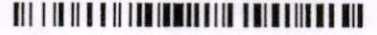


ADMISSION SHEET

Registration Details :



Admission No : IP5-00174661 Admit Date : 02-Jun-2026 Admit Time : 05:40 PM UHID : BAH-00652229

Patient Details :

Patient Name	: Baby GORU MOKSHASRI SHIVANSHI	Age	: 0 Y 11 M 1 D
Guardian	: Mr GORU MANOJ KUMAR	DOB	: 01-07-2025 11:14 AM
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H NO 8-3-230/4/A, BALAJI NILAYAM, VENKATAGIRI COLONY, HYLAM COLONY Yousufguda Hyderabad Telangana INDIA 500045	Phone No	: 8977476364/ 8333037583
		E-mail	: MANOJKUMARGORU@GMAIL.COM

Admission Details :

Bed Type : PRIVATE ROOM Bed No : PVT 304 Ward Name : 3F-ZONE B
Room No : PVT 304 Admission Type : First Visit

Contact Details :

Name : Mr GORU MANOJ KUMAR Relationship : Father
Contact Address : H NO 8-3-230/4/A, BALAJI NILAYAM, VENKATAGIRI COLONY, HYLAM COLONY Yousufguda Hyderabad Telangana INDIA 500045 Phone No : 8977476364

(Handwritten Signature)
Signature

Doctor Details :

Doctor Name : Dr. KAPIL BHAGWATRAO SACHANE Specialisation : GENERAL PEDIATRICS
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : HEALTHINDIA INSURANCE TPA SERVICES PVT LTD

ACTIVITY RECORD FOR BIL

BAH-00652229 IP5-00174661
Baby GORU MOKSHASRI SHIVANSHI
01-07-2025 0 Y 11 M 1 D (F)
Dr. KAPIL BHAGWATRAO SACHANE



Name : _____

UHID No. : _____ IP No _____

Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
21/6/26	02:30 PM	CR	304	R

Cross Consultation Visit

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




**Rainbow[®]
Children's
Hospital**

It takes a lot to treat the little.

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

BAH-00652229 IP5-00174661
Baby GORU MOKSHASRI SHIVANSHI
01-07-2025 0 Y 11 M 1 D (F)
Dr. KAPIL BHAGWATRAO SACHANE



Patient Name:

Mokshasri Shivanshi

UHID ID:

Department:

Consultant:



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: Mother Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Fever: 2 days.
Decreased oral intake: 2 days.

History of present illness :

from 2 days
Fever - High grade, 101° F, not associated
with chills & rigor, Responding with
paracetamol.

No H/o cough, cold, wheezing, Dysentery

02/6/26 - CBP - 10.7 / 21.43 / 483
44.5 / 49

CRP - 39

CVE - (N)

On Ziyar & Jp - Eton.

No similar illness in neighbours

BAH-00652229 IP5-00174861
Baby GORU MOKSHASRI SHIVANSHI
01-07-2025 0 Y 11 M 1 D (F)
Dr. KAPIL BHAGWATRAO SACHANE



Pec

Physical Examination

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

Birth & Neonatal History:

✓ LSC/CIAB/3-619/
No NewStay.

□ TO
→ O

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Normal for age

Immunization History :

Immunized till date

BAH-00652229 IP5-00174661
Baby GORU MOKSHASRI SHIVANSHI
01-07-2025 0 Y 11 M 1 D (F)
Dr. KAPIL BHAGWATRAO SACHANE



History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile _____)
Weight (kgs)) 8.4 kg (Centile _____)

On Examination :

Temperature : 98.2°f Pulse Rate : 135/min B.P. 97/62 (72) SPO2 98% E RA
Resp. rate and type of breathing : 26/min

Rash _____
Lymphadenopathy _____
Oedema : _____
Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____
Air entry & breath sounds : _____
Any added sounds : _____
Relevant data from outside (Chest X-Ray, ABG, etc.,) None

Cardiovascular System :

Inspection of precordium : _____
Heart Sounds : _____
Any murmur : _____
Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : None

Per Abdomen :

Inspection _____
Palpation : _____
Auscultation : _____
Spine : _____ External Genitalia : _____
Relevant data from outside (CT, USG etc.,) None

BAH-00652229 IP5-00174861
Baby GORU MOKSHASRI SHIVANSHI
01-07-2025 0 Y 11 M 1 D (F)
Dr. KAPIL BHAGWATRAO SACHANE



y & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : A1e1t

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Acutefebrole illness



History & Physical Examination

Preventive aspects of the treatment: Resolution of symptoms.

