MBD-00037196 IP5-00175962
Ms LOR MEASSOMONEY
09-07-2007 18 Y 11 M 25 D (F)
Dr. SIRISHA RANI

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BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 4/7/26 Time: 1:00 pm

Blood Group of the Patient: B+ Blood Group on the Blood Bag: B+

Blood Bank Issue No: ~~20/6/26~~ NTRH26-07146 Date of Collection: 29/6/26 Date of Expiry: 03/8/26

Date & Time of Starting Transfusion: 04/20/26 1:00 pm Planned duration of Transfusion: 8hrs.

Check for Correct Unit: ☑ Correct Patient: ☑

Blood products cross checked by: Nurse 1: Anneb Nurse 2: Nr Clinton

Before starting transfusion vitals: Temp: 98.1F HR 73b/m RR: 19b/m BP: 104/57 (70) SpO_2 95% RA

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO_2	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
04/7/26	15 Min 1:15 pm	70b/m	98.1F	110/51 (71)	96%	—	—	—	—
"	15 Min 1:30 pm	68b/m	97.9F	111/52 (72)	97%	—	—	—	—
"	30 Min 2 pm	69	98.F	102/52 (72)	96%	—	—	—	—
"	30 Min 2:30 pm	67	98.2F	112/53 (73)	97%	—	—	—	—
"	30 Min 3:00 pm	70	98.2F	102/60 (72)	98%	—	—	—	—
"	1 Hr 4:00 pm	69	98.2F	109/62 (73)	97%	—	—	—	—
"	1 Hr 5:00 pm	72	98.4F	111/61 (74)	98%	—	—	—	—
"	6:00 pm	70 pm	98.2F	102/63 (73)	98%	—	—	—	—
"	8:00 pm								

Comments: N.I.L

Name of the Incharge-Nurse: Israel Name of the Nurse: Ramya

Signature of the Incharge-Nurse: Israel Signature of the Nurse: Ramya

Date & Time: 4/7/26 @ 7 pm Date & Time: 4/7/26 @ 2.30 pm

Docu. No. : RCHBH /FRM / CLINICAL / 078

CONSENT FOR BLOOD TRANSFUSION

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Name: Mr. Lor Meessomoney Age: 18yr Gender: Male ☐ Female ☐

UHID.No : MBD - 00037196 Date: 4/7/26

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 .....

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.

Patient (Or Patient Relative / Guardian):

Signature: .....

Name: Ros Srey Duong

Date & Time 04/07/26 @ 12:40pm.

Doctor (Who is talking the consent)

Signature: .....

Name: Dr. Ramya

Date & Time 4/7/26 ; 10 am.

Witness

Signature: .....

Name: Annes

Date & Time 4/7/26 1 pm

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 : IP5-00175962 **Admit Date** : 04-Jul-2026 **Admit Time** : 10:06 AM **UHID** : MBD-00037196

Patient Details :

Patient Name	: Ms LOR MEASSOMONEY	**Age**	: 18 Y 11 M 25 D
Guardian	: Mr LORSAMATH	**DOB**	: 09-07-2007
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: HUAZ RANI ENCLAVE ROAD 269/1 MICASA INN Pushpa Vihar Sector I South Delhi Delhi INDIA 110017	**Phone No**	: 9346145050
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : ER 02 **Ward Name** : 1B-EMERGENCY

Room No : ER 02 **Admission Type** : First Visit

Contact Details :

Name : Mr LORSAMATH **Relationship** : Father

Contact Address : HUAZ RANI ENCLAVE ROAD 269/1 MICASA INN Pushpa Vihar Sector I South Delhi Delhi INDIA 110017 **Phone No** : 9346145050

Signature

Doctor Details :

Doctor Name : Dr. SIRISHA RANI **Specialisation** : HEMATO ONCOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : SELFPAY

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Ms Lor Meassomoney Age : 18y 11M. **Gender:** ☐ Male ☑ Female

Date : 4/7/26 Time of Arrival : 9:50 AM Triage Completion Time : 9:52 AM

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

Source of Information : ☑ Parents ☐ Others (Specify) .....

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: 98.2°F PR: 116/m BP: 113/55 (69) RR: 20b/m SpO$_2$: 97% RA

Chief Complaints: Came for PRBC Transfusion

Triage Classification	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 Submer Signature of Triage Nurse : .....

Date & Time : 4/7/26 at 9:52 AM

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 01/07/26 Time of arrival : 9:59Am.

Chief Complaints: came for PRBC Transfusion. RBS: .....

Height : 159cms. Weight : 47.4kg BMI : ..... Head Circumference (<2 years) Nil

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

If yes , identify Nil

Pain Screening: ☐ Yes ☑ No If Yes, Pain Score: 0|10 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: Nil (Date/Time): Nil

Social History: Lives With parents.

