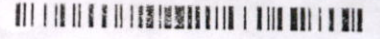


ADMISSION SHEET

Registration Details :



Admission No : IP5-00174412 Admit Date : 28-May-2026 Admit Time : 02:29 AM UHID : BAH-00657443

Patient Details :

Patient Name : Baby CHERUKUPALLI NATYA REDDY Age : 6 Y 8 M 16 D
Guardian : Mr CHERUKUPALLI NIKHIL KUMAR DOB : 12-09-2019
Gender : Female Religion :
Occupation : Martial Status : Single
Address (H) : H NO - 1-20-97, HOUSING BOARD , ARMOOR MUNCIPALLY , Armoor Nizamabad Telangana INDIA 503224 Phone No : 7893764535/ 6303028707
E-mail : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : SEMI PRIVATE Bed No : SPVT 202 Ward Name : 2F-SECOND FLOOR
Room No : SPVT 202 Admission Type : First Visit

Contact Details :

Name : Mr CHERUKUPALLI NIKHIL KUMAR Relationship : Father
Contact Address : H NO - 1-20-97, HOUSING BOARD , ARMOOR MUNCIPALLY , Armoor Nizamabad Telangana INDIA 503224 Phone No : 7893764535 / 6303028707


Signature

Doctor Details :

Doctor Name : Dr. NABEEL ALAM QADRI Specialisation : PEDIATRIC SURGERY
Referral Doctor : Sai Sankeerth Rao Phone No : 9985555489
Co-Consultant


Payment Details :

Payment Mode : DC/CC Card Deposit Amount : 10000.00
Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD

ACTIVITY RECORD FOR BILLING

Name : _____
 UHID No. : _____ IP No. : _____ Dept : _____
 Date of Admission: _____ Time: _____ Charge : _____ Time: _____
 Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

BAH-00657443 IP5-00174412
 Baby CHERUKUPALLI NATYA REDDY
 12-09-2019 6 Y 8 M 16 D (F)
 Dr. NABEEL ALAM QADRI



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/05/26	3:10 AM	ER	202	Annab

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
28/05	IV Placement	①	30484	Samshe
28/5/26	NHA	①	32654	Baruel

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

.....

Date : _____ Time : _____ Prepared By : _____

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
-------------	--------------	-------------------	--------------------




Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00657443 IPS-00174412
Baby CHERUKUPALLI NATYA REDDY
12-09-2019 8 Y 8 M 16 D
Dr. NABEEL ALAM QADRI (F)



Patient Name: _____ Natya Reddy

UHID ID: _____

Department: _____ Pediatric surgery

Consultant: _____



History & Physical Examination

Name : Natya Reddy Age/Sex 6y / F
Information given by: _____ Relationship Mother

Chief Presenting Complaints & Duration (Chronologically)

Abdomen pain
vomiting / x 1 day

History of present illness :

- H/o abdomen pain since yesterday afternoon
- R/o Right ilio fossa; diffuse, non radiating
- vomiting - 15 episodes, non bilious, non projectile
- vomiting food particles
- no H/o Fever/diarrhoea
- activity @
- urine, stool normal

(G7b5 v56 abdomen suggestive of acute appendicitis)

Patient

BAH-00657443 IP5-00174412
Baby CHERUKUPALLI NATYA REDDY
12-09-2019 6 Y 8 M 16 D (F)
Dr. NABEEL ALAM QADRI



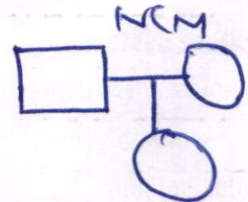
Pediatric Multisystemic ... al Examination

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

NOT significant

Birth & Neonatal History:

Term / LSW / 2.5kg / CIAB
NO HB NIU stay



Birth & Socio Economic History:

About Father : _____
About Mother : _____ upper middle class
Any additional Information : _____

Developmental History :

NO delay; DD = 100%

Immunization History :

BCG SCOT ⊕



paediatric multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 16.7kg (Centile _____)

On Examination :