Desired goals of the treatment: Hemodynamic stability

Planned Labs:

CBP
CRP / Done on opp basis.
WF

Blood culture
Widal
mp optimal.

NB Anub
26/6

Planned Management

W fluids
1ug Ceftriaxone
syp. Aree.
pantoprazole.

NB Anub
26/6

Signature of the Doctor: N. J. B.
Name of the Doctor: N. Pearson
Date & Time: 02/08/26, 6pm

Signature of the Consultant: [Signature]
Name of the Consultant: [Signature]
Date & Time: 02/08/26

DR. KAPIL BHAGWATRAO SACHANE
Registration No: 20220311356



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/24 9 AM	C/S/B PICU Resident	
	<p>Δ: Acute febrile illness <u>Plan</u></p> <p>Afebrile since admission. Child on room air. SpO₂: 99%, RR: 120/min RR: 28/min peripheral: Warm CVS: S1S2 ⊕ Chest: APL clear. CNS: alert, active PA: soft, NT</p>	<p>Cont antibiotics</p> <ul style="list-style-type: none"> - Ceftriaxone Dr. - Azithromycin Dr. - Encourage oral intake - If oral intake improve taper iv fluids by evening. - Trace blood culture, PAP optimal, Widel. - Monitor vitals. - Watch for fever.
2/6/24	C/S/B Dr. Kapil	
	<p>Δ: Acute febrile illness <u>Plan</u></p> <p>Afebrile since admission. Hemodynamically stable on room air</p> <p>Chest: BIL clear. CVS: S1S2 ⊕ CNS: alert, active. PA: soft, NT</p> <p>Accepting oral feeds well.</p>	<p>USG abdomen</p> <p>line with</p> <ul style="list-style-type: none"> - CBR, CRP - If less improve afebrile, discharge <p>note by 340 AM (Gobusse)</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6/26 4:30pm		C/S/B PICU Resident
	<p>Δ: Acute febrile illness - Plan:</p> <p>Afebrile since last 24hrs Oral intake better, Child hemodynamically stable on room air. Chest: B/L clear. CVS: S1S2 @ CNS: Alert active. PA: soft, NT. USG Abdomen: normal.</p>	<p>Plan:</p> <ul style="list-style-type: none"> ① Cont antibiotics ② Stop iv fluid ③ Encourage oral intake ④ Send CBP, CRP Hm. ⑤ Trau Blood & urine c/s. ⑥ keep discharge summary ready. <p>Noted by Sumana 03/09/26 @ 8pm</p>
4/6/24	<p>Δ: Acute febrile illness</p> <p>Afebrile. Stable on room air. SpO₂: 99%. PR: 126/min RR: 24/min Chest: B/L clear CVS: S1S2 @ PA: soft, NT.</p>	<p>Plan:</p> <ul style="list-style-type: none"> ① Cont antibiotics ② Encourage oral intake ③ Trau culture. ④ Monitor vitals ⑤ Watch for fever. ⑥ keep summary ready



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/6/24 11 ^{am}	C/S/B	Dr. Kapil
	<p>Δ: Acute febrile illness Afebrile. Stable on room air. SpO₂: 99%. PR: 128/72 RR: 26/min Chest: B/L clear CVS: S1C2 (+) PA: Soft, NT. USG abdomen: Normal.</p>	<p>Plan: Give Ceftriaxone dose (evening) Discharge: Zipras, Lamol. R/O on Monday.</p> <p style="text-align: right;">K. Sachane</p>
		<p style="text-align: center;">K. Sachane</p>
		<p style="text-align: center;">DR. KAPIL BHAGWATRAO SACHANE Registration No: 2002/03/1356</p>

BAH-00652229
 Baby GORU MOKSHASRI SHIVANSHI
 01-07-2025 0 Y 11 M 1 D (F)
 Dr. KAPIL BHAGWATRAO SACHANE

RESULT SHEET

Date	2/6	3/6/26			
Time	9am	6am			
Hb	10.7	11.6			
PCV	33.4	36.7			
RBC	4.28	4.59			
WBC	21430	12,310			
N/L	45/49	14/78			
Platelets	4.8 L	4.6 L			
CRP	39				
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
T/INR					
rotein / Sugar					

