

## ADMISSION SHEET



## Registration Details :

Admission No : IP5-00173893 Admit Date : 15-May-2026 Admit Time : 10:35 PM UHID : BAH-00653574

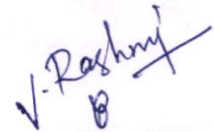
## Patient Details :

Patient Name : Master VIHAAN KUMAR Age : 0 Y 11 M 0 D  
Guardian : Mr M SAGAR GOUD DOB : 15-06-2025 04:42 PM  
Gender : Male Religion :  
Occupation : Martial Status : Single  
Address (H) : #ARUNODAYA NAGAR ROAD NO9 WEST Phone No : 7801026024/ 8121273317  
VIEW ENCLAVE APTS Nagole Hyderabad E-mail : sagargoud3666@gmail.com  
Telangana INDIA 500068

## Admission Details :

Bed Type : PRIVATE ROOM Bed No : PVT 301 Ward Name : 3F-ZONE B  
Room No : PVT 301 Admission Type : First Visit

## Contact Details :

Name : Mr M SAGAR GOUD Relationship : Father  
Contact Address : #ARUNODAYA NAGAR ROAD NO9 WEST Phone No : 7801026024 / 8121273317  
VIEW ENCLAVE APTS Nagole Hyderabad  
Telangana INDIA 500068  
Signature

## Doctor Details :

Doctor Name : Dr. HARISH JAYARAM Specialisation : PEDIATRIC SURGERY  
Referral Doctor : Self Phone No :  
Co-Consultant :

## Payment Details :

Deposit Amount : 0.00  
Payment Mode : Cash Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD









# PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00653574  
Master VIHAAN KUMAR IP5-00173893  
15-06-2025 0 Y 11 M 0 D  
Dr. HARISH JAYARAM (M)

Patient Name: Vihaan

UHID ID: \_\_\_\_\_

Department: \_\_\_\_\_

Consultant: \_\_\_\_\_

BAH-00653574

IP5-00173893

Master VIHAAN KUMAR

15-06-2025

0 Y 11 M 0 D

(M)

Dr. HARISH JAYARAM



### Pediatric Multiorgan History & Physical Examination

Name : Vihaan Age/Sex 11m/M

Information given by: \_\_\_\_\_ Relationship \_\_\_\_\_

#### Chief Presenting Complaints & Duration (Chronologically)

- Blood streaks in ileostomy output  
+ blood streaked mucus in diaper since afternoon

#### History of present illness :

As per informant, pt is having few blood streaks in ileostomy out-put since today afternoon, along with passage of blood streaked mucus in diaper.

No No vomiting / abdominal distension / fever / poor feeding / rash.

No ileocolic intussusception

↓

S/P laparotomy + resection anastomosis on 29/3/26

↓

Leak (+)

(outside)  
+ appendectomy

↓

division  
laparotomy & ileostomy done on 1/4/26  
(takedown of anastomotic site)



### Pediatric Multiorgan History & Physical Examination

**Past History :** (Including details of any previous investigation or treatment)

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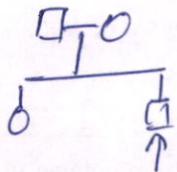
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**Birth & Neonatal History:**

FT / 3 kg / No NICU stay.  
2.7



**Birth & Socio Economic History:**

About Father : \_\_\_\_\_  
About Mother : \_\_\_\_\_  
Any additional Information : \_\_\_\_\_

**Developmental History :**

normal for age

**Immunization History :**

Completed till 7 months.

### Pediatric Multiorgan History & Physical Examination

#### Anthropometry :

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_) Height (cms): \_\_\_\_\_ (Centile) \_\_\_\_\_

Weight (kgs) ) 8.9 (Centile \_\_\_\_\_)

#### On Examination :

Temperature : 98.6°F Pulse Rate : 120/min B.P. \_\_\_\_\_ SPO2 98% (RA)

Resp. rate and type of breathing : RR - 26/min

Rash \_\_\_\_\_ -

Lymphadenopathy \_\_\_\_\_ -

Oedema : \_\_\_\_\_ -

Allergies (if any): \_\_\_\_\_ -

#### Respiratory System :

Inspection (any s/o distress) : no distress

Air entry & breath sounds : B/L VRS, B/L AE +

Any addes sounds : \_\_\_\_\_ -

Relevant data from outside (Chest X-Ray, ABG, etc..) \_\_\_\_\_ -

#### Cardiovascular System :

Inspection of procordium : \_\_\_\_\_ (N)

