

 Rainbow Children's Hospital	 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 : IP5-00176118 Admit Date : 08-Jul-2026 Admit Time : 05:26 PM UHID : BAH-00661007													
Patient Details : <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Patient Name : Master K KARTHIKEYA KRISHNA</td> <td style="width: 50%;">Age : 1 Y 6 M 11 D</td> </tr> <tr> <td>Guardian : Mr K KISHOR</td> <td>DOB : 27-12-2024 01:00 AM</td> </tr> <tr> <td>Gender : Male</td> <td>Religion :</td> </tr> <tr> <td>Occupation :</td> <td>Marital Status : Single</td> </tr> <tr> <td>Address (H) : PLOT NO 58 N/P, NANDI HILLS, HAYATHNAGAR. Hayatnagar Ranga Reddy Telangana INDIA 501505</td> <td>Phone No : 9391445057 / 7093532361</td> </tr> <tr> <td></td> <td>E-mail : TJASHWINI@GMAIL.COM</td> </tr> </table>		Patient Name : Master K KARTHIKEYA KRISHNA	Age : 1 Y 6 M 11 D	Guardian : Mr K KISHOR	DOB : 27-12-2024 01:00 AM	Gender : Male	Religion :	Occupation :	Marital Status : Single	Address (H) : PLOT NO 58 N/P, NANDI HILLS, HAYATHNAGAR. Hayatnagar Ranga Reddy Telangana INDIA 501505	Phone No : 9391445057 / 7093532361		E-mail : TJASHWINI@GMAIL.COM
Patient Name : Master K KARTHIKEYA KRISHNA	Age : 1 Y 6 M 11 D												
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	E-mail : TJASHWINI@GMAIL.COM												
Admission Details : Bed Type : GENERAL WARD Bed No : GW 142 Ward Name : 1F-GENERAL WARD II Room No : GW 142 Admission Type : First Visit													
Contact Details : Name : Mr K KISHOR Relationship : Father Contact Address : PLOT NO 58 N/P, NANDI HILLS, HAYATHNAGAR. Hayatnagar Ranga Reddy Telangana INDIA 501505 Phone No : 9391445057  Signature													
Doctor Details : Doctor Name : Dr. DR.V.V.R.SATYA PRASAD Specialisation : PEDIATRIC NEPHROLOGY Referral Doctor : Self Phone No : Co-Consultant : Dr. SRUTHI BALLA													
Payment Details : Deposit Amount : 0.00 Payment Mode : Cash Payor Name : SELFPAY													

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No. : _____ t: _____ Dept : _____

Date of Admission: _____ charge : _____ Time: _____

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

BAH-00661007 IP5-00176118
Master K KARTHIKEYA KRISHNA (M)
27-12-2024 1 Y 6 M 11 D
Dr. DR.V.V.R.SATYA PRASAD

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/7/26	6:30pm	ER	1441	Annab

Cross Consultation Visit

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

[illegible]

Signature

Samshe

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
8/7	IV placement	(1)	3491	Samyhy
8/7	Albumin transfusion	(1)	693769	Appr
9/7	NHA	(1)	969410	Self

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : 10/7/16

Time :

Prepared By :

Samyhy

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Samyhy			



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

BAH-00661007 IP5-00176118
Master K KARTHIKEYA KRISHNA (M)
27-12-2024 1 Y 6 M 11 D
Dr. DR.V.V.R.SATYA PRASAD





Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

C/O Generalised edema x 1 month

History of present illness :

C/O Generalised edema x 1 month

↓

Started as periorbital puffiness,
later progressed to anasarca.

↓

Admitted at outside hospital

02/07/26 - 06/07/26 → Diagnosed Nephrotic syndrome

↓

Received IV antibiotics (MagneX forte),
Prednisolone, Diuretics, Albumin.

✓ C3 - 1.44 g/l

✓ C4 - 0.53 g/l

✓ Mantoux - Negative

✓ ASO Titre - Negative

BAH-00661007 IP5-00176118
Master K KARTHIKEYA KRISHNA
27-12-2024 1 Y 6 M 11 D (M)
Dr. DR.V.V.R.SATYA PRASAD



Perinatal History & Physical Examination

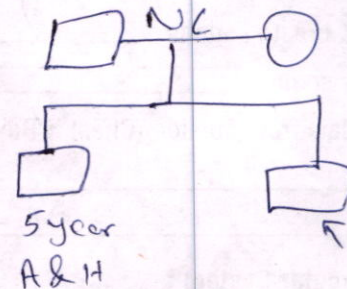
Past History : (Including details of any previous investigation or treatment)

Not significant

Birth & Neonatal History:

FT/LSCS/CIAB/3.1kg

NO H/O NICU admission



Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Lower middle class

Developmental History :

Achieved as per age in all 4 domains

Immunization History :

completely immunized as per NIS



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____
Weight (kgs)) 9.54 kg (Centile _____)

On Examination :

Temperature : 97.8° Pulse Rate : 108 bpm B.P. 110/70 SPO2 100% RA

Resp.rate and type of breathing : 26 br/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): NKA

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : _____

Ausculation : _____

Spine : _____

External Genitalia : _____

Relevant data from outside (CT, USG etc..) _____



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15/15

Cranial Nerves : 3/12

Motor System:

Nutriton : _____

Tone: _____ Power : 3/4

Co-ordinator : 3/4

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Plantars

Superficials: 3/4

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

New onset Nephrotic Syndrome

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

sepsis
Respiratory distress

Desired goals of the treatment :

Hemodynamic stability

Planned Labs:

CBP

CRP

W/B Annals
JPH

Planned Management

- IVF. DNS 15 ml/hr
(start after Albumin
& vasopressor)

- Albumin 50ml
over 4 hrs (in ward)
with mid & endway labia

- True CBP/CRP - if sepsis
markers negative start
INS. METHYLPREDNI 50mg IV OD

- INS. CASSX 10mg IV BD

- INS. LEFTRIAXONE 500mg IV BD

- SUP. CALCIUM PLUS 5ml PO OD

- Daily wt charting/ strict I/O charting

- Daily vitals monitoring
9.30 AM

Signature of the Doctor: Neel A.

Name of the Doctor: Dr. Nandan

Date & Time: 08/07/2024, 4:30 PM

Signature of the Consultant: [Signature]

Name of the Consultant: DR. V.V.R. SATYA PRASAD

Date & Time: 08/07/2024, 4:30 PM



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SS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/2/26 7:40pm	Ch/B Resident pt's 1st episode nephrotic syndrome do swelling of eyelids, legs. <u>O/E</u> - Pedal edema - HA - neg. - CVS - S₂ (+) - Axtr, clear.	<u>Plan</u> - ct 20 fluids, - Transfuse in albumin as per chart - Other medications as per chart. - monitor vitals. Chaf.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26 10 AM	Seen by Resident ACib- Nephrotic syndrome T.wt - 9.5 → 8.5 kg U/O - 940 ml @ 12 hrs. = 4.6 cc/kg/hr. 200 ml since morning. No fresh items O/E child alert, afebrile on room air hemodynamically stable. Chest clear, abdomen soft edema ⊕, improved.	Plan 1. Continue CEFTRIAXONE METHYLPREDNISOLONE 2. monitor vitals Daily wt checking strict input output monitoring 3. R/L & albumin today Sahithi
9/7/26 11 AM	SIB Dr. Satya Prasad	Plan. (1) R/L now (2) 50ml of 20% Albumin at 5 pm & midway endway last. (3) to give steroids at 3 pm.
	DR. V.V.R. SATYA PRASAD Registration No. 43599	

Patient Sticker

BAH-00661007 IP5-00176118
Master K KARTHIKEYA KRISHNA (M)
27-12-2024 1 Y 6 M 11 D
Dr. DR.V.V.R.SATYA PRASAD



RESS NOTES AND DOCTOR'S ORDER

& Time	Progress Notes	Doctor's Order
9/2/2026 2pm	Case Reviewed No new issues. u/p - ok. Child alert/active u/eass	S/B Dr. Suttin Adx - Give Albumin as planned 5pm. - Strict I/O charting - Daily wt. - No lab r/m.
9/2/26 4:30pm	SIB Resident no fever issues u/b - 463ml alert/active vitals stable o/g. Crs / normal M / normal PLA / normal pedal edema ⊕	plan- ① cont. same ② Albumin at 5pm ③ Daily wt Check ④ Strict I/O charting ⑤ monitor vitals ⑥ No lab r/m
		Madhwa



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/11/26 8:30am	SIB Resident Discussed with Dr. Sushma (Opnthd).	
	accidental fall of hardouk (Chlorhexidine) into eyes left eye no redness/congestion now	Plan. (1) to clean eyes with distilled water for 10-15 days (2) Refresh eye drops every hour (3) to Review tomorrow
10/7/26 9:20am	Seen by Resident- ASIS - New onset nephrotic syndrome T-wt - 8kg (8.5) V/O - 1840ml @ 24hrs - ~9.5ml/kg/hr No febrile issues O/E child asleep, afebrile hemodynamically stable. Chest clear. abd - slightly distended.	Madhva Plan 1. Continue medications as charted 2. RIV plan Dc today. 3. Ophthalmal opinion. \$ Santini
		DR. V.V.R. SATYA PRASAD Registration No: 13539



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[illegible]

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						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Nandan

Date & Time : 08/07/2026 4:30PM

Nurse Name & Signature : Amul

Date & Time : 07/07/2026 6:12

BAH-00681007
Master K KARTHIKEYA KRISHNA
27-12-2024 1 Y 6 M 11 D (M)
Dr. DR.V.V.R.SATYA PRASAD



RESULT SHEET

Date	OPD	8/7	9/7/2026		
Time		6pm			
Hb		10.1			
PCV		32.1			
RBC		4.27			
WBC		6080			
N/L		42.9/50			
Platelets		7,20,000			
CRP		5			
ESR					
PCT					
RBS					
Na	128		130		
K	4.3		3.5		
Cl	104		100		
Ca/Mg					
Phosphate					
Urea	39		27 ↓		
Creatinine	0.3		0.3		
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin	2.1				
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L	23		25		

BAH-00661007 IP5-00176118
Master K KARTHIKEYA KRISHNA
27-12-2024 1 Y 6 M 11 D (M)
Dr. DR.V.V.R.SATYA PRASAD



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Sheet No:

REGULAR PRESCRIPTIONS

Weight 10kg

Ward

DRUG : <u>Py METHYLPREDNISOLONE</u>				Date Time
Dose	Route	Frequency	Start Dt.	
<u>40mg</u>	<u>iv</u>	<u>OD</u>	<u>8/7</u>	
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : <u>REFRESH EYE DROPS</u>				Date Time
Dose	Route	Frequency	Start Dt.	
<u>2/2</u>	<u>EYS</u>	<u>HOURLY</u>	<u>9/12/26</u>	
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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

:				Date Time
	Route	Frequency	Start Dt.	
Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

Signature
VERIFIED BY : Name



DRUG CHART

Date of Admission: 08/07/2026 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:				



REGULAR PRESCRIPTIONS

Weight. 9.5kg Ward.

DRUG : <u>INJ. LEFTRIAXONE</u>				Date Time	<u>8/7 9/2017</u>
Dose	Route	Frequency	Start Date		
<u>500mg</u>	<u>IV</u>	<u>BD</u>	<u>08/07/26</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandan</u>				<u>6pm</u> <u>X</u> <u>6pm</u> <u>10pm</u> <u>6pm</u> <u>10pm</u> <u>6pm</u> <u>10pm</u>	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign				<u>8</u> <u>9</u> <u>9</u>	
DRUG : <u>INJ. LASEX</u>				Date Time	<u>8/7 9/2017</u>
Dose	Route	Frequency	Start Date		
<u>10mg</u>	<u>IV</u>	<u>BD</u>	<u>08/07/26</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandan</u>				<u>6pm</u> <u>X</u> <u>6pm</u> <u>10pm</u> <u>6pm</u> <u>10pm</u> <u>6pm</u> <u>10pm</u>	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign				<u>8</u> <u>9</u> <u>9</u>	
DRUG : <u>SYP. CALCIUM-PLUS</u>				Date Time	<u>8/7 9/2017</u>
Dose	Route	Frequency	Start Date		
<u>5ml</u>	<u>PO</u>	<u>OD</u>	<u>08/07/26</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandan</u>				<u>10pm</u> <u>6pm</u> <u>10pm</u> <u>6pm</u> <u>10pm</u> <u>6pm</u> <u>10pm</u> <u>6pm</u>	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign				<u>8</u> <u>9</u> <u>9</u>	
DRUG : <u>INJ. ESOMEPRAZOLE</u>				Date Time	<u>8/7 9/2017</u>
Dose	Route	Frequency	Start Date		
<u>10mg</u>	<u>IV</u>	<u>OD</u>	<u>08/07/26</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandan</u>				<u>4pm</u> <u>6pm</u> <u>4pm</u> <u>6pm</u> <u>4pm</u> <u>6pm</u> <u>4pm</u> <u>6pm</u>	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign				<u>8</u> <u>9</u> <u>9</u>	



Date Time								
	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
	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.	

DRUG :

Route

Start Date

Name & Signature of the Doctor

Additional Instructions:

VARIABLE DOSE

Date Time								
	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
	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.	

DRUG :

Route

Start Date

Name & Signature of the Doctor

Additional Instructions:

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
08/07/26	4:45 PM	INS. 20% ALBUMIN	50ml	IV	Neelish	Pinto Swarna
			OVER 4 HOURS			
08/07/26	9:45 PM	INS. LASIX	9mg (midway)	IV	Neelish	Soma Aparanjita
08/07/26	11:45 PM	INS. LASIX	9mg (Endway)	IV	Neelish	Soma Aparanjita
9/1/26	5 PM	20% ALBUMIN	50ml over 4 HRS	IV	Neelish	Priyanka Soma
9/1/26	7:45 PM	INS. LASIX	9mg midway	IV	Neelish	Priyanka Swarna
9/1/26	10 PM	INS. LASIX	9mg endway	IV	Neelish	Krishnakshi Chandra

[illegible]

Date : 10/2 Time:

[illegible]

Today w/ 8 legs

Temperature (°F)

104
103
102
101
100
99
98
97
96
95
94

98.6

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

0 1 2 3 4 5 6 7 8 9 10 11 12

Time

996
(92)
60

Heart Rate (Number)	116 bpm	90	100
---------------------	---------	----	-----

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

[illegible][illegible][illegible][illegible][illegible][illegible][illegible][illegible]

ACTIONS NB: Scores 3 should be recorded overleaf	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 in charge AND PICU fellow or PICU consultant to be informed.	

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)

* 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.

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)
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 08.10.24	Time: 6am	10pm	9/7 2am	6am
Doctor / Nurse / Family Concern?				
Temperature (F)	97.07	98.19	98.48	98.08
Heart Rate (bpm)	135bpm	120bpm	115bpm	132bpm
Blood Pressure (mmHg) *	106/64	106/63	107/63	107/82
Resp. Rate (bpm) (Over 1 Minute) *	26bpm	29bpm	28bpm	27bpm
Resp Rate (Number)	26bpm	29bpm	28bpm	27bpm
Resp Mod/ Severe Distress	None	None	None	None
Receiving O ₂ (l/min)	0.8	1.0	0.8	0.8
O ₂ Saturations (%)	98%	100%	99%	98%
Conscious Level	Normal	Normal	Normal	Normal
GCS *	15/15	15/15	15/15	15/15
TOTAL SCORE	1	1	1	1
Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials				

ACTIONS

NB: Scores 3 should be recorded overleaf

- 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 in charge AND PICU fellow or PICU 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:

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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)

BAH-00661007 IP5-00176118
Master K KARTHIKEYA KRISHNA
27-12-2024 1 Y 6 M 11 D (M)
Dr. DR.V.V.R.SATYA PRASAD



LUID 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.

		Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	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

4.6176705 ul/eqt day

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.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
9/1/24	08:00 am		poly	15ml						260ml	0	} Same
	09:00 am			15ml							0	
	10:00 am	DNS		15ml							0	
	11:00 am		Milk	15ml							0	
	12:00 pm			15ml							0	
	01:00 pm			15ml						203ml	0	
Total Intake :						Total Output :						
9/1/24	02:00 pm	DNS		15ml							0	} Same
	03:00 pm	DNS									0	
	04:00 pm									147ml	0	
	05:00 pm	Inj.		12.5ml							0	
	06:00 pm	Albumin		12.5ml						220ml	0	
	07:00 pm	↓		12.5ml						170ml	0	
Total Intake :						Total Output :						
9/2	08:00 pm	Albumin		12.5ml						225ml	0	} Choul
	09:00 pm		(ricki)	12.5ml							0	
	10:00 pm									270ml	0	
	11:00 pm	DNS		15ml							0	
	12:00 am			15ml							0	
	01:00 am			15ml							0	
Total Intake :						Total Output :						
10/2	02:00 am			15ml							0	} Choul
	03:00 am			15ml						130ml	0	
	04:00 am			15ml							0	
	05:00 am	DNS		15ml							0	
	06:00 am			15ml							0	
	07:00 am			15ml						220ml	0	
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						
						4-1,845						
						9.6093 cc/kg						

BAH-00661007 IP5-00176118
 Master K KARTHIKEYA KRISHNA (M)
 27-12-2024 1 Y 6 M 11 D
 Dr. DR.V.V.R.SATYA PRASAD

NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/7/26

Assessment:

Goals

- ☐ Maintain Airway and Oxygenation
☒ Maintain Personal Hygiene
☐ Identify Potential Complications
- ☒ Relieve Pain & Discomfort
☐ Prevent Infection
☐ Any Others. Specify
- ☒ Maintain Fluid Balance
☐ Meet Elimination Needs
- ☐ Improve Activity Tolerance
☒ Ensure Safety
- ☒ Maintain Good Nutritional Status
☐ Early Ambulation Reduce Anxiety
- ☒ Maintain Skin Integrity
☐ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
10pm	→ Assess the Baby General Condition, monitor vitals & record	11pm	→ Assessed the baby General condition, monitored vitals & recorded	By All this done pt condition is improved
12am	→ Continue IV fluids	1am	→ Continued IV fluids	
2am	→ monitor B/D Chart	3am	→ monitored B/D Chart	
4am	→ continue Albumin	5am	→ continued Albumin	
6am	→ Administered medication as per doctor order	8am	→ Administered medication as per doctor order	

Re-Assessment:

Special Notes:

completed Albumin transfusion
 monitor B/D Chart daily vitals

Nurse Signature:

[Signature]

Nurse Name:

Aparajita Lakshmi

Date & Time:

9/7/26 @ 8am

BAH-00661007
Master K KARTHIKEYA KRISHNA
27-12-2024 1 Y 6 M 11 D (M)
Dr. DR.V.V.R.SATYA PRASAD

NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 9/12/24

Shift: ☒ Morning ☐ Afternoon ☐ Night

Assessment:

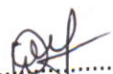
Goals

- | | | | | | |
|---|---|--|---|--|--|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☒ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☒ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☒ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8am	* Assess the general condition of the patient.	8am	* Assessed the general condition of the patient.	By done all the procedure the patient can be Stable
10am	* maintain personal hygiene.	10am	* maintained personal hygiene.	
12pm	* maintain in fluid.	12pm	* maintained in fluid.	
1pm	* monitor vitals.	1pm	* monitored vitals.	

Re-Assessment: monitor vitals

Special Notes:

Nurse Signature: 

Nurse Name: Dmpe

Date & Time: 9/12/24 @ 2pm

BAH-00661007 IP5-00176118
Master K KARTHIKEYA KRISHNA (M)
27-12-2024 1 Y 6 M 11 D
Dr. DR.V.V.R.SATYA PRASAD

NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 9/7/26

Assessment:

↓ Urine output

Goals

- ☒ Maintain Airway and Oxygenation ☒ Relieve Pain & Discomfort ☒ Maintain Fluid Balance ☐ Improve Activity Tolerance ☒ Maintain Good Nutritional Status ☐ Maintain Skin Integrity
☒ Maintain Personal Hygiene ☒ Prevent Infection ☐ Meet Elimination Needs ☒ Ensure Safety ☐ Early Ambulation Reduce Anxiety ☒ Patient & Family Education
☐ Identify Potential Complications ☐ Any Others. Specify

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess general condition of the patient.	2:5 pm	Assessed general condition of the patient.	By done as implementation as per doctor's order.
3pm	Maintain the I/O chart.	3:10 pm	Maintained I/O chart.	
5pm	Administer I.V. Albumin 50 ml over 4 hours.	5:5 pm	I.V. Albumin connected 12.5 ml/hr.	
6pm	Monitor vital signs.	6:10 pm	Monitored vital signs.	
7pm	Maintain fluid balance.	7pm	Maintained fluid balance.	

Re-Assessment:

Re-Assessment done by checking vitals.

Special Notes:

Monitor Urine output strictly.

Nurse Signature:



Nurse Name:

Swarna

Date & Time:

9/7/26

8pm

BAH-00661007 IP5-00176118
Master K KARTHIKEYA KRISHNA
27-12-2024 1 Y 6 M 12 D (M)
Dr. DR.V.V.R.SATYA PRASAD



NURSING CARE RECORD

Rainbow
Children's
Hospital
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BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/26

Assessment: pt having dull activity

Goals

- ☒ Maintain Airway and Oxygenation
- ☒ Relieve Pain & Discomfort
- ☒ Maintain Fluid Balance
- ☒ Improve Activity Tolerance
- ☒ Maintain Good Nutritional Status
- ☒ Maintain Skin Integrity
- ☒ Maintain Personal Hygiene
- ☒ Prevent Infection
- ☒ Meet Elimination Needs
- ☒ Ensure Safety
- ☒ Early Ambulation Reduce Anxiety
- ☒ Patient & Family Education
- ☐ Identify Potential Complications
- ☐ Any Others. Specify.....

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the pt General Condition	8:10pm	→ Assessed the pt General Condition	pt is stable
10pm	→ Check the vital signs	10:10pm	→ Checked the vital signs	
12am	→ plan for Administration medication	12:10am	→ providing medication as per doctor Order	
2am	→ plan for strict I/O Chart	2:10am	→ providing Comfortable position	
8am	→ providing Comfortable position	8:10am		

Re-Assessment: Re-Assessment every 4th hourly

Special Notes: strict I/O chart

Nurse Signature: [Signature]

Nurse Name: Chandona

Date & Time: 10/7/26 @ 8am



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Satya Prasad Department: ER Date of Admission: 8/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time	ER 6:30	1st floor 8:30pm-8pm	1st floor 8pm-8:30	2nd floor 8:30-9pm	1st floor 2pm-8pm	1st floor 8pm-8:30
	Medical Condition (Any special condition to be noted):		NA	NA	NA	NA	NA	NA
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	98.2°F	98.1°F	98.0°F	98.3°F	98.4°F	98.2°F
	Res:	28bpm	28bpm	27bpm	28bpm	27bpm	28bpm	
	SpO ₂ :	99%	100%	99%	99%	100%	99%	
	Pulse:	105bpm	106bpm	102bpm	108bpm	104bpm	105bpm	
	BP:	99/67	100/69	98/60	98/60	100/66	98/62	
Fall Risk Score:	11	11	11	11	11	11		
Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10		
Recommendations	Safety Needs:		Yes	Yes	Yes	Yes	Side rails	Yes
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		NA	NA	NA	NA	NA	NA
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		NA	NA	NA	NA	NA	NA
Post Operative Procedure Special Orders:			NA	NA	NA	NA	NA	NA
Handed Over By Name :			poja	K. Sraavanthi	Aparanjitha	Ding	Poojanka	Chandan
Signature :			[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:			8/7/26	8/7/26	9/7	9/7	9/7	10/7/26
Time:			8:30pm	8:30pm	8:30pm	2pm	8pm	8am
Taken Over By Name :			K. Sraavanthi	Aparanjitha	Ding	Poojanka	Chandan	Ding
Signature :			[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:			8/7/26	8/7	9/7	9/7	9/7/26	10/7
Time:			@ 6:35pm	@ 8pm	8am	2pm	@ 8pm	8am

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area						
	Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:					
		Res:					
		SpO ₂ :					
		Pulse:					
		BP:					
		Fall Risk Score:					
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							



THE HUMPTY DUMPTY SCALE

8/7 gtr 10/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	9	u	4		
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	✓	2		
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1		
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2		
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1		
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1		
TOTAL			11	u	11		

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes	yes		
Call device within reach	yes	yes	yes		
Wheels Locked	yes	yes	yes		
Room free of clutter	yes	yes	yes		
Adequate Lighting	yes	yes	yes		
Wheel Chair Support	no	no	no		
Other Intervention(s) Specify	no	no	no		
Nurse's Name :	poorja	APR			
Signature :	Dr. Ravi				
Date :	8/7				
Time :	4:20 pm				



BRADEN 'Q' SCALE

					Date :	8/1/26	972h6	
					Time :	4:20pm	6am	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	
					TOTAL SCORE	28	28	
					Evaluator's Name	pooja	ppp	

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
8/12/26	4:20 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Pooja
9/12	12am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Appu
9/12	8am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Appu
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

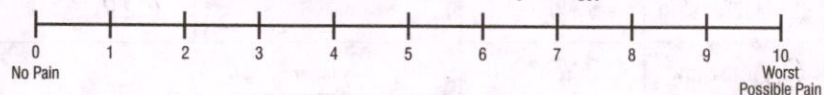
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

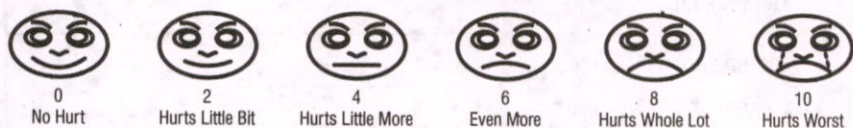
Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	8/7 DAY-1			9/8 DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0	0	0					
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		-	-	-	-					
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		-	-	-	-					
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		-	-	-	-					
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		-	-	-	-					
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		-	-	-	-					
Signature of the Nurse				Sudhakar			Swaraj						

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : Name : Souvik

Signature of Ward In Charge :

Signature : Name : Neelgiri

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Pa

Patient's / Learner Language: Telugu Patient / Learner Literacy: ☒ Read ☒ Write ☒ Speak Willingness to Learn: ☒ Yes ☐ No Healthcare Literacy: ☒ Yes ☐ No

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
8/12/26	4:15 PM	J	Infection control measures	F	4	0	1	1	NA	poorja
9/12/26	8am	q	soft low salt diet	f	1	0	1	1	-	nikitha

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)									
Learning Barriers:									
1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice					
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)					
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing						
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed									
Mechanism/s to overcome barrier/s:									
1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify						
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference							
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review									



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
8/7/26	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Scalping on steel leg on off	Hemodynamic St	Albumin inf	[Signature]	☐ Nursing ☒ Others:
8/7/26	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	new onset Nephrotic syndrome	lt - stability.	Albumin mg	[Signature]	☐ Medical ☒ Others:
9/7/26 8am	☐ Medical ☐ Nursing ☒ Others: dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	None	soft low salt diet	<u>RDA</u> E - 1200 kcal/d P - 20g/d	[Signature]	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

BAH-00661007 IP5-00176118
Master K KARTHIKEYA KRISHNA
27-12-2024 1 Y 6 M 11 D (M)
Dr. DR.V.V.R.SATYA PRASAD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DISCHARGE PLANNING FORM

Nationality: Indian

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: 10/12/20

2. Destination Post Discharge: ☒ Home
Family Members Notified (Person Contacted)

☐ Transfer
Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☐ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication ☒ Yes ☐ No

☐ Bathing ☒ Yes ☐ No

☐ Eating ☐ Yes ☒ No

☐ Walking ☐ Yes ☒ No

☐ Dressing ☐ Yes ☒ No

☐ Toileting ☐ Yes ☒ No

Explain to mother

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: personal hygiene

☐ Patient's Educational Topic/s discussed with the:

