

1

**ACTIVITY RECORD FOR BILLING**

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

UHID No. : \_\_\_\_\_ IP No. : \_\_\_\_\_ Dept : \_\_\_\_\_

KUH-00211197 IP5-00174025  
Master YADLA DEVASHISH  
16-05-2023 3 Y 0 M 3 D (M)  
Dr. NALLA ANURAG REDDY

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



Room / Bed No : \_\_\_\_\_ Ward : \_\_\_\_\_ le bed type : \_\_\_\_\_

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
16/5/26	2:35 pm	TR	148-A	[Signature]
22/5	7:20 pm	OT	132	[Signature]

**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
19/5	IV placement	①	50908	[Signature]
19/5/26	conscious sedation	①	9616147	[Signature]
21/5/26	Blood transfusion (PRB)	①	9619742	[Signature]
24/5/26	I.V. Placement	①	9624626	soomya
27/5	Lumbar puncture. conscious sedation	3 ①	9630493	[Signature]
28/5	Chemotherapy	①	9632590	[Signature]

**ANY OTHER INFORMATION**

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Date: 29/5/26

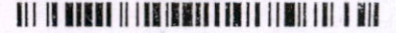
Time: 10AM

Prepared By: Keenings

Staff Nurse [Signature]	Shift / Ward Oncology	Billing Assistant	Billing Supervisor
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ADMISSION SHEET

Registration Details :



Admission No : IP5-00174025 Admit Date : 19-May-2026 Admit Time : 02:02 PM UHID : KUH-00211197

Patient Details :

Patient Name : Master YADLA DEVASHISH Age : 3 Y 0 M 3 D  
Guardian : Mr YADLA RAMANAMURTY DOB : 16-05-2023  
Gender : Male Religion :  
Occupation : Martial Status : Single  
Address (H) : FLAT NO 202, H NO 78, SRI SAI NILAYAM Phone No : 9491876210/ 7288048218  
Ramachandra puram Sangareddy Telangana E-mail : NOMAIL@GMAIL.COM  
INDIA 502032

Admission Details :

Bed Type : SHARED WARD Bed No : SW148(A) Ward Name : 1F-VIBGYOR  
Room No : SW148(A) Admission Type : First Visit

Contact Details :

Name : Mr YADLA RAMANAMURTY Relationship : Father  
Contact Address : FLAT NO 202, H NO 78, SRI SAI NILAYAM Phone No : 9491876210  
Ramachandra puram Sangareddy Telangana  
INDIA 502032

Signature

Doctor Details :

Doctor Name : Dr. NALLA ANURAAG REDDY Specialisation : HEMATO ONCOLOGY  
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

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

JH-00211197 IP5-00174025

Master YADLA DEVASHISH

5-05-2023 3 Y 0 M 13 D (M)

r. NALLA ANURAAG REDDY

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



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

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

### Pediatric Multiorgan History & Physical Examination

Name : Devanshi Age/Sex 3y/m  
Information given by: parents Relationship Grand

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

no fever x 1 month

#### History of present illness :

fever x 1 month - high grade, no chills/rigors.

No joint pains x 5 days

generalized weakness x 5 days

oral intake ↓

Wt. (A)



### Pediatric Multiorgan History & Physical Examination

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

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No Similar illness in the past

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**Birth & Neonatal History:**

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Term / NEM,

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**Birth & Socio Economic History:**

About Father : \_\_\_\_\_

About Mother : \_\_\_\_\_

Any additional Information : \_\_\_\_\_

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**Developmental History :**

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(N) for Age

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**Immunization History :**

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(N) for Age

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### Pediatric Multiorgan History & Physical Examination

**Anthropometry :**

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

Weight (kgs) ) 13.2kg (Centile \_\_\_\_\_)

**On Examination :**

Temperature : N Pulse Rate : \_\_\_\_\_ B.P. \_\_\_\_\_ SPO2 \_\_\_\_\_

Resp.rate and type of breathing : 20/min.

Rash \_\_\_\_\_

Lymphadenopathy +

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

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

**Respiratory System :**

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

Air entry & breath sounds : BL NVB ⊕

Any addes sounds : no added sounds

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

**Cardiovascular System :**

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

Heart Sounds : S<sub>1</sub>, S<sub>2</sub> ⊕

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

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

**Per Abdomen :**

Inspection \_\_\_\_\_

Palpation : soft ) HSM ⊕

Ausculation : \_\_\_\_\_

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

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



### Pediatric Multiorgan History & Physical Examination

#### Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15/15

Cranial Nerves : (2)

#### Motor System:

Nutrition : \_\_\_\_\_  
Tone: \_\_\_\_\_ Power \_\_\_\_\_  
Co-ordinator : (2)  
Posture : \_\_\_\_\_  
Involuntary Movements : \_\_\_\_\_

#### Reflexes :

#### DTR

#### Superficials:

Plantars \_\_\_\_\_

#### Sensory System :

\_\_\_\_\_

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

#### Clinical Summary & Diagnostic:

do / Suspected meningitis  
for further workup

### Pediatric Multiorgan History & Physical Examination

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

prevent sepsis

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

treat the child

**Planned Labs:**

CRP, LDH, S.E,  
done in OPD  
trans

**Planned Management**

- IVF DNS  
- NPO  
- BMA

Signature of the Doctor: Milind

Name of the Doctor: Dr. Milind

Date & Time: 29/5/26, 12pm

Signature of the Consultant: Dr. Anuraag

Name of the Consultant: Dr. Anuraag Reddy

Date & Time: ~~29/5/26, 12pm~~  
19/5/26, 4pm



## PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Anurag reddy Date : 19/5/26

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

Start Time of Assessment: ..... Weight: 13.2 kg

Allergic History: .....

**Chief Complaints:**  
Chl. fever since 1 month on/off  
- Persistent fever since last  
5 days  
High grade, Centmax. in natm  
- Joint pain x 5 days  
- Generalized weakness since  
5 days

**Pediatric Assessment Triangle**

A Appearance - TICLS .....

B Breathing

C Circulation

Normal  
 Abnormal

Pallor   
 Cyanosis   
 Mottling   
 Bleeding

↑ WOB  
 ↓ WOB  
 Normal  
 Gasping / Apnea

Initial Physiological Status:  Stable  Unstable  
 Life Threatening   
 Non Life Threatening

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

Significant Past History: Similar illness since 1 month

Medication History: IV antibiotics

Relevant Investigations: .....

**Primary Assessment**


**Airway**  Open  
 Maintainable  
 Not Maintainable


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


**Breathing**

Rate: 26/min SpO<sub>2</sub> on FiO<sub>2</sub> 99% on RA  
 Rhythm: regular  
 Retractions:  Suprasternal  ICR  SCR  
 Sternal  Supraclavicular  Nasal Flaring  
 Respiratory Noises:  Stridor  Wheezing  Grunting  
 Air Entry: BAL  
 Palpation Findings (If necessary).....

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

**Circulation**  HR: 110/min CFT  Central  Peripheral *23 sec* Any urgent interventions needed:  Yes  No  
 BP: 94/52/59 mmHg Murmurs:  Yes  No If Yes° .....  
 Pulse Volume:  Central  Peripheral *Good* Liver Span: .....  
 If in Shock:  Compensated ..... ECG: .....  
 Hypotensive ..... Any Signs of Heart Failure:  Yes  No  
 Muffled Heart Sound:  Yes  No Engorged Neck Veins:  Yes  No

**Disability**  GCS: 15/15 AVPU: ..... Any urgent interventions needed:  Yes  No  
 Pupils:  Responsive  Non-Responsive  If Yes° .....  
 Size  Right .....  
 Left .....  
 Active Seizures:  Yes  No Sugars: .....  
 Signs of Neurological compromise .....  
 .....

**Exposure**  Temp.: 98.1° F Any urgent interventions needed:  Yes  No  
 Any Rash:  Yes  No If Yes° .....  
 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:** CBC, WBC, S. Electrolyte → outside  
 Chest X-ray }  
 U/G Abdomen } opo basis  
 DCT

**Treatment Planned:**  
 1) Inf - PNs @ 10ml/hr  
 2) NPO  
 3) Bone marrow Aspiration & Bone marrow Biopsy

Need for Oxygen:  Yes  No if yes Low Flow  High Flow  PPV   
 Final Diagnosis with possible Differential Diagnosis (If necessary): PNO / ? IRA

Assessment done by  
 Name of the Doctor: Cai  
 Signature: [Signature]  
 Date & Time: 1.9.12.26

Sr. Doctor on Duty (If necessary)  
 Name of the Sr. Doctor: .....  
 Signature: .....  
 Date & Time: .....

