

Patient Sticker

FC not done

BAH-00660543 IP5-00175899
Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 13 D (M)
Dr. SIRISHA RANI



Groshong® NXT ClearVue™ Catheter

REF 7655405 (01)00801741035272
LOT REKY1633 (17)280731
2028-07-31 (10)REKY1633



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children's
hospital
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BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

Entered
Date : 21/7/26
Patient Name: Mst. Bandhav Date of Birth: 21/4/2022 Age: 4 Y
Gender: male Ward: P. OT UHID No.: BAH-00660543
Date of Surgery: 4/7/26 ☒ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2
Name of the Surgery: Groshong's line insertion for T-cell
All.

Time in : 3:30pm cash
Time Out : 4:30pm sbt

	NAME	AMOUNT
1. Surgeon	Dr. Sripa	SF 10000
2. Anaesthetist	Dr. Sridhara	AF 3000
3. Assistant Surgeon		OT 8000
4. OT Technician	Sridhar	
5. Circulating Nurse	Bebi	
6. Assistant Nurse	Rani	

Special Equipment: ☐ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator
☒ C-ARM 79687886 ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others

ultrasound guide procedure

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9687885

Order by: Y. Ramesh

MAST. ROGULA REDDY SANDHU
 Patient Sub No
 BAH-006605412
 6524/1619

ROU SHANG
 LIFE PLACEMENT
CONSUMABLES OF OT

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Circulating staff : Rome Technician : _____ Date : 4/7 Time : 3:00 PM

Anaesthesia Disposables			Surgical Disposables			Disposables (Baby Side)		
Issued	Used		Issued	Used		Issued	Used	
ET tube (4.0-4.5-5.0)	11/11	—	Major Pack	1	1	Inj Vit.K		
LMA 2	01	01	Sutures	242	—	Cord Clamp		
ECG leads : A (P) N	3	23	9915.5003	242	—	Suction Catheter		
HME filter : A (P) N	01	01				Feeding Tube		
Syringes : 10 cc	10	02				Vaccum Suction Set		
05 cc	10	02	Gloves 6.6-5 7.7-5	242	11	Surgical Gloves		
02 cc	10	02	6.6-5 7.7-5	242	—	Gauze Pack		
01 cc	5	—				Syringe 1ml / 2ml		
Cautery plate : A (P) N	01	—	Surgical blade 11.15	141	—	Surgical Blade # 20		
IV set	01	—	NG tube			Koochies (S)		
RL	01	—	Cautery pencil	1	—	NS 500ml	1	1
NS : 10ml / 100ml / 500ml / 1000ml	01	01	Koochies			Jelly	1	—
min spide	01	01	Ointments			Transodix	1	1
Vacuum set	01	—	Suction Catheter			10cc 5cc	242	141
Fentanyl	01	01	Cap, Mask	314	314	Jello 20 G	3	—
Morphine			Gauze Pack	242	1	20 G cannula	1	—
Ketamine			Mop Pack	1	—			
Propofol	03	02	Steristrip					
Rocuronium	01	0	Underpad	1	1			
Glycopyrolate	01	—	Draw sheet					
Myopyrolate 1pcc	02	—	Abgel					
Ondansetron	01	—	Foleys catheter			0.2 0.1	14	—
Pencan 25g/ Spinal Needle 22	01	—	Urobag			20 20 118	14	—
Bupivacaine 0.25%	01	—	Chest Drainage Catheter			0.2 mme (P)	01	—
Bupivacaine 0.25%(Heavy)			Romodrain bag			5cc comp 9cc (P)	01	—
Antibiotics			Bandage					
IV pcn	01	—	Tegaderm pad + plain	141	14			
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	1	—			
Justin 12.5 mg / 25mg / 100mg	01	—	Plastic Bed Sheet	1	—			
Tab. Misoprost : 200mg			Betadine Solution	1	1			
200mg 100mg 100mg	14	—	Microshield	1	—			
Gauze + 4/4 way	141	141	Cotton Balls	1	—			
Dress + Tissue	141	—	Latex Gloves	101	101			
IV cable 2m	141	141	Ramdione Scrub					
Q-ne splint 1/3	141	141	Saral					

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 9687822

Ordered by : _____

Doc. No. : RCH / FRM / GENERAL / 125

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No _____ Dept : _____

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

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

BAH-00660543 IP5-00175899
Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 12 D (M)
Dr. SIRISHA RANI



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
02/04/20	5:20 AM	ER	118	Musht
03/7/20	9 AM	118	145	chandana
03/7/20	7 AM	OT	145	Sevi

Cross Consultation Visit

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

IP5-00175899

21-04-2022 4 Y 2 M 12 D (M)

D. SIBISHA

4 Y 2 M 12 D

(M)

Dr. SIRISHA RANI

[illegible]

[illegible]



Date	Procedure	Quantity	Order No.	Signature
2/07	IV placements	1	5022	Refikun
3/7	PAC	(1)	9686726	2
3/7	Blood transfusion	(1)	9686730	4
3/7	Chemotherapy	(1)		
3/7	NHA	(1)	2424	2
6/7/26	Blood transfusion	1	9689837	Sub

ANY OTHER INFORMATION

Chest X-ray - 1

Date : 6/7/26

Time : 10:00 AM

Prepared By : Surekha

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Surekha	145		

Rainbow Children's Hospital - Banjara Hills

Rainbow
Children's
HospitalBAH-00660543
Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 12 D (M)
Dr. SIRISHA RANI2,3,4 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 : IP5-00175899

Admit Date : 03-Jul-2026

Admit Time : 04:52 AM UHID : BAH-00660543

Patient Details :

Patient Name	: Master POGULA REDDY BANDHAV	Age	: 4 Y 2 M 12 D
Guardian	: Mr POGULA REDDY PAVAN	DOB	: 21-04-2022
Gender	: Male	Religion	:
Occupation	:	Marital Status	: Single
Address (H)	: 13/349/J-14 NEAR CHAITHANYA SCHOOL Vaim Palle Cuddapah Andhra Pradesh INDIA 516329	Phone No	: 9550942903/ 9642403644
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type : GENERAL WARD

Bed No : GW 118

Ward Name : 1F-GENERAL WARD I

Room No : GW 118

Admission Type : First Visit

Contact Details :

Name	: Mr POGULA REDDY PAVAN	Relationship	: Father
Contact Address	: 13/349/J-14 NEAR CHAITHANYA SCHOOL Vaim Palle Cuddapah Andhra Pradesh INDIA 516329	Phone No	: 9550942903 / 9642403644

P. Reddy
Signature

Doctor Details :

Doctor Name	: Dr. SIRISHA RANI	Specialisation	: HEMATO ONCOLOGY
Referral Doctor	: SELF	Phone No	:
Co-Consultant	: Dr. SANDHYA VADDADI		

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : CARE HEALTH INSURANCE LIMITED

IAH-00660543 IP5-00175899
 Master POGULA REDDY BANDHAV
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 Dr. SRISHA RANI



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EFFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	3			
7	Nursing plan of care and handover sheets	4			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery	1			
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation	2			
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list	1			
26	Surgical safety checklist	1			
27	Operation Theatre notes	1			
28	Nurses clinical Presentation				
29	TPR & BP chart	4			
30	Intake and Out take chart (fluid chart)	2			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list <i>twowhops</i>	1			
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
45	<i>Echa</i>	4			
Total No. of Pages		38			

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

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Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

10 Fever
Weakness w
Dehydration w/ 15 days
2 days.

History of present illness :

Fever - Moderate-High grade, continuous, not associated with chills & R, poorly responding with paracetamol, 6+ hourly.

Now - Fever - Reduced

Weakness present

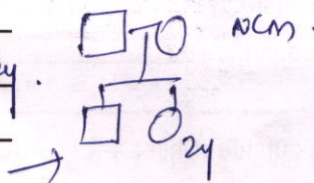
No H/o vomiting, loose motions.



Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

was NO NICU stay.  NCM.

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

for age

Immunization History :

vaccinated till age

(not)



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____)

Weight (kgs)) 16.6 (Centile _____)

On Examination :

Temperature : 98.4°F Pulse Rate : 106/min B.P. 99/66(70) SPO2 98.5% RA

Resp. rate and type of breathing : 24/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any addles sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : _____

Any murmur : S1 S2 ⊕

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

Per Abdomen :

Inspection _____

Palpation : _____

Ausculation : soft

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Aleef

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

TALE on chemotherapy



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Interim

Desired goals of the treatment : _____

Resolving symptoms

Planned Labs:

CBP

RBS

S. Electrolytes

Blood cl.

Planned Management

chemotherapy

BB Metaxol

Signature of the Doctor: _____

N.P.D.

Name of the Doctor: _____

N. Prathap

Date & Time: _____

03/07/2022

Signature of the Consultant: _____

Name of the Consultant: _____

Date & Time: _____

SANDHYA VADPADI
Registration No. 71884



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/20 9:40 AM	Morning visit Newly born Full AU High risk / on Induction wk-2 / Gas enteric clo large stools reg 1 ep of blood stained stool Alert, active feed fine S/E - PPWF, CFTLSSu WS MS PR = distended, ASD, soft Deemed vine Dano 26/6/20 Reg Asparaginase: 27/6 IT on 30/6.	high risk / CNS @ PPR / Adm 1) Vit K 2) RDP 2.0 stat 3) Int Transamin acid 4) stat ivf @ full m vinc & Dano today today ZED cups / shankha Ceftazone / to start 5) send stool clt. 1) CFT, creat, extra plain 2) gas to diet 3) chlorhexidine / mouth can did / care 4) Vincristine long today

Date & Time	Progress Notes	Doctor's Order
8/7/20 8:40 AM	Morning rounds	
	Newly diagnosed T-cell ALL High count WBCs / PPR / High risk / Induction W-2 / Enterocolitis	Adv. 1) cont as per chart. 2) IV Abx 3) Bone labs 4) (R/O) Pneumonia 5) gastrochek 6) NPO solid - 9 AM liquid - 12 PM 7) plan Cushing @ 3 PM 8) Tylenol SOS. 9) Consto-diet 10) plan Dexam after lunch / history time
Revised	had 1 blood stained stool @ 9 PM 2 more at 8 AM. (very small) No vomiting wt abd pain (+) U/O Ileus (+). O/E → PPRWFLCFCN ccy rtg/ pld / (+)	
	Ceftriaxone Dexamethasone Dura.	
	 Dr. Durrant 4/2/20 Dr. Durrant	

SIRISHA RANI

[illegible]

BAH-00660543 IP5-00175899
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Pat

RBS - 10mg/dl

BO

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RESULT SHEET

Date	3/7/28	4/7/28	6/7		
Time					
Hb	10.5	9.3	7.9		
PCV	32.3	29.2			
RBC	3.77	3.41			
WBC	7110	2960	1800		
N/L	41/56	52/43	22/73		
Platelets	23,000	41,000	1,16,000		
CRP					
ESR					
PCT					
RBS	69		104		
Na	132	133			
K	5	4.6			
Cl	95	96			
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP		67			
SGPT		36			
SGOT		27			
T.Bill/Conj		1.5/0.1			
T.Protein		7.4			
S.Albumin		4.5			
S.Globulin		2.9			
A/G Ratio		1.5			
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR		14/1.3			
APTT		33			
CSF Protein / Sugar					
Cells					
N/L	du	cl			



CHEMOTHERAPY PRESCRIPTION

All the chemotherapy medications are high risk / high alert drugs.
While administering chemotherapy drugs watch for nausea, vomiting, rashes,
urine output and any local extravasation of the drug.

