

**ACTIVITY RECORD FOR BILLING**

Name : \_\_\_\_\_

UHID No. : \_\_\_\_\_ Consultant: \_\_\_\_\_ Dept : \_\_\_\_\_

BAH-00656366 IP5-00174596  
Master AZAM MOHAMED HASSAN  
26-10-2020 5 Y 7 M 6 D (M)  
Dr. ABHISHEK RAVINDRA JAIN



Date of Admission: \_\_\_\_\_ Date of Discharge : \_\_\_\_\_ Time: \_\_\_\_\_

Room / Bed No : \_\_\_\_\_ Suggested Billable bed type : \_\_\_\_\_

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
01/06/20	12pm	ER	PIU	Arshad
1/6/20	8pm	PIU	104	Merlin

**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
01/06	IV Placement	①	37455	Samyah
1/6	IV in transfusion	①	9272923	Jubany
1/6	EKG		78392	A
2/6	QWIC Transfusion	1	2522	J
2/6				
03/06	lumbar puncture conscious sedation	①	9642828	patry

**ANY OTHER INFORMATION**

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Date: 3/6/26

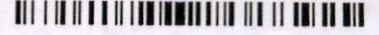
Time: 5PM

Prepared By: Arung

Staff Nurse  Arung	Shift / Ward  SPVT.	Billing Assistant	Billing Supervisor
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ADMISSION SHEET

Registration Details :



Admission No : IP5-00174596      Admit Date : 01-Jun-2026      Admit Time : 11:31 AM      UHID : BAH-00656366

Patient Details :

Patient Name : Master AZAM MOHAMED HASSAN      Age : 5 Y 7 M 6 D  
Guardian : Mr MOHAMED HASSAN FARAH      DOB : 26-10-2020  
Gender : Male      Religion :  
Occupation :      Martial Status : Single  
Address (H) : GHORI'S CLASSIC APARTMENTS, PARAMOUNT COLONY, GATE NO 02 Tolichowki Hyderabad Telangana INDIA 500008      Phone No : 6304729412 / 6305425201  
E-mail : gamadiid72@gmail.com

Admission Details :

Bed Type : SEMI PRIVATE      Bed No : SPVT 104      Ward Name : 1F-VIBGYOR  
Room No : SPVT 104      Admission Type : First Visit

Contact Details :

Name : Mr MOHAMED HASSAN FARAH      Relationship : Father  
Contact Address : GHORI'S CLASSIC APARTMENTS, PARAMOUNT COLONY, GATE NO 02 Tolichowki Hyderabad Telangana INDIA 500008      Phone No : 6304729412

*Mohamed*  
Signature

Doctor Details :

Doctor Name : Dr. ABHISHEK RAVINDRA JAIN      Specialisation : PEDIATRIC NEUROLOGY  
Referral Doctor : Self      Phone No :  
Co-Consultant :

Payment Details :


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



**Rainbow<sup>®</sup>  
Children's  
Hospital**  
It takes a lot to treat the little.

**PEDIATRIC IN-PATIENT  
MEDICAL RECORD**

BAH-00656366 IP5-00174596  
Master AZAM MOHAMED HASSAN  
26-10-2020 5 Y 7 M 6 D (M)  
Dr. ABHISHEK RAVINDRA JAIN



Patient Name: Azam Mohammed

UHID ID: \_\_\_\_\_

Department: \_\_\_\_\_

Consultant: \_\_\_\_\_

BAH-00656366 IP5-00174596  
Master AZAM MOHAMED HASSAN  
26-10-2020 5 Y 7 M 6 D (M)  
Dr. ABHISHEK RAVINDRA JAIN



### Pediatric Multiorgan History & Physical Examination

Name : \_\_\_\_\_ Age/Sex \_\_\_\_\_

Information given by: \_\_\_\_\_ Relationship \_\_\_\_\_

#### Chief Presenting Complaints & Duration (Chronologically)

flup case of Mild improvement of hyperactivity-  
sleep disturbances ⊕  
biting excessive mouthing

#### History of present illness :

flup Generalised onset seizures - Behavioural issues  
flup speech regression  
Autistic traits  
CASPR2 autoimmune encephalitis

NO fresh complaints → Cold, fever, cough

NO H/O Seizures / ab(N) activity

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26-10-2020 5 Y 7 M 6 D (M)  
Dr. ABHISHEK RAVINDRA JAIN

### Pediatric Multiorgan History & Physical Examination

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

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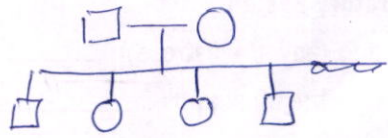
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**Birth & Neonatal History:**

Less / 4-5 kg / No H/o NICU stay.



**Birth & Socio Economic History:**

About Father : \_\_\_\_\_ }  
About Mother : \_\_\_\_\_ } Middle class .  
Any additional Information : \_\_\_\_\_

**Developmental History :**

} child is @ development since till last year . (Oct 2025)  
later on complements started

**Immunization History :**

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### Pediatric Multiorgan History & Physical Examination

#### Anthropometry :

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_) Height (cms): \_\_\_\_\_ (Centile) \_\_\_\_\_)

Weight (kgs) ) 19 kg (Centile \_\_\_\_\_)

#### On Examination :

Temperature : 98.2° F Pulse Rate : 116/min B.P. \_\_\_\_\_ SPO2 97% on RA

Resp. rate and type of breathing : \_\_\_\_\_

Rash \_\_\_\_\_

Lymphadenopathy } Nil.

Oedema : \_\_\_\_\_

Allergies (if any): \_\_\_\_\_

#### Respiratory System :

Inspection (any s/o distress) : \_\_\_\_\_

Air entry & breath sounds : B/L AEP

Any addes sounds : \_\_\_\_\_

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

#### Cardiovascular System :

Inspection of procordium : \_\_\_\_\_

Heart Sounds : \_\_\_\_\_

Any murmur : \_\_\_\_\_

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

#### Per Abdomen :

Inspection \_\_\_\_\_

Palpation : \_\_\_\_\_

Ausculation : } soft INT.

Spine : \_\_\_\_\_ External Genitelia : \_\_\_\_\_

Relevant data from outside (CT, USG etc..) \_\_\_\_\_

BA-4-00656366  
Master AZAM MOHAMED HASSAN  
26-10-2020  
Dr. ABHISHEK RAVINDRA JAIN (M)  
IPS-00174596  
5 Y 7 M 6 D

**Pediatric History & Physical Examination**

**Central Nervous System :**

Level of Consciousness : AVPU/GCS score : \_\_\_\_\_

Cranial Nerves : Restless, Conscious, some eye contact

**Motor System:**

Nutrition : \_\_\_\_\_

Tone : Mild hypotonia Power \_\_\_\_\_

Co-ordinator : \_\_\_\_\_

Posture : \_\_\_\_\_

Involuntary Movements : Gait - (N)  
Spine - (N)

**Reflexes :**

DTR } (+)  
Plantars \_\_\_\_\_

**Superficials:**

**Sensory System :**

Bladder / Bowel : \_\_\_\_\_

**Clinical Summary & Diagnostic:**

Generalized onset seizures. Flby speech regression.  
CASPR2 - Autoimmune encephalitis  
Autistic traits.