Temperature : 98°F Pulse Rate : 100/min B.P. 100/60 SPO2 97% RA

Resp. rate and type of breathing : 24/min

Rash _____ NO PUPUR/NO PITONES

Lymphadenopathy _____ NO

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____ NORMAL

Air entry & breath sounds : _____ Bilateral Air entry ⊕, Equal

Any addes sounds : _____ NO

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

Cardiovascular System :

Inspection of precordium : _____ NORMAL

Heart Sounds : _____ S₁ ⊕

Any murmur : _____ NO

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

Per Abdomen :

Inspection _____ NORMAL

Palpation : _____ Tenderness ⊕ in right iliac fossa

Auscultation : _____ ⊕; bowel sounds ⊕

Spine : _____ ⊕ External Genitalia : _____

Relevant data from outside (CT, USG etc.,) 27/8/2019

(S/O Appendicitis)



Pediatric neurology history & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : (N) 15/15

Cranial Nerves : All cranial nerves intact

Motor System:

Nutrition : _____

Tone : _____ Power 5/5 both upper & lower limbs

Co-ordinator : Normal

Posture : _____

Involuntary Movements : _____

Reflexes : ++/++

DTR _____ Superficials: ++

Plantars Heftlow

Sensory System :

_____ (N)

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Awk Abdomen under Abdomen

(Awk Appendicitis)

BAH-00657443 IP5-00174412
 Baby CHERUKUPALLI NATYA REDDY
 12-09-2019 8 Y 8 M 16 D (F)
 Dr. NABEEL ALAM QADRI



Pediatric History & Physical Examination

Preventive aspects of the treatment: _____

TO treat cause

Desired goals of the treatment: _____

TO prevent complications

Planned Labs:

CBP, CRP
 Serum Electrolytes
 Blood grouping

(1 EDTA, 1 plain Extra)

U&E, BUN, Cr (KOF) Tomorrow

Planned Management

1. NPO
2. IV fluids
3. If persistent vomiting → to secure NG tube
4. Int. upizolin, Ondansetron, Ereneprozole, prochlorperal
5. Monitor vitals
6. plan for LOP opportunity tomorrow

M B Anand
 28/05/2020

Signature of the Doctor: Bikaji

Name of the Doctor: Dr. Soi

Date & Time: 28/05/2020; 2 AM

Signature of the DR. HARISH JAYARAM

Name of the Consultant: Dr. Harish

Date & Time: 28/5/20 8:20 AM

Patient St

BAH-00657443 IPS-00174412
Baby CHERUKUPALLI NATYA REDDY
12-09-2019 8 Y 8 M 16 D (F)
Dr. NABEEL ALAM QADRI



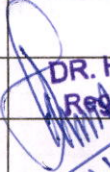
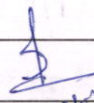


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26 8:20am	<p>c/o Dr. Harish</p> <p>c/o right lower abd pain afw multiple episodes of vomit - 1 day Fever spike (+) vital - stable P/A - soft mild tenderness in RLQ</p>	<p>Adv</p> <p>① NBM NBM ② USG Abd & pelvis</p>
28/5/26 10:30am	<p>Core Reviewed</p> <p>USG - 67mm Mild Increased Vascularity No fat stranding / probe tenderness</p>	<p>Adv</p> <p>Start clear liquids</p>
		<p>To give Med g conservative management</p>
		<p>Dr. NABEEL ALAM QADRI Reg. No. 75241 28/5 10:30am</p>

BAH-00657443 IPS-00174412
 Baby CHERUKUPALLI NATYA REDDY
 12-09-2019 6 Y 8 M 16 D (F)
 Dr. NABEEL ALAM QADRI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26 2:30pm	C/S/B Dr. Nikhita	
	A/cis - Subacute Appendicitis No clovenity	
	Afebrile Vitals - stable	A/cis - Clear liquids allowed
	P/A - soft	
 DR. HARISH JAYARAM Registration No: 66254 28/5/26 5 AM		 Dr. Nikhita 28/5/26 2:30pm
29/5/26 8:20 AM	S/B Dr. Harish	
	A/cis - Subacute App	<u>Plan</u>
	Afebrile Vitals - stable	- Soft diet - Plan d/c today
	P/A - soft	
 DR. HARISH JAYARAM Registration No: 66254 29/5/26 8:20 AM		 Dr. Nikhita 29/5/26 8:20 AM