Siblings in household ☑ Yes ☐ No (if yes How Many?) (1) Sister

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

Time of Initial assessment completed by ER Nurse : 9:55Am

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

Time	Nursing Notes
12pm	→ Dr. Seen tupt and assit tupt.
	→ vitals are Recorded.
	→ IV placement done
	→ pre medication given.

Samples collected by: Nr. Keerthana Time: 10Am

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: 98bl/m BP: 113/60 CFT: <2sec	Shift - out from ER to: ER
RR: 22bl/m SPO_2 : 100%	Time of Shift - out: (DC)
GCS: 15/15 Temperature : 98°F	Handover given to:
Pain Score: 0/10	(Nurse's Name)
Repeat RBS (if applicable): Nil	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV placement DONE

Name of the Nurse : Keerthi Signature of the Nurse :

Date & Time : 04/07/26 @ 12:30pm

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ IP N MBD-00037196 IP5-00175962
Ms LOR MEASSOMONEY
09-07-2007 18 Y 11 M 25 D (F)
Dr. SIRISHA RANI
t: _____ Dept : _____

Date of Admission: _____ scharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
4/7/26	-	ER	ER (OC)	Amrit

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
4/7/26	Cardiac monitor	12:40pm.		7310	Thoran
	Infusion pump				

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
4/7/22	IV placement	①	7077	
	Blood transfusion	①	7311	

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Sirisha Rani Date : 4/7/26

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

Start Time of Assessment: 10:15 am Weight: 97.4 kg

Allergic History: .....

Chief Complaints:
K/C/O HBE β thelassemia/
Transfusion dependent
↓
Now came for PRBC transfusion.

Pediatric Assessment Triangle

A Appearance - TICLS .....

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 ☐

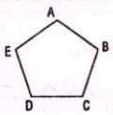
Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Significant Past History: .....

Medication History: .....

Relevant Investigations: .....

Primary Assessment



Airway

- ☐ Open
- ☐ Maintainable
- ☐ Not Maintainable

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

Breathing

Rate: 20/min SpO_2 on FiO_2 100% on RA
Rhythm: Regular
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: B/L AE (+)
Palpation Findings (If necessary).....

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

Circulation

HR: 87/min

CFT: Central ..... Peripheral .....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

BP: 113/55 (69) mmHg

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

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

Muffled Heart Sound: ☐ Yes ☑ No

Engorged Neck Veins: ☐ Yes ☑ No

Murmurs: ☐ Yes ☑ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☑ No

Disability

GCS: 15/15 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.: 98.2°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:

Cross matching

CBP done on OPD basis

Treatment Planned:

• PRBC transfusion - 2 units.

i/v premedication & lasix

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

Final Diagnosis with possible Differential Diagnosis (If necessary): Came for Blood transfusion

Assessment done by

Name of the Doctor: Dr. Ramya

Signature: .....

Date & Time: 4/7/26; 10:15am

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: .....

Signature: .....

Date & Time: .....

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DRUG CHART

Date of Admission: 4/7/20 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:				

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REGULAR PRESCRIPTIONS

Weight. 47.4kg Ward. ....

DRUG :				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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Weight. 47.4kg Ward. .....

DRUG :	Date▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
		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
4/7/26	12:35 pm	Inj AVIL	1ml	IV		Annu Kaur
4/7/26	12:39 pm	Inj HYDROCORTISONE	100mg	IV		Annu Kaur
4/7/26	1:00 pm	PRBC transfusion	2units over 6hrs (3hrs each unit)	IV		Annu Kaur
4/7/26						
4/7/26	4:30 pm	Inj LASIX (midway)	25mg	IV		Ramu Abhishek.
4/7/26		Inj LASIX (endway)	25mg	IV		

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I.V. FLUIDS CHART

Weight. 47.4kg 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

Signature .....

VERIFIED BY : Name .....

Patient Stic

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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: ER

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	Tab Hydroxyurea	1 tab	PO	BD	3/7/26	☑ C ☐ DC
2	Tab Shelcal (500mg)	1 tab	PO	OD		☑ C ☐ DC
3	Tab Folvite 5mg	1 tab	PO	OD		☑ C ☐ DC
4	Tab Udiliv	1 tab	PO	BD		☑ C ☐ DC
5	Tab Defirast	1 tab	PO	BD		☑ 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 : Dr. Ramya

Date & Time : 4/7/26 ; 10:20am

Nurse Name & Signature: Anneb

Date & Time : 4/7/26 1 Pm

Patient

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
		PRBC	Mouth	I.V	N.G							
4/18	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm	PRBC	-	100ml	-	-	-	-			0	
Total Intake :						**Total Output :**						
	02:00 pm	PRBC	-	100ml	-	-	-	-	-	-	0	
	03:00 pm	PRBC	-	100ml	-	-	-	-	-	-	0	
	04:00 pm	PRBC	-	100ml	-	-	-	-	-	✓	0	
	05:00 pm	PRBC	-	100ml	-	-	-	-	-	-	0	
	06:00 pm	PRBC	-	100ml	-	-	-	-	-	✓	0	
	07:00 pm	PRBC	-	100ml	-	-	-	-	-	-	0	
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

Patient Sticker

FLUID CHART

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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.

