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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ BAH-00641122 IP5-00175966 Master ABDIMALIK OMAR HASSAN 06-06-2020 6 Y 0 M 28 D (M) Dr. SIRISHA RANI __Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
4/7/26	12:30pm	EB	[illegible]	[signature]

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

Date : 4/7/21 Time : Dupe Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

A. Omar Hassan

BDA-00641122

124

Patient Sticker

Dr. Srishta Rani

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DEFICIENCY 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	1			
7	Nursing plan of care and handover sheets	1			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
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	1 +1			
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaestesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart				
30	Intake and Out take chart (fluid chart)	1			
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				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note	1			
43	BP Monitoring chart				
44	RBS monitoring chart				
	Others :-	4			
	:-	2			
	Total No. of Pages	25			

Doc. No. : RCHBH/ FRM / GENERAL / 126

Signature and Date : 4/7/26

(P.T.O)

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

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00175966 **Admit Date** : 04-Jul-2026 **Admit Time** : 11:43 AM **UHID** : BAH-00641122

Patient Details :

Patient Name	: Master ABDIMALIK OMAR HASSAN	**Age**	: 6 Y 0 M 28 D
Guardian	: Mr OMAR HASSAN	**DOB**	: 06-06-2020
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: STAR INN HOTEL , B 91, JUBILEE HILLS , NEAR APOLLO HOSPITAL , RD NO 3, JOURNALIST COLONY Film Nagar Hyderabad Telangana INDIA 500096	**Phone No**	: 7601056842
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : GENERAL WARD **Bed No** : GW 144 **Ward Name** : 1F-GENERAL WARD II

Room No : GW 144 **Admission Type** : First Visit

Contact Details :

Name : Mr OMAR HASSAN **Relationship** : Father

Contact Address : STAR INN HOTEL , B 91, JUBILEE HILLS , NEAR APOLLO HOSPITAL , RD NO 3, JOURNALIST COLONY Film Nagar Hyderabad Telangana INDIA 500096 **Phone No** : 7601056842

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

BAH-00641122 IP5-00175966
Master ABDIMALIK OMAR HASSAN
06-06-2020 6 Y 0 M 28 D (M)
Dr. SIRISHA RANI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 3pm	Procedure notes	
	Under sterile aseptic precautions, Lumbar puncture done clear CSF seen, intra thecal medication administered. procedure uneventful	
	vitals stable	Plan 1. monitor vitals. 2 discharge today Shri

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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Master ABDIMAJIK OMAR HASSAN
06-06-2020 6 Y 0 M 28 D (M)
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CONSENT FOR PROCEDURAL SEDATION

Authorization By: ☐ Patient ☑ Patient Attendant

I, the undersigned do hereby acknowledge the following:

- I have been made aware by the doctors in language known to me the details of sedation planned for the procedure
  Short sedation.
- I have been made aware of the possible complications from the procedure of sedation as follows:
- Changes in heart rate, blood pressure, need for oxygen supplementation, allergic reactions, upper airway obstruction, laryngospasm, conversion to general anaesthesia
- I have been made aware that the sedation is being advised to relieve pain and anxiety during the procedure. It will help me remain calm, comfortable, and cooperative, allowing the procedure to be performed smoothly and safely.
- I have been clearly explained about the benefits, risk, and alternative of the sedation which is General Anaesthesia.
- I authorize Dr. _____ and his / her team to perform the procedural sedation upon the patient / myself.
- 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: .....

Name: Omar Hassan.

Relationship with patient: Brother.

Date & Time: .....

Witness:

Signature: .....

Name: .....

Date & Time: 4/7/26

Doctor (who is taking consent):

Signature: ..... Name: Dr. prathusha. Date 4/7/26 Time: .....