BAH-00652229 IP5-00174661
 Baby GORU MOKSHASRI SHIVANSHI
 01-07-2025 0 Y 11 M 1 D (F)
 Dr. KAPIL BHAGWATRAO SACHANE



.....ICATION RECONCILIATION FORM

Drug Allergies:

Not known any Drug Allergies

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

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

Shifting From: ER

Shifted to: Ward

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

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : N. Parthasarathy N. Parthasarathy

Date & Time : 2/6/26, 6:20 pm

Nurse Name & Signature: Anush Anush

Date & Time : 2/6/26 6:55 pm

BAH-00852229 IP5-00174861
 Baby GORU MOKSHASRI SHIVANSHI
 01-07-2025 0 Y 11 M 1 D (F)
 Dr. KAPIL BHAGWATRAO SACHANE

DRUG CHART

Date of Admission: 2/6/16 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 : Syo. CROCIN DS				Date Time																
Dose	Route	Frequency	Start Date																	
2.5ml	PO	SOS	02/6																	
Doctor's Signature		Valid Period	Pharm.																	
N. PM																				
Additional Instructions:																				
(5ml/240mg) 16 Temp ≥ 100°F																				

DRUG : Syo. METALP				Date Time																
Dose	Route	Frequency	Start Date																	
3ml	PO	SOS	02/6																	
Doctor's Signature		Valid Period	Pharm.																	
N. PM																				
Additional Instructions:																				
16 Temp ≥ 102°F																				

DRUG : CROCIN DROPS				Date Time																
Dose	Route	Frequency	Start Date																	
1.2ml	PO	SOS	02/6																	
Doctor's Signature		Valid Period	Pharm.																	
N. PM																				
Additional Instructions:																				
16 Temp ≥ 99.9°F.																				

Signature
VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight 8.4kg Ward

DRUG : <u>IV. CEFTRIAXONE</u>				Date Time	<u>2/6</u>	<u>2/6</u>	<u>4/6</u>													
Dose	Route	Frequency	Start Date																	
<u>400mg</u>	<u>IV</u>	<u>12H</u>	<u>02/06</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>N. Pratswale</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>SYP. AZITHROMYCIN</u>				Date Time	<u>2/6</u>	<u>3/6</u>	<u>4/6</u>													
Dose	Route	Frequency	Start Date																	
<u>4ml</u>	<u>PO</u>	<u>24H</u>	<u>02/06</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>N. Pratswale</u>																				
Additional Instructions: <u>(5ml/100mg)</u>																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>LI. DANTOPRAZOLE</u>				Date Time	<u>2/6</u>	<u>3/6</u>	<u>4/6</u>													
Dose	Route	Frequency	Start Date																	
<u>10mg</u>	<u>IV</u>	<u>24H</u>	<u>02/06</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>N. Pratswale</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