Sheet No. : ①		Weight (kg) 16.6kg	Body Surface Area:	Diagnosis: T cell ALL.	Protocol:					
DATE	TIME	Composition of Chemotherapy (if infusion, mention ml / hr = Mcg / kg / min. etc.)	DOSE	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
3/7	1pm	1mg VINCRISTINE in 10 ml NS.	1 MG	IV	over 10 mins	Aty	Dnya Bhaskar	3/7	d	Dnya Bhaskar
5/7/26	3pm	1mg DAUNORUBICIN in 300ml 1/2 NS	16mg	IV.	60ml/h	d	Dnya Archana	5/7	d	Dnya pintu

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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: ICU

Shifted to: Ward

S.N	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	<u>Prochlorperazine</u>					☐ C ☐ DC
2	<u>Depaulmethasone</u>	<u>400 mg</u>				☐ C ☐ DC
3	<u>Vincristine</u>	<u>1 mg</u>				☐ C ☐ DC
4	<u>Methotrexate</u>	<u>10 mg</u>				☐ C ☐ DC
5	<u>Dexamethasone</u>	<u>10 mg</u>				☐ 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 : N. Prathibha - N-PM

Date & Time : 03/07/2022, 4:30am

Nurse Name & Signature : Neelima

Date & Time : 03/07/2022 @ 5:30am

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:																			

Weight. 16.6 kg Ward.

Page: 2/4



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

DRUG :			Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Start Date		Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor			Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:			Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
3/7	2pm	1mg VITAMIN K	5mg	iv	AJ	Mithy 2:10pm Gluc.
3/7	10am	1mg ABIL	8mg	iv	AJ	Mithy 10:30a Blusug
3/7	10am	RDP	2 units	iv	AJ	Mithy 10:30a Blusug
3/7	11am	PPF	1 unit	iv	AJ	Mithy 11:30a Blusug
4/7	10:50AM	1mg ABIL	8mg	iv	AJ	Dar 10:45a Aparanjitha
4/7	10:50AM	SDP	1 unit	iv	AJ	Dar
6/7	10.50P	PRBC	1 unit	iv 4 hour	d	Mithy Sulabha
6/7	10.50P	1mg Avil	0.3ml	iv	A	Mithy Sulabha
6/7		1mg CASIX	5mg	iv	d	Mithy Sulabha

VERIFIED BY : Name Signature



Weight. 16.6 kg Ward.

[illegible]

Signature

VERIFIED BY: Name:



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : 2 & D drops				Date Time	3/7	4/7	5/7	6/7												
Dose	Route	Frequency	Start Dt.																	
IML	PO	OD	3/7																	
Name & Signature of the Doctor Starting the Drugs: <i>Ashwath</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : Inj CEFTRIAXONE				Date Time	3/7	4/7	5/7	6/7												
Dose	Route	Frequency	Start Dt.																	
800mg	IV	BD	3/7																	
Name & Signature of the Doctor Starting the Drugs: <i>Ashwath</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : T. DEXAMETHASONE				Date Time	3/7	4/7	5/7	6/7												
Dose	Route	Frequency	Start Dt.																	
1 hb	PO	BD	3/7																	
Name & Signature of the Doctor Starting the Drugs: <i>Ashwath</i>																				
Additional Instructions: 1 hb = 4mg																				
Daily Doctor's Endorsement by a Sign																				
DRUG : Inj AMIKACIN				Date Time	3/7	4/7	5/7													
Dose	Route	Frequency	Start Dt.																	
120mg	IV	BD	3/7																	
Name & Signature of the Doctor Starting the Drugs: <i>Ashwath</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

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Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 12 D (M)
Dr. SIRISHA RANI



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : <i>ly amikacin</i>				Date Time	<i>6/7</i>														
Dose <i>250mg</i>	Route <i>IV</i>	Frequency <i>OD</i>	Start Dt. <i>6/7/26</i>																
Name & Signature of the Doctor Starting the Drugs: <i>[Signature]</i>																			
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

Ward



Doc. No. : RCH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)
**Children's Observation &
Early Warning Scoring Chart**

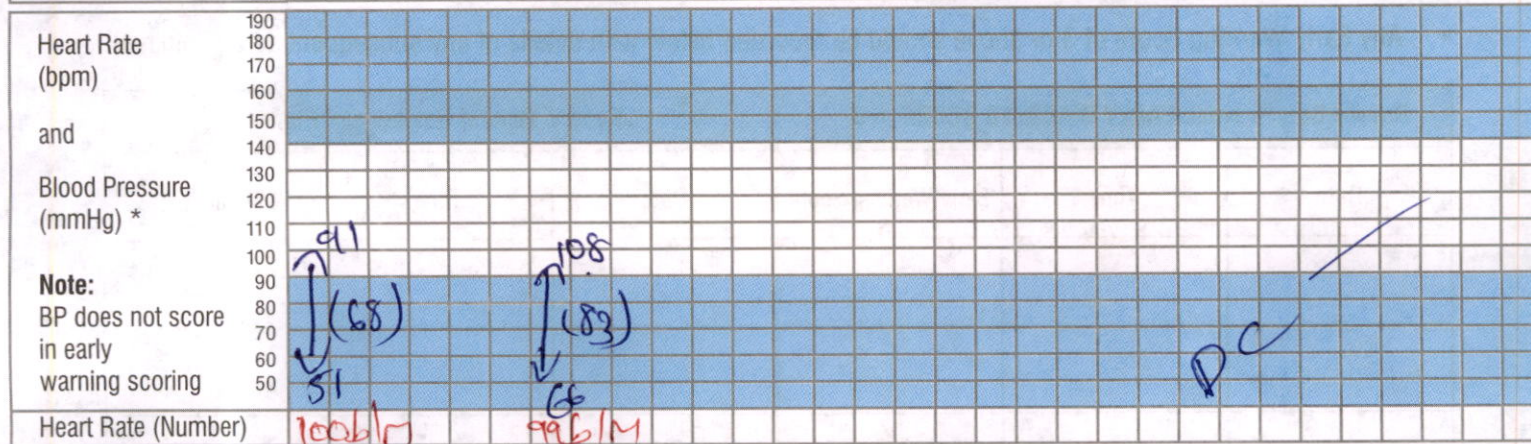
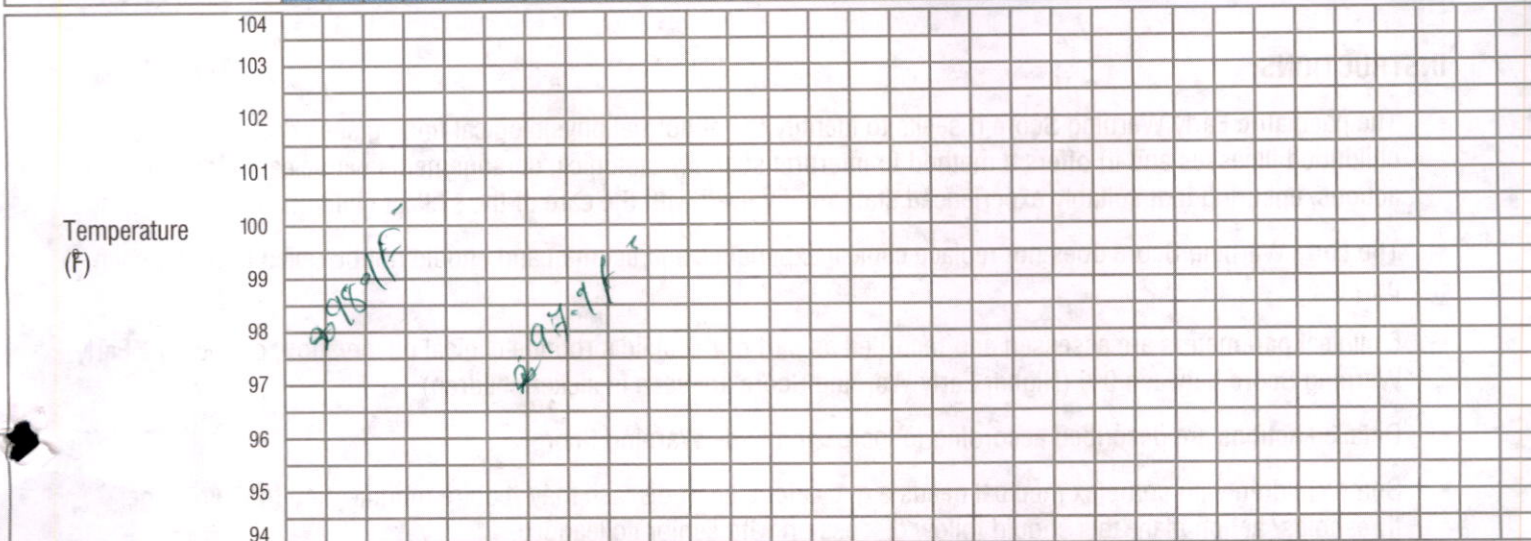
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 6/7 Time: 2PM 6PM

Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)	100%	100%

Conscious Level	Normal	
	Altered	
GCS *	15/15	15/15

TOTAL SCORE		
Number of shaded boxes	1	1
Pain Score	2	2
Observer's Initials	0	5

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:

- 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)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 5/7/22	Time: 6 AM	Location: 109/10	Room: 13m	Shift: 10 PM	
Doctor / Nurse / Family Concern?					
Temperature (°F)					
Heart Rate (bpm)					
Blood Pressure (mmHg) *					
Note: BP does not score in early warning scoring					
Heart Rate (Number)	99b/m	98b/m	100b	106b/m	106b/m
Resp. Rate (bpm) (Over 1 Minute) *					
Resp Rate (Number)	28b/m	28b/m	28b	28b/m	28b/m
Resp Distress	Mod/ Severe				
Mod/ Severe	None / Mild				
Receiving O ₂ (l/min)					
O ₂ Saturations (%)	100%	100%	100%	99%	98%
Conscious Level	Normal				
Normal	Altered				
GCS *	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE					
Number of shaded boxes	1	1	1	0	1
Pain Score	0	0	0	0	0
Observer's Initials	S	S	S	M	S

ACTIONS

NB: Scores 3 should be recorded overleaf

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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.
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BAH-00660543 IP5-00175899
Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 12 D (M)
Dr. SIRISHA RANI



: RCH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years) Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 4/5/26	Time: 2AM	6AM	10AM	1PM	7PM	10PM
Doctor / Nurse / Family Concern?						
Temperature (F)						
Heart Rate (bpm)						
Blood Pressure (mmHg) *						
Note: BP does not score in early warning scoring						
Heart Rate (Number)	130b/min	126b/min	118b/min	112b/min	102b/min	105b/min
Resp. Rate (bpm) (Over 1 Minute) *						
Resp Rate (Number)	30b/min	28b/min	26b/min	26b/min	28b/min	28b/min
Resp Mod/ Severe Distress None / Mild						
Receiving O ₂ (l/min)						
O ₂ Saturations (%)	99%	100%	100%	99%	100%	99%
Conscious Level Normal / Altered						
GCS *	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE						
Number of shaded boxes	1	1	1	1	1	1
Pain Score	0	0	0	0	0	0
Observer's Initials	0	0	0	0	0	0

