

ACTIVITY RECORD FOR BILLING

Name : _____

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

Date of Admission: _____ Discharge : 16/5/20 Time: _____

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

BAH-00650628 IP5-00173907
Baby GANDHE ESHITHA
27-09-2021 4 Y 7 M 19 D (F)
Dr. SIRISHA RANI



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
16/5/20	1:30pm	ER	oncology	<i>PS</i>

Cross Consultation Visit

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
15/5/26	IV placement	1	1338	E
16/5	Blood transfusion (mSCS cells)	①	96.11544	Duy

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : 16/5 Time : 8pm Prepared By :

<p>Staff Nurse</p> <p>Duy</p>	<p>Shift / Ward</p> <p>Emergency on call</p>	<p>Billing Assistant</p>	<p>Billing Supervisor</p>
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ADMISSION SHEET

Registration Details :



Admission No : IP5-00173907 Admit Date : 16-May-2026 Admit Time : 01:18 PM UHID : BAH-00650628

Patient Details :

Patient Name : Baby GANDHE ESHITHA Age : 4 Y 7 M 19 D
Guardian : Mr GANDHE ARUN KUMAR DOB : 27-09-2021
Gender : Female Religion :
Occupation : Martial Status : Single
Address (H) : H NO 2-40, PONNALA (V), NEAR MEE SEVA Phone No : 8187007000/ 7382430003
Dudheda Medak Telangana INDIA 502277 E-mail : NO@GMAIL.COM

Admission Details :

Admission Type : DAY CARE Bed No : HO DC 2 Ward Name : 1F-HEMATO-ONCOLOGY
Room No : HO DC 2 Admission Type : First Visit

Contact Details :

Name : Mr GANDHE ARUN KUMAR Relationship : Father
Contact Address : H NO 2-40, PONNALA (V), NEAR MEE SEVA Phone No : 8187007000
Dudheda Medak Telangana INDIA 502277

Arun
Signature

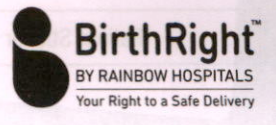
Doctor Details :

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

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : SELFPAY

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ADMISSION CRITERIA – ONCOLOGY

Admission / Transfer from:

- Emergency Outpatient (OPD) Ward Operation Theater Others:

Tick (✓) any of the following criteria requiring admission / transfer to ONCOLOGY

- For Chemotherapy-Day Care or IP Admission as per the Type of Chemotherapy
- Febrile Neutropenias (ANC <500 cells / mm3)
- Netropenic Enterocolitis
- Mucositis Induced Significant Diarrohea or Pain
- Neurological Complications (like Seizures, Bleeding, Thrombosis) that can arise while on Chemotherapy Treatment or at the Time of Presentation and also for other Systemic Problems like Pancreatitis during Chemotherapy
- Management of Oncological Emergencies
- Bleeding Problems (where it is indicated)
- Evaluation and Management of Severe Anemias
- Day Care Admissions for PRBC Transfusions
- Evaluation and Management of Sick Children who come with Hematological Problems like Severe Anemia like Autoimmune Hemolytic Anemia/ Bleeding/ Others
- Primary Immunodeficiency Disorders with Infections that Warrants Hospitalisation
- Management and Evaluation of Hemophagocytic LymphoHisticytosis
- Any Systemic Disorders with Significant Hematological issues like JRA / SLE with Secondary HLH

Signature of the Doctor: *A*
Name of the Doctor: *Dr. Sirisha*
Date & Time: *16/15/20 @ 12:00*

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Dr. SIRISHA RANI



DISCHARGE CRITERIA – ONCOLOGY

Discharge to:

- HDU / Step down ICU Ward Outside Facility Others: home

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

- Completion of chemotherapy, with no debilitating side effects.
- Resolution of febrile episode, with no fever > 24hrs and Absolute Neutrophil count (ANC) > 500cells/mm3.
- Admitted patients - Once the admitting problem gets resolved or made a plan to manage further on out-patient basis.