Patient Sticker

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ప్రాసీజరల్ సెడేషన్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, క్రింది విషయాలను అంగీకరిస్తున్నాను:

నాకు తెలిసిన భాషలో, వైద్యులు ఈ క్రింది ప్రాసీజర్‌కు ఇచ్చే సెడేషన్ గురించి పూర్తి వివరాలు నాకు తెలిపారు:

_____

- సెడేషన్ వల్ల సంభవించగల సాధ్యమైన క్రింది సమస్యలు/ప్రమాదాలు గురించి నాకు తెలిపారు:
  గుండె వేగం మారడం, రక్తపోటు మారడం, ఆక్సిజన్ అవసరం, అలర్జీ ప్రతిచర్యలు, ఎగువ శ్వాసనాళ అడ్డంకి, లారింజోస్పాసమ్, జనరల్ అనస్థీషియాగా మారాల్సిన అవకాశం.
- ప్రాసీజర్ సమయంలో నొప్పి, భయం, ఆందోళన తగ్గించేందుకు సెడేషన్ ఇవ్వడం అవసరం అని నాకు వివరించారు. ఇది ప్రాసీజర్ సజావుగా, సురక్షితంగా జరగడానికి సహాయపడుతుంది.
- సెడేషన్కు సంబంధించిన ప్రయోజనాలు, ప్రమాదాలు, ప్రత్యామ్నాయం (జనరల్ అనస్థీషియా) గురించి నాకు స్పష్టంగా వివరించారు.
- డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ ప్రాసీజర్ సెడేషన్ చేయడానికి నేను అనుమతిస్తున్నాను.
- పై సమాచారాన్ని నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ఉన్న ప్రశ్నలన్నీ, నాకు అర్థమయ్యే భాషలో సమాధానమిచ్చారు. 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: .....

BAH-00641122 IP5-00175966
Master ABDIMALIK OMAR HASSAN
06-06-2020 6 Y 0 M 28 D (M)
Dr. SIRISHA RANI

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CONSENT FOR SPECIAL PROCEDURES

Patient Name : Omar Hassan Gender: ☑ Male ☐ Female

UHID No : BAH-00641122 Department : Hematonco. Date : .....

I ..... S / D / W / O .....

Here by give consent for procedure of : L.P. I.T.T injution.

For my patient, Named : .....

he doctors have clearly explained to me that the procedure has following possible complications:

..... pain, bleeding, Headache .....

.....

.....

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

.....

.....

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: .....

atient Attendant :

Signature : .....

Name : Omar Hassan

Relationship with Patient: Brother.

Date & Time : 4/7/26 @ 2p

Witness :

Signature : .....

Name : Chenala

Date & Time : 4/7/26 @ 2p

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Prashanth

Date & Time : 4/7/26.

ప్రత్యేక విధానాలకు సమ్మతి

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రోగి పేరు ..... లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి ..... విభాగం ..... తేదీ .....

నేను ..... S/D/W/O .....

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా .....

నా రోగికి, పేరు : .....

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

.....

.....

.....

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు : .....

సహాయకుడు(అటెండెంట్)

సంతకము .....

పేరు .....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము .....

పేరు .....

సాక్షి

సంతకము .....

పేరు .....

తేదీ మరియు సమయము .....

Patient Sticker

BAH-00641122 IP5-00175966
Master ABDIMALIK OMAR HASSAN
06-06-2020 6 Y 0 M 28 D (M)
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Moderate Sedation Flow-Sheet

Immediate Pre-Sedation Assessment

B.P	P.R	R.R	Temp	SPO_2	Pain Score	Weight
117/62	98 b/m	22 B/m	98.3 F	99%.		28-3kg.

Diagnosis: B ALL.

Procedure: L.P + IT Chemotherapy.