Patient Sticker

BAH-00656366

IP5-00174596

Master AZAM MOHAMED HASSAN

26-10-2020

6 Y 7 M 6 D

(M)

Dr. ABHISHEK RAVINDRA JAIN



### History & Physical Examination

Preventive aspects of the treatment: \_\_\_\_\_

Desired goals of the treatment : \_\_\_\_\_

#### Planned Labs:

Sleep ECG

{Planned} Collected in ER  
{EDTA}

#### Planned Management

IVIG 2gm/kg (10gm/once daily for 4 days)

Syp. Valance

Teb Loperem

Inj Methylprednisolone

Inj Pantop.

Signature of the Doctor: Ranya

Name of the Doctor: Dr. RANYA

Date & Time: 11/6/26

Signature of the Consultant: Abhishek

Name of the Consultant: Dr. Abhishek

Date & Time: 11/6/26





## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/6/20	<u>Slitting notes.</u>	
<del>9 AM</del>		
9 PM	AIDS! - Autoimmune encephalitis	
	on room APs	plan.
	hemodynamically stable.	1. shift to ward.
	no fever spikes.	
	vitals.	2. monitor vitals.
	TKR - 70	
	Bp 97/55 (70 mmHg)	3. w/T fever spikes.
	RR - 20.	
	Received IV Ig 10gm.	<del>Notes by malim</del>
		@ 9:30 PM
		Dr. Madhavi



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/26 8:30AM	C/S/B Neuroteam	
	Δ: <u>CASPR2 AUTOIMMUNE ENCEPHALITIS</u>	
	<p><u>History</u>: Seizures (GTCS)          Behavioral Issues          Autistic Trait          Speech Regression          (Developmentally (N) child till last year)</p>	<p>CASPR2          AIE</p>
	<p>Oromotor dyskinesia (+) ⇒ Excessive Biting (+)</p>	
	<p><u>Issues</u>: No fresh complaints          - Received 1 dose of IvIg          pulse steroids</p>	
	<p><u>O/E</u>: Vitals: HR - 86/min ; RR: 20/min          HMF: spont. limb movements (+)          Not recognizing parents / not responding when called.          CN: B/L pupils NSRL.          Tone: hypertonia (+) → to be reassessed (N)          Reflex: <math>\begin{matrix} +2 &amp; +2 \\ +2 &amp; +2 \end{matrix}</math></p>	
	<p>Cerebellar sensory → to be reassessed</p> <p>Abhishek</p>	<p><u>plan</u></p> <ol style="list-style-type: none"> <li>1) Continue IvIg IvIg 10gm Today</li> <li>2) continue pulse steroids till Evig</li> <li>3) vitals monitoring</li> <li>4) Trace measles IgM report</li> <li>5) Add 4. Cizodon 0.5mg (P.T.O) (+)</li> <li>6) EEG taken next night</li> </ol>



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
02/06	<u>cls/B Neuroteam</u>	
05:30pm	No fresh complaints	
	• EEG - done	
	• CSF - IgG measles +ve (625)	
	<u>Δ: SSPE</u>	
		<u>Plan</u>
		① To start
	EEG: no periodic complexes	Tab. Isoprimazine
	CSF - IgG measles +ve (625)	
	No fresh complaints	2) Intra thecal
	No seizures	Interferon d2b -
	vitals: stable	(RELIFERON)
	① motor examination	



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
03/06: 8:40AM	<u>C/S/B Neuroteam</u>	<u>Δ: ISPE</u>
	<ul style="list-style-type: none"> <li>• No fresh complaints</li> <li>• <u>EEG</u>: no periodic complexes</li> <li>CSF: IgG, measles; ELISA +ve (625)</li> </ul>	
	<ul style="list-style-type: none"> <li>• No fresh seizures</li> <li>• Sleeping comfortably</li> <li>• Biting / Aggressive behaviours: ↓ than before</li> <li>• <u>vitals</u>: HR: 64/min RR: 18/min</li> </ul>	
	<p><u>O/E</u>: Child asleep  <u>CNS</u>: to be reassessed</p>	<p><u>Adv</u></p> <ol style="list-style-type: none"> <li>1) T. ISOPRINOSINE 500</li> <li>2) plan - Intrathecal Interferon α2b (RELIFERON)</li> </ol>
	<p>IT x 6 weeks      ↓      - S-C: ITN α2b</p>	<ol style="list-style-type: none"> <li>3) vitals monitoring</li> <li>4) IVE</li> <li>5) Add lamivudine        Clevudine + Isoprino        + Intrathecal ITN α2b</li> <li>6) S/O for sleep dist. -        Syp melatonin</li> </ol>
		<p>Abhishek</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
03/06 03pm	<p><u>Procedure Notes</u></p> <p><u>LP</u></p>	
	<p>Under strict aseptic conditions, lumbar puncture was performed and intrathecal Interferon <math>\alpha 2b</math> was given slowly. No bleeding or other complications.</p>	
	<p>pre procedure &amp; } vitals stable          post procedure }</p>	
	<p><u>Post procedure</u></p>	
	<p>HR - 82/min</p>	
	<p>RR - 22/min</p>	
	<p>BP: 97/78 mmHg</p>	
	<p>SpO<sub>2</sub>: 98% RA</p>	
03/06 6pm	<p><u>C/S/B Neuroteam</u></p>	<p><u>Add</u></p>
	<p>e) No fresh complaints          i) Child conscious          • No seizures          vitals: stable</p>	<p>i) T. Isoprenaline          ii) T. Lamivudine 100mg          1/2 tab / OD</p>
	<p><u>(N) motor examination</u></p>	
	<p>1st dose          Intrathecal Interferon <math>\alpha 2b</math> given</p>	

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 26-10-2020 5 Y 7 M 8 D (M)  
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## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
04/06 9AM	<u>C/S/B Neuroteam</u>	
	<u>SSPE</u>	<u>Adv</u>
	No fresh complaints	continue
	Child asleep	T. Isopinesine
	Sleep - improved	T. Kammedine
	Behavioural issues: ↓ than before	continue IT IFN - dex
	vitals - stable	plan (D)
	(A) motor examination	<u>Adv</u> - LFT, CBP, S-G
	1 <sup>st</sup> dose intrathecal	Add T. MELATONIN 0mg
	IFN - dex given	1/2 tab @ night

*Abhishek*



BAH-00656366 IP5-00174596  
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 26-10-2020 5 Y 7 M 6 D (M)  
 Dr. ABHISHEK RAVINDRA JAIN



## RESULT SHEET

Date					
Time					
Hb					
PCV					
RBC					
WBC					
N/L					
Platelets					
CRP					
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					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					



BAH-00656366 IP5-00174596  
 Master AZAM MOHAMED HASSAN (M)  
 26-10-2020 5 Y 7 M 6 D  
 Dr. ABHISHEK RAVINDRA JAIN

## 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: 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	Syp. Valance	3ml	PO	BD	1/6/26	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2	Tcb LobeZam Sng	5 Tcb	PO	OD	1/6/26	<input checked="" 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: Dr. RAmYA