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Sevanthi

Date and Time: 8/12/20 6:30pm



NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 9/1/26 Time: 8am

Weight: 9.5 kgs Centile: <5th

Height: 75.5 cm Centile: <5th

Inference: underweight child

RDA: — Calories: 1200 kcal/d Protein: 20g/d

Diet Recommendations: soft low salt diet

Re-Assessment: avoid spicy, chilled, outside foods

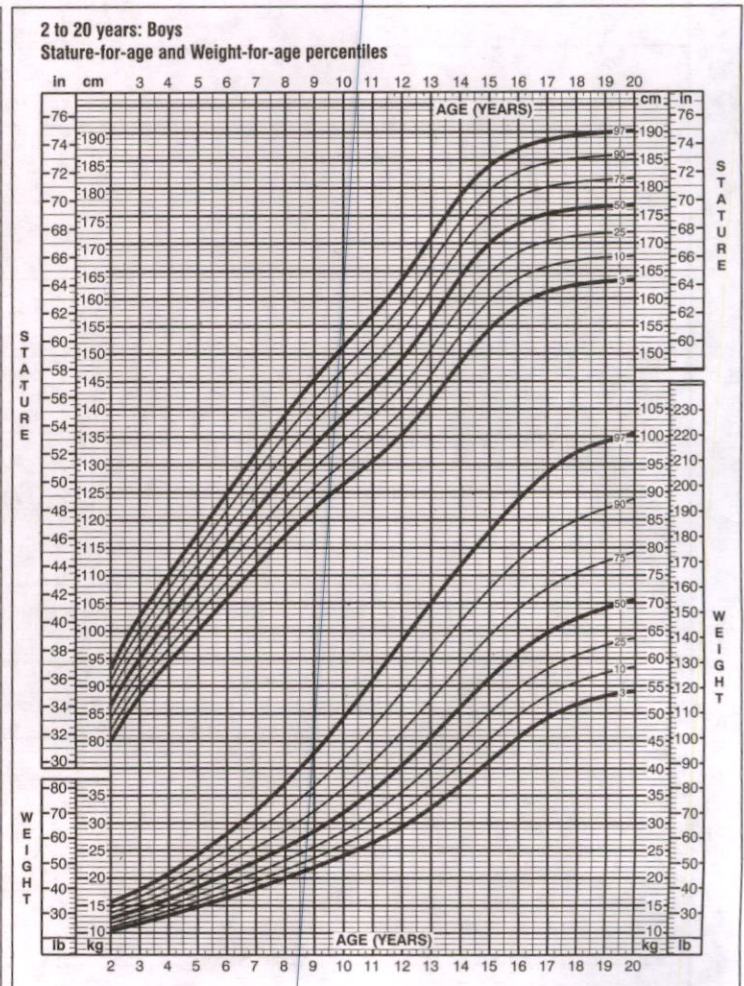
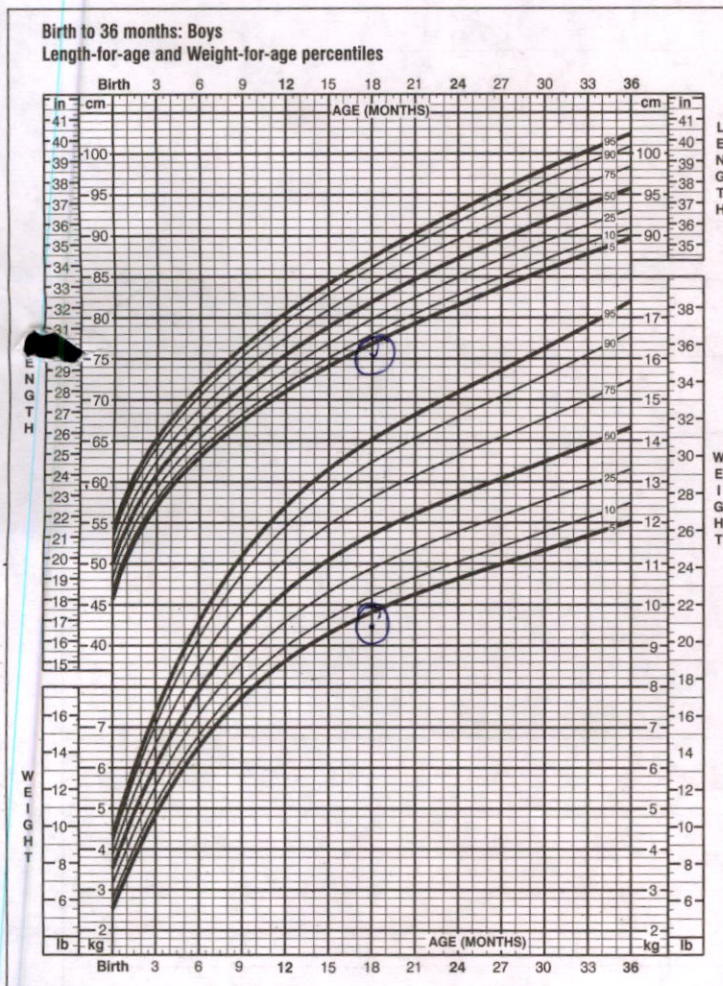
Food Allergies: No Veg/Non-veg: Non-veg

Diagnosis: New onset of Nephrotic Syndrome

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: *Nikitha*

GROWTH CHART (BOYS)



Dietician's Name: *Nikitha*

Dietician's Signature: *Nikitha*

Daily Notes:

10/7/26
8:30am

Chilled & Stable Intake & poor.

Continue to Soft low salt diet.

- Nowhere



Albumin

CONSENT FOR BLOOD TRANSFUSION

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: Karthikeya Krishna Age: 1y 6m Gender: Male ☒ Female ☐
UHID.No: BAH-00661007 Date: 8/7/26

Type of Blood Product: ☐ Fresh Frozen Plasma ☐ Packed Red Blood Cells ☐ Random Donor Platelets
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood
☒ Albumin ☐ Red Blood Cell ☐ Others

I 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 ... 

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):

Signature: [Signature]

Name: [Signature]

Date & Time: 9/7/26 @ 6pm

Doctor (Who is talking the consent)

Signature: [Signature]

Name: Saini

Date & Time: 9/7/26 4pm

Witness

Signature: [Signature]

Name: Swarna

Date & Time: 9/7/26 @ 6pm

రక్త మార్పిడి కొరకు అంగీకార పత్రము

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

రక్త ఉత్పత్తి రకాలు:

- ☐ తాజా ఘనీభవించిన ప్లాస్మా ☐ ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు ☐ Random Donor Platelets
☐ క్రయో ప్రెసిపిటేట్ ☐ ఒకే ధాత ఫ్లేటిలెట్స్ ☐ Whole Blood
☐ మొత్తం రక్తం ☐ ఎర్ర రక్త కణం ☐ ఇతరులు.....

నేను ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడిస్, హైపటెటిస్ జి సర్వేస్ యాంటిజన్, హైపటెటిస్ యాంటిబడిస్, మలేరియా మరియు సిప్లిస్ 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 తెలితవచ్చు 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, ఫ్రెష్ ఫ్రోజెన్ 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

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 9/7/26 Time: 6pm

Blood Group of the Patient: Blood Group on the Blood Bag:

Blood Bank Issue No: Date of Collection: Date of Expiry:

Date & Time of Starting Transfusion: 9/7/26 @ 6pm Planned duration of Transfusion: 1 hr

Check for Correct Unit: ☐ Correct Patient: ☐

Blood products cross checked by: Nurse 1: Priyanka Nurse 2: Swarna

Before starting transfusion vitals: Temp: 96.1°F HR: 120 RR: 28 BP: 99/67 SpO₂: 100%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
<u>9/7/26</u>	15 Min	<u>115</u>	<u>97.1°F</u>	<u>110/70</u>	<u>100%</u>	-	-	-	-
	15 Min	<u>101</u>	<u>96.5°F</u>	<u>99/67</u>	<u>100%</u>	-	-	-	-
	30 Min	<u>120</u>	<u>97.8°F</u>	<u>100/54</u>	<u>98%</u>	-	-	-	-
	30 Min	<u>105</u>	<u>97.3°F</u>	<u>98/80</u>	<u>99%</u>	-	-	-	-
	30 Min								
	1 Hr								
	1 Hr								