IP5-00174661
 BAH-00652229
 Baby GORU MOKSHASRI SHIVANSHI
 01-07-2025 0 Y 11 M 1 D (F)
 Dr. KAPIL BHAGWATRAO SACHANE

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

2/6/26

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

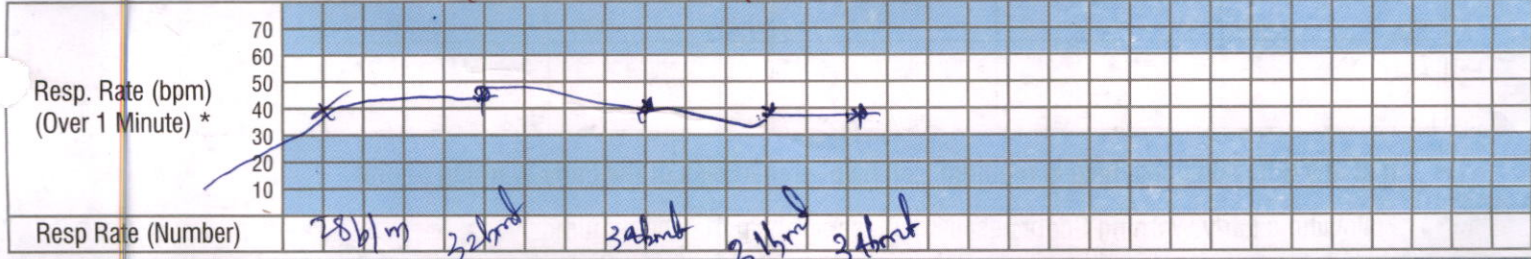
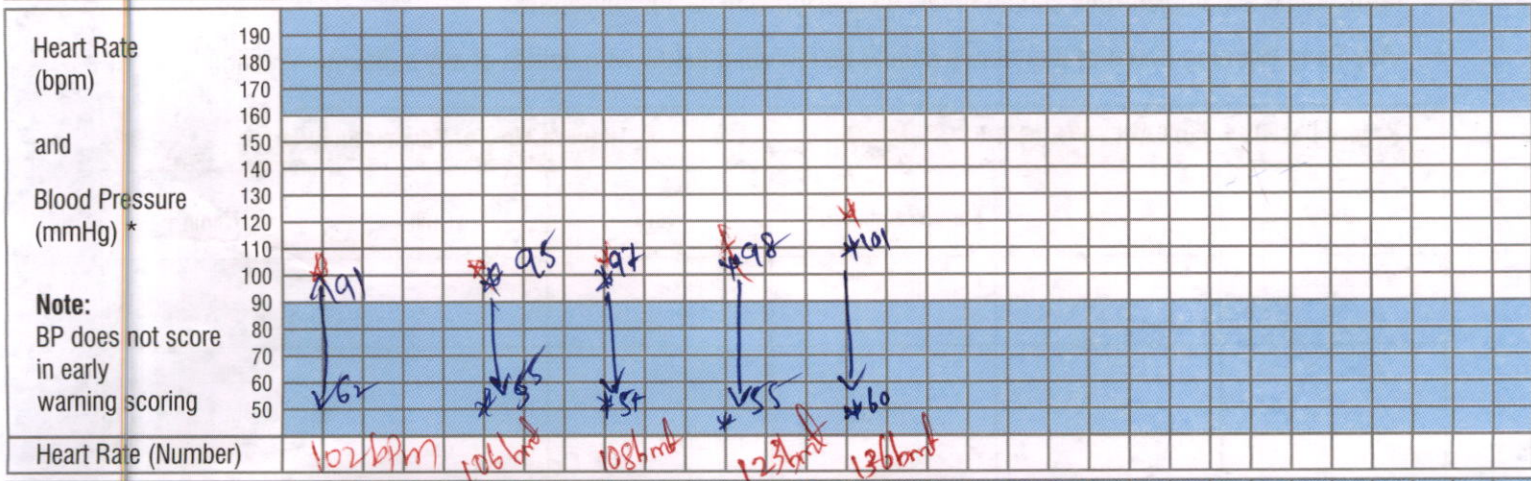
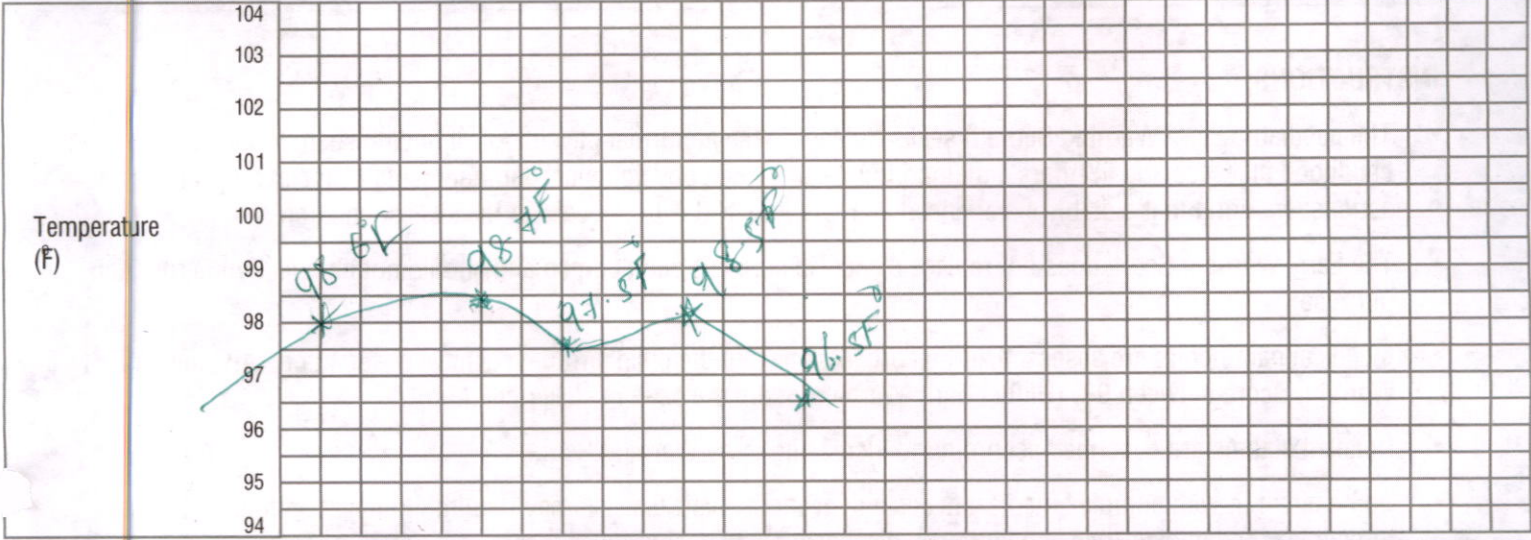
Pratiksha
Rainbow's Children's Hospital
 It takes a lot to treat the little.