Heart Sounds : S<sub>1</sub>S<sub>2</sub> +

Any murmur : \_\_\_\_\_ -

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc..) : \_\_\_\_\_ (N)

#### Per Abdomen :

Inspection \_\_\_\_\_ Icostomy (+)

Palpation : soft

Auscultation : IPS +

Spine : \_\_\_\_\_ (N) External Genitelia : \_\_\_\_\_ (N)

Relevant data from outside (CT, USG etc..) \_\_\_\_\_ -



### Pediatric Multiorgan History & Physical Examination

#### Central Nervous System :

Level of Consciousness : AVPU/GCS score : ✓ A

Cranial Nerves : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Motor System:

Nutriton : \_\_\_\_\_

Tone: \_\_\_\_\_ Power \_\_\_\_\_

Co-ordinator : \_\_\_\_\_

Posture : \_\_\_\_\_

Involuntary Movements : \_\_\_\_\_

#### Reflexes :

DTR

Superficials:

Plantars \_\_\_\_\_

#### Sensory System :

\_\_\_\_\_

Bladder / Bowel : \_\_\_\_\_

#### Clinical Summary & Diagnostic:

\_\_\_\_\_

\_\_\_\_\_ ? Enteritis.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



### Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Sepsis

Desired goals of the treatment : Hemodynamic stability

**Planned Labs:**

- CBP, CRP, SE, Blood c/s,
- 1 extra plain vial LFT
- X ray abdomen AP view
- (erect posture)
- ESE
- USG abdomen tomorrow

(Case discussed to Dr Nabeel)

N/B  
Abhishek

**Planned Management**

- IV fluid
- IV ceftriaxone
- IV Esomeprazole

Signature of the Doctor: [Signature]  
Name of the Doctor: DR. SOMO SHREE  
Date & Time: 15/5/26 10:15 pm.

Signature of the Consultant: [Signature]  
Name of the Consultant: DR. HARISH JAYARAM  
Registration No: 66254  
Date & Time: 16/5/26 9.50 AM

BAH-00653574 IP5-00173893  
Master VIHAAN KUMAR  
15-06-2025 0 Y 11 M 0 D (M)  
Dr. HARISH JAYARAM



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<del>16/5/26</del> <del>9:51 AM</del>		<u>CLS/B Dr. Harish</u>
	Offbnile vitals stable	<u>Adv</u>
	P/A - soft Stomach functional.	1) Full feeds.
		2) Distal wlogram. today.
		Malika Dr. Malika
		16/5/26 9:51 AM







BAH 00653574 IP5-00173893  
 Master VIHAAN KUMAR  
 15-01-2025 0 Y 11 M 0 D (M)  
 Dr. HARISH JAYARAM



## RESULT SHEET

Date	15/5				
Time					
Hb	11.2				
PCV	31.1				
RBC	4.84				
WBC	14.78				
N/L	20/69.2				
Platelets	555				
CRP	5				
ESR					
PCT					
RBS					
Na	136				
K	4.8				
Cl	106				
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP	211				
SGPT	16				
SGOT	35				
T.Bill/Conj	0.5 <sup>0.1</sup> 0.4				
T.Protein	6.3				
S.Albumin	4.3				
S.Globulin	2				
A/G Ratio	2				
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					



BAH-00653574  
 Master VIHAAN KUMAR  
 15-06-2025 0 Y 11 M 0 D (M)  
 Dr. HARISH JAYARAM  
 IP5-00173893



# DRUG CHART

Date of Admission: 15/5/26 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)

<b>DRUG :</b>				Date Time																
Dose	Route	Frequency	Start Date																	
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:																				

<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Date																		
Doctor's Signature		Valid Period	Pharm.																		
Additional Instructions:																					

<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Date																		
Doctor's Signature		Valid Period	Pharm.																		
Additional Instructions:																					

VERIFIED BY : Name ..... Signature .....