ACTIONS

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Doc. No. : RCH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)
**Children's Observation &
Early Warning Scoring Chart**

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 3/4/22	Time: 6 AM	10 AM	4 PM	6 PM	10 PM
Doctor / Nurse / Family Concern?					
Temperature (°F)	97.3	98.4	99.1	98.1	98.4
Heart Rate (bpm)	119	120	115	111	122
Blood Pressure (mmHg) *	109/67	105/65	89/61	101/60	90/70
Resp. Rate (bpm)	29	23	25	26	26
Receiving O ₂ (l/min)	100%	99%	100%	99%	99%
O ₂ Saturations (%)	100%	99%	100%	99%	99%
GCS *	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE	1	1	1	0	1
Number of shaded boxes	0	0	0	0	0
Pain Score	0	0	0	0	0
Observer's Initials	SR	SR	SR	SR	SR

ACTIONS

NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
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Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 12 D (M)
Dr. SRISHA RANI

Patient Stic



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FLUID CHART

Sheet No. : ①

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

Date	Time	Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

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Dr. SIRISHA RANI



FLUID CHART

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Sheet No. : 2

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		
3/7	08:00 am	↓		50ml		/	/			✓	0	Ch
	09:00 am			50ml		/	/				0	Ch
	10:00 am	DM		50ml		/	/				0	Ch
	11:00 am	↓		50ml		/	/				0	Ch
	12:00 pm	↓				/	/				0	Ch
	01:00 pm	↓				/	/		✓	0	Ch	
	Total Intake :			Total Output :								
3/7	02:00 pm	↓				/	/			0	Ch	
	03:00 pm	↓		50ml		/	✓		✓	0	Ch	
	04:00 pm	DM		50ml		/	/			0	Ch	
	05:00 pm	5ml mvlt		50ml		/	/			0	Ch	
	06:00 pm	5ml mvlt		50ml		/	/		✓	0	Ch	
	07:00 pm	5ml Kcl		50ml		/	/		✓	0	Ch	
	Total Intake :			Total Output :								
	08:00 pm	↓		50ml		/	/			0	Ch	
	09:00 pm	DM		50ml		/	/			0	Ch	
	10:00 pm	5ml mvlt	Idly	50ml		/	/			0	Ch	
	11:00 pm	5ml Kcl		50ml		NA	✓	NA	✓	0	Ch	
	12:00 am	↓		50 ml		/	/		✓	0	Ch	
	01:00 am	↓		50 ml		/	/		✓	0	Ch	
	Total Intake :			Total Output :								
	02:00 am	↓		50ml		/	/			0	Ch	
	03:00 am	DM		50ml		/	/			0	Ch	
	04:00 am	5ml mvlt		50ml		NA	/	NA	✓	0	Ch	
	05:00 am	5ml mvlt		50ml		NA	/	NA	✓	0	Ch	
	06:00 am	5ml Kcl	Idly			/	✓	/	✓	0	Ch	
	07:00 am		NPO			/	/		✓	0	Ch	
	Total Intake :			Total Output :								
Total 24 hrs. Intake			Total 24 hrs. Output									

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Master POGULA REDDY BANDHAV
21-04-2022
Dr. SIRISHA RANI 4 Y 2 M 12 D (M)



FLUID CHART

Sheet No. : 8

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								
4/2	08:00 am			SON		/	✓				✓	0	} Appc
	09:00 am			SON		/						0	
	10:00 am	ABST NPO		SON		/						0	
	11:00 am	SON		SON		/				✓	0	} Appc	
	12:00 pm	SON		SON		/					0		
	01:00 pm	SON		SON		/						0	
Total Intake :						Total Output :							
4/3	02:00 pm			0		0							}
	03:00 pm												
	04:00 pm			0	OT	0							
	05:00 pm												
	06:00 pm	H2O								✓	0	}	
	07:00 pm												
Total Intake :						Total Output :							
4/2	08:00 pm			SON		/							}
	09:00 pm			SON		/							
	10:00 pm	SON				/							
	11:00 pm	SON				/							
	12:00 am	SON		SON		/							
	01:00 am	SON		SON		/				✓			
Total Intake :						Total Output :							
5/2	02:00 am			SON		/							}
	03:00 am			SON		/	✓						
	04:00 am			SON		/				✓			
	05:00 am			SON		/							
	06:00 am					/	✓			✓			
	07:00 am					/	✓						
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							



FLUID CHART

Sheet No. : 12

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		
5/7/26	08:00 am	DNST		SOM	/	✓	/	/	✓	0	mrfu	
	09:00 am	SOM + 100ml water	SOM	✓					0			
	10:00 am	150ml	SOM	✓					0			
	11:00 am		SOM	✓					0			
	12:00 pm		SOM	✓					0			
	01:00 pm		SOM	✓					0			
Total Intake :						Total Output :						
5/12/26	02:00 pm		SOM	/	✓	/	/	✓	0	mrfu		
	03:00 pm		SOM					✓	0			
	04:00 pm	DNST + 100ml	SOM					✓	0			
	05:00 pm	SOM + 100ml	SOM					✓	0			
	06:00 pm		SOM					✓	0			
	07:00 pm		SOM					✓	0			
Total Intake :						Total Output :						
5/17/26	08:00 pm		SOM	/	/	/	/	✓	0	mrfu		
	09:00 pm	DNST + 100ml	SOM					✓	0			
	10:00 pm	SOM + 100ml	SOM					✓	0			
	11:00 pm		SOM					✓	0			
	12:00 am		SOM					✓	0			
	01:00 am		SOM					✓	0			
Total Intake :						Total Output :						
6/17/26	02:00 am		SOM	/	/	/	/	✓	0	mrfu		
	03:00 am	DNST + 100ml	SOM					✓	0			
	04:00 am	SOM + 100ml	SOM					✓	0			
	05:00 am		SOM					✓	0			
	06:00 am		SOM					✓	0			
	07:00 am		SOM					✓	0			
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 31/7/26

Assessment: Baby Came for Chemotherapy

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
5AM	⇒ Assess the pt general condition.	5:05AM	⇒ Assessed the pt general condition.	By doing all the procedures the baby condition is Improved.
5:30AM	⇒ provide the comfortable position.	5:35AM	⇒ provided the comfortable position.	
6AM	⇒ Check the vitals.	6:05AM	⇒ Checked the vitals.	
6:30AM	⇒ provide side rails.	6:35AM	⇒ provided side rails.	
7AM	⇒ Dr. advised to Chemomedicine.	7:05AM	⇒ Dr. advised the medicine.	
	⇒ Administer the Medication as per doctors order.		⇒ Administer the medication as per doctors order.	

Re-Assessment:

Special Notes: Re-assessment is done by checking vital signs. ~~esp~~ plan, EDTA samples is there. Came for chemotherapy.

Nurse Signature:

Nurse Name: prameela (015802)

Date & Time: 31/7/26 @



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 3/7

Assessment: Baby having discomfort

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
9am	→ Assess the baby general condition	9:10am	→ Assessed the baby general condition	baby condition is normal
10am	→ monitor the vital	10:10am	→ monitored the vitals	
12pm	→ provide comfortable position	12:10pm	→ provided comfortable position	
1pm	→ Administer medication as per doctor orders	1:10pm	→ Administered medication as per doctor orders	

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name: Sirisha

Date & Time: 3/7/26 @ 2pm

BAH-00660543 IP5-00175899
 Master POGULA REDDY BANDHAV
 21-04-2022 4 Y 2 M 12 D (M)
 Dr. SIRISHA RANI

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/2026

Assessment: The baby is 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 general condition of the baby	8:10pm	⇒ Assessed the general condition of the baby	The baby condition is Improving slowly
12am	⇒ provide comfortable bed and position	12:10 AM	⇒ provided comfortable bed and position	
4am	⇒ monitor vital signs	4:10 AM	⇒ monitored vital signs	
6am	⇒ plan for grocial line tomorrow	6:10 AM	⇒ planned for grocial line tomorrow	
8am	⇒ Administered medication as per doctor order	8:10 AM	⇒ Administered medication as per doctor order	

Re-Assessment:

Baby is feeling discomfortable

Special Notes:

Nurse Signature: Rama

Nurse Name: Rama

Date & Time: 4/7/2026 8am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 4/7/26

Assessment: Baby Having Distress

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
10am	→ Assess the Baby General Condition, monitor vitals & record	10:30am	→ Assessed the Baby General Condition, monitored vitals & recorded	By Anil's doc PA condition is improved
11am	→ provide comfortable position	11:30am	→ provided comfortable position	
12pm	→ plan to do Grooshan 1m 3pm npo 9am	12:30pm	→ planned to do Grooshan 1m 3pm npo 9am	
1pm	→ Administer medication as per doctor order	2pm	→ Administered medication as per doctor order	

Re-Assessment: 3pm

Special Notes: plan, Grooshan 1m 3pm npo 9am

Nurse Signature: A

Nurse Name: Aparanjitha

Date & Time: 4/7/26 2:30pm

BAH-00660543 IP5-00175899
Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 13 D (M)
Dr. SIRISHA RANI



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 21/5/26

Assessment: pt having discomfort.

- | | | | | | | |
|-------|---|---|---|---|---|---|
| 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	8PM	→ Assessed pt General condition	pt condition is improved
10PM	→ monitor vital signs	10PM	→ monitor vital signs	
2AM	→ maintain I/O chart	2AM	→ maintained I/O chart	
8AM	→ Administer the medications as per doctor's order	8AM	→ Administered the medications as per doctor's order.	

Re-Assessment: 21/5

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Sravanthi

Date & Time: 21/5/26 8AM



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/4/26

Assessment: Patient having loose stool

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 patient general condition.	8:10am	Assessed the patient general condition.	By 8am as the pt condition is improving.
9am	check the vital.	9:10am	checked the vital sign	
10am	Maintain I.V fluid balance	10:30am	Maintained I.V fluid balance	
11am	provide comfortable position	11:30am	provided comfortable position	
12pm	provide good nutritional	12:30pm	provided good nutritional	
1pm	Administer medication as per doctor's order	1:30pm	Administered medication as per doctor's order	

Re-Assessment:

(Nil)

Special Notes:

CBP, RBS T/m

Nurse Signature: Highu

Nurse Name: Keithu

Date & Time: 5/4/26 @ 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/7/2026

Assessment: Baby having chemo.

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 the general condition of the patient.	2pm	* Assessed the general condition of the patient.	By doing all the procedure the patient can be Stable.
up	* maintain personal hygiene.	up	* maintained personal hygiene.	
sp	* maintain IV fluid.	sp	* maintained IV fluid.	
sp	* monitor vitals.	6p	* monitored vitals.	
7p	* maintain good nutrition.	7p	* maintained good nutrition.	