KUH-00211197 IP5-00174025  
 Master YADLA DEVASHISH  
 16-05-2023 3 Y 0 M 3 D (M)  
 Dr. NALLA ANURAG REDDY

①



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
19/5 3pm	<p><u>Procedure notes</u>            Under strict aseptic conditions the            meco cleaned, bone marrow aspiration and            biopsy done over posterior iliac spine. Child            tolerated well</p>	<p>- TO send for morphology,            Biopsy</p>
	<p>PLA = LIVER 2cm x 1cm            Spec tip ⊕            CVS R2            Ture ⊕</p>	<p>① IN fluid @ 5am 1hr            ② T: XIN/antibi, Inj LASK            ③ I/O charting obk            ④ monitor vitals</p>
	<p><i>(Signature)</i>            Dr Anurag Reddy            73299 @ 3pm</p>	<p>⑤ PRBC today (T/M) ⊕            (after round)            ⑥ send blood grouping xtyping</p>
		<p>Noted by            V. Ravina            602729            19/5/26 @ 3pm</p>

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/5/26	<u>Morning Rounds</u>	
8am	<u>do Suspected leukemia</u>	
	No fever/vomiting oral intake (N)	
	vitals - stable no tachycardia pallor (+)	plan ①. Collect BM (A) ↳ R/W further plan
		②. Cont IVF, allopurinol, lasix ③. T/m CBP, S/G, uric acid + 1 extra plain
	→ If fever (+), R/W antibiotic → PRBC T/m	20/5 @ 10:30 am noted by K. Brauerath
20/5/26	<u>Evening rounds</u>	
3pm	No fever No bleeding manifestation	plan
	o/e child alert vitals stable wop =	1. Continue IV fluids 2. CBP, uric acid electrolytes, extra plain } T/m
	N.S Severe	3. PRBC transfusion T/m + D/O charting.
		25/5/26 leas

(3)

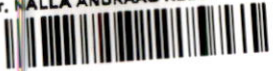
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Acute Leukemia	Thrombocytometry
	ALL	AML
21/8/26 8am	Morning Rounds No Newly diagnosed B-ALL	
	No Complaints Vitals (2) Constitution (2)	Plan 1. Sp. Nephthalac 10ml now stat 2. PRBC today 3. Cont. Gt IVF 4. Shift to Oncology ward
		Noted by Nblh Ramaadhevi @ 21/8/26 @ 8am

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Counselling notes</u>	
10.22 Am	<p>stem</p> <p>stem ——— (LR) ——— 2</p> <p>→ B-Au ———→ 3 1/2 year      ———→ 2 1/2 year ———→ 1 year</p> <p>✓ stage —?      why —?      R ———?</p> <p>Sted Nil &lt;10 year      &lt;50,000 ✓</p> <p>Kaygo FISH, (MSA) ——— high center (pos)</p>	



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	3 1/2 years ————— 6 months	
	3 years maintenance	
	<p>Induction → Condition high dose            MTP</p> <p>↓</p> <p>steroids ——— (daily - 1mg/kg oral) 4-5 weeks</p> <p>VCR, Dexam; Peg asparaginase</p> <p>weekly one</p> <p>↓</p> <p>2 doses - emergency, 1 day</p> <p>x(5)</p> <p>3LP — Int MTP 1st cycle 1st hydrocortisone</p>	
	<p>steroids — hunger, wt gain</p> <p>anger, irritability</p> <p>(BPTT) (Rugars) - temp.</p>	
	VCR - conjunctivitis, jaw pain, leg pain	
	<p>(Dexam) - nausea, vomiting, loose motions, flat abdomen.</p> <p>20 days</p>	
	<p>Peg asparaginase - allergic reaction.</p> <p>parvovirus</p> <p>clots -</p>	
	- hair loss,	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	90-95% ✓	
	5-10% - Relapse	
	5-10% - risk to life	
<del>22/5/26</del> Pam	Morning Rounds <del>clo Newly diagnosed B-AU</del>	
	No fever / vomiting passed stooly thrice y'day oral intake - (2)	(5)
	Uto - good vitals - stable	<sup>plan</sup> ①. Start supportive care ②. Dexta today - 10 AM & 8 PM ③ - 3 PM CBP, SG, ure nit, phosphate 1 p/b in
	Dr. Anuraag Reddy 53495	20 EGTT today
		alofalms call 013735 at 11 AM



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<del>22/5/26</del>	<u>Evening Rounds</u>	
3pm	no specific complaints vitals (N)	plan ①. trace reports ②. 2D Echo today
		Noted by <u>Sumya</u> @ 13:35 at 4pm
<del>23/5/26</del>	<u>Morning rounds</u>	
8am	Newly diagnosed B-DM / on Insulin <u>Alia Ave / FISH - awaiting (L) of Dexa</u>	
	No fever / vomiting oral intake (N)	plan ①. Cont IVF ②. 2D Echo today ③. LP D/T <sub>m</sub> + growing line ④. Dexa full dose from today
	vitals (N)	⑤. during LP - labs T <sub>m</sub> ⑥. Review NGV to send today.
		Noted by <u>Sumya</u>
		⑦. labs on Monday CBP/UB
		⑧. trace karyotype
		Noted by <u>Sumya</u> 23/5/26 @ 11pm.

Dr. Anurag Reddy  
 23/5/26 @ 9:30am  
 Dr. Anurag Reddy





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## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/26		
9 AM	<p>Newly diagnosed B-ALL / CALLS ⊕ /            standard cytogenetics / cns-awarded.            on Induction-day 5 of dexa.</p>	
	<p>No fever            No vomiting</p>	
	<p>Vitals Stable</p>	<p>Plan            1. Continue supportive care            2. Trace labs            3. Lumbar puncture Today            4. 2D Echo Today            5. oral dexa from today evening.</p>
		<p>⊕ Send viral markers serum</p>
		<p>N/B            Kayima            015876            26/5/26 @ 12pm</p>
4 PM	<p>Evening Rounds</p>	
	<p>No complaints            Vitals ⊕</p>	<p>Plan            ⊕ 2D Echo Today            ⊕ trace viral markers ⊕</p>
		<p>N/B            Kayima            015876            26/5/26            4 PM</p>

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/5/26 9am	Newly diagnosed B-ALL / standard cytogenetics	CAUS ⊕ Dexa - Day 6 of Induction
	No fever No vomiting vital - stable	<p>Plan</p> <ol style="list-style-type: none"> <li>1. continue Dexamethasone</li> <li>2. lumbar puncture today</li> <li>3. CBP electrolytes RBS } tomorrow (random blood sugar)</li> <li>4. Prednisolone response to check tomorrow</li> <li>5. Chemotherapy tomorrow.</li> </ol>
27/5/26 9am	<u>Procedure Notes</u>	N/A Karinga 0158-16 27/5/26 9am Callam have
	child was positioned. Parts cleaned and draped. 24g needle inserted and CSF from L4-L5 space. CSF collected for analysis and malignant cells. Needle closed and removed. Hemostasis achieved. Post procedure vitals are stable	N/A

Dr. Anuraag Reddy  
 Dr. Anuraag Reddy

N. K. S.



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/5/26 4pm	<u>Evening rounds</u>	
	No Complaints vitals @	<p>flaw</p> <p>① CR, Hb, RBS - Tm</p> <p>② Tm Chemotherapy</p> <p>N/B Kavina 015946 27/5 @ 5pm</p>
28/05 8AM	<p><u>BALL/CALLA ⊕ / GPR</u></p> <p>FISH standard / CNS-awaited</p> <p>NO Fever</p> <p>activity normal</p> <p>vitals - stable</p> <p>Systemic Examination normal</p> <p>(Lp on 27/5)</p>	<p>Ⓣ of induction</p>
		<p>① Tm Loh</p> <p>② steroid decrease to check today</p> <p>③ Chemotherapy today</p> <p>④ anti-viral</p>
	<p>Dr. Anuraag Reddy        4:29 @ 3:25 AM</p>	<p>N/B Kavina 015946 28/5/26 8 PM</p> <p>(DNA)</p>

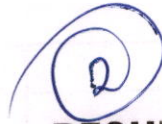


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**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
29/5/26	<u>Morning Rounds</u>	
8.30am	<p>B-ALL (ANA ⊕) / CNS - awaited  <u>Std cytogenetics / Dg of induction</u></p>	
	<p>No fever/vomiting          oral intake ⊕</p>	
	<p>vitals ⊕</p>	<p><u>plan</u></p>
		<p>① discharge today</p>
		<p>② Rx on 3/6/28          ± CBP, Rx. in OP</p>
		<p>Tab-AMLODIPINE (2.5mg)          1/2 ——— OD</p>
	<p>NB          Kachina @ 11 AM</p>	<p>to check  <u>nlha</u></p>
		<p><i>[Signature]</i>          29/5          @ 9:30 AM</p>
		<p>Dr. SANDHYA VADDADI          Reg. No: 71084</p>

KUH-00211197 IP5-00174025  
Master: YADLA DEVASHISH  
16-05-2023 3 Y 0 M 10 D (M)  
Dr. NALLA ANURAAG REDDY



## RESULT SHEET

Date	28/5				
Time	8 AM				
Hb	9.5				
PCV	27.8				
RBC	3.46				
WBC	2.99				
N/L	34/62				
Platelets	122				
CRP					
ESR					
PCT					
RBS	105				
Na	134				
K	4.8				
Cl	101				
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					



KUH-00211197 IP5-00174025  
 Master YADLA DEVASHISH (M)  
 16-05-2023 3 Y 0 M 4 D  
 Dr. NALLA ANURAG REDDY

B  
 1

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

BirthRight™  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

RESULT SHEET

← OP →

~~B One~~ B One

Date	19/5/26	19/5/26	21/5	22/5	24/5	26/5
Time			10AM		4pm	8am
Hb	7	7	5.2	10.7	12.1	9.3
PCV	mw - 76.5	74.4		32.7	35	28.3
RBC	2.95	2.95		4.01	4.4	3.46
WBC	9380	8780	5260	5670	4350	6.49
N/L	7/54	11/72	5/61	15/32	20/75	19/79
Platelets	1.68	1.61	1.17	1.40	1.21	84,000
CRP	82	Blacks - 37%	33%			
ESR						
PCT						
RBS						85
Na	138-138		140	141	139	135
K	4.1		4.1	4.1	5	4.0
Cl	104		102	103	105	105
Ca/Mg						
Phosphate				5.5	5	
Urea						
Creatinine	0.3					
ALP	139					
SGPT	36					
SGOT	28					
T.Bill/Conj	0.5/0.2					
T.Protein	6.8					
S.Albumin	3.8					
S.Globulin	3					
A/G Ratio	1.2					
Uric Acid	5.2	5.2	2.8	2.1		
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells	LDH 365					
N/L		A	A	A		

DCF One

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : .....

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.....

.....

Radiology :    USG : .....

                  X-Ray : .....

                  ECHO : .....

                  CT : .....

                  MRI : .....

                  Others (ECG, Contrast Studies etc.): .....



REGULAR PRESCRIPTIONS

Dept. 13kg Ward Oncology

**DRUG:** SYP SPT RAN

Dose	Route	Frequency	Start Dt.	Date/Time	22/5	23/5	24/5	25/5	26/5	27/5	28/5
<u>5ml</u>	<u>PO</u>	<u>Q12H</u>	<u>22/5</u>	<u>8AM</u>	X	X	X	<u>Stop</u>	X	<u>Stop</u>	X
Name & Signature of the Doctor starting the Drugs: <u>[Signature]</u>											
Additional Instructions: <u>on MON/WED/FRI</u>					<u>8pm</u>	<u>Stop</u>	X	X	<u>Stop</u>	X	<u>Stop</u>
Daily Doctor's Endorsement by a Sign.					<u>M</u>			<u>A</u>		<u>d</u>	

**DRUG:** SYP MOKTEL

Dose	Route	Frequency	Start Dt.	Date/Time	22/5	23/5	24/5	25/5	26/5	27/5	28/5
<u>5ml</u>	<u>PO</u>	<u>OD</u>	<u>22/5</u>	<u>8pm</u>	X	<u>Stop</u>	X	<u>Stop</u>	X	<u>Stop</u>	X
Name & Signature of the Doctor starting the Drugs: <u>BVKSOI</u>											
Additional Instructions: <u>(Every 24th hr)</u>											
Daily Doctor's Endorsement by a Sign.					<u>M</u>	<u>M</u>	<u>M</u>	<u>A</u>	<u>A</u>	<u>A</u>	<u>A</u>

**DRUG:** SYP CALCIMAX PLUS

Dose	Route	Frequency	Start Dt.	Date/Time	22/5	23/5	24/5	25/5	26/5	27/5	28/5
<u>2.5ml</u>	<u>PO</u>	<u>OD</u>	<u>22/5</u>	<u>8pm</u>	X	<u>Stop</u>	X	<u>Stop</u>	X	<u>Stop</u>	X
Name & Signature of the Doctor starting the Drugs: <u>BVKSOI</u>											
Additional Instructions:											
Daily Doctor's Endorsement by a Sign.					<u>M</u>	<u>M</u>	<u>M</u>	<u>A</u>	<u>A</u>	<u>A</u>	<u>A</u>

**DRUG:** 2g DEXAMETHAZONE

Dose	Route	Frequency	Start Dt.	Date/Time	23/5	24/5	25/5	26/5	27/5	28/5
<u>1.5mg</u>	<u>IV</u>	<u>Q12H</u>	<u>23/5</u>	<u>8am</u>	<u>Stop</u>	<u>Stop</u>	<u>Stop</u>	<u>Stop</u>	<u>Stop</u>	<u>Stop</u>
Name & Signature of the Doctor starting the Drugs: <u>[Signature]</u>										
Additional Instructions: <u>8am - 8pm</u>										
Daily Doctor's Endorsement by a Sign.					<u>d</u>	<u>M</u>	<u>V</u>	<u>A</u>		<u>26/5 10AM</u>

VERIFIED

VERIFIED

VERIFIED

VERIFIED



Sheet No: .....

REGULAR PRESCRIPTIONS

Dept. 1369 Ward Amx

VERIFIED  
 Signature  
 VERIFIED  
 Name  
 VERIFIED

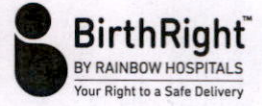
DRUG: TAMLOBIPINE				Date	23/5	24/5	25/5	26/5	27/5	28/5	29/5
				Time							
Dose	Route	Frequency	Start Dt.		X	X	X	X	X	X	Korimara Divide
1/2 tab	PO	BD	23/5								
Name & Signature of the Doctor starting the Drugs:											
Additional Instructions:											
Daily Doctor's Endorsement by a Sign.											

DRUG: Syrup VITAMIN-D				Date	23/5	24/5	25/5	26/5	27/5	28/5
				Time						
Dose	Route	Frequency	Start Dt.		X	X	X	X	X	X
5ml	PO	Q24h	23/5							
Name & Signature of the Doctor starting the Drugs:										
Additional Instructions:										
Daily Doctor's Endorsement by a Sign.										

DRUG: Tab DEXAMETHAZONE				Date	26/5/26	27/5/26	28/5/26
				Time			
Dose	Route	Frequency	Start Dt.		X	X	X
4-3tbl	PO	Q12h	26/5				
Name & Signature of the Doctor starting the Drugs:							
Additional Instructions:							
Daily Doctor's Endorsement by a Sign.							

DRUG :				Date						
				Time						
Dose	Route	Frequency	Start Dt.							
Name & Signature of the Doctor starting the Drugs:										
Additional Instructions:										
Daily Doctor's Endorsement by a Sign.										

KUH-00211197 IP5-00174025  
 Master YADLA DEVASHISH  
 16-05-2023 3 Y 0 M 6 D (M)  
 Dr. NALLA ANURAAG REDDY



### STAT / ONCE ONLY DRUGS

Name: Master DEVASHISH

Weight: 13.9 kgs

Sheet No: 1

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
22/5	10 AM	INS D6x A	1.5 mg IN 100 ML NS OVER 2 HRS	IV	<u>Nikil</u>	<u>10:10 AM</u> <u>Sumita</u>	<u>Nirva</u>
22/5	8 PM	INS D6x A	1.5 mg IN 100 ML NS OVER 2 HRS	IV	<u>Nikil</u>	<u>Sumita</u>	<u>Subhankar</u> 8:5 PM
27/5/26		<u>2 mg MIDAZOLAM</u>	<u>0.5 mg</u>	IV	<u>Nikil</u>	<u>PROT</u>	
27/5/26	9:00 AM	<u>1 mg MIDAZOLAM</u>	<u>1 mg</u>	IV	<u>d</u>	<u>Karima</u>	<u>Divya</u>

**VERIFIED**

KUH-00211197 IP5-00174025  
 Master YADLA DEVASHISH (M)  
 16-06-2023 3 Y 0 M 3 D  
 Dr. NALLA ANURAAG REDDY

①



# DRUG CHART

Date of Admission: 19/5/26 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.
- S** - 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)

IG :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature			Valid Period	Pharm.
Additional Instructions:				

JG :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature			Valid Period	Pharm.
Additional Instructions:				

.G :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature			Valid Period	Pharm.
Additional Instructions:				

VERIFIED BY : Name .....

KUH-00211197  
 Master YADLA DEVASHISH  
 16-05-2023 3 Y O M 3 D  
 Dr. NALLA ANURAAG REDDY (M)

0.59

REGULAR PRESCRIPTIONS

Weight 13kg Ward. Oncology

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 : T. ALLOPURINOL				Date Time
1/2 tab po	TID		19/5	20/5 21/5 22/5 23/5 24/5 25/5
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : INTELASIK				Date Time
5mg IV		BD	19/5	20/5 21/5 22/5 23/5 24/5 25/5
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : LANJOPRAZOLE				Date Time
1 tab po		OD	19/5	20/5 21/5 22/5 23/5 24/5 25/5 26/5 27/5 28/5
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

VERIFIED

VERIFIED

KUH-00211197 IP5-00174025  
 Master YADLA DEVASHISH  
 16-05-2023 3 Y 0 M 3 D (M)  
 Dr. NALLA ANURAG REDDY

Weight. 13 kg Ward. Omno

Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
DRUG :	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.

Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
VARIABLE DOSE	Dose	Dose	Dose	Dose
DRUG :	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.

**STAT / ONCE ONLY DRUGS**

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
19/5/26	3:45 PM	1mg MIDAZOLAM	1mg	IV	A	Sham 3:45 Savite
19/5/26	5:22 PM	2mg ONDANSETRON	2mg	IV	A	Pulak 5:30 PM Savite
19/5/26	5:24 PM	150mg PARACETAMOL	150mg	IV	A	Pulak 5:30 PM Savite
21/5/26	2pm	10ml Dexamethasone	10ml	P/O	Sham	Sham Ravina
21/5	5PM	2; Avil	0.3ml	IV	Sham	Anuradh Rajamani
		2; LARIN	5mg	IV	Sham	Hold
21/5	5PM	250ml over 4 hours PASC	250ml over 4 hours	IV	Sham	Anuradh 5:5 PM Rajamani
21/5	1PM	1.5mg Dexamethasone	1.5mg	IV	Sham	Pulak
		in 10ml NS over 3 hrs				

Signature  
VERIFIED BY: Name

**VERIFIED**

I.V. FLUIDS CHART

Weight. 13.3kg Ward. Quar



ion of I.V. Fluid  
 (ml/hr = Mcg/kg/min. etc)

			Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
19/5	3PM	Ivf. DNS	IV	40ml/hr	sai	shrisishu	20/5	d	Saif Nashu
20/5	8AM	DNS	IV	↓ 50ml/hr	R	shrisishu	20/5	R	Shafiq R
20/5	7PM	RL	IV	130 ml/hr	R	shrisishu	20/5	R	Shafiq Anil

Signature

VERIFIED BY : Name



Weight: 13 kg Ward: Oncology

Patient Sticker

100 100 100  
 i/v METHOTREXATE 12 mg  
 i/v CYTARABINE 30 mg  
 i/v HYDROCORTISONE 100 mg



VERIFIED

DRUG: <u>100</u> <u>100</u> <u>100</u>				Date Time
Dose	Route	Frequency	Start Date	
	IT		27/5	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Anurag</u>				<input checked="" type="checkbox"/> 27/5 <input type="checkbox"/> 31/6 <input type="checkbox"/> 17/6
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				<u>AS</u>

VERIFIED

DRUG: <u>100</u> <u>100</u> <u>100</u>				Date Time
Dose	Route	Frequency	Start Date	
0.8mg	iv	<del>STAT</del>	29/5	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Anurag</u>				<del><input checked="" type="checkbox"/></del> 29/5 <input type="checkbox"/> 4/6 <input type="checkbox"/> 11/6 <input type="checkbox"/> 18/6
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				<u>AS</u>

VERIFIED

DRUG: <u>100</u> <u>100</u> <u>100</u>				Date Time
Dose	Route	Frequency	Start Date	
14mg	iv	<del>STAT</del>	28/5	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Anurag</u>				<del><input checked="" type="checkbox"/></del> 28/5 <input type="checkbox"/> 4/6 <input type="checkbox"/> 11/6 <input type="checkbox"/> 18/6
Additional Instructions: <u>1st 200mg dose over 6 hours</u>				
Daily Doctor's Endorsement by a Sign				<u>AS</u>

VERIFIED

DRUG: <u>100</u> <u>100</u> <u>100</u>				Date Time
Dose	Route	Frequency	Start Date	
950	iv	<del>STAT</del>	28/5	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Anurag</u>				<input checked="" type="checkbox"/> 28/5 <input type="checkbox"/> 11/6
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				<u>AS</u>





KUH-00211197 IP5-00174025  
 Master YADLA DEVASHISH  
 16-05-2023 3 Y 0 M 3 D (M)  
 Dr. NALLA ANURAAG REDDY



## MEDICATION RECONCILIATION FORM

Drug Allergies: .....  Not known any Drug Allergies

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

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

Shifting From: ICU ..... Shifted to: Ward .....

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

Date & Time : 19/5/26 .....

Nurse Name & Signature: [Signature] .....

Date & Time : 19/5/26 2pm .....



## 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: 22/5/24 Time: 9am 1pm 4pm 7pm 10pm 3Am 6Am  
 Doctor / Nurse / Family Concern? \_\_\_\_\_

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

Heart Rate (bpm) and Blood Pressure (mmHg) *	190							
	180							
	170							
	160							
	150							
	140							
	130							
	120							
	110							
	100							
	90							

**Note:** BP does not score in early warning scoring

Heart Rate (Number)	106 bpm	108 bpm	110 bpm	106 bpm	104 bpm	102 bpm	100 bpm
---------------------	---------	---------	---------	---------	---------	---------	---------

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

Resp Distress	Mod/ Severe	None / Mild						
Receiving O <sub>2</sub> (l/min)	O <sub>2</sub> Saturations (%)		100%	100%	100%	100%	100%	100%
Conscious Level	Normal	Altered	C	C	C	C	C	C
GCS *			15/15	15/15	15/15	15/15	15/15	15/15

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

<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
	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:

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- 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

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<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)



10

Doc. No. : RCH/FRM/CLINICAL/125

**PRESCHOOL (1-5 years)**  
**Children's Observation & Early Warning Scoring Chart**

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

**BirthRight**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

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

Date: 24/5..... Time: 9Am | 1pm - 4pm | 7pm | 10pm | 3Am | 6Am

Doctor / Nurse / Family Concern?

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

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

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

Resp Distress	Mod/ Severe None / Mild							
Receiving O <sub>2</sub> (l/min)	O <sub>2</sub> Saturations (%)	100%	100%	100%	100%	100%	100%	100%
Conscious Level	Normal / Altered	C	C	C	C	C	C	C
GCS *		15/15	15/15	15/15	15/15	15/15	15/15	15/15
<b>TOTAL SCORE</b>		6	6	6	6	6	6	6
Number of shaded boxes		0	0	0	0	0	0	0
Pain Score		0	0	0	0	0	0	0
Observer's Initials		SR	SR	SR	SR	SR	SR	SR

<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
	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.
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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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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 : 26/5..... Time: 9am 1pm 4pm 7pm 10pm 3Am 6Am

Doctor / Nurse / Family Concern?

Temperature (F)	104							
	103							
	102							
	101							
	100							
	99							
	98							
	97							
	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)		108b/m	104b/m	110b/m	108b/m	106b/m	102b/m	100b/m

Resp. Rate (bpm) (Over 1 Minute) *	70							
	60							
	50							
	40							
	30							
	20							
	10							
Resp Rate (Number)		26b/m	24b/m	26b/m	28b/m	28b/m	26b/m	26b/m

Resp Distress	Mod/ Severe None / Mild							
Receiving O <sub>2</sub> (l/min)	O <sub>2</sub> Saturations (%)	100%	100%	100%	100%	99%	98%	99%
Conscious Level	Normal Altered	C	C	C	C	C	C	C
GCS *		15/15	15/15	15/15	15/15	15/15	15/15	15/15

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

<b>ACTIONS</b>	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.
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- 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

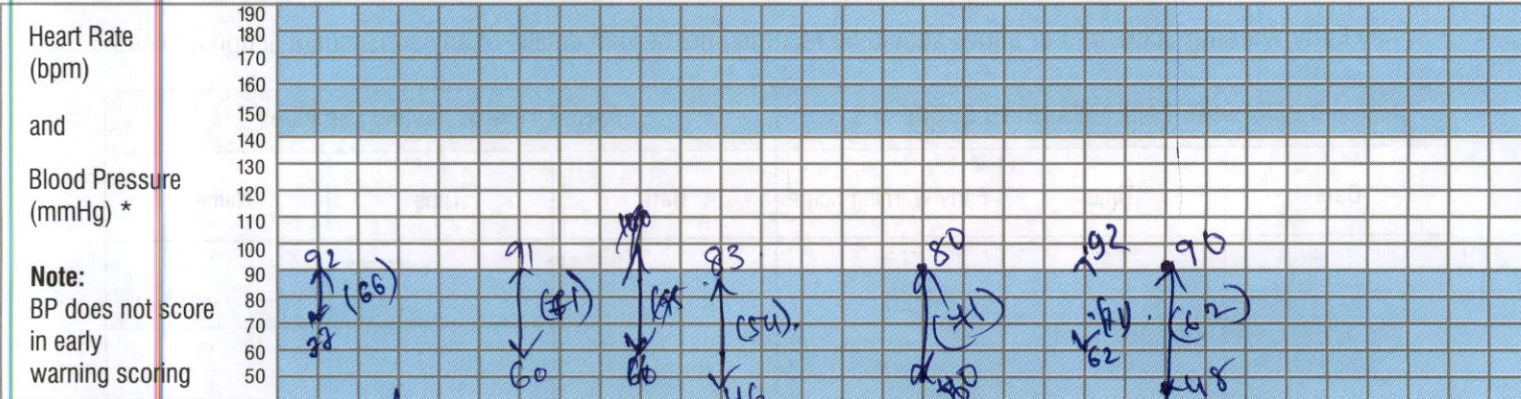
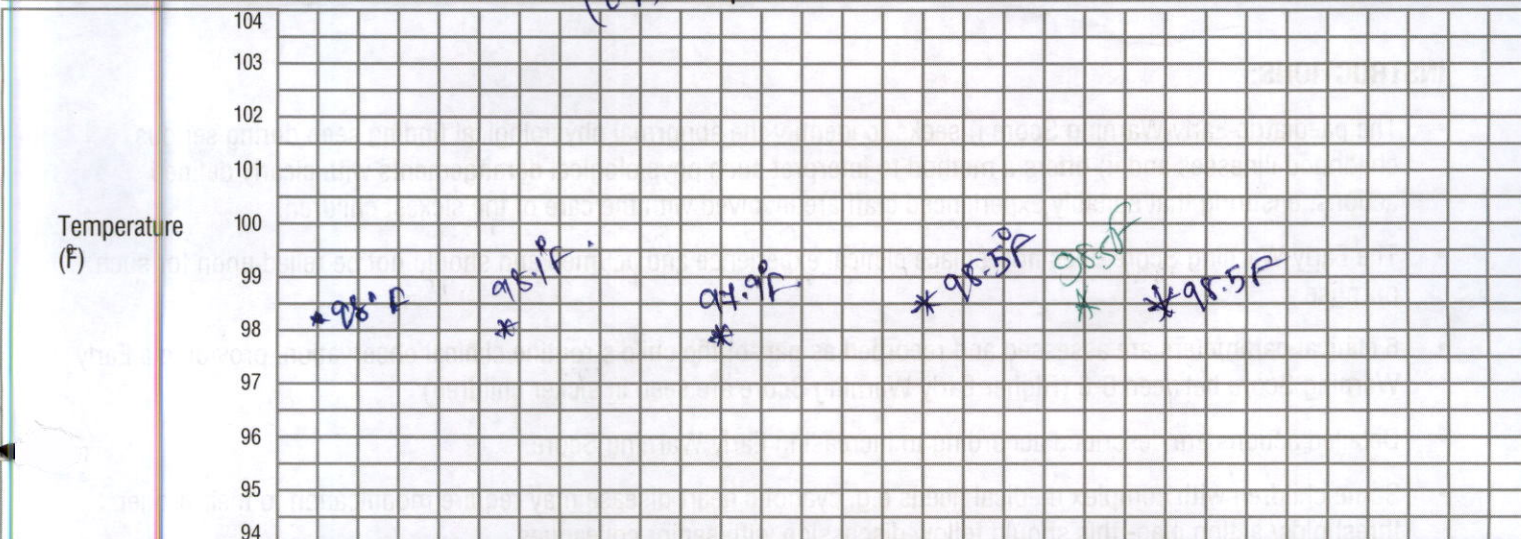
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<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION :</b> I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
<b>B</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 : 28/5 Time: 9AM 1 PM 4 PM 7 PM 10 PM 2 AM 6 AM  
 Doctor / Nurse / Family Concern?