Date & Time: 1/6/26 ; 11am

Nurse Name & Signature: Amal

Date & Time: 1/06/26 12pm

BAH-00656366 IP5-00174596  
 Master AZAM MOHAMED HASSAN (M)  
 26-10-2020 5 Y 7 M 6 D  
 Dr. ABHISHEK RAVINDRA JAIN



## 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: ICU

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	INJ METHYL PREDNISOLONE	600mg	IV	OD	1/6	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
	INJ PANTOPRAZOLE	20mg	IV	OD	1/6	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
3	Syp VALACE	3ml	PO	BD	1/6	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
4	TAB CLOBAZAM	5mg	PO	TDS	1/6	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
5	SYP CEFIXIME	5ml	PO	BD	1/6	<input checked="" 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
						<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: Dr. Kishan M

Date & Time: 1/6/26 6pm

Nurse Name & Signature: [Signature]

Date & Time: 1/6/26 6n

BAH-00658366 IP5-00174596  
 Master AZAM MOHAMED HASSAN  
 26-10-2020 5 Y 7 M 7 D (M)  
 Dr. ABHISHEK RAVINDRA JAIN



Sheet No: .....

REGULAR PRESCRIPTIONS

Weight .....

Ward .....

DRUG: <u>Syp. CEFIXIME</u>				Date/Time	<u>1/6</u>	<u>2/6</u>	<u>3/6</u>													
Dose	Route	Frequency	Start Dt.																	
<u>5ml</u>	<u>PO</u>	<u>BD</u>	<u>1/6</u>	<u>10AM</u>	<u>X</u>	<u>Contd</u>	<u>Contd</u>	<u>Contd</u>												
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Anant</u>																				
Additional Instructions: <u>100mg/5ml</u>				<u>10AM</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u>																
Daily Doctor's Endorsement by a Sign																				

DRUG: <u>TAB. SIZODON</u>				Date/Time	<u>1/6</u>	<u>3/6</u>														
Dose	Route	Frequency	Start Dt.																	
<u>1/2 TAB</u>	<u>PO</u>	<u>OD</u> <u>at night</u>	<u>02/06</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandan</u>				<u>10PM</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u>																
Additional Instructions: <u>7 tab = 0.5mg</u>				<u>10PM</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u> <u>Contd</u>																
Daily Doctor's Endorsement by a Sign																				

DRUG: <u>Tab. ISOPRINOSINE</u>				Date/Time	<u>1/6</u>	<u>3/6</u>														
Dose	Route	Frequency	Start Dt.																	
<u>1 tab</u>	<u>PO</u>	<u>OD</u>	<u>02/06</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>V. L. Sawjanya</u>				<u>6PM</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u>																
Additional Instructions: <u>1 tab = 500mg</u>				<u>6PM</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u> <u>Sawjanya</u>																
Daily Doctor's Endorsement by a Sign																				

DRUG: <u>Inj. RELIFERON</u>				Date/Time																
Dose	Route	Frequency	Start Dt.																	
<u>3mIU</u>	<u>Intra</u> <u>thecal</u>																			
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

VERIFIED BY: Signature

BAH-00656366 IPS-00174596  
 Master AZAM MOHAMED HASSAN  
 26-10-2020 5 Y 7 M 7 D (M)  
 Dr. ABHISHEK RAVINDRA JAIN



Shee. ....

**REGULAR PRESCRIPTIONS**

Weight .....

Ward .....

<b>DRUG :</b> Tab. LAMIVUDINE				Date Time	3/6															
Dose	Route	Frequency	Start Dt.																	
1/2 tab	PO	OD	3/6																	
Name & Signature of the Doctor Starting the Drugs: V.L. Sawjanya																				
Additional Instructions: 1 tab = 100 mg																				
<b>Daily Doctor's Endorsement by a Sign</b>																				
<b>DRUG :</b> T. MELATONIN 10mg				Date Time																
Dose	Route	Frequency	Start Dt.																	
1/2 tab	PO	HS	4/6																	
Name & Signature of the Doctor Starting the Drugs: V.L. Sawj.																				
Additional Instructions:																				
<b>Daily Doctor's Endorsement by a Sign</b>																				
<b>DRUG :</b>				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
<b>Daily Doctor's Endorsement by a Sign</b>																				
<b>DRUG :</b>				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
<b>Daily Doctor's Endorsement by a Sign</b>																				

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



BAH-00856366 IP5-00174596  
 Master AZAM MOHAMED HASSAN  
 26-10-2020 5 Y 7 M 6 D (M)  
 Dr. ABHISHEK RAVINDRA JAIN

# DRUG CHART

Date of Admission: 01/06/20 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)

<b>DRUG :</b> <u>Syrp Crocin DS</u>				Date Time															
Dose	Route	Frequency	Start Date																
<u>5ml</u>	<u>PO</u>	<u>SoS</u>	<u>4/3</u>																
Doctor's Signature		Valid Period	Pharm.																
<u>[Signature]</u>																			
Additional Instructions:																			

<b>DRUG :</b>				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			

<b>DRUG :</b>				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			

VERIFIED BY : Name .....



REGULAR PRESCRIPTIONS

Weight. 19kg Ward. ....

<b>DRUG:</b> <u>Inj METHYL PREDNISOLONE</u>				Date Time	<u>1/6</u>	<u>2/6</u>				
Dose	Route	Frequency	Start Date							
<u>600mg</u>	<u>IV</u>	<u>Q24H</u>	<u>1/6/26</u>							
Name & Signature of the Doctor Starting the Drugs: <u>Dr Rampy</u>				<del>2pm 5pm</del> <del>Methyl Prednisolone</del> <del>Prone</del> <del>Stop</del> <del>5/2/26/26</del> <del>low</del>						
Additional Instructions:										
<b>Daily Doctor's Endorsement by a Sign</b>										
<b>DRUG:</b> <u>Inj PANTOPRAZOLE</u>				Date Time	<u>1/6</u>	<u>2/6</u>	<u>3/6</u>	<u>4/6</u>		
Dose	Route	Frequency	Start Date							
<u>20mg</u>	<u>IV</u>	<u>Q24H</u>	<u>1/6/26</u>							
Name & Signature of the Doctor Starting the Drugs: <u>Dr Rampy</u>				<del>6AM 5PM</del> <del>Methyl Prednisolone</del> <del>Amoxicillin</del> <del>Dicyclanil</del> <del>Strich</del>						
Additional Instructions:										
<b>Daily Doctor's Endorsement by a Sign</b>										
<b>DRUG:</b> <u>Syp. VALANCE</u>				Date Time	<u>1/6</u>	<u>2/6</u>	<u>3/6</u>	<u>4/6</u>		
Dose	Route	Frequency	Start Date							
<u>3ml</u>	<u>PO</u>	<u>Q12H</u>	<u>1/6/26</u>							
Name & Signature of the Doctor Starting the Drugs: <u>Dr Rampy</u>				<del>6AM</del> <del>X</del> <del>Amoxicillin</del> <del>Dicyclanil</del> <del>Loam</del>						
Additional Instructions:				<del>6PM</del> <del>Methyl Prednisolone</del> <del>Amoxicillin</del> <del>Loam</del>						
<b>Daily Doctor's Endorsement by a Sign</b>										
<b>DRUG:</b> <u>Tab LDBAZAM (5mg)</u>				Date Time	<u>1/6</u>	<u>2/6</u>	<u>3/6</u>			
Dose	Route	Frequency	Start Date							
<u>1tab</u>	<u>PO</u>	<u>HS</u>	<u>1/6/26</u>							
Name & Signature of the Doctor Starting the Drugs: <u>Dr Rampy</u>				<del>10PM</del> <del>Amoxicillin</del> <del>Dicyclanil</del> <del>Dicyclanil</del>						
Additional Instructions:										
<b>Daily Doctor's Endorsement by a Sign</b>										

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Weight. .... Ward. ....

Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Dose		Dose		Dose		Dose	
Start Date	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
1/6/26	12:15 pm	IV Ia injection	10gm	IV	Ramp	Subrata Jain
			2ml/hr for 15min			
			3ml/hr for next 15min			
			5 ml/hr for next 15min			
			8ml/hr for next 15min			
		lets on	12.5ml/hr next hrs.			
02/06	11:30AM ↓ 6pm	IV Ig	10gm	IV over 6 hrs	Neetha	Priyanka
			1 ml/hr for 15min			
			2 ml/hr for next 15min			
			4 ml/hr for next 15min			
			8 ml/hr for next 15min			
			16 ml/hr to continue rest			

Signature  
VERIFIED BY

BAH-00656366

IP5-00174596

Master AZAM MOHAMED HASSAN

5 Y 7 M 8 D

(M)

26-10-2020

Dr. ABHISHEK RAVINDRA JAIN



# I.V. FLUIDS CHART

Weight. .... Ward. ....

Position of I.V. Fluid  
(Specify, mention ml/hr = Mcg/kg/min. etc)

Route

Flow Rate  
ml/hr

Doctor  
Sign

Nurse  
Sign

Date of  
Stopping

Doctor  
Sign

Nurse  
Sign

3/6

9:30AM IVF - DNS

IV line

58  
ml/hr

dy

Ravera  
Soman

3/6

Raj

Signature

VERIFIED BY : Name

BAH-00658366 IP5-00174596  
 Master AZAM MOHAMED HASSAN (M)  
 26-10-2020 5 Y 7 M 7 D  
 Dr. ABHISHEK RAVINDRA JAIN

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

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



**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date : 4/10 Time: 6am 7am

Doctor / Nurse / Family Concern?

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

*Handwritten notes: 100.5°F, 100.2°F, (CROCODAS)*

Heart Rate (bpm) and Blood Pressure (mmHg) * <b>Note:</b> BP does not score in early warning scoring	190		
	180		
	170		
	160		
	150		
	140		
	130		
	120		
	110		
	100		
	90		

*Handwritten notes: 108/51mm*

Heart Rate (Number) 108/51mm

Resp. Rate (bpm) (over 1 Minute) *	70		
	60		
	50		
	40		
	30		
	20		
	10		
	0		

Resp Rate (Number) 23 b/m

Resp Distress Mod/ Severe None / Mild

Receiving O<sub>2</sub> (/min) O<sub>2</sub> Saturations (%) 98%

Conscious Level Normal Altered

GCS \* 15/15

**TOTAL SCORE** Number of shaded boxes 1

Pain Score 2

Observer's Initials S

- 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

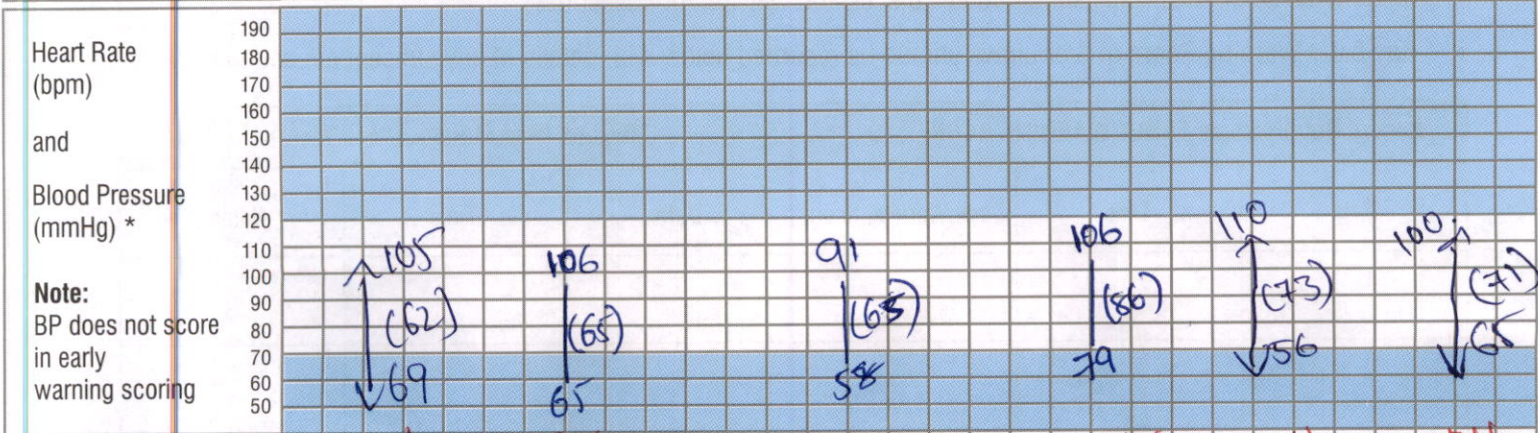
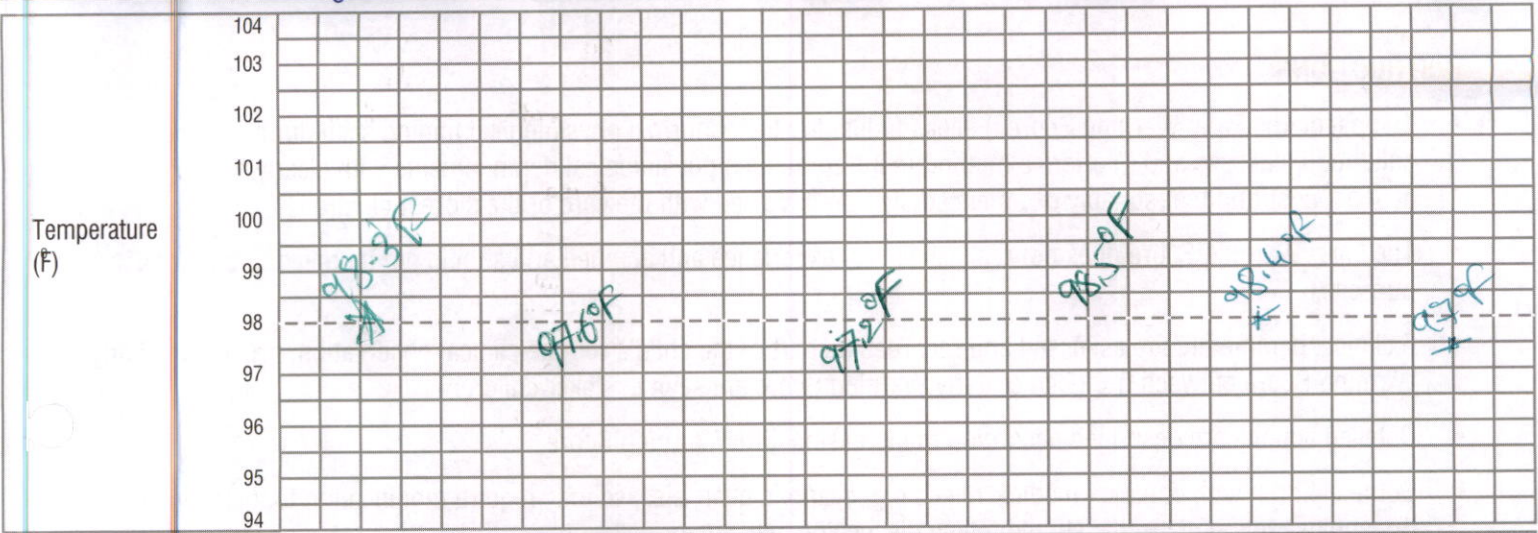
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION :</b> 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>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

