sign. | | Dr. Sign. | |
| 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 | | Dose | |
| | Dr. Sign. | | Dr. Sign. | | Dr. Sign. | | Dr. Sign. | | Dr. Sign. | |
| Route | Dose | | Dose | | Dose | | Dose | | Dose | |
| | Dr. Sign. | | Dr. Sign. | | Dr. Sign. | | Dr. Sign. | | Dr. Sign. | |
| Start Date | Dose | | Dose | | Dose | | Dose | | Dose | |
| | 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 |
|--------|---------|----------------|-----------------------------|-------|-----------|------------------|
| 3/6/26 | 12:30pm | Dij. MIDAZOLAM | 1mg | IV | Nlsr | alashwa veena |
| 3/6/26 | 12:30pm | Dij. KETAMINE | 15mg | IV | Nlsr | alashwa veena |
| | | | | | | |
| | | | | | | |
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| | | | | | | |
| | | | | | | |

Signature
VERIFIED BY: Name

BAH-00634009 IP5-00174681
 Baby DUNNA PURVI
 10-03-2020 6 Y 2 M 24 D (F)
 Dr. SIRISHA RANI



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: ICU Shifted to: Quadr

| 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 | syp. Levipill | 2ml | PO | 12 H | | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 2 | Syo-Septon | 5ml | PO | | | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 3 | Syp. Calmar plus | 5ml | PO | | Monday Wednesday Friday 24H | <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: N. Prakashan

Date & Time: 03/6/20 8:50am

Nurse Name & Signature: Sagar

Date & Time: 3/6/20 @ 9:30am

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) |

Patient

BAH-00634009 IP5-00174881
 Baby DUNNA PURVI
 10-03-2020 6 Y 2 M 24 D (F)
 Dr. SIRISHA RANI



3/6.



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 Thrombophlebitis Score | Sign. Nurse | |
|-----------------------|----------|-----------------|--------|-----|-----|-----------------------|-----------|-------|----------|-------|--------------------------------|-------------|--|
| | | | 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

FLUID CHART

Sheet No. :

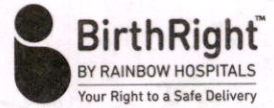
1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

| 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

BAH-00634009 IP5-00174681
Baby DUNNA PURVI
10-03-2020 6 Y 2 M 24 D (F)
Dr. SIRISHA RANI



CONSENT FOR SPECIAL PROCEDURES

Patient Name : Dunna Purvi Gender: Male Female

UHID No : 634009 Department : P40 Date : 3/6/26

I Bindu Sri S/D/W/O Dunna Venkatesh

Here by give consent for procedure of : lumbal puncture

For my patient, Named : Dunna Purvi

The doctors have clearly explained to me that the procedure has following possible complications:

bleeding, infection, neurotoxicity

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

nil

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: D. Siddhik

Patient Attendant : [Signature]
Signature :

Name : M. Bindu Sri

Relationship with Patient: Mother

Date & Time : 3/6/2026

Witness : [Signature]
Signature :

Name : Dunna Venkatesh

Date & Time : 3/6/2026

Doctor (who is taking the consent) :

Signature : [Signature]

Name : D. Siddhik

Date & Time : 3/6/26, 11:20

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం పురుషుడు స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

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

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు (అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము