

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

Date of Admissi _____

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

Consultant: _____ Dept : _____

Date of Discharge : _____ Time: _____

PHW-00110942 IP5-00175961
Master ANUMANDLA KARTHIK
05-01-2015 11 Y 5 M 29 D (M)
Dr. SIRISHA RANI



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
4/7/26	10:40 am	ER	onco	Annu

Cross Consultation Visit

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

[illegible]

Signature

Chapter

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
4/7	Blood transfusion	(3)	9687459	[Signature]
	Lumbar puncture			
	conscious sedation			

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : 4/7/26

Time : 5pm

Prepared By : [Signature]

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
[Signature]	Day shift Oncology		

ADMISSION SHEET
Registration Details :

Admission No : IP5-00175961

Admit Date : 04-Jul-2026

Admit Time : 09:33 AM **UHID** : PHW-00110942

Patient Details :

Patient Name	: Master ANUMANDLA KARTHIK REDDY	Age	: 11 Y 5 M 29 D
Guardian	: Mr ANUMANDLA MADAN MOHAN REDDY	DOB	: 05-01-2015
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H.NO-3-112/8/A/4, BEERAPPA NAGAR Torrrur Warangal Telangana INDIA 506163	Phone No	: 9949007332/ 8096505063
		E-mail	: na@gmail.com

Admission Details :
Bed Type : DAY CARE

Bed No : HO DC 2

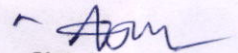
Ward Name : 1F-HEMATO-ONCOLOGY

Room No : HO DC 2

Admission Type : First Visit

Contact Details :

Name	: Mr ANUMANDLA MADAN MOHAN	Relationship	: Father
Contact Address	: H.NO-3-112/8/A/4, BEERAPPA NAGAR Torrrur Warangal Telangana INDIA 506163	Phone No	: 9949007332 / 8096505063


 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 : 4987.87

Payor Name : NIVA BUPA HEALTH INSURANCE
 COMPANY LTD

PHW-00110942 IP5-00175961
Master ANUMANDLA KARTHIK
05-01-2015 11 Y 5 M 29 D (M)
Dr. SIRISHA RANI



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ADMISSION CRITERIA – ONCOLOGY

Admission / Transfer from:

☒ Emergency ☐ Outpatient (OPD) ☐ Ward ☐ Operation Theater ☐ Others:

Tick (✓) any of the following criteria requiring admission / transfer to ONCOLOGY

- ☐ For Chemotherapy-Day Care or IP Admission as per the Type of Chemotherapy
- ☐ Febrile Neutropenias (ANC <500 cells / mm³)
- ☐ Netropenic Enterocolitis
- ☐ Mucositis Induced Significant Diarrohea or Pain
- ☐ Neurological Complications (like Seizures, Bleeding, Thrombosis) that can arise while on Chemotherapy Treatment or at the Time of Presentation and also for other Systemic Problems like Pancreatitis during Chemotherapy
- ☐ Management of Oncological Emergencies
- ☐ Bleeding Problems (where it is indicated)
- ☐ Evaluation and Management of Severe Anemias
- ☐ Day Care Admissions for PRBC Transfusions
- ☐ Evaluation and Management of Sick Children who come with Hematological Problems like Severe Anemia like Autoimmune Hemolytic Anemia/ Bleeding/ Others
- ☐ Primary Immunodeficiency Disorders with Infections that Warrants Hospitalisation
- ☐ Management and Evaluation of Hemophagocytic LymphoHisticytosis
- ☐ Any Systemic Disorders with Significant Hematological issues like JRA / SLE with Secondary HLH

Signature of the Doctor: *Dr. Sarani*

Name of the Doctor: *Dr. Sarani*

Date & Time: *4/7/16 @ 10AM*

PHW-00110942 IP5-00175961
Master ANUMANDLA KARTHIK
05-01-2015 11 Y 5 M 29 D (M)
Dr. SIRISHA RANI



DISCHARGE CRITERIA – ONCOLOGY

Discharge to:

☐ HDU / Step down ICU

☐ Ward

☐ Outside Facility

☒ Others: Hall

Tick (✓) any of the following criteria requiring discharge / transfer from ONCOLOGY

- ☐ Completion of chemotherapy, with no debilitating side effects.
- ☐ Resolution of febrile episode, with no fever > 24hrs and Absolute Neutrophil count (ANC) > 500cells/mm3.
- ☐ Admitted patients - Once the admitting problem gets resolved or made a plan to manage further on out-patient basis.