BAH-00653574 IP5-00173893  
 Master VIHAAN KUMAR  
 15-06-2025 0 Y 11 M 0 D (M)  
 Dr. HARISH JAYARAM



## 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: Ward .....

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 : Amashree .....

Date & Time : 15/5/26 10:30 pm .....

Nurse Name & Signature: Abhishek .....

Date & Time : 15/5/26 10:30 pm .....

BAH-0065357  
 Master VIHARAN KUMAR  
 15-06-2025 0 Y 11 M 0 D (M)  
 Dr. HARISH AYARAM

IP5-00173893

15/6/26

Doc. No. : RCHBH / FRM / CLINICAL / 124

**INFANT (<1 year)**  
**Children's Observation & Early Warning Scoring Chart**

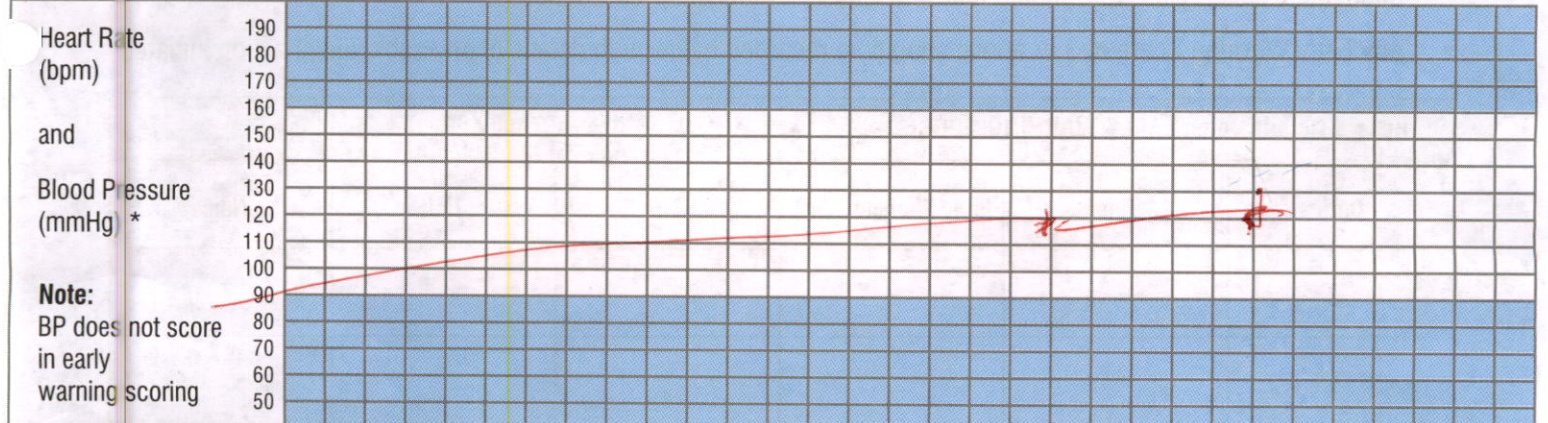
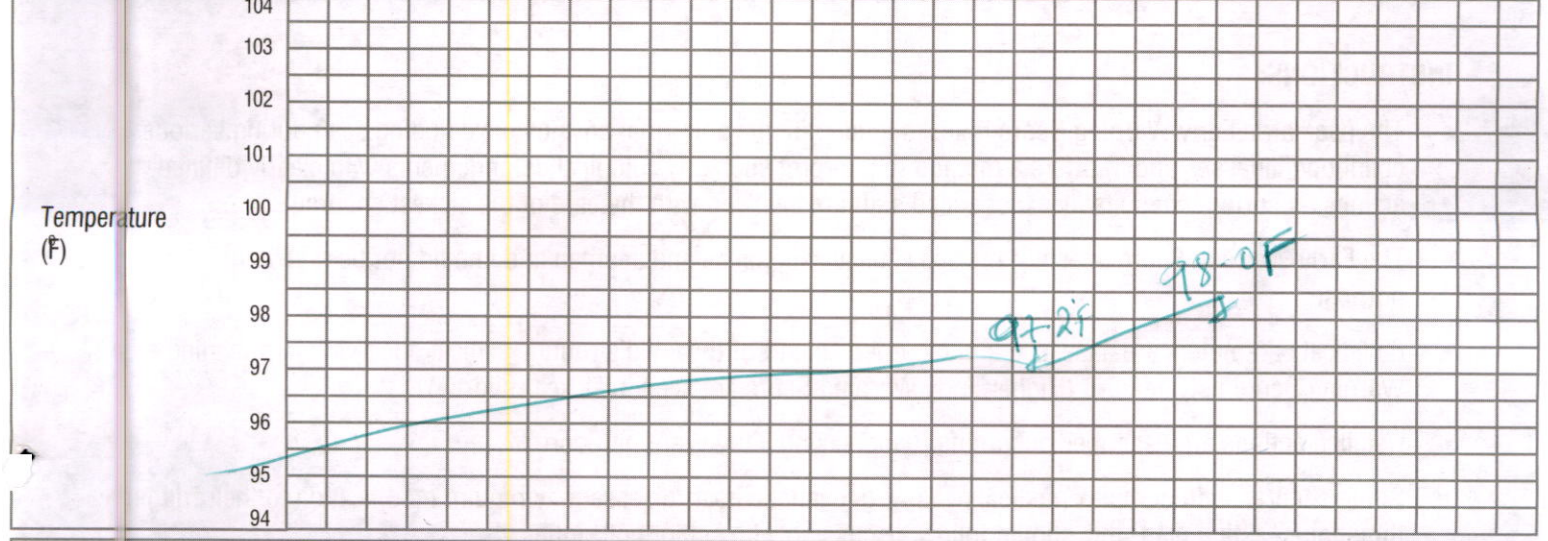
Pratiksha  
**Rainbow Children's Hospital**  
 It takes a lot to treat the little.

**BirthRight**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

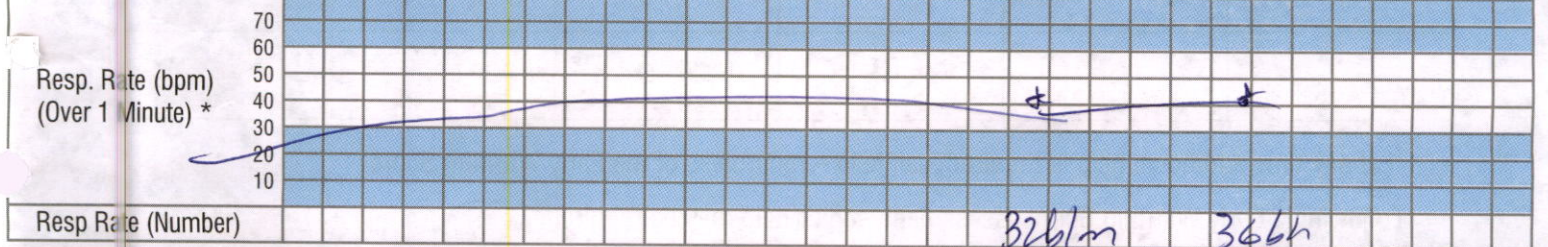
**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date: ..... Time: 11:30 AM 8 AM

Doctor/Nurse/Family Concern?



Heart Rate (Number) 119 bpm 120 bpm



Resp Rate (Number) 32 bpm 36 bpm

Resp Distress Mod/ Severe None / Mild

Receiving O<sub>2</sub> (l/min) O<sub>2</sub> Saturations (%)

Conscious Level Normal / Altered 99% 99%

GCS \* 15/15 15/15

**TOTAL SCORE** Number of shaded boxes 0 0

Pain Score 0 0

Observer's Initials R R

- ACTIONS**
- Score 1 : Continue normal observation by staff nurse
  - Score 2 : Shift in charge nurse to be informed and continue hourly observations
  - Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
  - Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
  - Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

\* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

## 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.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION:</b> 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>B</b>	<b>BACK GROUND:</b> 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)
<b>A</b>	<b>ASSESSMENT:</b> 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.
<b>R</b>	<b>RECOMMENDATION:</b> 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)

BAH-0063574 IP5-00173893  
 Master VISHAAN KUMAR  
 15-08-2015 0 Y 11 M 1 D (M)  
 Dr. HARISH JAYARAM

Doc. No. : RCHBH / FRM / CLINICAL / 124

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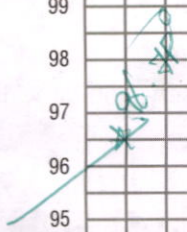
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 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date: ..... Time: .....