Comorbidities:

- ☑ Risk, benefits & alternatives discussed;
- ☑ Patient understand & elects to proceed
- ☑ Consents for procedure and sedation signed and dated

ASA Physical Status

- ☐ ASA PS 1: Healthy Patient
- ☑ ASA PS 2: Mild Systemic Disease, no functional limitations
- ☐ ASA PS 3: Severe Systemic Disease, functional limitations
- ☐ ASA PS 4: Severe Systemic Disease, constant threat to life
- ☐ ASA PS 5: Moribund Patient unlikely to survive 24 hrs.
- ☐ ASA PS 6: A declared braindead patient whose organs are being removed for donor purposes
- ☐ E: Emergency procedure

GCS: E 4 M 6. V 5

☐ IV Site: Gauge:

Sedation Plan:

Allergies:

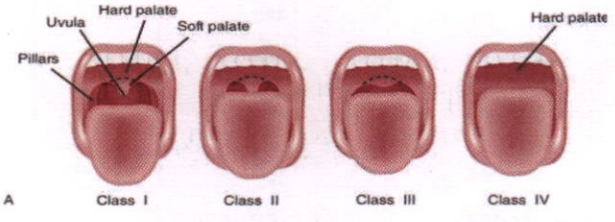
AIRWAY EVALUATION

Mouth:

- ☑ Normal
- ☐ Loose Teeth
- ☐ Small Mouth
- ☐ Protruding Incisors
- ☐ Receding Lower Jaw
- ☐ Dentures

Neck:

- ☑ Normal
- ☐ Decreased ROM
- ☐ Thyromental Distance Less Than 6 cm
- ☐ Short Neck



Mallampati Class: ☐ I ☐ II ☐ III ☐ IV

Monitoring of Patient Intra – Procedure

Procedure Monitoring

Heart Rate (HR), Respiratory Rate (RR), Oxygen Saturation (O_2 Sat) continuously monitored, and Level of Consciousness (LoC) to be monitored and recorded minimally every 15 minutes until 15 minutes after the last administration of any sedation, then every 30 minutes, then every 1 hour until stable. Respiratory status to be monitored continuously.

Level of Consciousness (LOC):

- ☑ A - Alert
- ☐ V - Verbally Responsive
- ☐ P - Painfully Responsive
- ☐ U - Unresponsive

Observation to be documented every 15 mins

TIME	BP	PR	RR	O_2 Sat%	O_2 Supplementation	Comments / Initials
Baseline	117/62	76b/m	20B/m	99% RA		

DRUG & IV Fluid: (including Nitrous Oxide)	ROUTE	DOSE	TIME GIVEN	SUBSEQUENT DOSES AND TIME
Inj. Ketamine	IV			
Inj. Midazolam.	IV.			

Doctor Notes: .....

.....

.....

Time of transportation to post sedation care room: ..... LOC: .....

Doctor Name: Dr. Prashanti ..... Signature: .....

Post Sedation Care Room

Time																							
Monitoring	180																						
ECG NBP Oximeter	160																						
Pain Score (0-10)	140																						
Sedation Score (0-4).....	120																						
	100																						
	80																						
	60																						
	40																						

TOTAL ALDRETTE SCORE AT DISCHARGE =
(If 9 and more patient can discharge from post Sedation care unit

Activity :	Consciousness:	Respiration:	Oxygen Saturation:	Circulation:
Four extremities = 2	Fully awake = 2	Breathe Deep= 2	Sat O_2>92 % on room air = 2	BP +/- 20 mm hg of pre-op = 2
Two extremities = 1	Arousal oncalling=1	Dyspnea, limited breathing = 1	Needs oxygen to maintain Sat O^2>90% = 1	BP +/- 20-50 mm hg of pre-op = 1
No extremities = 0	Unresponsive=0	Apnea = 0	Saturation <90% with oxygen = 0	Bp +/-50 mm hg of Pre-Op = 0

Patient Discharge Time: .....

Nurse Name: ..... Signature: .....

Date: ..... Time: .....

Consultant Name: ..... Signature: .....