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 7PM 9PM 12AM 3AM 6AM

Doctor/Nurse/Family Concern?



Resp Mod/ Severe Distress	None / Mild				
Receiving O ₂ (l/min)					
O ₂ Saturations (%)		98%	97%	98%	97%
Conscious Level	Normal / Altered	(15/15)	(15/15)	(15/15)	(15/15)
GCS *		(15/15)	(15/15)	(15/15)	(15/15)
TOTAL SCORE		0	0	0	0
Number of shaded boxes		0	0	0	0
Pain Score		0	0	0	0
Observer's Initials		Q	Q	Q	Q

ACTIONS

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

NB: Scores 3 should be recorded overleaf

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)
	Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations are child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
	I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am worried because the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
	RECOMMENDATION: I need you to ... come to see the child in the next (XX mins) AND is there anything I need to do at the time? (e.g. stop the fluid/ repeat observation)

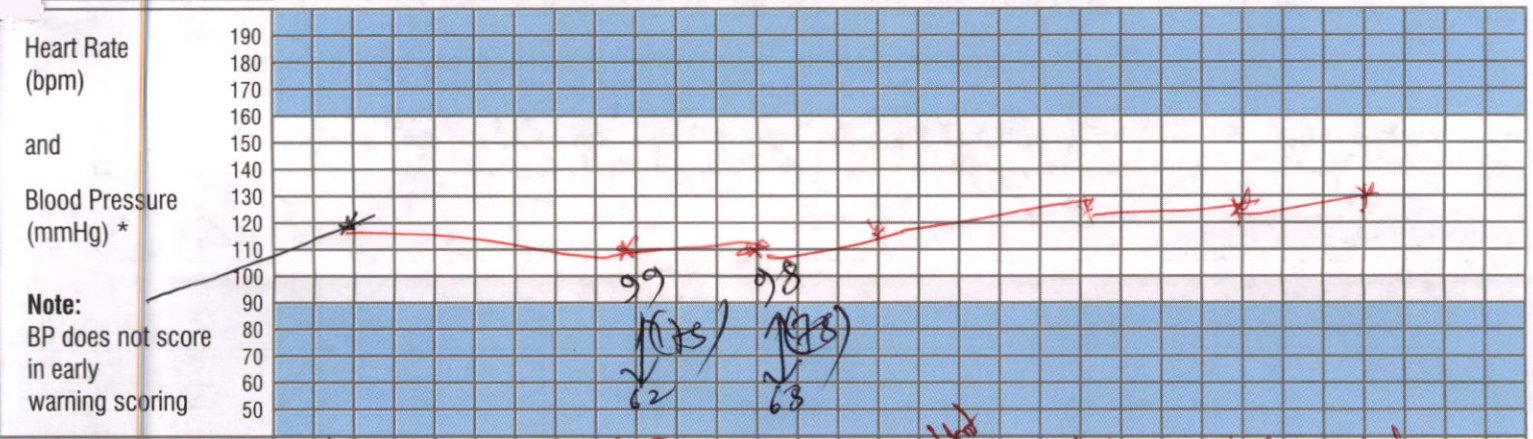
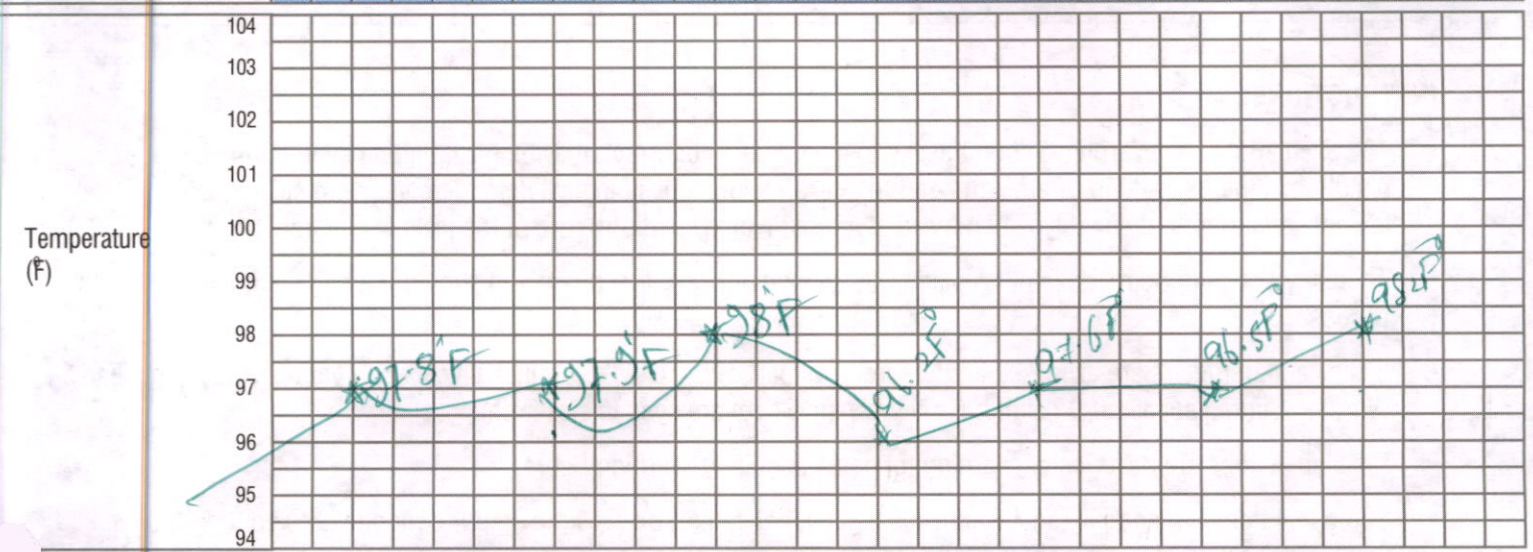
3/5/26

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

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

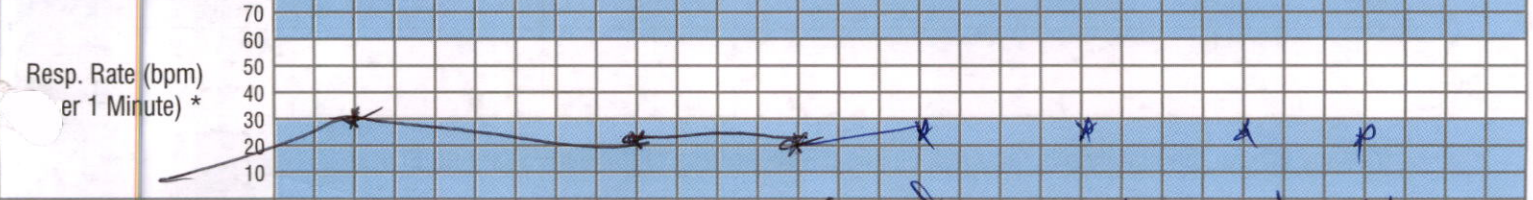
EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time: 10AM	3PM	6PM	9:30 PM	12AM	3AM	6AM
Doctor/Nurse/Family Concern?							