Doctor/Nurse/Family Concern? *Am*

Temperature (F)  
 104  
 103  
 102  
 101  
 100  
 99  
 98  
 97  
 96  
 95  
 94



Heart Rate (bpm)  
 and  
 Blood Pressure (mmHg) \*  
 Note: BP does not score in early warning scoring

Heart Rate (Number)

Resp. Rate (bpm) (Over 1 Minute) \*

Resp Rate (Number)

Resp Distress Mod/ Severe None / Mild

Receiving O<sub>2</sub> (l/min)  
 O<sub>2</sub> Saturations (%)

Conscious Level Normal Altered

GCS \*

**TOTAL SCORE**

Number of shaded boxes

Pain Score

Observer's Initials

**ACTIONS**

NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
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# FLUID CHART



Sheet No. : 2 ..... 16/5/26

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 Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am	DMS											
	09:00 am		milk	18 ml									
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

BAH-0083574 IP5-00173893  
 Master VHAAN KUMAR  
 15-06-2015 0 Y 11 M 1 D (M)  
 Dr. HARISH JAYARAM

301

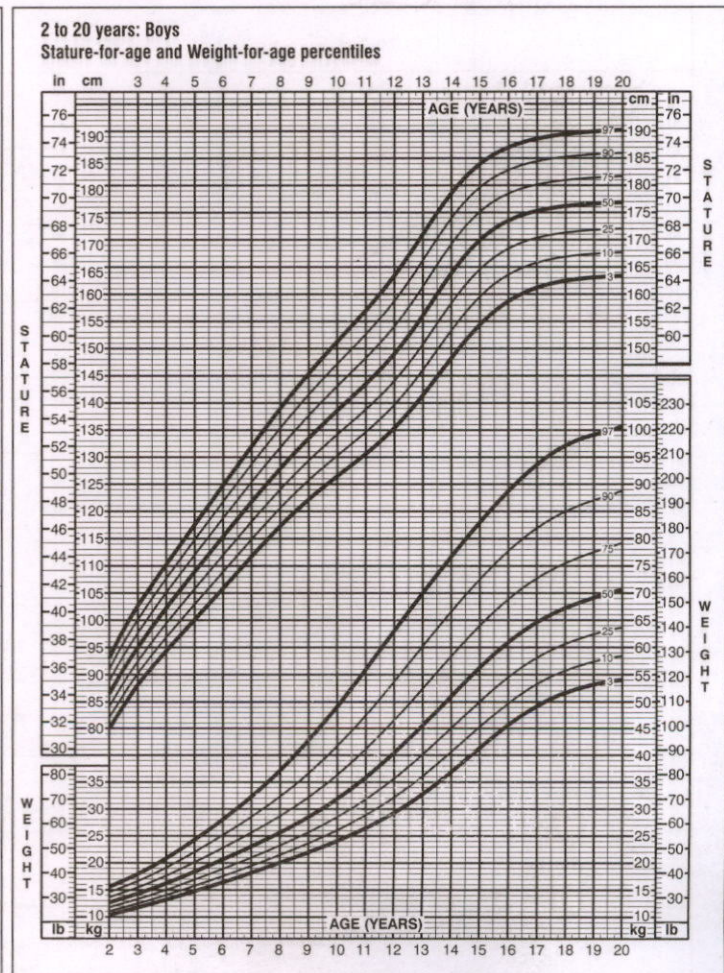
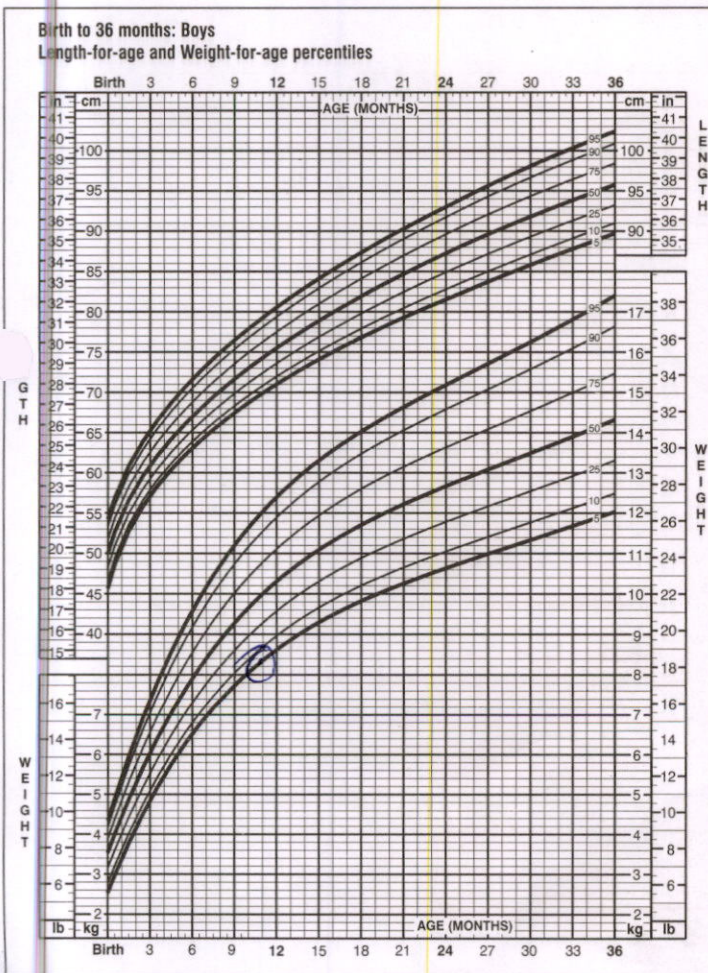


# NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 16/5/26 Time: 8am

Weight: 8.9 kg Centile: 75th  
 Height: 60 cm Centile: 75th  
 Inference: underweight child  
 RDA: - Calories: 98 kcal/kg/d Protein: 1.6/kg/d  
 Diet Recommendations: DBM feeds  
 Re-Assessment: Stage III weaning foods [HCE advised]  
 Food Allergies: Ragi Veg/Non-veg: NON-veg  
 Diagnosis: ? enteritis s/p bonyony ileostomy  
 Nutritional Intervention -  Oral  Enteral  Parenteral  
 Patient's Signature: *[Signature]*

## GROWTH CHART (BOYS)



Dietician's Name *Sarita*

Dietician's Signature *[Signature]*



ADMISSION SHEET



Registration Details :

Admission No : IP5-00173893 Admit Date : 15-May-2026 Admit Time : 10:35 PM UHID : BAH-00653574

Patient Details :

Patient Name : Master VIHAAN KUMAR Age : 0 Y 11 M 0 D  
Guardian : Mr M SAGAR GOUD DOB : 15-06-2025 04:42 PM  
Gender : Male Religion :  
Occupation : Martial Status : Single  
Address (H) : #ARUNODAYA NAGAR ROAD NO9 WEST Phone No : 7801026024/ 8121273317  
VIEW ENCLAVE APTS Nagole Hyderabad E-mail : sagargoud3666@gmail.com  
Telangana INDIA 500068

Admission Details :

Bed Type : PRIVATE ROOM Bed No : PVT 301 Ward Name : 3F-ZONE B  
Room No : PVT 301 Admission Type : First Visit

Contact Details :