Re-Assessment: CBP, RBS 7/m

Special Notes:

Nurse Signature:

[Signature]

Nurse Name:

Dinika [08165]

Date & Time:

5/7/26 @ 8p

BAH-00660543 IP5-00175899
Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 13 D (M)
Dr. SIRISHA RANI



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: pt having chemo

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 pt general condition	8pm	→ Assessed pt general condition	pt condition is normal.
10pm	→ monitor vital signs	10pm	→ monitored vital signs	
2am	→ maintain i/o chart	2am	→ maintained i/o chart	
8am	→ Administer the medications as per doctors orders.	6am	→ Administered the medications as per doctors orders.	

Re-Assessment: will

Special Notes: CBP, RBS done

Nurse Signature: Sri

Nurse Name: sruwanthi

Date & Time: 6/7/26 8am



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. S.R. Department: luno Date of Admission: 03/07/20

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	<u>Teeth All.</u>							
BACKGROUND	Area	Shift Time	<u>ER</u> <u>5:28</u> <u>am</u>	<u>1st floor</u> <u>5:35AM-8AM</u>	<u>1st floor</u> <u>8am-2pm</u>	<u>1st floor</u> <u>2pm-8pm</u>	<u>1st floor</u> <u>8pm-10pm</u>	<u>1st floor</u> <u>8pm-10pm</u>
	Medical Condition (Any special condition to be noted):		<u>nic</u>	<u>NIL</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
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:	<u>98°F</u>	<u>98.1°F</u>	<u>98.5°F</u>	<u>98.5°F</u>	<u>98.2°F</u>	<u>98.1°F</u>
	Res:	<u>26bw</u>	<u>29m</u>	<u>25b/m</u>	<u>26bw</u>	<u>28b/m</u>	<u>27bw</u>	
	SpO ₂ :	<u>97%</u>	<u>99%</u>	<u>99%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	
	Pulse:	<u>100bw</u>	<u>102bm</u>	<u>103bm</u>	<u>111bw</u>	<u>110b/m</u>	<u>112bw</u>	
	BP:	<u>99/62</u>	<u>95/61</u>	<u>99/70</u>	<u>98/60</u>	<u>100/70</u>	<u>101/60</u>	
	Fall Risk Score:	<u>1</u>	<u>1</u>	<u>1</u>	<u>1</u>	<u>1</u>	<u>1</u>	
Recommendations	Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	
	Safety Needs:	<u>yes</u>	<u>side bark</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	
	Physiotherapy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>nic</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:		<u>nic</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>nic</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Nursul</u>	<u>pramee</u>	<u>Srishe</u>	<u>Chandam</u>	<u>Rama</u>	<u>Appo</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>03/07</u>	<u>3/7/20</u>	<u>3/7</u>	<u>3/7/20</u>	<u>4/7/20</u>	<u>4/7</u>	
Time:		<u>5:30w</u>	<u>8AM</u>	<u>2PM</u>	<u>6PM</u>	<u>8AM</u>	<u>2PM</u>	
Taken Over By Name :		<u>pramee</u>	<u>Srishe</u>	<u>Chandam</u>	<u>Rama</u>	<u>Aparanjitha</u>	<u>Srishe</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>3/7/20</u>	<u>3/7</u>	<u>3/7/20</u>	<u>4/7/2020</u>	<u>4/7</u>	<u>4/7</u>	
Time:		<u>5:35AM</u>	<u>8AM</u>	<u>2PM</u>	<u>8PM</u>	<u>8AM</u>	<u>2PM</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. S.R. Department: ONCO Date of Admission: 3/7/26

SITUATION	Diagnosis: <u>Cervical my.</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:			
	Area	Shift Time	1st Shift 8:00 AM - 2:00 PM	2nd Shift 2:00 PM - 8:00 PM	3rd Shift 8:00 PM - 6:00 AM	
BACKGROUND	Medical Condition (Any special condition to be noted):		NA	NA	NA	NA
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp: <u>98.5</u>	Temp: <u>98.5</u>	Temp: <u>98.2</u>	Temp: <u>97.5</u>	
	Res:	<u>28</u>	<u>28</u>	<u>28</u>	<u>28</u>	
	SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>	
	Pulse:	<u>110</u>	<u>110</u>	<u>100</u>	<u>112</u>	
	BP:	<u>95/50</u>	<u>96/50</u>	<u>99/69</u>	<u>95/59</u>	
	Fall Risk Score:	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	
	Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	
	Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Sowathi</u>	<u>Mithu</u>	<u>Diny</u>	<u>Sowathi</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>5/7/26</u>	<u>5/7/26</u>	<u>5/7</u>	<u>6/7/26</u>	
Time:		<u>8AM</u>	<u>2PM</u>	<u>8P</u>	<u>8AM</u>	
Taken Over By Name :		<u>Mithu</u>	<u>Diny</u>	<u>Sowathi</u>	<u>Sowathi</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>5/7</u>	<u>5/7</u>	<u>6/7/26</u>	<u>6/7/26</u>	
Time:		<u>8AM</u>	<u>2P</u>	<u>8PM</u>	<u>8AM</u>	

Patient Sti



THE HUMPTY DUMPTY SCALE

03/7 4/7 5/7 6/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	2	3	3	3	
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	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	1	1	1	1	
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	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	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	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	1	
TOTAL			11	11	11	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	yes
Call device within reach	yes	yes	yes	yes
Wheels Locked	yes	yes	yes	yes
Room free of clutter	yes	yes	yes	yes
Adequate Lighting	yes	yes	yes	yes
Wheel Chair Support	no	yes	no	no
Other Intervention(s) Specify	no	no	no	no
Nurse's Name :	Rushi	Poy	South	South
Signature :	[Signature]	[Signature]	[Signature]	[Signature]
Date :	03/7	4/7	5/7	6/7
Time :	5am	8am	6am	6am



BRADEN 'Q' SCALE

					Date :	03/11/2022	4/17/2022	5/2/2022	6/2/2022
					Time :	5am	6am	6am	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	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	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	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	4	4	
FRICION-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	4	4	
Nutritional Usual food intake pattern	1. Very Poor: Is on liquid diet or tube feedings/TPN, 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 or 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	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	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23									
Docu. No. : RCHBH /FRM / CLINICAL / 119									
					TOTAL SCORE	28	28	28	28
					Evaluator's Name	Nuvu	Rama	Rama	Rama

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
03/7/26	5am	9/10	abd	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	ndr	Jessy
03/7/26	1pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Raj
03/7/26	9pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rama
04/7/26	5am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rama
04/7	1pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Appy
04/7	9pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	sravanthi
5/7	5am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	sravanthi
5/7	1pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	nithin
5/7	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Dhruv
6/7	2Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	sravanthi

Re-assessment Frequency:

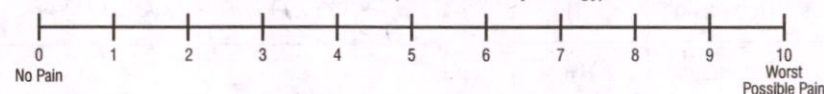
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, 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

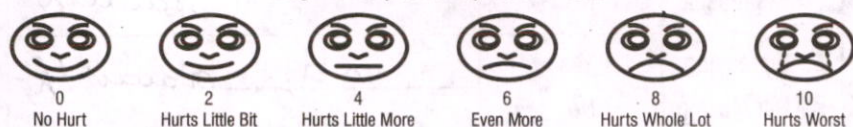
Numerical Pain Scale (Obstetric and Gynecology)



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



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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		
03/04/20	5m 5		medication	F	1	0	1	1	MR	Handwritten
3/7/20	8am 9		Soft High protein diet	F	1	0	1	1	-	Handwritten

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:

Neutly diag: T-cell ALL

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
3/7	☒ Medical ☐ Nursing ☐ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	T-cell ALL	H stability	Chemo therapy	[Signature]	☐ Nursing ☐ Others:
3/7 5am	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	T-cell ALL	H stability	Chemo	[Signature]	☒ Medical ☐ Others:
3/7/26 8am	☐ Medical ☐ Nursing ☒ Others: Deletion	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	T-cell ALL	Soft High protein diet	RDA E: 1350kcal/d P: 23g/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-00660543 IP5-00175899
Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 12 D (M)
Dr. SIRISHA RANI

CHECKLIST FOR THROMBOPHLEBITIS

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	3/7 DAY-1			4/2 DAY-2			5/7 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	1	1	0	1	1	
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	-	-	-	-	5	5	-	L	L	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-	5	5	-	1	1	
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	5	-	4	e	
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	-	-	-	-	5	5	-	1	1	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	1	1	-	1	1	
Signature of the Nurse				pravi Choudhary Appu R. Li m R. R. Li									

Signs 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.

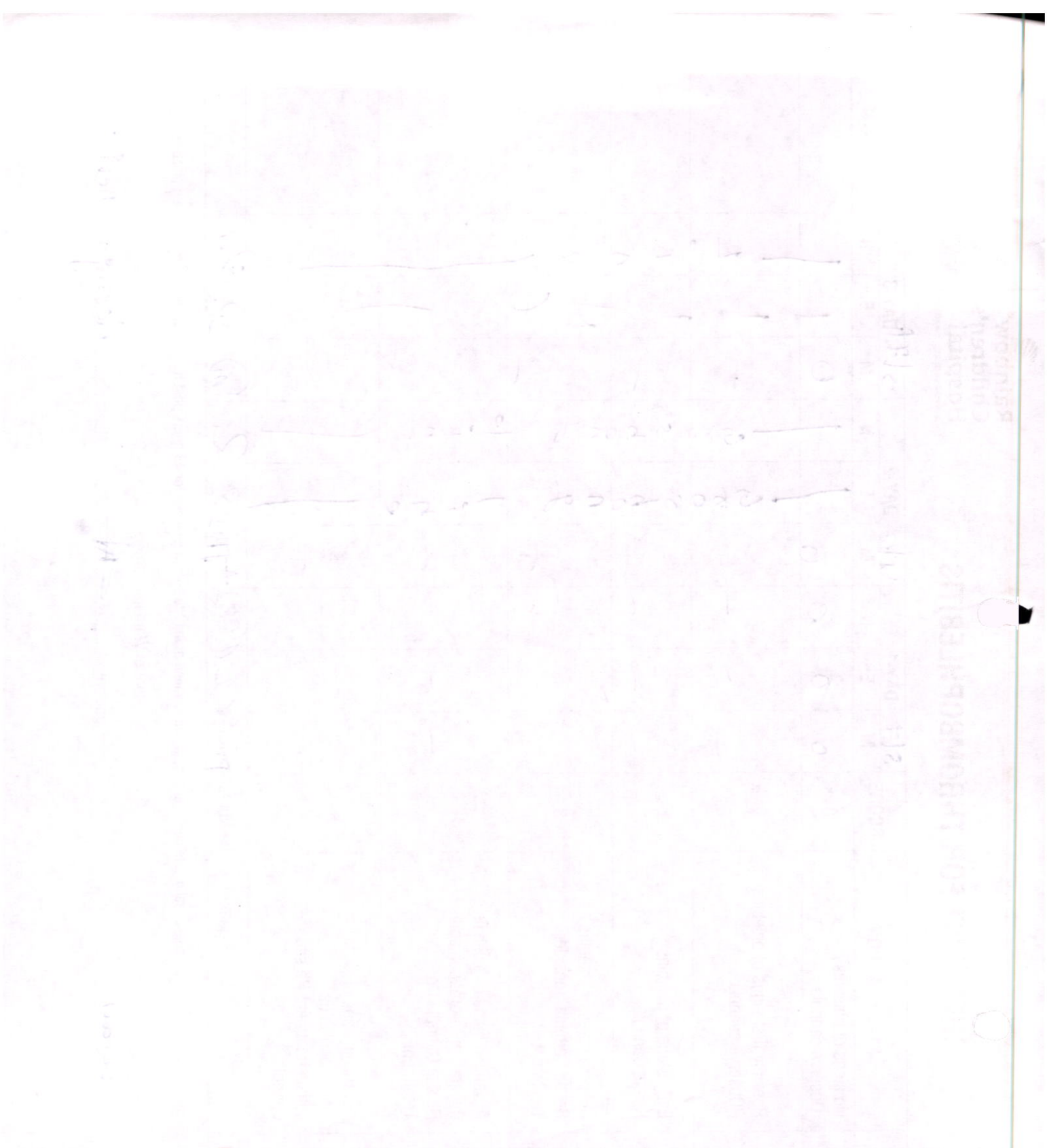
Shift In Charge :