Note:
 BP does not score in early warning scoring

Heart Rate (Number)	120	118	112	114	124	128	132
---------------------	-----	-----	-----	-----	-----	-----	-----



Resp Rate (Number)	30	28	26	28	26	32	34
--------------------	----	----	----	----	----	----	----

Resp Mod/ Severe Distress	None / Mild						
---------------------------	-------------	--	--	--	--	--	--

Receiving O ₂ (l/min)							
O ₂ Saturations (%)	99%	99%	99%	98%	99%	97%	98%

Conscious Level	Normal / Altered						
-----------------	------------------	--	--	--	--	--	--

GCS *	(14/5)	(14/5)	(14/5)	(15/5)	(15/5)	(15/5)	(15/5)
-------	--------	--------	--------	--------	--------	--------	--------

TOTAL SCORE							
Number of shaded boxes	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0
Observer's Initials	J	J	J	J	J	J	J

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

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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

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- 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.
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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!
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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 is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)



2/6/26

FLUID CHART

Sheet No. : 1

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

Date	Time	Intake			Output					IV Site Thrombophlebitis 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		H ₂ O								0	Durga
Total Intake :					Total Output : 0-0 m ^o							
	08:00 pm										0	Uruk
	09:00 pm		H ₂ O	25ml						✓	0	Uruk
	10:00 pm		H ₂ O	25ml						✓	0	Uruk
	11:00 pm	DMS	H ₂ O	25ml						✓	0	Uruk
	12:00 am		H ₂ O	25ml							0	Uruk
	01:00 am		H ₂ O								0	Uruk
Total Intake :					Total Output : 0-2 m ^o 1							
	02:00 am										0	Sneha
	03:00 am		H ₂ O	25ml							0	Sneha
	04:00 am		H ₂ O	25ml						✓	0	Sneha
	05:00 am	DMS	H ₂ O	25ml							0	Sneha
	06:00 am		H ₂ O	25ml						✓	0	Sneha
	07:00 am		H ₂ O								0	Sneha
Total Intake :					Total Output : 0-2 m ^o 0							

Total 24 hrs. Intake **Total 75ml/day**

Total 24 hrs. Output **0-4 m^o 1**



3/6/26

FLUID CHART



Sheet No. :

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

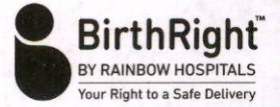
Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am										0	SMK	
	09:00 am		H ₂ O	low							0	SMK	
	10:00 am	ORS	H ₂ O	low					✓		0	SMK	
	11:00 am			low					✓		0	SMK	
	12:00 pm		H ₂ O								0	SMK	
	01:00 pm										0	SMK	
Total Intake :						Total Output : 5-2 ml							
	02:00 pm										0	SMK	
	03:00 pm		H ₂ O	low							0	SMK	
	04:00 pm			low					✓		0	SMK	
	05:00 pm								✓		0	SMK	
	06:00 pm		H ₂ O								0	SMK	
	07:00 pm										0	SMK	
Total Intake :						Total Output : 0-2 ml							
	08:00 pm										0	SMK	
	09:00 pm		H ₂ O	low					✓		0	SMK	
	10:00 pm			low							0	SMK	
	11:00 pm		H ₂ O	low							0	SMK	
	12:00 am			low					✓		0	SMK	
	01:00 am										0	SMK	
Total Intake :						Total Output : 0-2 ml							
	02:00 am										0	SMK	
	03:00 am		H ₂ O	low					✓		0	SMK	
	04:00 am			low							0	SMK	
	05:00 am		H ₂ O	low					✓		0	SMK	
	06:00 am			low					✓		0	SMK	
	07:00 am		H ₂ O	low							0	SMK	
Total Intake :						Total Output : 0-2 ml							

Total 24 hrs. Intake **16ml - 10ml/day**

Total 24 hrs. Output **0-2 ml**

BAH-00852229 IPS-00174661
 Baby GORU MOKSHASHI SHIVANSHI
 01-07-2025 0 Y 11 M 1 D (F)
 Dr. KAPIL BHAGWATRAO SACHANE

304



NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 3/6/26 Time: 9:30am

Weight: 8.4 kg Centile: 710th

Height: 60 cm Centile: 710th

Inference: underweight child

RDA: - Calories: 98 kcal/kg/d Protein: 1.5/kg/d

Diet Recommendations: PBm foods

Re-Assessment: Stage - II weaning foods [HEC advised]