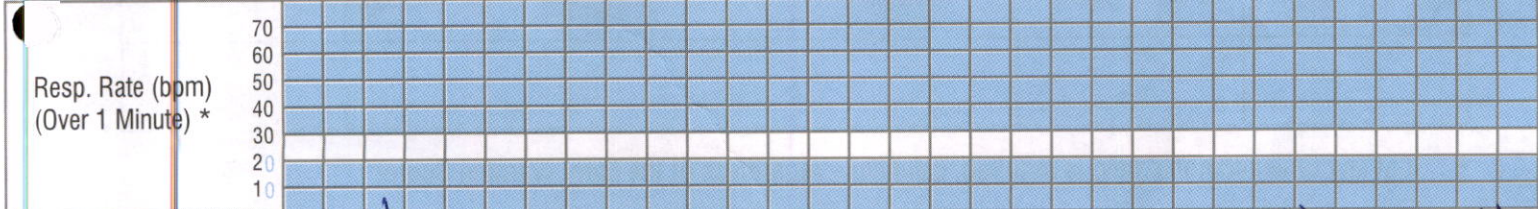
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 3/6/26 Time:

Doctor / Nurse / Family Concern? for 10AM 2AM 6PM 10PM 2AM



Heart Rate (Number) 118h 90blm 103blm 130blm 115blm 107blm



Resp Rate (Number) 28h 24blm 24blm 24blm 29blm 28blm

Resp Mod/ Severe Distress None / Mild

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

Conscious Level Normal / Altered

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

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

**ACTIONS**  
 NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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\* 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:

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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

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<b>R</b>	<b>RECOMMENDATION :</b> I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date : 26/10/20 Time: \_\_\_\_\_

Doctor / Nurse / Family Concern? 10P 20

Temperature (F)	104		
	103		
	102		
	101		
	100		
	99		
	98		
	97	97.2P	97.0P
	96		
	95		
	94		

Heart Rate (bpm) and Blood Pressure (mmHg) *	190		
	180		
	170		
	160		
	150		
	140		
	130		
	120		
	110		
	100		
	90		
	80		
	70		
60			
50			
Note: BP does not score in early warning scoring			
Heart Rate (Number)	110 (69) ↓ 63 118L	107 (92) ↓ 60 109L	91

Resp. Rate (bpm) (Over 1 Minute) *	70			
	60			
	50			
	40			
	30			
	20			
	10			
	Resp Rate (Number)	28L	28L	

Resp Distress	Mod/ Severe None / Mild		
Receiving O <sub>2</sub> (l/min)			
O <sub>2</sub> Saturations (%)		98.7	98.1
Conscious Level	Normal Altered		
GCS *		15/15	15/15

<b>TOTAL SCORE</b>			
Number of shaded boxes	1	1	
Pain Score	0	0	
Observer's Initials	C	C	

<b>ACTIONS</b> NB: Scores 3 should be recorded overleaf	Score 1	: Continue normal observation by staff nurse
	Score 2	: Shift in charge nurse to be informed and continue hourly observations
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IP5-00174596  
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 26-10-2020 5 Y 7 M 8 D  
 Dr. ABHISHEK RAVINDRA JAIN



# CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

## INSTRUCTIONS:

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<b>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
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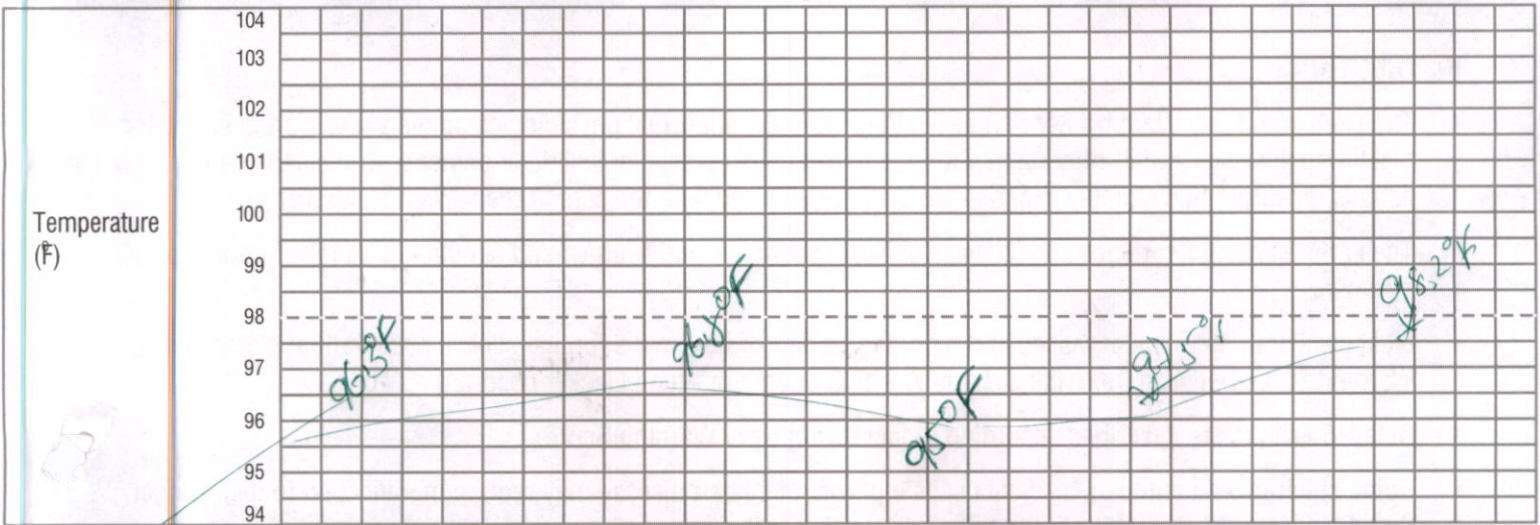
Doc. No. : RCHBH/ FRM / CLINICAL / 126