 Name : Souvali

Signature of Ward In Charge :

Signature :  Name : Neeraja. Devi

NOTE : Phlebotomy
Signature of SN
Signature :
Docu. No. : RCHBH / FM





DISCHARGE PLANNING FORM

Nationality: Indian.

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

1. Anticipated Date of Discharge: 5/7/26.

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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: Hand hygiene

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: prameela.

Date and Time: 3/7/26 @ 6AM

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00660543 IP5-00175899 Master POGULA REDDY BANDHAV 21-04-2022 4 Y 2 M 12 D (M) Dr. SIRISHA RANI 		Date & Time of Admission 03/07/26 @ 4:52 am	Date & Time of Transfer Order 03/07/26 @ 5:28 am
		Transfer Ordered by Dr. preethiba.	Reason for Transfer Admission
From Unit ER.	To Unit 118.	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 22	Number of Imaging Films nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	EDTA	①	
2.	plain	①.	
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Mr. Umeswari		Name of Person Ordered Transfer Dr. preethiba.	
Patient & Clinical Records Received by : prameela.			
Date & Time of Patient Received : 3/7/26 @ 5:30 AM			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00660543 IP5-00175899 Master POGULA REDDY BANDHAV 21-04-2022 4 Y 2 M 13 D (M) Dr. SIRISHA RANI 		Date & Time of Admission 3/7/26 @ 4:52am	Date & Time of Transfer Order 4/7/26 @ 3PM
		Transfer Ordered by Dr. SIRISHA R.	Reason for Transfer Admission
From Unit 145	To Unit OT	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 	Number of Imaging Films nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If yes, what?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.	nil	nil	
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. SIRISHA R.	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received : 4/07/26 @ 3:15PM			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready



anesthesiology IC EVALUATION

Name: Pogula Reddy bandhav Age: 4 Sex: male UHID No: DAH 00660543

Date: 3/7/2026 Time: 9:30 PM Proposed Operation: Crocheting line placement

Diagnosis: Tcell ALL

B.P / CRT: 101/60 H.R: 111 Weight: 10.6 kg ASA Physical Status: ☐ 1 ☐ 2 ☒ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 10.5 Glucose: _____ Protein: _____ HIV: _____ X-Ray: _____
PCV: 32.3 Urea: _____ Alb: _____ HBS Ag: _____ ECG: _____
WBC: _____ Creat: _____ Total Bill: _____ HCV: _____ 2D Echo: _____
Plate: 23,000 Na: 132 Dir. Bill: _____ Blood group: Bpos Stress/Angio: _____
PT: _____ K: 5 LDH: _____ T3: _____ Other: _____
PTT: _____ Ca++: _____ Alk phos: _____ T4: _____
INR: _____ Mg++: _____ Amylase: _____ TSH: _____
Cl-: 9.5 SGOT/SGPT: _____

Allergies: nil

Medical History: CVS: (-)

RESP: (-)

CNS: (-)

Renal: (-)

Hepatic / GE: C/O loose stool => blood stool

Physical Activity: act

Others: 2 RDP transfused, must FFP transfused today.

Past Anaesthetic History: MAC for Lumbar puncture

Physical Exam: No obvious focal abnormal

Airway: MP 1 2 3 4

Mouth Opening: (N)

Mentohyoid Distance: (N)

Neck: (N)

Teeth: (N)

Lungs: clear

Heart: S1S2

CNS: CNS-Pul

Pregnant: ☐ Yes ☐ No ☐ NA

Venous Access Site: +

Spine Exam for regional: (N)

Anaesthetic Plan: ☒ MAC ☐ REGIONAL ☐ GA-ETT ☐ LMA

Peri-Operative Plan Explained to the Patient: ☒ Yes ☐ No

CURRENT MEDICATIONS	DOSAGE
/	/
/	/
/	/
/	/

Pre-Operative Instructions:

- DVT Prophylaxis:
 - Water / ORS 2 Hours
 - Others 6 Hours
- NIL ORAL
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☒ Discussed with Patient
- Other Instructions:

(C) Repeat CBP, electrolyte tomorrow

Signature: [Signature] Name: Rooshab m



ANAESTHESIA CHART

Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☒ No	Fasting Status: Adequate
Physical Status: ☒ Patient Identified	☒ Consent Present
	☒ Chart Reviewed

H.R: 101 bpm B.P / CRT: 90/60 mmHg SpO₂: 99% on RA R.R: 18/min Last Feed: 9am

Pre-OP Diagnosis: T Cell ALL Operation: Groshong line placement Date: 4/2/26

Surgeon: Dr. Shilpa Anaesthesiologist: Dr. SD Dr. RB Technician: S. S. S. S.

TIME	N ₂ O / AIR (O ₂) LPM	HALO / ISO / SEVO	Drugs	Antibiotic	Suppository	Blood Loss	NOTES
3:30	100	0	0.8 mg IV				
4:00	100	0	30 mg IV				
4:30	100	0	60 mg IV				
5:00	100	0					
5:30	100	0					
6:00	100	0					
6:30	100	0					
7:00	100	0					
7:30	100	0					
8:00	100	0					
8:30	100	0					
9:00	100	0					
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20:30	100	0					
21:00	100	0					
21:30	100	0					
22:00	100	0					
22:30	100	0					
23:00	100	0					
23:30	100	0					
24:00	100	0					

LAB Values

ABG

GRBS

Others

☒ Equipment Checked and Functional ☒ BP ☐ Cuff Site: Left U ☐ Art Site: Left U ☒ EKG Lead: 3 lead ☒ Temp Site: RT axilla ☒ FIO ₂ Monitor ☒ Agent Monitor ☒ Pulse Oximeter ☒ Capnograph ☒ Ventilator ☐ Nerve Stimulator Position: Spine ☐ Pressure Points Checked Eye Care: ☐ Oint ☐ Tape ☐ Padding ☒ Awake	Temp: ☐ HME ☐ Cling Film ☒ Hugger's ☐ Other Times: Anaes Start: 3:30pm OP Start: 4:00pm OP End: 8:00pm Leave OR: 8:30pm Anaesthesia: ☒ GA ☐ Monitored Anaesthesia Care ☐ Regional Line (Size & Location) ☐ CVP: ☐ ART: ☒ IV: 22G Left U ☐ IV: ☐ IV:	Induction ☒ IV ☒ Pre O ₂ ☐ Others ☐ Mask ☐ Airway ☐ Oral ☐ Tracheostomy ☐ Drug: ☐ Awake ☐ Video Laryngoscopy ☐ Fiberoptic Blade # Attempts: Difficulty Why? ☒ Bilat = BS ☐ Semi-Closed Circle ☒ Closed Circle ☐ Other	Regional: Extremity ☐ Spinal ☐ Epidural ☐ Caudal Others: Position: Site: Needle Size: Depth: Parasthesia: Yes No Catheter at skin: cm Drug Name & Conc: Bolus: Infusion: Block Level: Comments: Transportation to ☒ PACU ☐ ICU ☐ Other Relaxant Reversed: Yes No NA Name of the Doctor: Dr. Pranda Signature of the Doctor:
--	---	--	--

Date & Time: 4/6/20 @ 6:20 PM

Patient Sticker

EPIDURAL ANALGESIA RECORD

b)

[illegible]

Date and Time :



CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: Groshong line placement

Anaesthesiologist: Dr. Shobha Surgeon: Dr. Subramanyam

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery. Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk(s): The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders
☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease
☐ Others Dental caries, Bronchitis, Laryngitis

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☐ Regional Anaesthesia ☐ General Anaesthesia ☐ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: P. Reddy PAVAN
Name: P. Reddy PAVAN
Relationship with patient: Father
Date & Time: 3/7/2026 10 pm

Witness:

Signature: Soupar
Name: Soupar
Date & Time: 3/7/2026 10 PM

Doctor (who is taking consent):

Signature: Dr. Shobha Name: Dr. Shobha Date: 3/7/2026 Time: 10 pm

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అవస్థాపక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

రిజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్మల్ బ్లడ్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై లిస్ట్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ రిజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. దీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెన్స్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, రిజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

CONSENT FOR BLOOD TRANSFUSION



BAH-00660543 IP5-00175899
Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 12 D (M)
Dr. SIRISHA RANI

Name: Age: Gender: Male ☐ Female ☐
UHID.No : Date: 4/7/22

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
Nil

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 d 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: M. Haritha
Name: M. Haritha
Date & Time: 4/7/22 @ 10:30am

Doctor (Who is talking the consent)

Signature: S
Name: Sainthi
Date & Time: 4/7/22 @ 10:30am

Witness

Signature: Res
Name: Aparanile
Date & Time: 4/7/22 @ 10:30am

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 |
| ☐ క్రయోప్రెసిపిటేట్ | ☐ 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, హైపటైటిస్ బి సర్వైస్ యాంటిజన్, హైపటైటిస్ యాంటిబడిస్, మలేరియా మరియు సిప్లిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణీత కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలెత్తవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు

పైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి చికిత్స చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. చికిత్స చేస్తున్న సమయంలో అన్ని రకముల రక్తమార్పిడులకు (మొత్తం రక్తం / లేదా రక్త ఉత్పత్తులు ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ప్లెష్ ప్రోజెన్ ప్లాస్మా, క్రయోప్రెసిపిటేట్ 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: 04/7/26 Time: 10:30am

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

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

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

Check for Correct Unit: ☐ Correct Patient: ☒

Blood products cross checked by: Nurse 1: pinku Nurse 2: Aparajitha

Before starting transfusion vitals: Temp: 98.2F HR 112b/m RR: 28 b/m BP: 98/62 SpO₂ 100%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
<u>4/7</u>	15 Min	<u>116</u>	<u>98.8°F</u>	<u>98/62</u>	<u>100%</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>
	15 Min	<u>118</u>	<u>98.2°F</u>	<u>100/60</u>	<u>99%</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>
	30 Min								
	30 Min								
	30 Min								
	1 Hr								
	1 Hr								

Comments:

Name of the Incharge-Nurse: Neeraja

Name of the Nurse: Mashin

Signature of the Incharge-Nurse: (M)

Signature of the Nurse: Mashin

Date & Time: 4/7/26 @ 10:30am

Date & Time: 4/7/26 @ 10:30am

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2,
Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

PLATELETAPHERESIS

Qty. 250 ml. Prepared from Human Whole Blood by Apheresis using Cell Separator (Qty. 250 ml ± 20 ml.)