Heart Rate (Number) 22 b/m 80 b/m 80 b/m 98 b/m - 112 b/m 96 b/m



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

Resp Distress Mod/ Severe None / Mild

Receiving O<sub>2</sub> (l/min) O<sub>2</sub> Saturations (%) 99% 100% 100% 98% 100% 99%

Conscious Level Normal Altered c c c c c c

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

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

- 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: Scores 3 should be recorded overleaf  
 \* 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>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: 24.5.23 Time: 10:00 AM 1 4 7 10 PM 3 AM 6 AM

Doctor / Nurse / Family Concern? pm pm pm

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

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

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

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

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

<b>ACTIONS</b>	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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## CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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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 : 22/5 Time: 10 1 3 7 10pm 3AM 6AM

Doctor / Nurse / Family Concern? am pm pm pm 10pm 3AM 6AM

Temperature (F)	104						
	103						
	102						
	101						
	100						
	99	98.1F*	98.0F*	97.6F*	98.0F*	*98.5F	*98.0F
	98						*97.5F
	97						

Heart Rate (bpm) and Blood Pressure (mmHg) *	190						
	180						
Note: BP does not score in early warning scoring	170						
	160						
Heart Rate (Number)	150						
	140						
Heart Rate (Number)	130						
	120						
Heart Rate (Number)	110	99 (E5)	95 (E8)	98 (A1)	99 (A1)	99 (A1)	80 (S0)
	100	52	55	60	66	60	40
Heart Rate (Number)	90	79b/t	90b/t	108b/t	110b/t	106 b/m	90 b/m
	80						
Heart Rate (Number)	70						
	60						
Heart Rate (Number)	50						
	40						

Resp Rate (Number)	70						
	60						
Resp Rate (Number)	50						
	40						
Resp Rate (Number)	30						
	20						
Resp Rate (Number)	10						
	0						
Resp Rate (Number)	0	26b/t	24b/t	24b/t	24b/t	26b/m	26b/m

Resp Distress	Mod/ Severe						
	None / Mild	.	.		*	.	.
Receiving O2 (l/min)	Receiving O2 (l/min)						
	O2 Saturations (%)	99%	100%	98%	100%	99%	100%
Conscious Level	Normal	c	c	c	c	c	c
	Altered						
GCS *	GCS *	15/15	15/15	15/15	15/15	15/15	15/15

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

<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
	Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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## 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>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)

3

**PRESCHOOL (1-5 years)**  
**Children's Observation & Early Warning Scoring Chart**



ic. No. : RCH/ FRM / CLINICAL / 125

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

Date: 21/5/26 Time: 10AM 2PM 6PM 10PM 3PM 6AM  
 Doctor / Nurse / Family Concern?

Today weight 13.5 kg

Temperature (F)	104	103	102	101	100	99	98	97	96	95	94
	98.2	98.2	98.2	98.2	98.0	98.0	98.0	98.0	98.0	98.2	98.2

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	100/60	102/60	112/60	98/60	98/60	98/60	98/60	98/60	98/60	98/60	98/60	98/60	98/60	98/60	98/60
Heart Rate (Number)	125	125	125	101	101	101	101	101	101	101	101	101	101	101	101

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

Resp Distress	Mod/ Severe	None / Mild
Receiving O <sub>2</sub> (l/min)	0	0
O <sub>2</sub> Saturations (%)	99	99
Conscious Level	Normal	Altered
GCS *	15/15	15/15

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

- 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:

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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
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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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KUH-00211197 IP5-00174025  
 Master YADLA DEVASHISH  
 16-05-2023 3 Y 0 M 5 D (M)  
 Dr. NALLA ANURAG REDDY



loc. No. : RCH/ FRM / CLINICAL / T25

4

**PRESCHOOL (1-5 years)**  
**Children's Observation & Early Warning Scoring Chart**

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

**BirthRight**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

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

Date : 22/5	Time: 9AM	10AM	11AM	12PM	1PM	2AM	3AM	6AM
Doctor / Nurse / Family Concern?								
Temperature (F)	104							
	103							
	102							
	101							
	100							
	99	98.5*	98.5*	98.5*	98.5*	98.5*	98.5*	98.5*
	98	97.5*	97.5*	97.5*	97.5*	97.5*	97.5*	97.5*
97								
96								
95								
94								
Heart Rate (bpm)	190							
	180							
and Blood Pressure (mmHg) *	150							
	140							
Note: BP does not score in early warning scoring	130							
	120							
Rate (Number)	110	100 (69)	97 (65)	101 (69)	103 (69)	99 (49)	90 (41)	96 (48)
	100	100/58	97/51	101/58	103/51	99/50	90/48	96/61
Resp. Rate (bpm) (Over 1 Minute) *	90							
	80							
Resp Rate (Number)	70							
	60	24/m	24/m	24/m	24/m	25 b/m	25 b/m	25 b/m
Resp Mod/ Severe Distress None / Mild	50							
	40							
Receiving O <sub>2</sub> (/min) O <sub>2</sub> Saturations (%)	30							
	20	100%	100%	100%	100%	99%	100%	98%
Conscious Level Normal / Altered	10							
		C	C	C	C	C	C	C
GCS *		15	15	15	15	15/15	15/15	15/15
		15	15	15	15	15/15	15/15	15/15
TOTAL SCORE								
Number of shaded boxes		0	0	0	0	0	0	0
Pain Score		0	0	0	0	0	0	0
Observer's Initials								
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: Scores 3 should be recorded overleaf								

\*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

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<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)



**PRESCHOOL (1-5 years)**  
**Children's Observation & Early Warning Scoring Chart**



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

Date : 19/15 Time: 5pm 1pm 2AM 3AM 4am 9pm 6pm

Doctor / Nurse / Family Concern?

Temperature (F)	104							
	103							
	102							
	101							
	100							
	99							
	98							
	97							
	96	96.8°F	98.2°F	98.5°F	97.9°F	98.1°F	98.2°F	96.5°F
	95							
94								

Heart Rate (bpm)	190							
	180							
and	170							
	160							
Blood Pressure (mmHg) *	150							
	140							
Note: BP does not score in early warning scoring	130	105	98	95	86	85		105
	120	(80)	(50)	(12)	(59)	(59)		(65)
	110	65	48	59	47	48		50
	100							
	90							
	80							
	70							
	60							
	50							

Heart Rate (Number) 85b/m 95b/m 100b/m 85b/m 85b/m 89b/m

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

Resp Rate (Number) 28b/m 28b/m 28b/m 28b/m 28b/m 28b/m 26b/m

Resp Mod/ Severe Distress None / Mild

Receiving O<sub>2</sub> (l/min) O<sub>2</sub> Saturations (%) 100% 100% 100% 100% 100% 100% 98%

Conscious Level Normal Altered 15/15 15/15 15/15 15/15 15/15 15/15 15/15

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

**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.
- 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)

KUH-00211197 IP5-00174025  
 Master YADLA DEVASHISH  
 16-05-2023 3 Y 0 M 3 D (M)  
 Dr. NALLA ANURAG REDDY

1



## Nursing General Admission Assessment Form For Pediatrics

**Diagnosis:**

Arrival Time: 7:00 PM Mode of Arrival: by walk Admitting From:  ER  OPD  Direct

Allergy / Adverse Reaction ..... Body Weight: 13.3 Kg

..... NO Allergy Reaction Height: ..... cm

Past Medical History: Obtained From  Patient  Family Member  Medical Record  Other (specify) .....

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>NA</u>	<u>NA</u>	<u>NA</u>

Family History: ..... NO

Has the child or close family member had recent contact with a communicable disease?  Yes  No

If Yes, please list, .....

Was the child's birth normal?  Yes  No If No, please describe problems: .....

Are the child's immunization up to date?  Yes  No

Current Medication:  None  Yes, If Yes, fill reconciliation form

Observations: Weight: ..... Length: ..... Head Circumference (< 2 years): .....

Temp: 97.6 of HR: 89 RR: 29 BP: 105/72

Pain Score: 0/10 Specify Site: ..... (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment:  Yes  No Score: 10 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

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

Character of Pain ..... Location ..... Frequency ..... Duration .....

**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

Special Feeding Method

Feeding Problem

Special diet

No Abnormality Detected

Inform consultant for positive criteria

**Psychological Screening:**

No Significant Findings

Unusual concerns about patient's Psychological Status:  Yes  No

If Yes Consultant Notified: ..... (Date/Time): .....

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

**Social History:** Lives With .....

Siblings in household  Yes  No (if yes How Many?) .....

All Information Obtained From  Patient  Mother  Father  Other Family Member

**Orientation has been given regarding the following aspects:**

Call Bell in Reach:  Yes  No

Waste Disposal Explained:  Yes  No

Infusion Pump:  Yes  No

Hand hygiene Explained:  Yes  No

Others

Patient Rights & Responsibilities:  Yes  No

Information given to mother .....

Nurse Signature: [Signature] .....

Nurse Name: Shirley .....

Date: 11/15/26 .....

Time: 2:00 PM .....

KUH-00211197 IP5-00174025  
 Master YADLA DEVASHISH  
 15-05-2023 3 Y 0 M 10 D (M)  
 Dr. NALLA ANURAAG REDDY



# FLUID CHART

Sheet No. : 10

- 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
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
28/5	08:00 am			-						100y		[Signature]
	09:00 am			-								
	10:00 am	H <sub>2</sub> O	100y	-								
	11:00 am			-						20y		
	12:00 pm			-								
	01:00 pm			-						50y		
<b>Total Intake :</b>			100ml			<b>Total Output :</b>					100y	
28/5	02:00 pm	H <sub>2</sub> O	100ml	-								[Signature]
	03:00 pm		100ml	-								
	04:00 pm			-						200ml		
	05:00 pm			-								
	06:00 pm	H <sub>2</sub> O	50ml	50ml								
	07:00 pm			33ml						50ml		
<b>Total Intake :</b>			233ml			<b>Total Output :</b>					300ml	
	08:00 pm			33ml.						230ml		[Signature]
	09:00 pm			33ml								
	10:00 pm	Pul		33ml								
	11:00 pm	antib		33ml								
	12:00 am	H <sub>2</sub> O		33ml						200ml		
	01:00 am			33ml								
	<b>Total Intake :</b>			248ml			<b>Total Output :</b>					
	02:00 am											[Signature]
	03:00 am									200ml		
	04:00 am											
	05:00 am											
	06:00 am									300ml		
	07:00 am											
	<b>Total Intake :</b>						<b>Total Output :</b>					

**Total 24 hrs. Intake** 581.0 - 43.604kg

**Total 24 hrs. Output** 1630.500ml/hr



# FLUID CHART

Sheet No. : 9

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		
27/5/26	08:00 am	N								330 ml		[Signature]
	09:00 am	P										
	10:00 am	O										
	11:00 am	H <sub>2</sub> O	100ml									
	12:00 pm	Jelly	2pc									
	01:00 pm	H <sub>2</sub> O	100ml									
<b>Total Intake :</b> 200ml						<b>Total Output :</b> 330ml						
	02:00 pm											[Signature]
	03:00 pm	Rice	1cup							120ml		
	04:00 pm	H <sub>2</sub> O	180ml									
	05:00 pm											
	06:00 pm	H <sub>2</sub> O	100ml							430ml		
	07:00 pm											
<b>Total Intake :</b> 280ml						<b>Total Output :</b> 550ml						
	08:00 pm									150ml		[Signature]
	09:00 pm	chapati										
	10:00 pm											
	11:00 pm	Rice										
	12:00 am	onion										
	01:00 am	H <sub>2</sub> O	200ml							50ml		
<b>Total Intake :</b> 200ml						<b>Total Output :</b> 250ml						
	02:00 am									100ml		[Signature]
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am									100ml		
<b>Total Intake :</b> 100ml						<b>Total Output :</b> 200ml						
<b>Total 24 hrs. Intake</b>			680° - 52,300kg			<b>Total 24 hrs. Output</b>			1,330° - 4,2600kg			

m - (1)

# 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	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
26/5	08:00 am	H2O	80ml	50ml						180ml	Kavina		
	09:00 am	Jelly	2p.e	50ml						100ml			
	10:00 am	H2O	120ml	50ml									
	11:00 am	poha	1cup							310ml			
	12:00 pm												
	01:00 pm												
<b>Total Intake : 350 ml</b>						<b>Total Output : 540 ml</b>							
26/5	02:00 pm	chapati	1p.e								Kavina		
	03:00 pm	Rice	1cup							50ml			
	04:00 pm	Egg	1p.e										
	05:00 pm	H2O	180ml										
	06:00 pm	Juice	10ml										
	07:00 pm	H2O	150ml							410			
<b>Total Intake : 330 ml</b>						<b>Total Output : 460 ml + 1 CM</b>							
26/5	08:00 pm	milk	60ml								pooja		
	09:00 pm	Omlet	1							50ml			
	10:00 pm	H2O	100ml										
	11:00 pm									200ml			
	12:00 am												
	01:00 am												
<b>Total Intake : 160ml</b>						<b>Total Output : 250ml</b>							
27/5	02:00 am										Jyoti		
	03:00 am		100ml							100ml			
	04:00 am												
	05:00 am												
	06:00 am									270ml			
	07:00 am									50ml			
	<b>Total Intake : 100ml</b>						<b>Total Output : 420ml</b>						

**Total Intake : 940 = 39.16 cc/kg**

**Total 24 hrs. Output : 1,720 = 5.51 cc/kg**

Im-1

KUH-00211197 IP5-00174025  
 Master YADLA DEVASHISH  
 16-05-2023 3 Y O M 8 D (M)  
 Dr. NALLA ANURAAG REDDY

# FLUID CHART



Sheet No. : 4

- All measurements in ml.
- Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
- 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		
25/5	08:00 am	milk	50ml	40ml						310ml	}	Gargi Somya
	09:00 am		N	40ml								
	10:00 am			40ml								
	11:00 am		P	40ml								
	12:00 pm			40ml						20ml		
	01:00 pm		O.	40ml								
<b>Total Intake :</b>			280ml			<b>Total Output :</b>					510ml	
	02:00 pm			40ml							}	Somya
	03:00 pm			40ml								
	04:00 pm			40ml								
	05:00 pm			40ml								
	06:00 pm			40ml								
	07:00 pm	chapathi H <sub>2</sub> O	100ml	40ml								
<b>Total Intake :</b>			180ml			<b>Total Output :</b>						
	08:00 pm	roti		40ml						130	}	pooja
	09:00 pm	H <sub>2</sub> O	100ml	40ml								
	10:00 pm	rice		40ml								
	11:00 pm	milk	20ml	40ml						150ml		
	12:00 am			40 ml								
	01:00 am			40 ml						50ml		
<b>Total Intake :</b>			360 ml			<b>Total Output :</b>					330ml	
	02:00 am			40 ml						150ml	}	pooja
	03:00 am			40 ml								
	04:00 am			40 ml						50ml		
	05:00 am			40 ml								
	06:00 am			40 ml						100ml		
	07:00 am			40 ml								
<b>Total Intake :</b>			240 ml			<b>Total Output :</b>					300ml	

**Total 24 hrs. Intake**      1060 ÷ 49.6cc/kg/day

**Total 24 hrs. Output**      1140 ÷ 3.57cc/kg/day

KUH-00211197  
 Master YADLA DEVASHISH  
 16-09-2023 3 Y 0 M 6 D  
 Dr. WALLA ANURAAG REDDY (M)



# FLUID CHART

Sheet No. : 6

- 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
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am			50ml								} Soomya. I → catheter changed
	09:00 am	H <sub>2</sub> O	100ml	50ml					150ml			
	10:00 am			-								
	11:00 am			-								
	12:00 pm			50ml					200ml			
	01:00 pm			50ml								
<b>Total Intake :</b>			300ml			<b>Total Output :</b>					350ml	
	02:00 pm	curd rice		50ml							} Soomya.	
	03:00 pm	H <sub>2</sub> O	100ml	50ml					250ml			
	04:00 pm			50ml								
	05:00 pm			50ml								
	06:00 pm			50ml					180			
	07:00 pm			50ml								
<b>Total Intake :</b>			400ml			<b>Total Output :</b>					430ml	
	08:00 pm	Rice		50ml					50ml		} pooja.	
	09:00 pm	H <sub>2</sub> O	100ml	50ml								
	10:00 pm			50ml					250ml			
	11:00 pm			50ml					50ml			
	12:00 am			50ml					20ml			
	01:00 am			50ml					100ml			
<b>Total Intake :</b>			400ml			<b>Total Output :</b>					245ml	
	02:00 am			50ml					100ml		} pooja.	
	03:00 am			50ml								
	04:00 am			50ml					50ml			
	05:00 am			50ml					50ml			
	06:00 am			50ml								
	07:00 am			50ml					100ml			
<b>Total Intake :</b>			300ml			<b>Total Output :</b>					300ml	

**Total 24 hrs. Intake**      1400 ÷ 105.2 cc/kg/day

**Total 24 hrs. Output**      1325 ÷ 4.15 cc/kg/hr



# FLUID CHART



Sheet No. : 8

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		
23/5/20	08:00 am	Infant		40ml					10	100ml	I	Sourinja
	09:00 am	H <sub>2</sub> O	100ml	40ml								
	10:00 am			50ml.						150ml		
	11:00 am			40ml								
	12:00 pm			40ml						100ml		
	01:00 pm			40ml								
<b>Total Intake :</b>			350ml.			<b>Total Output :</b>					370ml.	
23/8	02:00 pm	Rice		50ml							I	Sourinja
	03:00 pm	H <sub>2</sub> O	100ml	50ml						180ml		
	04:00 pm			50ml								
	05:00 pm			50ml						120ml		
	06:00 pm			50ml								
	07:00 pm			50ml						120ml		
<b>Total Intake :</b>			400ml.			<b>Total Output :</b>					420ml. + 1M	
23/5	08:00 pm	Roti		50ml							I	pooja
	09:00 pm	H <sub>2</sub> O	100ml	50ml						180ml.		
	10:00 pm			50ml								
	11:00 pm			50ml								
	12:00 am			50ml								
	01:00 am	H <sub>2</sub> O	50ml	50ml						100ml		
<b>Total Intake :</b>			450ml			<b>Total Output :</b>					280ml	
24/5	02:00 am			50ml							I	Sourinja
	03:00 am			50ml								
	04:00 am			50ml								
	05:00 am			50ml								
	06:00 am	H <sub>2</sub> O	50ml	50ml								
	07:00 am			50ml						350ml		
<b>Total Intake :</b>			350ml			<b>Total Output :</b>					350ml	

**Total 24 hrs. Intake**  $1,550 \div 64.58 \text{cc/kg}$

**Total 24 hrs. Output**  $1,420 \div 438 \text{cc/kg}$

# FLUID CHART

Sheet No. : ..... 4 .....

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		
20/05/23	08:00 am	Pongal		50ml						160ml	0	M-1
	09:00 am	1/2 Idli		50ml							0	
	10:00 am	water	100ml	50ml							0	
	11:00 am			50ml							0	
	12:00 pm			50ml							0	
	01:00 pm	water	50ml	50ml						200ml	0	
<b>Total Intake :</b>			500ml			<b>Total Output :</b>					360ml	M-1
	02:00 pm	Rice	1/2cup	50ml							0	M-1
	03:00 pm	paneer curry		50ml						130ml	0	
	04:00 pm			50ml							0	
	05:00 pm	water	150ml	-							0	
	06:00 pm	milk		-							0	
	07:00 pm			50ml						190ml	0	
<b>Total Intake :</b>			350ml			<b>Total Output :</b>					320ml	M-1
	08:00 pm	Rice		50ml						130ml	0	poojit
	09:00 pm	Roti		50ml							0	
	10:00 pm	H2O	150ml	50ml						210ml	0	
	11:00 pm	water	100ml	50ml							0	
	12:00 am			50ml							0	
	01:00 am			50ml							0	
<b>Total Intake :</b>			550ml			<b>Total Output :</b>					340ml	
	02:00 am			50ml							0	Ch
	03:00 am			50ml							0	
	04:00 am			50ml						400ml	0	
	05:00 am			50ml							0	
	06:00 am			50ml							0	
	07:00 am			50ml						150ml	0	
<b>Total Intake :</b>			300ml			<b>Total Output :</b>					550ml	

Total 24 hrs. Intake: 1700 ÷ 127.8 cc/kg

Total 24 hrs. Output: 1570 ÷ 4.9 cc/kg/m

# FLUID CHART

Sheet No. 33

(1233 hrs)

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	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
21/5/26	08:00 am		milk	50ml/hr						0	RL	
	09:00 am		Jelly	50ml/hr					370ml	0		
	10:00 am	DNS		50ml/hr					220ml	0		
	11:00 am			50ml/hr						0		
	12:00 pm			50ml/hr						0		
	01:00 pm			50ml/hr	50ml/hr					140ml		0
<b>Total Intake :</b> 300ml					<b>Total Output :</b> 430ml							
	02:00 pm			50ml		✓			150ml	0	RL	
	03:00 pm	DNS								0		
	04:00 pm	AZO	100ml	50ml						0	Rajamani	
	05:00 pm			52.5						0		
	06:00 pm			52.5					150ml	0		
	07:00 pm			52.5						0		
<b>Total Intake :</b> 357.5ml					<b>Total Output :</b> 300ml - MTD							
	08:00 pm	Caref		50ml						0	Sanam	
	09:00 pm	Reed		50ml						0		
	10:00 pm	AZO	100ml	50ml					500ml	0		
	11:00 pm			50ml						0		
	12:00 am			50ml						0		
	01:00 am	AZO	100ml	50ml						0		
<b>Total Intake :</b> 500ml					<b>Total Output :</b> 500ml							
	02:00 am			50ml						0	Sanam	
	03:00 am			50ml						0		
	04:00 am			50ml						0		
	05:00 am			50ml						0		
	06:00 am			50ml					200ml	0		
	07:00 am			50ml						0		
<b>Total Intake :</b> 300ml					<b>Total Output :</b> 200ml							

**Total 24 hrs. Intake**    1457.5 : 109.500 (kg)

**Total 24 hrs. Output**    1730 = 5.500 (kg)

M → (1)

KUH-00211197 IP5-00174025  
 Master YADLA DEVASHISH  
 16-05-2023 3 Y O M 3 D (M)  
 Dr. NALLA ANURAG REDDY

# 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											
	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								69ml			
	06:00 pm	DNS							300ml			
	07:00 pm			50ml					200ml			

Total Intake :

Total Output :

	08:00 pm			50ml								
	09:00 pm			50ml					210ml			
	10:00 pm			50ml								
	11:00 pm	DNS		50ml								
	12:00 am			50ml								
	01:00 am								230ml			

Total Intake :

Total Output :

	02:00 am											
	03:00 am			50ml								
	04:00 am	DNS		50ml								
	05:00 am			50ml								
	06:00 am								200ml			
	07:00 am											

Total Intake :

Total Output :

Total 24 hrs. Intake

Total 24 hrs. Output

KUH-00211197 IP5-00174025  
 Master YADLA DEVASHISH  
 16-05-2023 3 Y 0 M 3 D (M)  
 Dr. NALLA ANURAAG REDDY

# FLUID CHART



Sheet No. : .....

①

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	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
22/5/23	08:00 am		idely	50ml/hr					200ml	0	S	
	09:00 am		mltk	50ml/hr						0		
	10:00 am	DNS							100ml	0		
	11:00 am			50ml/hr					200ml	0		
	12:00 pm			50ml/hr						0		
	01:00 pm		Rice						110	0		
<b>Total Intake :</b>					<b>Total Output :</b>							
22/5/23	02:00 pm		Rice	50ml						0	R	
	03:00 pm			50ml						0		
	04:00 pm			50ml						0		
	05:00 pm	DNS		50ml					160ml	0		
	06:00 pm			50ml						0		
	07:00 pm			50ml						0		
<b>Total Intake :</b>					<b>Total Output :</b>							
22/5/23	08:00 pm			50ml					360ml	0	S	
	09:00 pm		chapatti	50ml					270ml	0		
	10:00 pm	DNS								0		
	11:00 pm			50ml						0		
	12:00 am			50ml						0		
	01:00 am			50ml						0		
<b>Total Intake :</b>					<b>Total Output :</b>							
22/5/23	02:00 am			50ml						0	S	
	03:00 am									0		
	04:00 am	DNS		50ml						0		
	05:00 am			50ml						0		
	06:00 am			50ml					840ml	0		
	07:00 am									0		
<b>Total Intake :</b>					<b>Total Output : 1700 ml</b>							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**