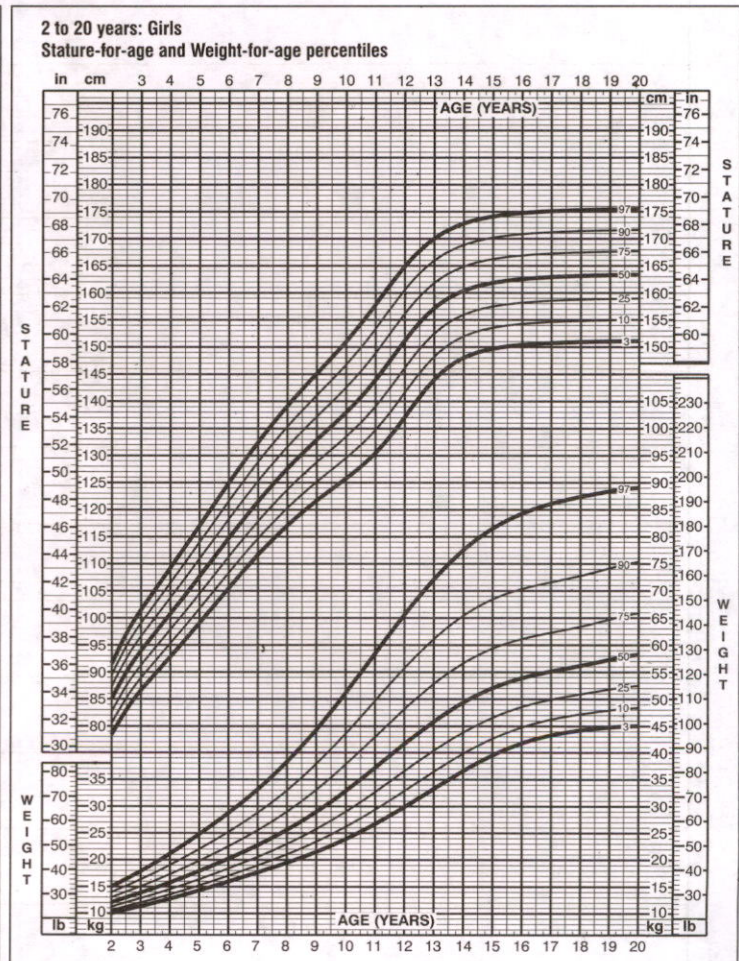
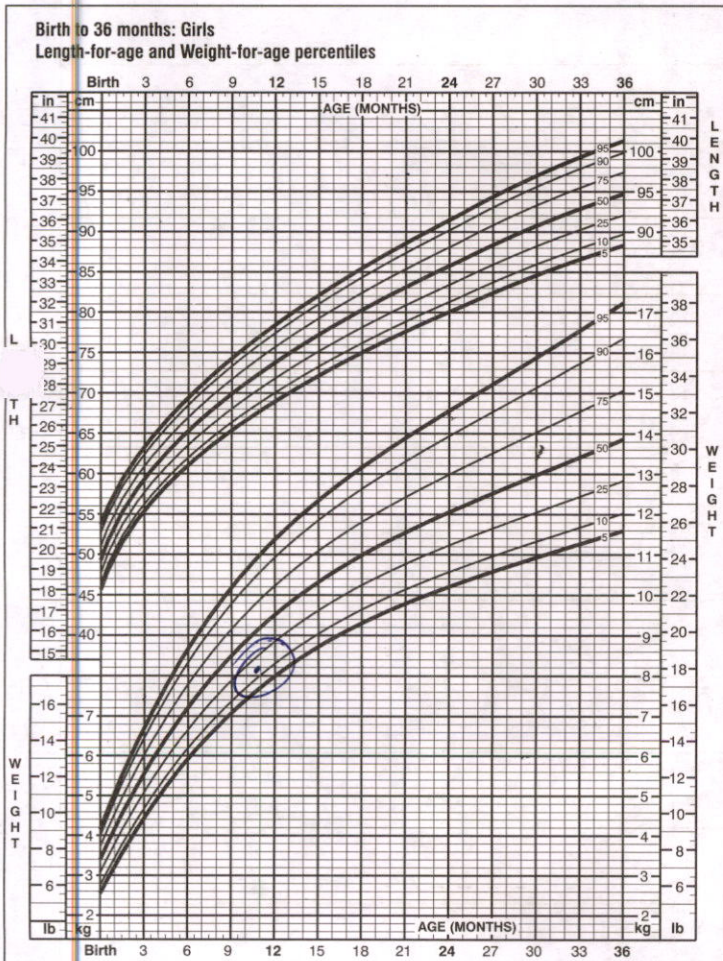
Food Allergies: No Veg/Non-veg: veg

Diagnosis: AFI [acute febrile illness]

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: *[Signature]*

GROWTH CHART (GIRLS)



Dietician's Name: *[Signature]*

Dietician's Signature: *[Signature]*