B

HIV I & II/ HBsAG/ HCV - Non reactive
VDRL - Non reactive
MP - Negative

Donor Type: Replacement

Unit No.: BAH26-P0161
Blood Group: B Rh Positive
Collection Date: 03/Jul/2026
Expiry Date: 08/Jul/2026

1. Do Not Dispence Without Prescription. 2. Check Blood Group On Label & Recipient's Group And Name Before Administration. 3. Shake Gently Before Use. 4. Do Not Add Any Medication. 5. Use Immediately After Issuc. 6. Use Sterile Transfusion Set With Filter. 7. Do Not Use If There Is Any Visible Evidence Of Deterioration Like Haemolysis Clotting Or Discoloration. 8. Store Continuously At 22° C - 24° C With Gentle Agitation Or Below.
9. Administer Without Warming.

Issue Label / CROSSMATCHING Report

Patient : **Master POGULA REDDY BANDHAV**
Patient's Blood Group : B Rh Positive
Hosp/Dr : Rainbow Childrens Hospital, DR. SIRISHA RANI
UHID No.: BAH-00660543 Wd-Bed No.:
Product : SDP
Blood Group : B Rh Positive
Unit No.: **BAH26-P0161**
X-Matching Report: Group Specific
X-matched by: MONOJ

Issue Dt : 04/Jul/2026
Colln. Dt : 03/Jul/2026
Exp. Dt : 08/Jul/2026
Issued By : MONOJ

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road
No.2, Banjara Hills, Hyderabad, Telangana State
Lic No. 46/HD/TS/2018/BB/G

BAH-0660543 IP5-00175899
Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 12 D (M)
Dr. SIRISHA RANI



CONSENT FOR CHEMOTHERAPY

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name : Bandhav Age : 4 yr Gender : Male ☒ Female ☐
UHID No : 660543 Department : Oncology Date : 3/7/26
Type of Chemotherapy : intravenous

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

The doctor have explained to me about the benefits and alternative for this procedure that None

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

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

Patient Attendant :

Signature : M. Haritha

Name : Haritha

Relationship with Patient : mother

Date & Time : 3/7/2026 3:15 PM

Witness :

Signature : chandana

Name : chandana

Date & Time : 3/7/2026 3:15 PM

Doctor (who is taking the consent):

Signature : Ahanksha

Name : Ahanksha

Date & Time : 3/7/26 3:15 PM



CONSENT FOR BLOOD TRANSFUSION

Name: Master POGULA Reddy Bandhav Age: 4Y Gender: Male ☒ Female ☐

UHID.No : BAH-00660543 Date: 6/7/26

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: M. Haritha

Name: M. Haritha

Date & Time 6/7/26 @ 9:30a

Doctor (Who is talking the consent)

Signature: A

Name: SRANANI

Date & Time 6/7/26 @ 9:30 Am

Witness

Signature: Sudha

Name: Sudha Anil Kumar

Date & Time 6/7/26 9:30a

రక్త మార్పిడి కొరకు అంగీకార పత్రము

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

రక్త ఉత్పత్తి రకాలు:

- ☐ తాజా మిశ్రితబింబిన ప్లాస్మా ☐ ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు ☐ Random Donor Platelets
☐ క్రయో ప్రెసిపిటేట్ ☐ ఒకే ధాత స్లేటిలెట్స్ ☐ 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. ధాత రక్తాన్ని హెచ్ బి యాంటీ బిడిన్, హైపటైటిస్ బి సర్పేస్ యాంటీజెన్, హైపటైటిస్ యాంటీబిడిన్, మలేరియా మరియు సిస్టిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణీత కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలెత్తవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు

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

సహాయకుడు(అటెన్డెంట్)

సాక్షి

సంతకము

సంతకం

పేరు

పేరు

తేదీ మరియు సమయము

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు



BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 6/7/26 Time: 10:50 AM

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

Blood Bank Issue No: BAH26-01503 Date of Collection: 6/7/26 Date of Expiry: 4/8/26

Date & Time of Starting Transfusion: 6/7/26 Planned duration of Transfusion: 4 hours

Check for Correct Unit: ☒ Correct Patient: ☒

Blood products cross checked by: Nurse 1: Midhu Nurse 2: Surekha

Before starting transfusion vitals: Temp: 98.2°f HR: 102 RR: 22 BP: 99/71 SpO₂: 98%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
	15 Min	102	98.2°f	99/62	98%	-	-	-	-
6/7/26	15 Min	107	97.5°f	100/64	98%	-	-	-	-
6/7/26	30 Min	100	97.9°f	107/82	99%	-	-	-	-
6/7/26	30 Min	98	98.6°f	93/85	100%	-	-	-	-
6/7/26	30 Min	110	98.8°f	111/62	99%	-	-	-	-
6/7/26	1 Hr	103	97.3°f	100/69	97%	-	-	-	-
6/7/26	1 Hr	99	97.6°f	98/64	98%	-	-	-	-
6/7/26									

Comments: WU

Name of the Incharge-Nurse: Neeraja Name of the Nurse: Surekha

Signature of the Incharge-Nurse: Neeraja Signature of the Nurse: Surekha

Date & Time: 6/7/2026 @ 10:50 AM Date & Time: 6/7/26 @ 10:50 AM

BAH-00650543 IP5-00175899
Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 12 D (M)
Dr. SIRISHA RANI

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

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 3/7/26 Time: 10:30am

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

Blood Bank Issue No: BAH26-01200 Date of Collection: 3/7/26 Date of Expiry: 5/7/26

Date & Time of Starting Transfusion: 3/7/26 @ 10AM Planned duration of Transfusion: 1 hour

Check for Correct Unit: ☒ Correct Patient: ☒

Blood products cross checked by: Nurse 1: mithu Nurse 2: sirisha

Before starting transfusion vitals: Temp: 98.5°F HR: 103 RR: 25b/m BP: 89/61 SpO₂: 99

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
3/7	15 Min	107	98.5°F	89/65	98%	-	-	-	-
3/7	15 Min	111	99.1°F	99/71	99%	-	-	-	-
3/7	30 Min	105	99.2°F	107/82	100%	-	-	-	-
3/7	30 Min	99	99.5°F	93/85	99%	-	-	-	-
3/7	30 Min	115	98.3°F	101/65	100%	-	-	-	-
3/7	1 Hr	112	97.5°F	117/71	98%	-	-	-	-
3/7	1 Hr	103	98.9°F	111/61	100%	-	-	-	-

Comments: cu

Name of the Incharge-Nurse: Neeraja sister Name of the Nurse: sirisha

Signature of the Incharge-Nurse: Neeraja sister Signature of the Nurse: sirisha

Date & Time: 3/7/26 @ 10:30am Date & Time: 10:30am 3/7/26

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2
Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

FRESH FROZEN PLASMA B.P

Qty. 210 ml. Prepared from Whole human blood collected in 63 ml. of C.P.D./
SAGM Solution.

B

HIV I & II/ HBsAG/ HCV - Non
reactive
VDRL - Non reactive
MP - Negative
NAT(HIV I & II/ HBsAG/ HCV)- Non
reactive

Unit No.: BAH26-01200
Blood Group: B Rh Positive
Collection Date: 17/May/2026
Expiry Date: 17/May/2027

1)administer Without Warming. 2)shake Gently Before Use.3)do Not
Add Any Medication. 4)check Blood Group on Label & Recipient's
Group and Name Before Administration. 5)use Sterile Transfusion Set
With Filter. 6)do Not Dispense Without Prescription. 7)do Not Use if
There is Any Visible Evidence. 8)store Between -30° C or Below.
9)resuspend Thawed Precipitate Carefully & Completely Into Residual
Plasma. 10)before Use Must Be Thawed With Agitation in a Water Bath
Between 30° C to 37° C.

Issue Label / CrossMatching Report

Patient : Master POGULA REDDY BANDHAV
Patient's Blood Group : B Rh Positive
Hosp/Dr : Rainbow Childrens Hospital, DR. SIRISHA RANI
UHID No.: BAH-00660543 Wd-Bed No.:
Product : FFP
Blood Group : B Rh Positive
Unit No.: BAH26-01200
XMatching Report: ABO Compatible
X-matched by: K.SAIKUMAR

Issue Dt : 03/Jul/2026
Colln. Dt : 17/May/2026
Exp. Dt : 17/May/2027
Issued By :

**Rainbow Hospital Blood Centre, Rainbow Childrens
Hospital**

D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road
No.2, Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2,
Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

PLATELET CONCENTRATE I.P.

Qty. 58 ml. Prepared from Whole human blood collected in 49 ml. of C.P.D./
SAGM Solution.

B

HIV I & II/ HBsAG/ HCV - Non
reactive
VDRL - Non reactive
MP - Negative
NAT(HIV I & II/ HBsAG/ HCV)- Non
reactive

Unit No.: BAH26-01562
Blood Group: B Rh Positive
Collection Date: 30/Jun/2026
Expiry Date: 05/Jul/2026

1. Do Not Dispense Without Prescription. 2. Check Blood Group On
Label & Recipient's Group And Name Before Administration. 3. Shake
Gently Before Use. 4. Do Not Add Any Medication. 5. Use Immediately
After Issue.

Issue Label / CrossMatching Report

Patient : Master POGULA REDDY BANDHAV
Patient's Blood Group : B Rh Positive
Hosp/Dr : Rainbow Childrens Hospital, DR. SIRISHA RANI
UHID No.: BAH-00660543 Wd-Bed No.:
Product : RDP
Blood Group : B Rh Positive
Unit No.: BAH26-01562
XMatching Report: Group Specific
X-matched by: K.SAIKUMAR

Issue Dt : 03/Jul/2026
Colln. Dt : 30/Jun/2026
Exp. Dt : 05/Jul/2026
Issued By :

**Rainbow Hospital Blood Centre, Rainbow Childrens
Hospital**

D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road
No.2, Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2,
Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

PLATELET CONCENTRATE I.P.

Qty. 60 ml. Prepared from Whole human blood collected in 49 ml. of C.P.D./
SAGM Solution.

B

HIV I & II/ HBsAG/ HCV - Non
reactive
VDRL - Non reactive
MP - Negative
NAT(HIV I & II/ HBsAG/ HCV)- Non
reactive

Unit No.: BAH26-01564
Blood Group: B Rh Positive
Collection Date: 30/Jun/2026
Expiry Date: 05/Jul/2026

1. Do Not Dispense Without Prescription. 2. Check Blood Group On
Label & Recipient's Group And Name Before Administration. 3. Shake
Gently Before Use. 4. Do Not Add Any Medication. 5. Use Immediately
After Issue. 6.