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



**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date : 16/20 Time: 9/6/26  
 Doctor / Nurse / Family Concern? 10pm 9pm 8pm 7pm 6pm



Heart Rate (bpm)	Blood Pressure (mmHg) *
118	105/60 (70)
92	92/46 (56)
110	110/70 (70)
98	98/66 (77)

Heart Rate (Number) 110b/m 102b/m 90b/m

Resp Rate (bpm)	Resp Rate (Number)
22	22b/m
24	24b/m
22	22b/m
26	26b/m
26	26b/m

Resp Mod/ Severe Distress None / Mild

Receiving O<sub>2</sub> (/min) O<sub>2</sub> Saturations (%) 99-1 99-1 99-1 98-1 99-1

Conscious Level Normal / Altered  
 GCS \* 15/15 15/15 15/15 1 15/15

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

- ACTIONS**
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<b>A</b>	<b>ASSESSMENT:</b> I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
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 26-10-2020 5 Y 7 M 6 D (M)  
 Dr. ABHISHEK RAVINDRA JAIN



# 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 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													
<b>Total Intake :</b>						<b>Total Output :</b>								
	02:00 pm													
	03:00 pm													
	04:00 pm													
	05:00 pm													
	06:00 pm													
	07:00 pm													
	<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm													
	09:00 pm													
	10:00 pm													
	11:00 pm	NO I.V											Aruna	
	12:00 am													
	01:00 am												Aruna	
	<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												Aruna	
	03:00 am													
	04:00 am												Aruna	
	05:00 am	NO I.V											Aruna	
	06:00 am												Aruna	
	07:00 am													
	<b>Total Intake :</b>						<b>Total Output :</b>							
<b>Total 24 hrs. Intake</b>												<b>Total 24 hrs. Output</b>		



# 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			
02/06/24	08:00 am					/							
	09:00 am					/						0	shy
	10:00 am	no IUF				/						0	shy
	11:00 am					/						0	shy
	12:00 pm					/						0	shy
	01:00 pm					/						0	shy
<b>Total Intake :</b>						<b>Total Output :</b>							
2/6	02:00 pm					/						0	shy
	03:00 pm					/						0	shy
	04:00 pm	no IUF				/						0	shy
	05:00 pm					/						0	shy
	06:00 pm					/						0	shy
	07:00 pm					/						0	shy
<b>Total Intake :</b>						<b>Total Output :</b>							
2/6	08:00 pm					/						0	shy
	09:00 pm					/						0	shy
	10:00 pm					/						0	shy
	11:00 pm	no IUF				/						0	shy
	12:00 am					/						0	shy
	01:00 am					/						0	shy
<b>Total Intake :</b>						<b>Total Output :</b>							
3/6	02:00 am					/						0	shy
	03:00 am					/						0	shy
	04:00 am	no IUF				/						0	shy
	05:00 am					/						0	shy
	06:00 am					/						0	shy
	07:00 am					/						0	shy
<b>Total Intake :</b>						<b>Total Output :</b>							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

Master AZAM MOHAMED HASSAN  
 26-10-2020 6 Y 7 M 7 D (M)  
 Dr. ABHISHEK RAVINDRA JAIN

# FLUID 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 Thrombophlebitis Score	Sign. Nurse
			Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am										0	Ravina
	09:00 am										0	
	10:00 am	ONS	NPO	50ML	NA			NA			0	Ravina
	11:00 am			50ML	NA						0	
	12:00 pm			50ML							0	Ravina
	01:00 pm			50ML							1	cannula changed
<b>Total Intake :</b>						<b>Total Output :</b>						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm	NPO									0	Aruna
	06:00 pm	NPO									0	
	07:00 pm	NPO									0	Aruna
<b>Total Intake :</b>						<b>Total Output :</b>						
	08:00 pm										0	
	09:00 pm	NPO									0	Shrishe
	10:00 pm	NPO									0	
	11:00 pm	NPO									0	Shrishe
	12:00 am										0	
	01:00 am										0	
<b>Total Intake :</b>						<b>Total Output :</b>						
	02:00 am	NPO									0	Shrishe
	03:00 am	NPO									0	Shrishe
	04:00 am	NPO									0	Shrishe
	05:00 am										0	
	06:00 am										0	Shrishe
	07:00 am										0	
<b>Total Intake :</b>						<b>Total Output :</b>						

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

Master AZAM MOHAMED HASSAN (M)  
 26-10-2020 5 Y 7 M 7 D  
 Dr. ABHISHEK RAVINDRA JAIN

# 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 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												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
<b>Total 24 hrs. Intake</b>						<b>Total 24 hrs. Output</b>							

# CONSENT FOR SPECIAL PROCEDURES

Patient Name : mohammed hassan Gender:  Male  Female  
UHID No : BAH-0065366 Department : PICU Date : 3/6/26

I Azra Mohammed hasan father S/D/W/O mohammed hassan

Here by give consent for procedure of : lumbur puncture

For my patient, Named : .....

The doctors have clearly explained to me that the procedure has following possible complications:  
Bleeding, Infection,

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

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: Dr. Aneeth

**Patient Attendant :**  
Signature : mohammed  
Name : .....  
Relationship with Patient: Father  
Date & Time : 3/6/26 3pm

**Witness :**  
Signature : Rahul  
Name : Rahul  
Date & Time : 03/06/26 3pm

**Doctor (who is taking the consent) :**  
Signature : MA  
Name : Dr. Aneeth  
Date & Time : 3/6/26 3pm

# CONSENT FOR SPECIAL SEDATION

Patient Name: mohammed hassan Gender:  Male  Female

UHID No: BH-00656366 Department: PICU Date: .....

I Azan mohammed hassan S/D/W/O mohammed hassan

Here by give consent for procedure for my patient : Lumbar puncture

The doctors have explained to me in language known to me the details of sedation as follows:

- Type of Sedation : IV ketamine
- Possible complications from the procedure of sedation:  
hypotension, bradycardia

The doctors have explained to me about the benefits, risk, alternative of the procedure.

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

**Patient Attendant :**

Signature : Mohammed

Name : .....

Relationship with Patient: father

Date & Time : 21.01.26

3pm

**Witness :**

Signature : Rahul

Name : Rahul

Date & Time : 03.01.26

3pm

**Doctor (who is taking the consent) :**

Signature : Dr. Nathan

Name : Dr. Nathan

Date & Time : 26/1/26 3pm

## ప్రత్యేక మత్తు కోసం సమ్మతి

రోగి పేరు : ..... వయస్సు ..... లింగం పు స్త్రీ

యు.హెచ్.ఐ.డి. .... విభాగము .....

తేదీ .....

నేను ..... కుమారుడు / కుమార్తె / భార్య .....

..... అను విధానంకై పూర్తి అంగీకారం తెలుపుతున్నాను.