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

Total 24 hrs. Intake		**Total 24 hrs. Output**	

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Ms LOR MEASSOMONEY
09-07-2007 18 Y 11 M 25 D (F)
Dr. SIRISHA RANI

Patier

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1	1				
Gender	Male	2					
	Female	1	1				
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1				
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1				
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1				
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1				
	TOTAL		08				

Intervention : -Fall Risk : Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

Bed in low position		YES				
Call device within reach		YES				
Wheels Locked		YES				
Room free of clutter		YES				
Adequate Lighting		YES				
Wheel Chair Support		NO				
Other Intervention(s) Specify		NO				
Nurse's Name :		Anu				
Signature :						
Date :		7/12				
Time :		10:17				

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Patient

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sirisha Rani Department: Oncology Date of Admission: 4/7/20

SITUATION	Diagnosis: Thalesemia	Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time	FR / 1pm					
	Medical Condition (Any special condition to be noted):	No					
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.2F					
	Res:	20b/pm					
	SpO_2:	97%					
	Pulse:	87bpm					
	BP:	113/58					
	Fall Risk Score:	08					
	Pain Score:	0/0					
Recommendations	Safety Needs:	Yes					
	Physiotherapy	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	No					
	Special Diet:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	No					
	Post Operative Procedure Special Orders:	No					
	Handed Over By Name :	Anil					
	Signature :	[signature]					
	Date:	4/7/26					
	Time:	1pm					
	Taken Over By Name :	Ramy					
	Signature :	[signature]					
	Date:	4/7					
	Time:	2.40 pm					

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

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09-07-2007 16 Y 11 M 25 D (F)
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BRADEN 'Q' SCALE

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				Date :	GM			
				Time :				
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4			
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4			
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4			
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4			✓
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4			
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4			
				TOTAL SCORE	28			
				Evaluator's Name	[illegible]			

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Risk Score	Category	Action	Support Surfaces **(Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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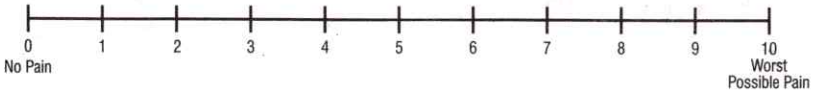
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
9/7/26	10:20	0/0	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NO / NO	Anuel
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

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MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis: Hemophilia A

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
4/7	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Hemophilia	Hypaemic	PRBC		☐ Nursing ☐ Others:
4/7/10	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	T Haemarthrosis	Hemodynamic stability	PRBC transfusion		☐ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I.

Patient's / Learner Language: English Patient / Learner Literacy: ☒ Read ☐ Write ☒ Speak Willingness to Learn: ☐ Yes ☒ No Healthcare Literacy: ☐ Yes ☐ No

Identified Education Needs:

1. Diagnosis
2. Treatment and Care Plan
3. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights
13. Risk / Safety
14. Activity / Exercise
15. Social & Rehabilitation Needs
16. Special Discharge / Follow-up Education / Coping Skills
17. Others .....

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
4/2/25	10:10 Am	10	Fall Risk Education	Mother	1	All	1	1	No	

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C Caregiver O: Other (Specify) .....

Learning Barriers:

1. No Learning Barriers
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify .....

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:

1. None
2. Obtain translator
3. Reassurance & Support
4. Teach Family / Others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify .....

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

Rainbow Children's Hospital - Banjara Hills

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BirthRight by Rainbow

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TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

MBD-00037196 IP5-00175962
Ms LOR MEASSOMONEY
09-07-2007 18 Y 11 M 25 D (F)
Dr. SIRISHA RANI

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Ms LOR MEASSOMONEY**	**Age :**	**18 Y 11 M 25 D**
IP No:	**IP5-00175962**	**Sex:**	**Female**
Consultant:	**Dr. SIRISHA RANI**	**Ward/Bed No:**	**1F-HEMATO-ONCOLOGY/HO DC 3**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.....)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name:
Relationship: Mother
Date: 4/7/26 Time: 10:08
Witness Name:
Witness Signature:

Patient Address:
HUAZ RANI ENCLAVE ROAD 269/1
MICASA INN Pushpa Vihar Sector I
South Delhi Delhi INDIA 110017