Issue Label / CrossMatching Report

Patient : Master POGULA REDDY BANDHAV
Patient's Blood Group : B Rh Positive
Hosp/Dr : Rainbow Childrens Hospital, DR. SIRISHA RANI
UHID No.: BAH-00660543 Wd-Bed No.:
Product : RDP
Blood Group : B Rh Positive
Unit No.: BAH26-01564
XMatching Report: Group Specific
X-matched by: K.SAIKUMAR

Issue Dt : 03/Jul/2026
Colln. Dt : 30/Jun/2026
Exp. Dt : 05/Jul/2026
Issued By :

**Rainbow Hospital Blood Centre, Rainbow Childrens
Hospital**

D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road
No.2, Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

CONSENT FOR BLOOD TRANSFUSION

BAH-00660543 IP5-00175899
Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 12 D (M)
Dr. SIRISHA RANI

Name: Age: 44 Gender: Male ☒ Female ☐
UHID.No : Date: 3/7/26

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 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: P Reddy Pavan

Name: P REDDY PAVAN

Date & Time: 3/7/26 C 2pm

Doctor (Who is talking the consent)

Signature: Sirisha

Name: Sirisha

Date & Time: 3/7/26 C 2pm

Witness

Signature: Sirisha

Name: Sirisha

Date & Time: 3/7/26 C 2pm

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 రూప ప్లేటిలెట్స్ | Whole Blood |
| ☐ మొత్తం రక్తం | ☐ ఎర్ర రక్త కణం | ఇతరులు |

నేను ఇందు మూలముగా రెయిన్టీ ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హాప్ ఐ వి యాంటీ బడిస్, హైపటెటిస్ జి సర్వేస్ యాంటిజెన్, హైపటెటిస్ యాంటిబడిస్, మలేరియా మరియు సిపిస్ 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 ప్రతివర్గం సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్వసానాలు తెల్లత్వవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు

మైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి చికిత్స చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. చికిత్స చేస్తున్న సమయంలో అన్ని రక్తముల రక్తమార్పిడులకు (మొత్తం రక్తం / లేదా రక్త ఉత్పత్తులు ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ఫ్రెష్ ఫ్రోజెన్ 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



INFORMED CONSENT FOR SURGERY / PROCEDURE

Authorization By: ☐ Patient ☒ Patient Attendant

I, the undersigned do hereby agree to undergo the following surgery(s), Procedure(s) on patient / myself at Rainbow Children's Hospital. (Avoid technical terms and leave no blank space)

1. GROCHONG LINE PLACEMENT
2. _____

I acknowledge the following:

1. I have been made aware of the benefits and reasons of the surgery / procedure as indicated by the clinical observations and / or diagnostics performed.
2. The benefits and risks of this surgery / procedure have been explained to me. I have also been told about the alternatives available for this surgery / procedure including the advantages and disadvantages of the alternatives.

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
<u>FOR CHEMOTHERAPY</u>	<u>HICKMANN LINE PLACEMENT</u>

3. As with any procedure, I am aware that risks such as blood loss, infection, cardiac arrest, anesthetic allergic reactions, paralysis, Deep Vein thrombosis (DVT), Pulmonary thromboembolism (PTE) etc may arise necessitating attention. Therefore, in addition to consenting to the performance of the above-mentioned surgery/procedure(s), I also consent and authorize the rendering of such other care and treatment as patient/my surgeon or his / her designee reasonably believes necessary should one or more of these and or other unforeseeable events occur.

Apart from the listed above, I have also been explained about the possible complications of the surgery / procedure are as follows:

- a. BLEEDING
- b. _____

1. I authorize Dr. DR. SHILPA and his / her team to perform the procedural sedation upon the patient / myself.
2. I recognize that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes.
3. I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: P. Reddy Pavan
Name: P. REDDY PAVAN
Relationship with patient: FATHER
Date & Time: 4/7/26 @ 2pm

Witness:

Signature: M. Houtha
Name: M. Houtha
Date & Time: 4/7/26 @ 2pm

Doctor (who is taking consent):

Signature: _____ Name: Dr. SHILPA Date: 4/7/26 Time: 3:17pm

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్బో చిల్డ్రెన్ హాస్పిటల్లో చేయబడబోయే క్రింది శస్త్రచికిత్స(లు) / ప్రాసీజర్(లు) చేయడానికి అంగీకరిస్తున్నాను. (టెక్నికల్ పదాలు వాడవద్దు మరియు ఖాళీ స్థలం వదిలివేయకండి)

1

2

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

1. క్లినికల్ పరిశీలనలు మరియు/లేదా చేసిన పరీక్షల ఆధారంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
2. ఈ శస్త్రచికిత్స / ప్రాసీజర్ కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి.
ఈ శస్త్రచికిత్స / ప్రాసీజర్ కు ఉన్న ప్రత్యామ్నాయాల గురించి, వాటి ప్రయోజనాలు మరియు నష్టాలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

3. ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్ లాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీషియా వల్ల అలెర్జిక్, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు.
అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్ నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినప్పుడు, రోగి/నా కోసం అవసరమని వైద్యుడు భావించే ఇతర చికిత్సలను చేయడానికి కూడా నేను అనుమతిస్తున్నాను.

అదనంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ వల్ల సంభవించగల ఇతర సమస్యలు కూడా నాకు వివరించబడ్డాయి:

a.	
b.	

4. డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్ ను చేయడానికి నేను అనుమతిస్తున్నాను.
5. వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
6. పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భాష సమాధానం ఇచ్చారు.
ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో, స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

SU
SA

BAH-00660543 IP5-00175899
Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 13 D (M)
Dr. SIRISHA RANI

Surgeon : Dr. S. Sridhar
Asst. Surgeon : Dr. Sridhar
Anaesthetist : Dr. Sridhar
Scrub Nurse : Roma

Patient Name : MST. Bandhavi Age : 44 Gender : male
UHID No. : 175899 Surgery Name : Cesarean
Date : 4/7/26 In-time : 3pm Out-time : Parent

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Before Induction of Anaesthesia >>

SIGN IN		Time: <u>3:17pm</u>
Patient Has Confirmed		
Identity	☒ Yes ☐ No	
Site	☒ Yes ☐ No	
Procedure	☒ Yes ☐ No	
Consent	☒ Yes ☐ No	
Site Marked	☐ Yes ☐ No ☒ NA	
Anaesthesia Safety Check Completed	☒ Yes ☐ No	
Pulse Oximeter on Patient & Functioning	☒ Yes ☐ No	
Does Patient have a:		
Known Allergy?	☐ Yes ☒ No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	☐ Yes ☒ No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☒ No ☐ NA	
Blood Units Reserved	☐ Yes ☒ No ☐ NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?		
	☐ Yes ☒ No ☐ NA	
Signature : <u>B. Sridhar</u>		
Name : <u>Dr. Sridhar</u>		

Before Skin Incision >>

TIME OUT		Time: <u>3:38pm</u>
Confirm all team members have introduced themselves by Name and Role		
☒ Yes ☐ No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	☒ Yes ☐ No	
Correct Site	☒ Yes ☐ No	
Correct Procedure	☒ Yes ☐ No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? <u>100% Bleeding Hematoma</u>		
☒ Yes ☐ No ☐ NA		
Anaesthesia Team Reviews: <u>50ml</u>		
Are There Any Patient-specific Concerns? ☐ Yes ☒ No ☐ NA		
Nursing Team Reviews: <u>Low platelets</u>		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☐ Yes ☒ No ☐ NA		
Is Essential Imaging Displayed? ☐ Yes ☒ No ☐ NA		
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☐ Yes ☒ No		
Signature : <u>S. Sridhar</u>		
Name : <u>Dr. Sridhar</u>		

Before Patient Leaves Operating Room

SIGN OUT		Time: <u>5pm</u>
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	☒ Yes ☐ No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☒ Yes ☐ No ☐ NA	
The Specimen is Labelled (including patient name)	☒ Yes ☐ No ☐ NA	
Whether there are any Equipment Problems to be addressed	☐ Yes ☒ No ☐ NA	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient?	☐ Yes ☒ No	
Signature : <u>B. Sridhar</u>		
Name : <u>Dr. Sridhar</u>		

Patient Sticker

BAH-00660543 IP5-00175899
Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 13 D (M)
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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 4/7/22

Department : P-OT Duration of Procedure : 1 hr.

Name of Surgeon : Dr - Shilpa Date of Admission : 2/7/22

Bundle Care Criteria : (Tick (✓) if done)

		Staff Signature
1.	Antibiotic given prior to surgery ? ☒ Yes ☐ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☒ Yes ☐ No Name of the Antibiotic : inj Amikacin 120mg	B
2.	Hair Removal ☒ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : Skin preparation done (cleanse surgical area with antiseptic agent)? ☐ Yes ☐ No	C
3.	Patient's body temperature immediately post operation (Recovery Room) 36.1°C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	B
4.	Name of doctor or staff administering the antibiotic : Sirisha Date & Time of antibiotic administration : @ 10 AM, 4/7/22 Date & Time procedure started : @ 3:28 PM, 4/7/22	C

- Ensure form is filled in completely by assigned staff whenever patient had surgery
- If any bundle care criteria has not been observed or unmet, assigned staff must inform infection control nurse for management
- All forms (Bundle care and when required SSI form) are completed properly
- Forms must always be kept in Infection Control folder in respective department

Docu. No. : RCHBH/ FRM / CLINICAL / 038

BAH-00660543
Master POGULA REDDY BANU
21-04-2022 4 Y 2 M 13 D (M)
Dr. SIRISHA RANI



3roshong® NXT ClearVue™ Catheter

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OPERATION THEATER NOTES

Patient's Name : Age : Gender : ☐ Male ☐ Female

UHID No.: Weight : Height :

Surgeon :		Asst. Surgeon :	
Anesthetist <i>Dr. Sundhara</i>	OT Nurse: <i>3:30pm</i>	OT Technician: <i>1</i>	
Pre-Operative Diagnosis:			
Surgical Procedure : <i>Growthang's line insertion</i>			
Indications for Surgery : <i>T-cell ALL - chemotherapy</i>			
Date :	Start Time : <i>3:30pm</i>	End Time : <i>4:30pm</i>	
Pre Operative Preparations: <i>Stitch area prepared & betadine</i> <i>painter's and sterile drapes applied.</i>			
Post Operative Diagnosis: <i>T-cell ALL & Growthang's line insertion</i>			
Peri-Operative Complications: <i>nil</i>			
Operation Notes: <i>USG guided cannulated basilic vein, guide</i> <i>wire passed. Then dilated to dilator & sheath.</i> <i>Dilator removed. Growthang line threaded through</i> <i>the sheath. Position confirmed, sheath secured.</i> <i>and line fixed at 22cm. at skin.</i> <i>Backflow confirmed. Heptacel flush given and</i> <i>sterile dressings applied.</i>			

BAH-00660543 IP5-00175899
Master POGULA REDDY BANDHAV
21-04-2022 4 Y 2 M 13 D (M)
Dr. SIRISHA RANI



Patient Sticker


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POST-SURGICAL CARE PLAN FORM

Procedure Done: Grossing line insertion

Post-Surgical Diagnosis: T-cell ALL - for Grossing line

Post-Operative Monitoring Parameters /Frequency:

ECG, NBP, pulse only

Wound Care:

Stoke dressing of the wound.