వైద్యులు నాకు తెలిసిన భాషలో మత్తుమందు వివరాలను ఈ క్రింది విధంగా వివరించారు:

● సెడేషన్ రకం .....

● మత్తు ప్రక్రియ నుండి తలెత్తు సమస్యలు:

.....

.....

ప్రక్రియ యొక్క ప్రయోజనాలు, ప్రమాదం, ప్రత్యామ్నాయం గురించి వైద్యులు నాకు వివరించారు.

నేను పైన పేర్కొన్న విషయాన్ని నాకు తెలిసిన భాషలో అర్థం చేసుకున్నాను మరియు మత్తుమందు ఇవ్వడానికి సమ్మతిని ఇచ్చాను.

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము .....

సంతకము .....

పేరు .....

పేరు .....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

తేదీ మరియు సమయము .....

సంతకము .....

పేరు .....

Mohammed hassan

Patient Sticker

KAM-00652366

### Moderate Sedation Flow-Sheet

#### Immediate Pre-Sedation Assessment

B.P	PR	R.R	Temp	SPO <sub>2</sub>	Pain Score	Weight
96/70	100	20	98	98.4		20kg.

Diagnosis: Autoimmune encephalitis

Procedure: Lymphostructure

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 M V

IV Site: Gauge:

Sedation Plan: ketamine

Allergies:

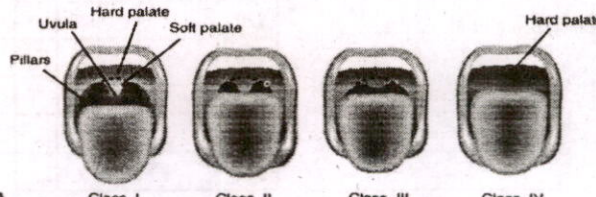
**AIRWAY EVALUATION**

**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<sub>2</sub> 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 <sub>2</sub> Sat%	O <sub>2</sub> Supplementation	Comments / Initials
Baseline						
3:15pm	96/70	100	20	98	RA	
3:30pm	100/70	110	24	98	RA	
3:45pm	100/60	100	26	98	RA	

DRUG & IV Fluid: (including Nitrous Oxide)	ROUTE	DOSE	TIME GIVEN	SUBSEQUENT DOSES AND TIME
7mg ketamine	IV	10mg	3:15pm	
7mg ketamine	IV	10mg	3:30pm	

Doctor Notes: ..... procedure uneventful .....  
 .....  
 .....

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

Doctor Name: ..... Dr Nathan ..... Signature: ..... [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 <sub>2</sub> > 92% on room air = 2	BP +/- 20 mm hg of pre-op = 2
Two extremities = 1	Arousal on calling = 1	Dyspnea, limited breathing = 1	Needs oxygen to maintain Sat O <sub>2</sub> > 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

10/6

# CONSENT FOR BLOOD TRANSFUSION



BAH-00658366 IP5-00174596  
 Master AZAM MOHAMED HASSAN  
 26-10-2020 5 Y 7 M 7 D (M)  
 Dr. ABHISHEK RAVINDRA JAIN



Name: ..... Age: ..... Gender: Male  Female

UHD.No: ..... Date: .....

- Type of Blood Product:**
- Fresh Frozen Plasma
  - Packed Red Blood Cells
  - Random Donor Platelets
  - Cryoprecipitate
  - Single Donor Platelet
  - Whole Blood
  - Albumin
  - Red Blood Cell
  - Others ..... P.V. / G.

I ..... hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immuno-deficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in the "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that .....

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

**Consent (Or Patient Relative / Guardian):**  
 Signature: Mohamed  
 Name: MOHAMED HASSAN  
 Date & Time: 2/6/26 @ 6p

**Doctor (Who is talking the consent)**  
 Signature: [Signature]  
 Name: Soumya  
 Date & Time: 2/6/26 @ 5:30pm

**Witness**  
 Signature: [Signature]  
 Name: [Signature]  
 Date & Time: 2/6/26 @ 6p

**రక్త మార్పిడి కొరకు అంగీకార పత్రము**

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

- రక్త ఉత్పత్తి రకాలు:**
- |   |   |  |
|---|---|--|
| <input type="checkbox"/> తాజా ఘనీభవించిన ప్లాస్మా | <input type="checkbox"/> ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు | <input checked="" type="checkbox"/> Random Donor Platelets |
| <input type="checkbox"/> క్రయోప్రెసిపిటేట్        | <input type="checkbox"/> ఒకే ధాత ప్లేటిలెట్స్           | <input type="checkbox"/> Whole Blood                       |
| <input type="checkbox"/> మొత్తం రక్తం             | <input type="checkbox"/> ఎర్ర రక్త కణం                  | <input type="checkbox"/> ఇతరులు.....                       |

నేను ..... ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడీస్, హైపటెటిస్ బి సర్ఫేస్ యాంటిజెన్, హైపటెటిస్ యాంటిబడీస్, మలేలియా మరియు సిఫిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణయ కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలెత్తవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు .....

పైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి చికిత్స చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. చికిత్స చేస్తున్న సమయంలో అన్ని రకముల రక్తమార్పిడులకు (మొత్తం రక్తం / లేదా రక్త ఉత్పత్తులు ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ప్లెష్ ఫ్రాజెన్ ప్లాస్మా, క్రయోప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెండెంట్)	సాక్షి
సంతకము .....	సంతకం .....
పేరు .....	పేరు .....
తేదీ మరియు సమయము .....	తేదీ మరియు సమయము .....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)  
సంతకము .....  
పేరు .....



## BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 2/06/26 Time: 6pm

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

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

Date & Time of Starting Transfusion: ..... Planned duration of Transfusion: .....

Check for Correct Unit:  Correct Patient:

Blood products cross checked by: Nurse 1: Priyanka Nurse 2: Ankitha

Before starting transfusion vitals: Temp: 98.5°f HR: 112/bn RR: 26/bn BP: 96/70 SpO<sub>2</sub>: 98%

**PLEASE MONITOR THE FOLLOWING:**

Date	Time	HR	Temperature	Blood Pressure	SpO <sub>2</sub>	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
<u>2/06/26</u>	<u>15 Min</u>	<u>112</u>	<u>98.5°f</u>	<u>109/60</u>	<u>97%</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	<u>15 Min</u>	<u>112</u>	<u>97.0°f</u>	<u>96/70</u>	<u>98%</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	<u>30 Min</u>	<u>115</u>	<u>99.0°f</u>	<u>102/50</u>	<u>99%</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	<u>30 Min</u>	<u>105</u>	<u>97.5°f</u>	<u>110/60</u>	<u>96%</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	<u>30 Min</u>	<u>106</u>	<u>98.0°f</u>	<u>96/60</u>	<u>98%</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	<u>1 Hr</u>	<u>110</u>	<u>98.5°f</u>	<u>110/70</u>	<u>99%</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	<u>1 Hr</u>								

Comments: .....