BAH-00657443 IP5-00174412
 Baby CHERUKUPALLI NATYA REDDY
 12-09-2019 6 Y 8 M 16 D (F)
 Dr. NABEEL ALAM QADRI



RESULT SHEET

Date	28/5/26				
Time	2:44am				
Hb	12.1				
PCV	36.3				
RBC	4.50				
WBC	11.17				
N/L	72/22				
Platelets	264				
CRP	5				
ESR					
PCT					
RBS					
Na	139				
K	4.3				
Cl	101				
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bil/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					

BAH-00657443 IP5-00174412
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 12-09-2019 6 Y 6 M 16 D (F)
 Dr. NABEEL ALAM QADRI



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

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : B. Nabeel Alam Qadri

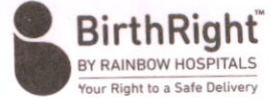
Date & Time : 28/05/2025; 2AM

Nurse Name & Signature: Annab

Date & Time : 28/05/2025 2:50A

Nathi
Patient Stick

BAH-00657443 IP5-00174412
Baby CHERUKUPALLI NATYA REDDY
12-09-2019 6 Y 8 M 16 D (F)
Dr. NABEEL ALAM QADRI



UG CHART

Date of Admission: 28/05/19 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:																					

VERIFIED BY : Name Signature

IP5-00174412
 Baby CHERUKUPALLI NATYA REDDY
 6 Y 8 M 16 D (F)
 Dr. NABEEL ALAM QADRI

H/FRM / CLINICAL / 126

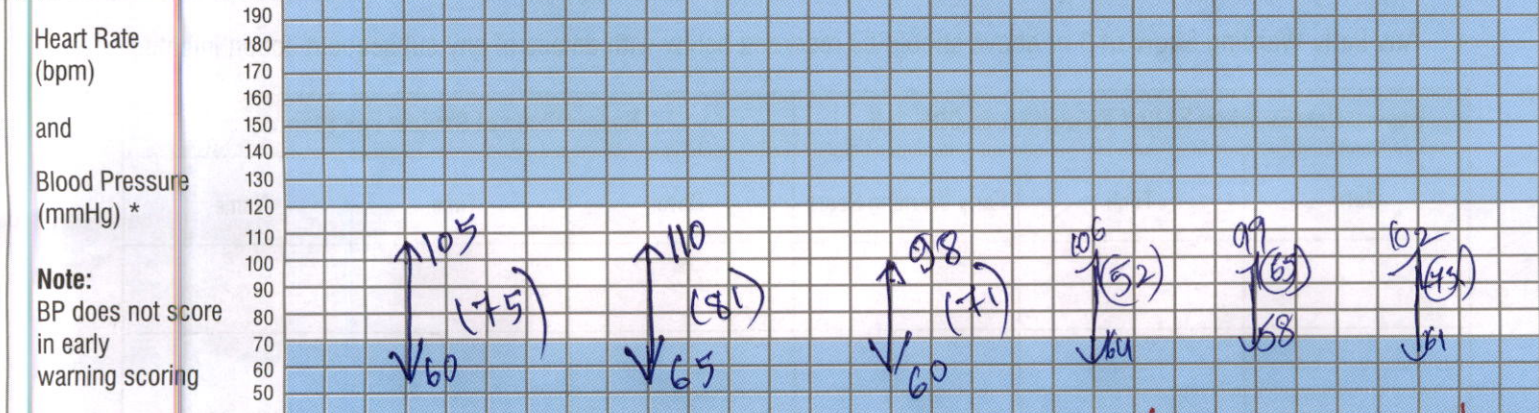
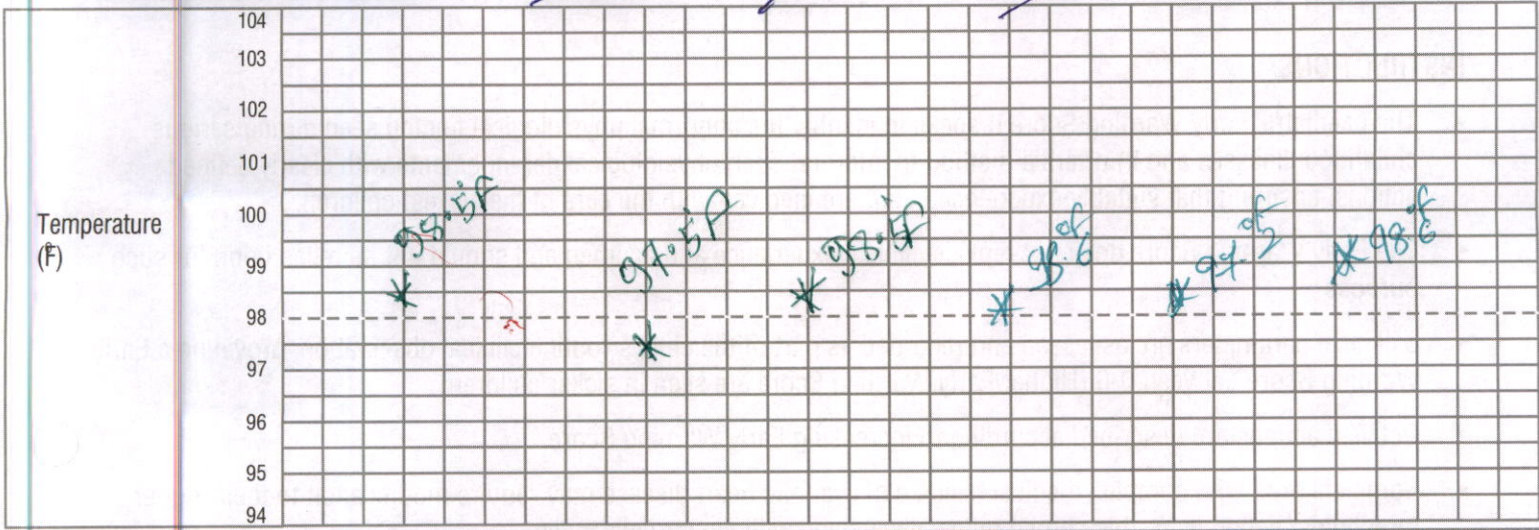
28/6/22