Name : Mr M SAGAR GOUD Relationship : Father  
Contact Address : #ARUNODAYA NAGAR ROAD NO9 WEST Phone No : 7801026024 / 8121273317  
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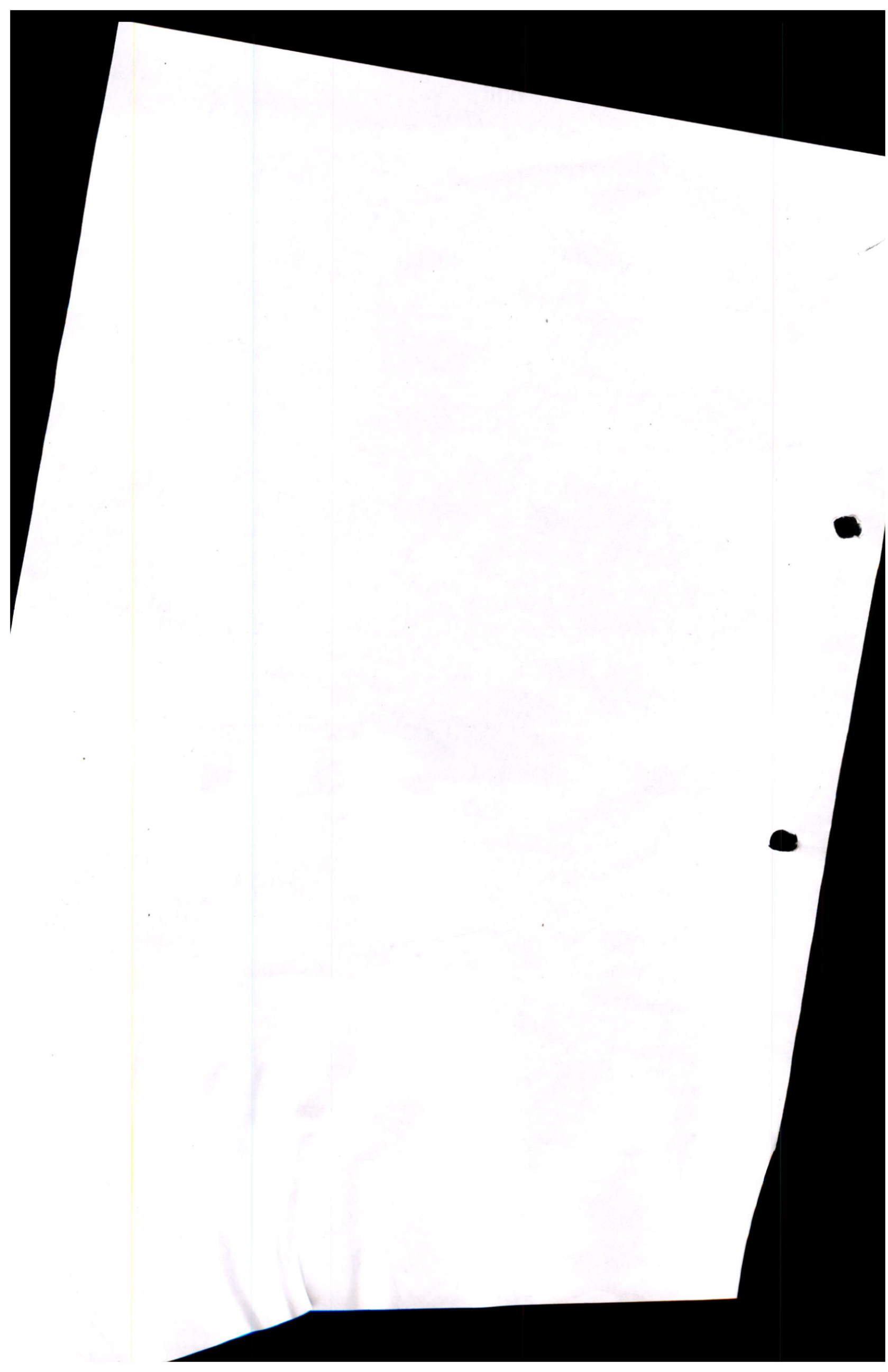
*V. Rashmi*  
B  
Signature

Doctor Details :

Doctor Name : Dr. HARISH JAYARAM Specialisation : PEDIATRIC SURGERY  
Referral Doctor : Self Phone No :  
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00  
Payor Name : MEDI ASSIST INSURANCE TPA PV LTD




**ACTIVITY RECORD FOR BILLING**

Name : \_\_\_\_\_  
 UHID No. : \_\_\_\_\_ Consultant: \_\_\_\_\_ Dept : \_\_\_\_\_  
 Date of Admission: \_\_\_\_\_ Date of Discharge : \_\_\_\_\_ Time: \_\_\_\_\_  
 Room / Bed No : \_\_\_\_\_ Ward : \_\_\_\_\_ Suggested Billable bed type : \_\_\_\_\_

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 Master VIHAAN KUMAR  
 13-08-2025 0 Y 11 M 0 D (M)  
 Dr. HARISH JAYARAM



**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
15/5/26	11 <sup>0</sup> .15pm	ER	301	

**Cross Consultation Visit**

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