Drain /Special Lines/Catheters:

Grossing line instn.

Special Patient Positioning and Requirements:

Supine

Nutritional Instructions:

Nil

When to Start Mobilization:

2 hrs

Special Referrals:

nil

The new order for all required medications documented in the doctor order/medication sheet:

☒ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Any fever, infection.

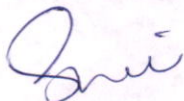
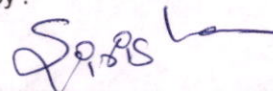
Treating Surgeon
(Signature & Stamp)

[Signature]

Date: 4/7/22 Time: 4:58 pm

Note: Plan of care will be readjusted if necessary.

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00660543 IPS-00175899 Master POGULA REDDY BANDHAV 21-04-2022 4 Y 2 M 13 D (M) Dr. SIRISHA RANI 		Date & Time of Admission 3/7/26 @ 4:15 PM	Date & Time of Transfer Order 3/7/26 @ 7 PM
		Transfer Ordered by Dr. Shilpa	Reason for Transfer Post op
From Unit OT	To Unit 195	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 28	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Nil		
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. Shilpa	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received : 4/7/26 @ 7 PM			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

- ☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready



NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 3/7/26 Time: 8AM

Weight: 16.6 kgs Centile: 50th

Height: 103 cms Centile: 50th

Inference: well child

RDA: — Calories: 1350 kals/d Protein: 23g/d

Diet Recommendations: Soft High protein diet

Re-Assessment: Avoid spicy, chilled and outside foods

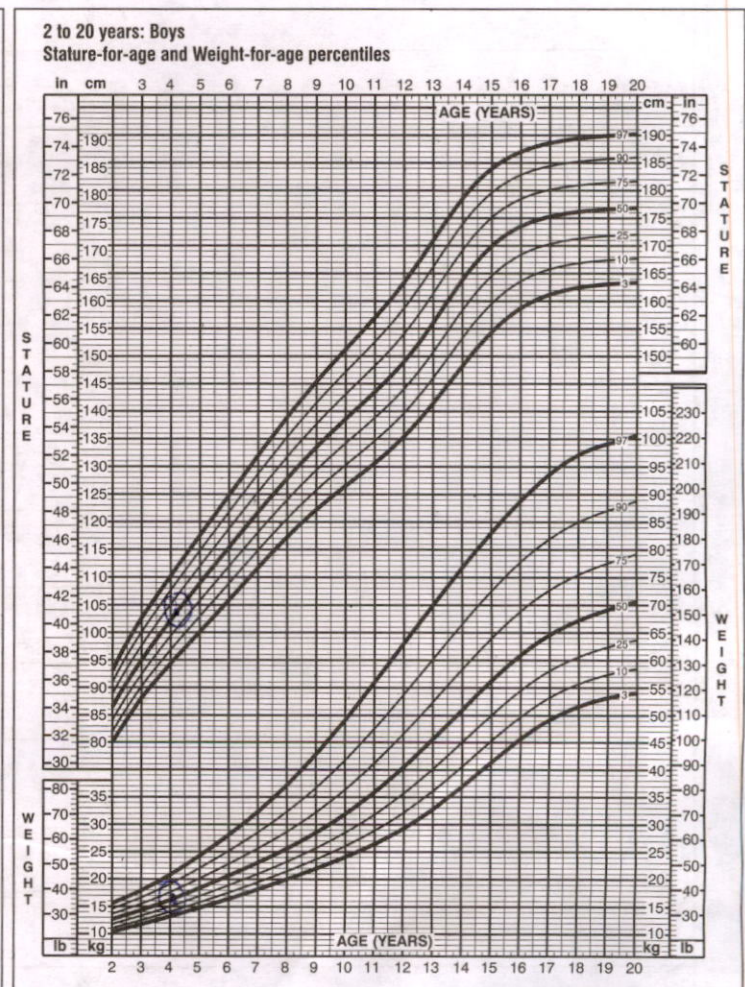
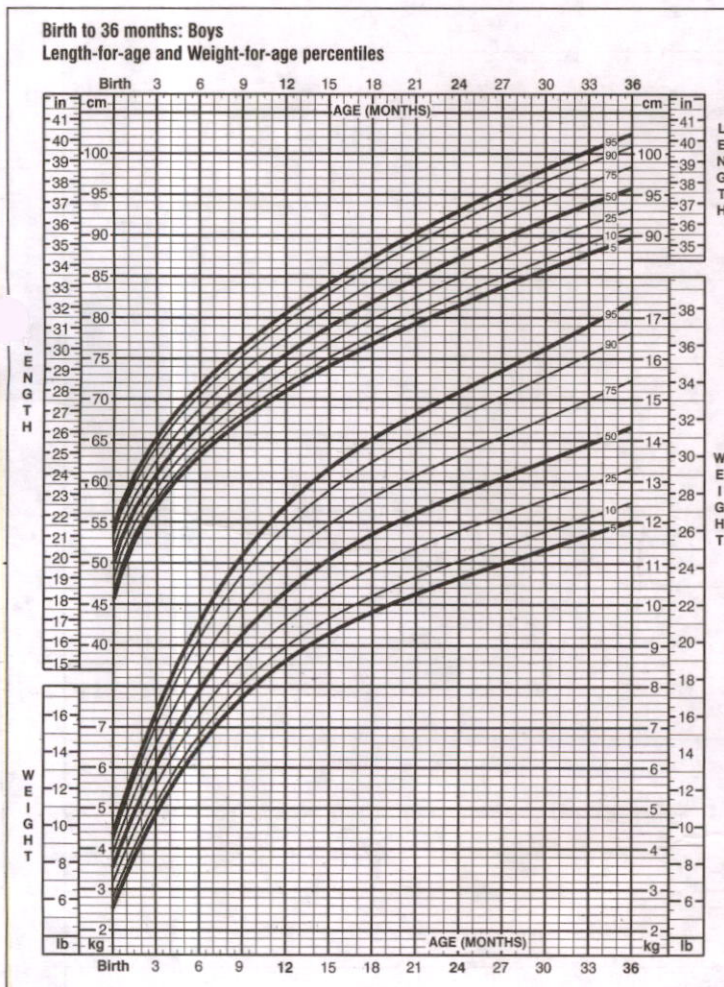
Food Allergies: NO Veg/Non-veg: non veg

Diagnosis: T-ALL on chemotherapy

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: M. Hanitha

GROWTH CHART (BOYS)



Dietician's Name: Mounica

Dietician's Signature: Mounica

Daily Notes:

~~4/3/26~~
10am

child is on NPO

— mourning.

~~5/3/26~~
8am

Child is stable. Intake is fair

Continue $\bar{c}$ soft high protein diet. ~~Wills~~

~~6/3/26~~
9:30am

child is stable. oral intake is better

continue $\bar{c}$ soft high protein diet — mourning



EMERGENCY ROOM TRIAGE FORM

Patient's Name: POGULA REDDY BANDHAV Age: 4y/2m Gender: ☒ Male ☐ Female
Date: 21/12/26 Time of Arrival: 11:30 AM Triage Completion Time: 11:36 AM
Allergies: ☐ No ☒ Yes ☐ Food ☐ Medications ☐ Other (Specify): ☐ Not known any drug Allergies
Source of Information: ☒ Parents ☐ Others (Specify):
Mode of Arrival: ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance ☒ Normal ☐ Sick Looking	Work of Breathing ☒ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea	☒ Stable ☐ Unstable: ☐ Not - Life - Threatening ☐ Life - Threatening
Circulation / Colour ☒ Normal ☐ Abnormal ☐ Bleeding		

Initial Vital Signs: Temp: 98.4 F PR: 106 bpm BP: 99/66 RR: 24 bpm SpO₂: 100% RA
Chief Complaints: reluctantly diagnosed P cell-AII. Now c/o low

Triage Classification	CTAS
☐ Level 1: Resuscitation	☐ Immediate
☐ Level 2: EMERGENT: Life or limb threatening	☒ < 15 min
☐ Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4: LESS URGENT: Significant illness but not life threatening	☐ 60 min
☐ Level 5: NON - URGENT: May receive care when convenient	☐ 120 min

NOTE: All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

- Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
- Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☒ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☒ Not applicable

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☒ No
If yes, State Location:
- Are your parents / close contacts at home healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☒ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse: Ranadevi

Signature of Triage Nurse: Ranadevi

Date & Time: 21/12/26 11:36 AM



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 3/7/26 Time of arrival : 4:38a
Chief Complaints: 4/10 - Teel all, now low platelet count. RBS: NA 69 mg/dl
Height : - Weight : 16.60kg BMI : NA Head Circumference (<2 years) : -
Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: -
If yes, identify NA
Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker
☐ Character NA ☐ Location NA ☐ Frequency NA ☐ Duration less

RISK FOR FALL:

- ☒ If patient is < 6 years
tick below fall risk intervention directly
☐ If Patient is > 6 years
Assess the below parameters
- History of Falling: within past 3 months ☐ Yes ☐ No
- Ambulatory Aids:**
- Wheelchair ☐ Yes ☐ No
• Uses furniture for support ☐ Yes ☐ No
- Gait/Transferring:**
- Bedrest / immobile ☐ Yes ☐ No
• Weak ☐ Yes ☐ No
• Impaired ☐ Yes ☐ No
- Mental Status:** Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- ☒ Escort while ambulating
☒ Assist Patient
☒ Educate patient and family on fall precautions/prevention

Functional Screening: ☒ No Abnormalities Detected

- ☐ Mobility Problem
☐ Walking Problem
☐ Developmental Delay
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

- ☐ Underweight
☐ Overweight
☐ Feeding Problem
☐ Special diet
☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

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

Social History: Lives With parent

Siblings in household ☐ Yes ☐ No (if yes How Many?) -

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

Time of Initial assessment completed by ER Nurse : 4:40a

Nursing Notes (Including Labs / Medications / Other Care):

Time	Nursing Notes
5:28 a	Dr pratibha assessed the child. - w/ plaintiff den Symptoms sent to ward.

Samples collected by: Rafiel

Time: 5:28 a

Samples sent by :

Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :	Details of Shift - out
HR: <u>110 bpm</u> BP: <u>99/62</u> CFT: <u>43 sec</u> RR: <u>24 bpm</u> SPO ₂ : <u>97%</u> GCS: <u>15/15</u> Temperature: <u>98°F</u> Pain Score: <u>0/10</u> Repeat RBS (if applicable): <u>nil</u>	Shift - out from ER to: <u>118</u> Time of Shift - out: <u>5:28 a</u> Handover given to: <u>prameela</u> (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): 1st plaintiff

Name of the Nurse: [Signature]

Signature of the Nurse: [Signature]

Date & Time: 05/07/2025 5:28 a