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

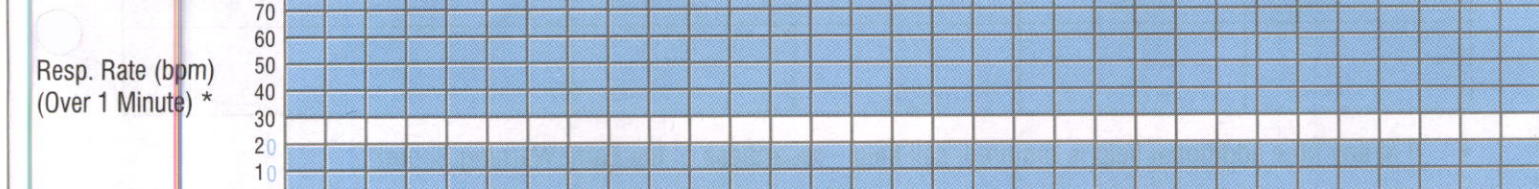


EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 10AM 1:40PM 6PM 10PM 2AM 6AM
 Doctor / Nurse / Family Concern? _____



Heart Rate (Number) 105b/m 98b/m 100b/m 106b/m 99b/m 113b/m



Resp Rate (Number) 22b/m 24b/m 24b/m 24b/m 22b/m 23b/m

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

Receiving O₂ (l/min) O₂ Saturations (%) RIA 100% RIA 98% RIA 99% PA 100% PA 99% PA 100%

Conscious Level Normal Altered - - - - - -

GCS * 15/15 15/15 15/15 15/15 15/15 15/15

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

Pain Score 0 0 0 0 0 0

Observer's Initials [Signature] [Signature] [Signature] [Signature] [Signature] [Signature]

- 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 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)