Stamp

BAH-00641122 IPS-00175966
Master ABDIMALIK OMAR HASSAN
06-06-2020 6 Y 0 M 28 D (I
Dr. SIRISHA RANI

NPO - 7:40AM (Solid & liquid)

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master. Abdimalik Omar. Age : 6y Gender: ☑ Male ☐ Female

Date : 04/07/26 Time of Arrival : 11:34AM Triage Completion Time : 11:36 AM.

Allergies: ☐ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): Nil ☐ Not known any drug Allergies

Source of Information : ☐ Parents ☐ Others (Specify) Nil

Mode of Arrival : ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☐ Normal
☐ Sick Looking

Circulation / Colour
☐ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing
☐ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS
☐ Stable
☐ Unstable :
☐ Not – Life - Threatening
☐ Life – Threatening

Initial Vital Signs: Temp: 98.3°F PR: 98b/m BP: 117/62(76) RR: 22b/m SpO_2: 99% RA

Chief Complaints: Came for line removal Today & L.P

Triage Classification K/C/O - B-ALL.	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:

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☐ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☐ No
3. 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

1. 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: .....
2. 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 : NR Sudheer

Signature of Triage Nurse : .....

Date & Time : 4/7/26 at 11:36 AM.

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 4-7-26 Time of arrival : 11:40 am

Chief Complaints: Come for line Removal - RBS: -

Height : - Weight : 28.3kg BMI : Head Circumference (<2 years) Nil

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:

If yes , identify -

Pain Screening: ☐ Yes ☐ No If Yes, Pain Score: 0 Pain Tool Used: ☐ N Pass ☑ FLACC ☐ Wong Baker

☐ Character Nil ☐ Location Nil ☐ Frequency Nil ☐ Duration Nil

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: - (Date/Time): -

Social History: Lives With family

Siblings in household ☐ Yes ☐ No (if yes How Many?) 2 brother & 1 sister

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

Time of Initial assessment completed by ER Nurse : 4-7-26 @ 12:03 pm

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

Time	Nursing Notes
11:40a	Seen by dr prathiba
	Assess pt vita checked & Recorde
	& shifted to the ward.

Samples collected by: / Time: /

Samples sent by : / Time: /

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 98 b/m BP: 117/62 (76) CFT: <2sec	Shift - out from ER to: Dxces 144
RR: 22 b/m SPO$_2$: 99%.	Time of Shift - out: 12:30 pm
GCS: 15/15 Temperature : 98.3F	Handover given to: Sreelekha (Nurse's Name)
Pain Score: 0	
Repeat RBS (if applicable): Nil	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): Line have

Name of the Nurse : Nr. Sasmita Signature of the Nurse : [signature]

Date & Time : 4.7.26 @ 12:05 pm

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
BAH-00641122 IP5-00175966 Master ABDIMALIK OMAR HASSAN 06-06-2020 6 Y 0 M 28 D (M) Dr. SIRISHA RANI	4/7/26 @ 11:43 Am	4.7.26 @ 12:05 Pm
	Transfer Ordered by Dr. Prathiba	Reason for Transfer Admission
From Unit ER	To Unit 144	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 20	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed op file over to attendant Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.	Nil	
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Nr. Sushmita	Dr. Prathiba

Patient & Clinical Records Received by : Sneha

Date & Time of Patient Received : 4/7/26 @ 12:30pm

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

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06-06-2020 6 Y 0 M 28 D (M)
Dr. SIRISHA RANI

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Sirisha Rani Date : 04/7/26.

Type of Admission: ☐ OPD ☐ ER ☐ Referral (if referral, Doctor's Name: .....

Start Time of Assessment: ..... Weight: 28.3 kg.

Allergic History: .....

Chief Complaints: .....
B-ALL on maintenance
Admitted for LP.

Pediatric Assessment Triangle

A Appearance - TICLS ..... (N)

B Breathing
- ☐ ↑ WOB
- ☐ ↓ WOB
- ☐ Normal
- ☐ Gasping / Apnea

C Circulation
- ☐ Normal
- ☐ Abnormal
  - Pallor ☐
  - Cyanosis ☐
  - Mottling ☐
  - Bleeding ☐

Initial Physiological Status: ☐ Stable ☐ Unstable
- Life Threatening ☐
- Non Life Threatening ☐

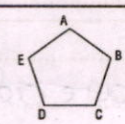
Any urgent interventions needed: ☐ Yes ☐ No
If Yes .....