Comments:

Name of the Incharge-Nurse: Dr. Arjun

Name of the Nurse: Swarna

Signature of the Incharge-Nurse: Dr. Arjun

Signature of the Nurse: Swarna

Date & Time: 9/7

Date & Time: 9/7

ALBUMIN

CONSENT FOR BLOOD TRANSFUSION



BAH-00661007 IP5-00176118
Master K KARTHIKEYA KRISHNA
27-12-2024 1 Y 6 M 11 D (M)
Dr. DR.V.V.R.SATYA PRASAD

Name: Age: Gender: Male ☐ Female ☐

UHID.No : Date: *8/12/26*

Type of Blood Product: ☐ Fresh Frozen Plasma ☐ Packed Red Blood Cells ☐ Random Donor Platelets
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood
☒ Albumin ☐ Red Blood Cell ☐ Others

..... 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

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 / Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Signature: *Kishor*

Name: *Kishor*

Date & Time *08/12/26 @ 7:45 pm*

Doctor (Who is talking the consent)

Signature: *Dr. Ramesh*

Name: *Dr. Ramesh*

Date & Time

Witness

Signature: *K. Sravanthi*

Name: *K. Sravanthi*

Date & Time *08/12/26 @ 7:45 pm*

రక్త మార్పిడి కొరకు అంగీకార పత్రము

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

రక్త ఉత్పత్తి రకాలు:

- | | | |
|---|---|---|
| ☐ తాజా ఘనీభవించిన ప్లాస్మా | ☐ ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు | ☐ Random Donor Platelets |
| ☐ క్రయాప్రెసిపిటేట్ | ☐ ఒకే ధాత స్పేటిలెట్స్ | ☐ Whole Blood |
| ☐ మొత్తం రక్తం | ☐ ఎర్ర రక్త కణం | ☐ ఇతరులు..... |

నేను ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి బికిత్తలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికి/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హెచ్ బి యాంటీ బడిస్, హైపటెటిస్ జి సర్వేస్ యాంటిజెన్, హైపటెటిస్ యాంటిబడిస్, మలేరియా మరియు సిఫ్టిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణీత కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్స్ సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిపర్కాలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్కవసానాలు తెల్లత్వవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు

పైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి బికిత్త చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. బికిత్త చేస్తున్న సమయంలో అన్ని రక్తమల రక్తమార్పిడులకు (మొత్తం రక్తం/ లేదా రక్త ఉత్పత్తులు ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ప్లెష్ ప్రోజెన్ ప్లాస్మా, క్రయాప్రెసిపిటేట్ 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

BAH-00861007 IP5-00176118
Master K KARTHIKEYA KRISHNA
27-12-2024 1 Y 6 M 11 D (M)
Dr. DR.V.V.R.SATYA PRASAD



**Rainbow[®]
Children's
Hospital**
It takes a lot to treat the little.

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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ALBUMIN BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 08/07/26 Time: 7:15 pm

Blood Group of the Patient: Blood Group on the Blood Bag:

Blood Bank Issue No: Date of Collection: 8/7/26 Date of Expiry:

Date & Time of Starting Transfusion: 8/7/26 Planned duration of Transfusion: 4 hours

Check for Correct Unit: ☒ Correct Patient: ☒

Blood products cross checked by: Nurse 1: Swarna Nurse 2: R. Sumanthi

Before starting transfusion vitals: Temp: 97.0°F HR 125 RR: 25 BP: 100/60 SpO₂ 99.1

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
<u>08/07/26</u>	<u>7:15</u> Min	<u>126</u>	<u>97.0°F</u>	<u>99/60</u>	<u>99.1</u>	-	-	-	-
<u>8/7/26</u>	15 Min	<u>146 bpm</u>	<u>97.5°F</u>	<u>100/62</u>	<u>100.1</u>	-	-	-	-
<u>8/7/26</u>	30 Min	<u>120 bpm</u>	<u>98.0°F</u>	<u>98/61</u>	<u>98.1</u>	-	-	-	-
<u>8/7/26</u>	30 Min	<u>116 bpm</u>	<u>98.5°F</u>	<u>97/59</u>	<u>100.1</u>	-	-	-	-
	30 Min	<u>101 bpm</u>	<u>98.1°F</u>	<u>101/64</u>	<u>100.1</u>	-	-	-	-
	1 Hr	<u>130 bpm</u>	<u>97.0°F</u>	<u>99/65</u>	<u>99.1</u>	-	-	-	-
	1 Hr	<u>120 bpm</u>	<u>97.0°F</u>	<u>99/60</u>	<u>99.1</u>	-	-	-	-

Comments:

Name of the Incharge-Nurse: Swarna

Name of the Nurse: Sumanthi

Signature of the Incharge-Nurse: Swarna

Signature of the Nurse: Sumanthi

Date & Time: 08/07/26 @ 7:15 pm

Date & Time: 08/07/26 @ 7:15 pm