BAH-00657443 IP5-00174412
 Baby CHERUKUPALLI NATYA REDDY
 12-09-2019 6 Y 8 M 16 D (F)
 Dr. NABEEL ALAM QADRI



Patient St

LINICAL / 126

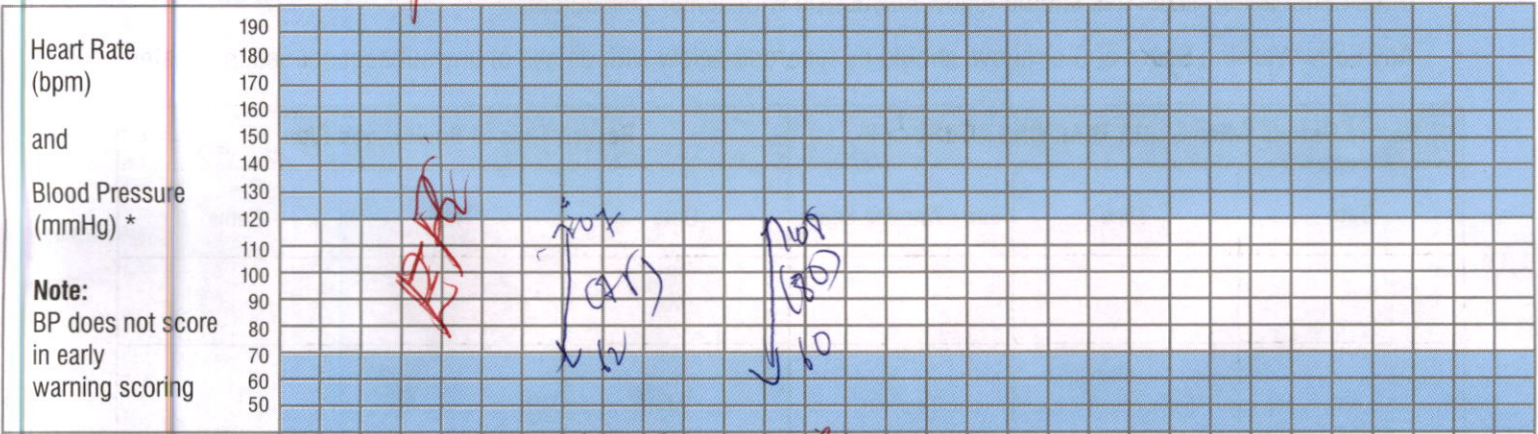
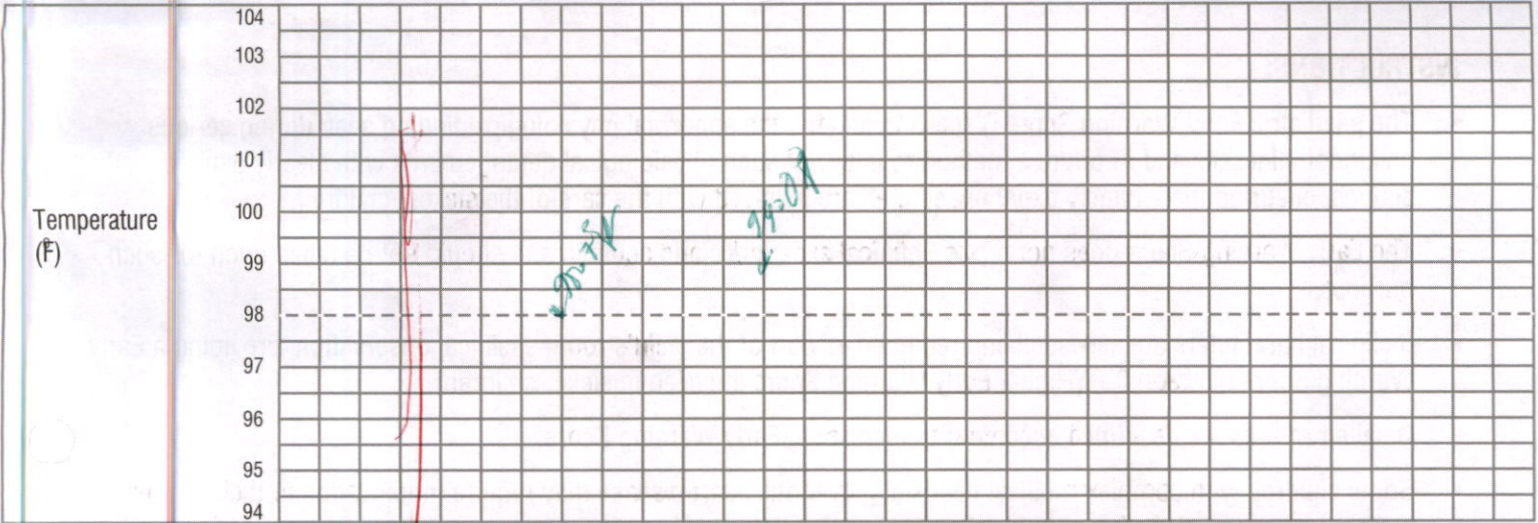
SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 4pm 6pm