Significant Past History: .....

Medication History: .....

Relevant Investigations: 4/7/26 – 11.4/3.22/41cu/57/24.2.

Primary Assessment



Airway

☐ Open
☐ Maintainable
☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☐ No
If Yes .....

Breathing

Rate: 22/min SpO₂ on FiO₂ 96.1 c RA

Rhythm: .....

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: .....

Palpation Findings (If necessary) .....

Any urgent interventions needed: ☐ Yes ☐ No
If Yes .....

Circulation

HR: 98/min

BP: 117/62 (76) mmHg

CFT — Central .... Peripheral .... <2sec

Any urgent interventions needed: ☐ Yes ☐ No ✓

If Yes ....

Pulse Volume: Central .... Peripheral .... Good

If in Shock: Compensated .... Hypotensive ....

Murmurs: ☐ Yes ☐ No

Liver Span: ....

ECG: ....

Any Signs of Heart Failure: ☐ Yes ☐ No

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Disability

GCS: .... AVPU: ....

Any urgent interventions needed: ☐ Yes ☐ No ✓

If Yes ....

Pupils: Responsive ☐ Non-Responsive ☐

Size — Right .... Left ....

Active Seizures: ☐ Yes ☐ No Sugars: ....

Signs of Neurological compromise ....

Exposure

Temp.: 98.3°F

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

Any Rash: ☐ Yes ☐ No,

If yes describe the rash ....

Active bleed ....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: ....

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings: ....

Labs Planned: ....

BP Done.

Treatment Planned: ....

— Daycare admission

— Line removal.

— LP.

Need for Oxygen: ☐ Yes ☐ No ✓ if yes Low Flow ☐ High Flow ☐ PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): B-ALL / Line removal plan

Assessment done by

Name of the Doctor: N.Prateeksha

Signature: N.P

Date & Time: 04/7/26, 11:40 am.

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: ....

Signature: ....

Date & Time: ....

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06-06-2020 6 Y 0 M 28 D (M)
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DRUG CHART

Date of Admission: 4/5/20 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 .....

BAH-00641122 IP5-00175966
Master ABDIMALIK OMAR HASSAN (M)
06-06-2020 6 Y 0 M 28 D
Dr. SIRISHA RANI

REGULAR PRESCRIPTIONS

Weight. 28.3 kg Ward. ....

DRUG : Inj. ONDANSETRON

Dose	Route	Frequency	Start Date
4 mg	IV	8H	04/7

Name & Signature of the Doctor Starting the Drugs: N. [signature]

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Dr. SIRISHA RANI

Weight. 28.3kg Ward. ....

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.	

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	3PM	Inj MIDAZOLAM	1.5mg	IV	[signature]	Pooja / Sahitha
3/7	3pm	Inj KETAMINE	10mg	IV	[signature]	Pooja / Sahitha

VERIFIED BY : Name .... Signature ....

Dr. SIRISHA RANI

I.V. FLUIDS CHART

Weight. 28.3 kg Ward. ....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
4/7/26		IVF-DNS	IV	50	N. P[illegible]				

VERIFIED BY : Name .... Signature ....

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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: ER Shifted to: Oncw.

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	syp. Septran	PO	5ml	12H. Monday wednesday friday	3/7/26.	☑ C ☐ DC
2	syp. 6MP	PO	2ml	~~24H~~	3/7/26.	☑ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : N. Prathika. N. P.

Date & Time : 04/7/26, 11:30 Am.

Nurse Name & Signature: Ns. Susmita

Date & Time : 4/7/26 @ 12:03 pm

Docu. No. : RCHBH /FRM / GENERAL / 090