Signature of the Doctor: [Signature]

Name of the Doctor: Sosiani

Date & Time: 10/5/22 @ 4pm

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 27-09-2021 4 Y 7 M 19 D (F)
 Dr. SIRISHA RANI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	s/B Resident	
16/5/26 3pm	c/o. Post injections Kochiobitran	
	No fever vitals stable	
	RS - BLAE (+) B/L crepitation (+) CFT < 25cc	<u>Plan</u> 1. Mesenchymal cells as advised 2. Monitor vitals
		<u>Dr. Arani</u> 16/5/26 3:pm
		NIB 19/4/26 16/5/26 @ 4pm

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RESULT SHEET

Date					
Time					
Hb					
PCV					
FBC					
WBC					
M/L					
Platelets					
CRP					
ESR					
PCT					
FBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					



DRUG CHART

Date of Admission: 16/5/26 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG : <u>Syrup PARACETAMOL</u>				Date Time																
Dose	Route	Frequency	Start Date																	
<u>5ml</u>	<u>Pb</u>	<u>6th Hly</u>	<u>14/5</u>																	
Doctor's Signature		Valid Period	Pharm.																	
<u>Jayalini</u>		<u>2 days</u>																		
Additional Instructions:																				
<u>(5ml/240mg) (If T > 100°F)</u>																				

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:																						

nature
VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 17-3kg Ward.

DRUG : Inj ONDENSEYRON				Date Time	16/5															
Dose	Route	Frequency	Start Date																	
3 mg	IV	BD	16/5	6am																
Name & Signature of the Doctor Starting the Drugs:																				
Jayashri																				
Additional Instructions:				GT																
Daily Doctor's Endorsement by a Sign																				
DRUG : Syrup DOMSTAL				Date Time	16/5															
Dose	Route	Frequency	Start Date																	
5ml	PO	TID	16/5	6am																
Name & Signature of the Doctor Starting the Drugs:																				
Jayashri																				
Additional Instructions:				GT																
Daily Doctor's Endorsement by a Sign																				
DRUG : Syrup SUCRAL				Date Time	16/5															
Dose	Route	Frequency	Start Date																	
10ml	PO	BD	16/5	6am																
Name & Signature of the Doctor Starting the Drugs:																				
Jayashri																				
Additional Instructions:				GT																
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
16/5	3:30pm	MESENCHYMAL STEM CELLS	10ml	IV	d	<u>[Signature]</u> Dinger
16/5	3:30pm	ly AVIL	0.4ml	IV	d	<u>[Signature]</u> Dinger
16/5	4pm	ly CASIX	8mg	IV	d	<u>[Signature]</u> Dinger
16/5	4pm	NS BOWLS	100ml	IV	d	<u>[Signature]</u> Dinger

Signature

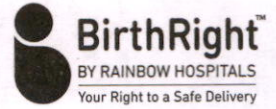
VERIFIED BY: [Signature]
 Time

BAH-00650628 IP5-00173907

Baby GANDHE ESHITHA

27-09-2021 4 Y 7 M 19 D (F)

Dr. SIRISHA RANI



MEDICATION RECONCILIATION FORM

Drug Allergies: Nil Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER Shifted to: Onw

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Syrup SUCRAL	10ml	PO	BD		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2	Syrup DERIPHYLINE	5ml	PO	BD		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
3	Tab VORICONAZOLE 200mg	1/2 tab	PO	BD		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Jayashri (J4)

Date & Time: 16/5/26 & 1:15 pm

Nurse Name & Signature: Renuka

Date & Time: 16/5/26 & 1:20 pm

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 27-09-2021 4 Y 7 M 19 D (F)
 Dr. SIRISHA RANI



FLUID CHART



Sheet No. : 10

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

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

Total 24 hrs. Intake []

Total 24 hrs. Output []

Patient Sticker

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FLUID CHART

Sheet No. :

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

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

Total 24 hrs. Intake

Total 24 hrs. Output

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 Baby GANDHE ESHITHA (F)
 27-09-21 4 Y 7 M 19 D
 Dr. SIRISHA RANI



: RCHBH/ FRM / CLINICAL / 126

(1-5)
SCHOOL AGE (5-12 years)
 Children's Observation &
 Early Warning Scoring Chart

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 27/09/21 Time: 3 PM

Doctor / Nurse / Family Concern?

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

98.8 F

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

90
 60

Heart Rate (Number)

124 b/m

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

24 b/m

Resp Rate (Number)

Resp Distress Mod/ Severe None / Mild

Receiving O₂ (l/min) O₂ Saturations (%)

0.9 l

Conscious Level Normal Altered GCS *

15/15

TOTAL SCORE
 Number of shaded boxes
 Pain Score
 Observer's Initials

0
 0
 F

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
- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see the child
- Score 4 : Shift in charge AND treating consultant (M & PM) or on call night hourly Obs
- 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

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.

IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)

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)

BACKGROUND: Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child's condition has changed in the last (XX mins). Their last set of observations (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)

ASSESSMENT: I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am worried. ... Come to see the child in the next (XX mins) AND I s there anything I need to the fluid/ repeat observation)