Doctor / Nurse / Family Concern?



Heart Rate (Number)



Resp Rate (Number)

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (/min) O₂ Saturations (%)

Conscious Level Normal / Altered

GCS *

TOTAL SCORE Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be recorded over leaf

Score 1	: Continue normal observation by staff nurse
Score 2	: Shift in charge nurse to be informed and continue hourly observations
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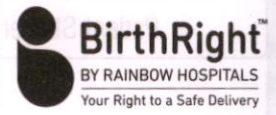
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A	ASSESSMENT : I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

Patient Stick

BAH-00657443 IP5-00174412
 Baby CHERUKUPALLI NATYA REDDY
 12-09-2019 6 Y 8 M 16 D (F)
 Dr. NABEEL ALAM QADRI



ID CHART

Sheet No. :

- 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	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	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							

28/5/20



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	↑	N	50ml						0	Barak	
	09:00 am	↑	N	50ml					-	0	Barak	
	10:00 am	I.V	0	50ml						0	Barak	
	11:00 am	DNS	coconut water	-						0	Barak	
	12:00 pm	↓		-						0	Barak	
	01:00 pm			-						0	Barak	
Total Intake :				150ml								Total Output : M-0 U-1
	02:00 pm	↑	N	50ml						0	Barak	
	03:00 pm	↑	N	50ml						0	Barak	
	04:00 pm	I.V		50ml					-	0	Barak	
	05:00 pm	DNS		-						0	Barak	
	06:00 pm	↓	fully water	-						0	Barak	
	07:00 pm			-						0	Barak	
Total Intake :				150ml								Total Output : M-0 U-2
	08:00 pm	↑	fully water	50ml						0	Barak	
	09:00 pm	↑		-						0	Barak	
	10:00 pm	I.V		-					✓	0	Barak	
	11:00 pm	DNS		-						0	Barak	
	12:00 am			50ml					✓	0	Barak	
	01:00 am	↓		50ml						0	Barak	
Total Intake :				150ml								Total Output : M-0 U-2
	02:00 am	↓		50ml						0	Barak	
	03:00 am	↓		50ml						0	Barak	
	04:00 am	I.V		50ml					✓	0	Barak	
	05:00 am	DNS		-						0	Barak	
	06:00 am	↓		-						0	Barak	
	07:00 am			-						0	Barak	
Total Intake :				150ml								Total Output : M-0 U-2

Total 24 hrs. Intake Total : 600ml

Total 24 hrs. Output M-0-U-7

202

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 28/5/20 Time: 10 am

Weight: 16.7 kgs Centile: < 5th

Height: 119 cms Centile: > 25th

Inference: Underweight Child

RDA: - Calories: 1450 kcal/d Protein: 25 g/d

Diet Recommendations: child is on clear liquids

Re-Assesment: (ORS, coconut water, water)