108A → 132

## NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 20/5/23 Time: 8am

Weight: 13.2kgs Centile: >25<sup>th</sup>

Height: 98cms Centile: >75<sup>th</sup>

Inference: well child

RDA: - Calories: 1300 kcal/d Protein: 22g/d

Diet Recommendations: soft diet

Re-Assessment: Avoid spicy, chilled, outside foods

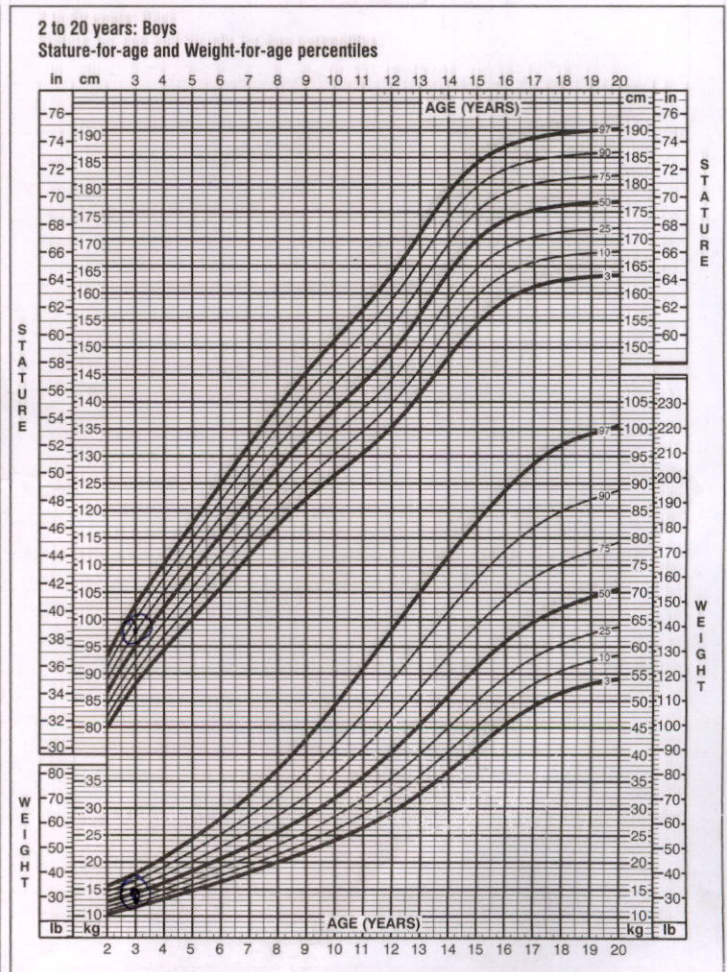
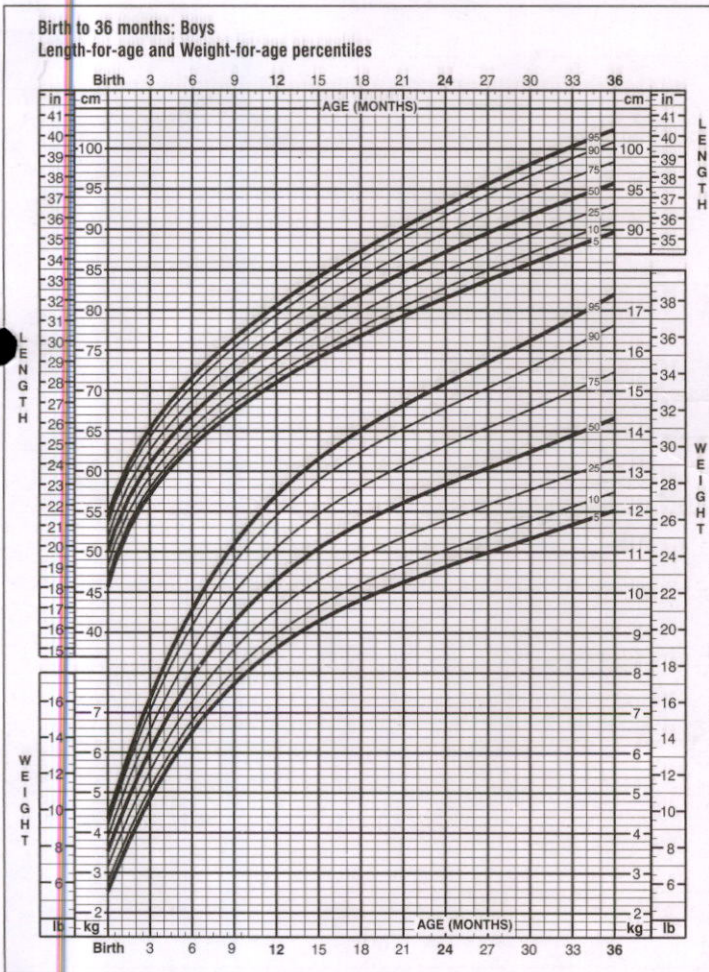
Food Allergies: No Veg/Non-veg: Non-veg

Diagnosis: PVD / 2 JRA

Nutritional Intervention -  Oral  Enteral  Parenteral

Patient's Signature: Y. Ramesh

### GROWTH CHART (BOYS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha

Daily Notes:

2/15/26  
11AM

child is stable. Oral intake is good.

Continue c soft diet

- Nikitha

1



### ACTIVITY RECORD FOR BILLING


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

UHID No. : \_\_\_\_\_ IP No. : \_\_\_\_\_ Dept : \_\_\_\_\_

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

Room / Bed No : \_\_\_\_\_ Ward : \_\_\_\_\_ Single bed type : \_\_\_\_\_

KUH-00211197      IP5-00174025  
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 Dr. NALLA ANURAG REDDY



### WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
16/5/26	2:35 pm	ER	148-A	
22/5	7:20 pm	OT	132	

### 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
1/15	CBP, CDA, uric acid		
	SE, CFT, creatinine	OPD	[Signature]
	CRP,		
19/6	DCT	50908	[Signature]
19/5/26	Bone marrow aspiration	26051006	[Signature]
	& Bopsy		
20/5/26	HemoC Panel	26051277	[Signature]
21/5/26	CBP, uric acid, electrolyte	26081833	[Signature]
22/5/26	CBP, SE, uric acid, PHT	26052177	[Signature]
24/5	CBP, SE, PHT	26052930	[Signature]
26/5	CBP, SE, RBS	26053413	[Signature]
26/5	2d echo	026598	[Signature]
26/5	HIV, HBsAg, HCV	26053515	[Signature]
25/5	CXR.	026427	[Signature]
27/5	CSF ANALYSIS	26053850	[Signature]
28/5	CBP; RBS, SE	26054056	[Signature]



**PROCEDURE**

Date	Procedure	Quantity	Order No.	Signature
19/5	iv placement	①	50908	[Signature]
19/5/26	conscious sedation	①	9616147	[Signature]
21/5/26	Blood transfusion (PRB)	①	9619742	[Signature]
24/5/26	I.V. Placement	①	9624626	[Signature]
27/5	Lumbar puncture. conscious sedation	3 ①	9630493	[Signature]
28/5	Chemotherapy	①	9632590	[Signature]

**ANY OTHER INFORMATION**

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Date : 29/5/26      Time : 10AM      Prepared By : Kenina

Staff Nurse <i>Mashum</i>	Shift / Ward <i>Oncology</i>	Billing Assistant	Billing Supervisor
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<del>22/5/26</del>	<u>Evening Rounds</u>	
3pm	no specific complaints vitals (N)	<p><u>plan</u></p> <ul style="list-style-type: none"> <li>①. trace reports</li> <li>②. 2D Echo today</li> </ul> <p><u>Mofelby</u>  <u>at 4pm</u></p> <p><u>Nishu</u></p>
<del>23/5/26</del> 8am	<u>Morning rounds</u> Newly diagnosed B-M / an Induction <u>AREA Que / FISH - awaited</u> (N) of Dexa	
	<p>No fever / vomiting oral intake (N) vitals (N)</p> <p><u>Dr Anurag Reddy</u>  <u>5:30 AM @ 3:30 AM</u>  <u>Dr Anurag Reddy</u></p>	<p><u>plan</u></p> <ul style="list-style-type: none"> <li>①. Cont IVF</li> <li>②. 2D Echo today</li> <li>③. LP D/T<sub>m</sub> + growing line</li> <li>④. Dexa full dose from today</li> <li>⑤. during LP - lets T<sub>m</sub></li> <li>⑥. Review NGV to send today</li> <li>⑦. labs on Monday CBP/UB</li> <li>⑧. <u>have karyotype</u></li> </ul> <p><u>Nishu</u></p> <p>Noted by Soumya 23/5/26 @ 11pm.</p>




(2)

**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
24/5/23	<u>Morning Rounds</u>	
8am	<p>Qo B-AU / GUA ⊕ / FISH - std cytogenetics          In Inductn - D<sub>3</sub> of Dexa</p>	
	No Complaints	
	U/o - (N)	
	oral intake (N)	
	vitals (N)	<p><u>Plan</u></p> <p>① 2D Echo Tm</p> <p>② Tm grossharp line in OT + LP</p>
<p><i>[Signature]</i>          24/5/23 @ 10:15 AM</p>		<p>③ Tm CBP, S/E, phosphate (low)</p> <p>④ Cont IVF</p> <p>MB Sounya 24/5 @ 11:30 am</p>
		<p><i>[Signature]</i></p>

KJH-02/1197 IP5-00174025  
 Master YADLA DEVASHISH 3 Y 0 M 8 D (M)  
 16-05-2023  
 Dr. NALLA ANURAAG REDDY



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**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
<del>25/5/23</del> 7am	<p><u>Morning Rounds</u></p> <p>B-AU/CAVA @ref Fish - 8td cytogenetic          on Induction - (D4) of Dexa</p> <p>No fever/vomiting          oral intake @          vitals - stable</p>	
	<p>N.B. Soumiya</p>	<p><u>plan</u></p> <ol style="list-style-type: none"> <li>① 2D Echo today</li> <li>② Groshing line today, LP today @ 3:30pm in OT</li> <li>③ Cont INF</li> <li>④ Viral screening - plan fol. NPO from 10am</li> </ol> <p>CRP, ABS SE } T/M          exhe plain</p> <p><i>(Signature)</i>          25/5/23 @ 9am</p>
25/05 5pm	<p><u>Procedure notes</u></p> <p>under strict aseptic conditions the area cleared; groshing line secured over left arm; prep wash @ fixed at 22cm; position confirmed by xray child tolerated well</p> <p>N.B. Soumiya</p>	<p>- TO do line xray after shifting to ward</p> <p>Dr. SANDHYA VADDADI          Reg. No: 71564</p>