Name of the Incharge-Nurse: Neeraja Pulakrishna

Name of the Nurse: Ankitha

Signature of the Incharge-Nurse: [Signature]

Signature of the Nurse: [Signature]

Date & Time: 2/6/26 @ 6p

Date & Time: 2/6/26 @ 6p

BAH-00656366 IP5-00174596  
Master AZAM MOHAMED HASSAN  
26-10-2020 5 Y 7 M 6 D (M)  
Dr. ABHISHEK RAVINDRA JAIN



# OD TRANSFUSION



Name: Azam Mohamed Hassan Age: 5y 7m Gender: Male  Female

UHID.No : ..... Date: 1/6/26

- Type of Blood Product:**
- Fresh Frozen Plasma
  - Packed Red Blood Cells
  - Random Donor Platelets
  - Cryoprecipitate
  - Single Donor Platelet
  - Whole Blood
  - Albumin
  - Red Blood Cell
  - Others IVIA

I ..... hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immunodeficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in the "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that .....

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

<b>Patient (Or Patient Relative / Guardian):</b>	<b>Doctor (Who is talking the consent)</b>
Signature: <u>Mohamed</u>	Signature: <u>Ranya</u>
Name: <u>Mohamed Hassan</u>	Name: <u>Dr. Ranya</u>
Date & Time: <u>01/06/2026</u>	Date & Time: <u>1/6/26; 11:30 AM</u>

**Witness**

Signature: [Signature]

Name: Subin

Date & Time: 1/6/26 @ 12 PM



104

# NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 2/6/26 Time: 9 AM

Weight: 19 kgs Centile: 25th

Height: 113 cm Centile: 50th

Inference: well child

RDA: - Calories: 1400 kcal/d Protein: 24 g/d

Diet Recommendations: soft diet

Re-Assessment: Avoid spicy & chilled & outside foods.

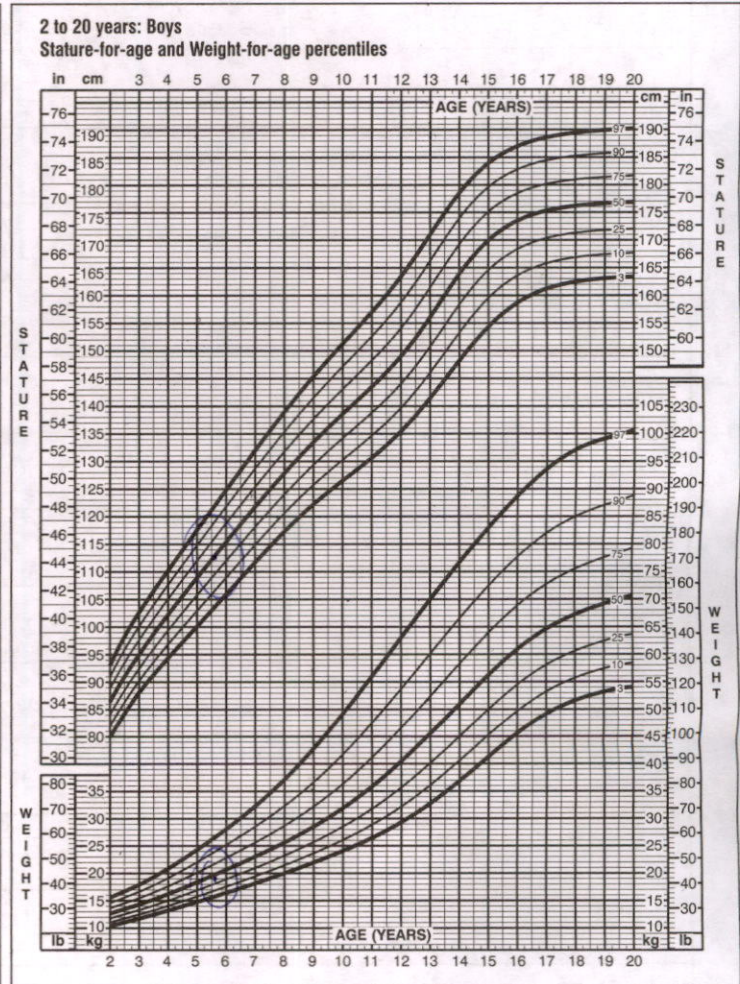
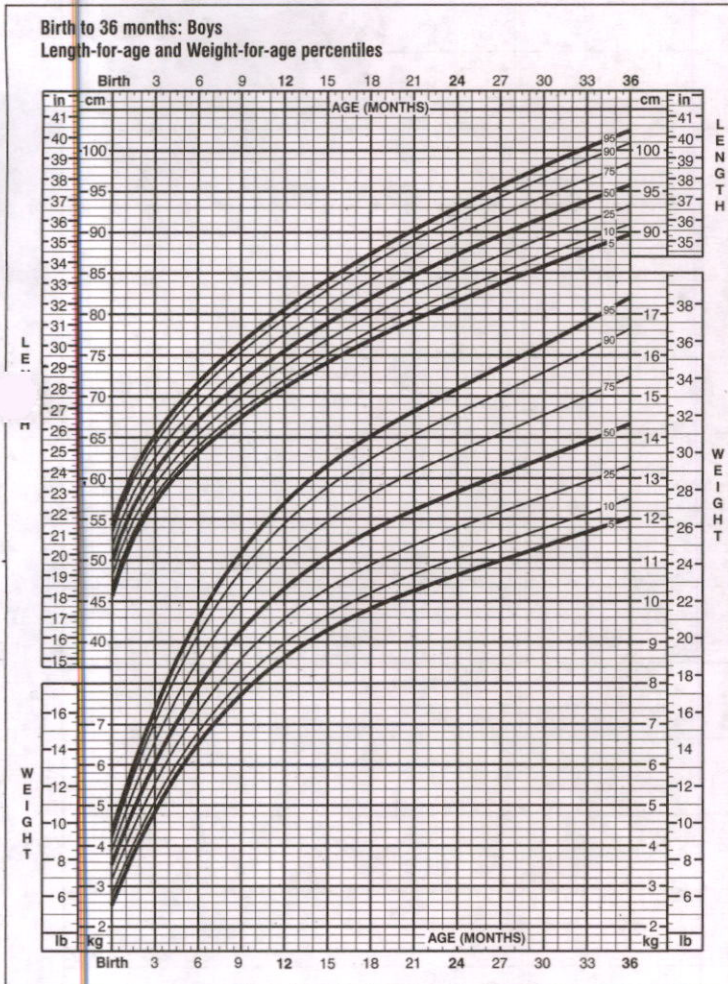
Food Allergies: No Veg/Non-veg: Non-veg

Diagnosis: Generalized onset seizures. Autoimmune Encephalitis.

Nutritional Intervention -  Oral  Enteral  Parenteral

Patient's Signature: Mohammed

## GROWTH CHART (BOYS)



Dietician's Name: Mounica

Dietician's Signature: Mounica

Daily Notes:

3/6/26  
11am

child is stable. oral intake is Fair.

continue  $\bar{E}$  soft diet - Monica

4/6/26  
10:50am

child is stable. oral intake is Better

continue  $\bar{E}$  soft diet - Monica.