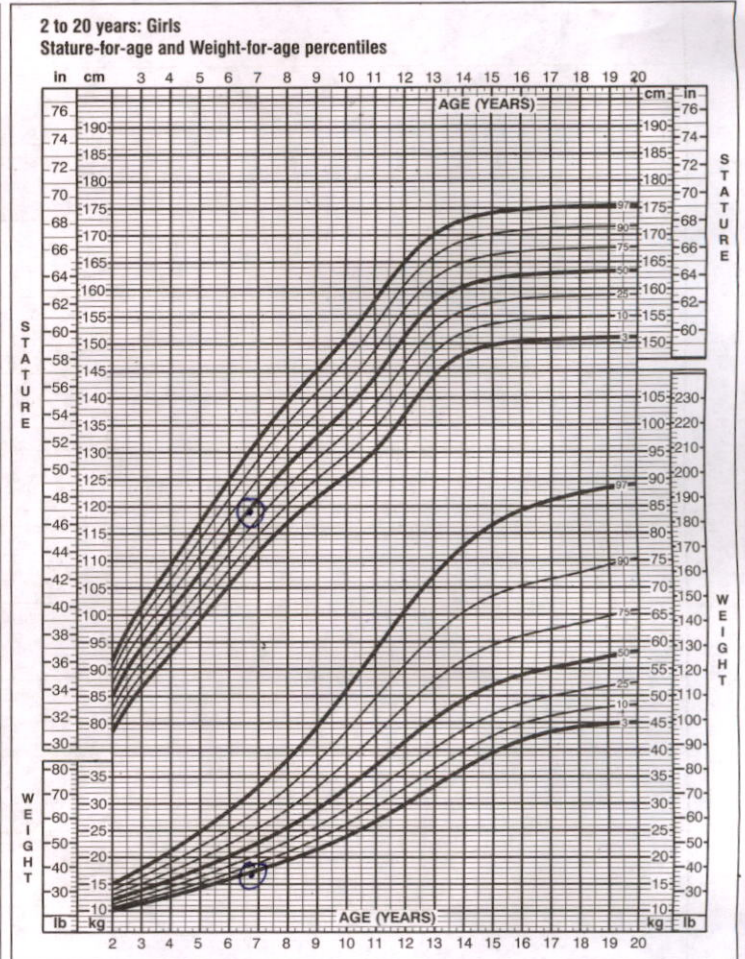
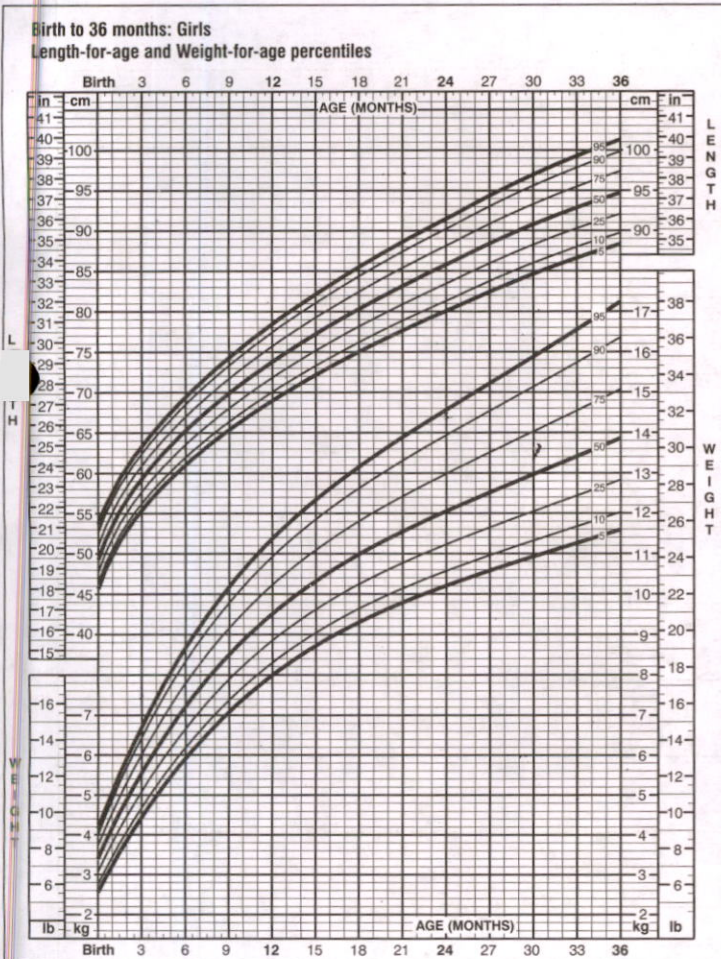
Food Allergies: No Veg/Non-veg: Non-veg

Diagnosis: Acute Appendicitis

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: [Signature]

GROWTH CHART (GIRLS)



Dietician's Name: Nikitha

Dietician's Signature: [Signature]