Signature of the Doctor: A

Name of the Doctor : Dr. Sarani

Date & Time: 11/7/26 @ 3pm

Date & Time	Progress Notes	Doctor's Order
4/5/22 12:40pm	<u>Procedure notes</u> K/clo B-cell ALL - on consolidation. Lumbar puncture - done. Intrathecal chemotherapy given. CSF - clear Procedure - uneventful. Vitals stable. No blood loss. - Chemotherapy given.	

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

PHW-00110942 IP5-00175961
Master ANUMANDLA KARTHIK
05-01-2015 11 Y 5 M 29 D (M)
Dr. SIRISHA RANI



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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Sirisha Rani Date : 04/7/20

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

Start Time of Assessment: _____ Weight: 39 kg

Allergic History: _____

Chief Complaints: _____

Keto. B-cell All

Admitted for LP, PRBC
transfusion 200.

Pediatric Assessment Triangle

A Appearance - TICLS (N)



B Breathing

☐ ↑ WOB
☐ ↓ WOB
☒ Normal
☐ Gasping / Apnea

C Circulation

☒ Normal
☐ Abnormal
 Pallor ☐
 Cyanosis ☐
 Mottling ☐
 Bleeding ☐

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

Any urgent interventions needed: ☐ Yes ☐ No

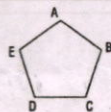
If Yes _____

Significant Past History: _____

Medication History: _____

Relevant Investigations: 1/7/20 - Hb-7.4, WBC-2020, N/L 77%, PC-245L
D8

Primary Assessment



Airway



☒ Open
☐ Maintainable
☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____

Breathing



Rate: 22/min SpO₂ on FiO₂ 98% on RA

Rhythm: _____

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: _____

Palpation Findings (If necessary) _____

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____

 **Circulation** HR: 108/min CFT ☐ Central per ☐ Peripheral per Any urgent interventions needed: ☐ Yes ☒ No
 BP: 105/65 (74) mmHg Murmurs: ☐ Yes ☐ No
 Pulse Volume: ☐ Central good ☐ 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: AVPU: Any urgent interventions needed: ☐ Yes ☒ No
 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
 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:
CBP

Treatment Planned:
Day care, NPO
LP
PRBC - SOS

Need for Oxygen: ☐ Yes ☒ No if yes Low Flow ☐ High Flow ☐ PPV ☐
 Final Diagnosis with possible Differential Diagnosis (If necessary): B-A-C-I + Distended for LP, PRBC SOS

Assessment done by
 Name of the Doctor: N. Peatnik
 Signature: N. P.
 Date & Time: 04/12/26, 9:30 am

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



DRUG CHART

Date of Admission: 9/7/26 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.
- 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:																			



REGULAR PRESCRIPTIONS

Weight. 39 kg Ward.

DRUG : <i>Wj. ONDANSERON</i>				Date Time															
Dose <i>4mg</i>	Route <i>IV</i>	Frequency <i>12H</i>	Start Date <i>04/7</i>																
Name & Signature of the Doctor Starting the Drugs: <i>N. Prabhakar.</i>																			
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																			



VARIABLE DOSE		Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
DRUG :		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Route	Start Date	Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Name & Signature of the Doctor		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Additional Instructions:		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.

VARIABLE DOSE		Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
DRUG :		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Route	Start Date	Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Name & Signature of the Doctor		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Additional Instructions:		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
04/12/26	1pm	PRBC	Just over 7 hours	IV	N.P.S	Ueen Santika
04/12/26	1pm	inj. Anal	5ml	W	N.P.S	Ueen Santika
04/12/26	12:40pm	Inj. Ketamine	20mg	IV	R	Plum Ueen
04/12/26	12:40pm	Inj. MIDAZOLAM	2mg	IV	R	Plum Ueen



I.V. FLUIDS CHART

Weight. 51 kg Ward.

[illegible]

MEDICATION RECONCILIATION FORM

Drug Allergies: No

☒ 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: Onco

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	Syr. Septoran	7.5ml	PO	12H Monday weekdays		☐ C ☐ DC
2	Syr. Lincolt	5ml	PO	24H		☐ C ☐ DC
3	Syr. Salivonaphm.	5ml	PO	24H		☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: N. Praveen Kumar - S. Pr

Date & Time: 04/11/26, 9:30 am

Nurse Name & Signature: Nr. Sushmita

Date & Time: 4/11/26, 9:40 am



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
4/12/20	9:30 AM	0/10	no	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	no no	Asus
				☐ 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		
				☐ 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:

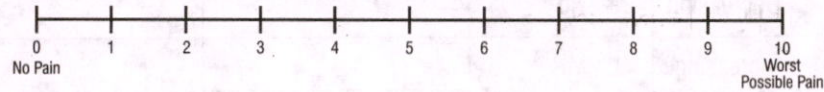
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

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

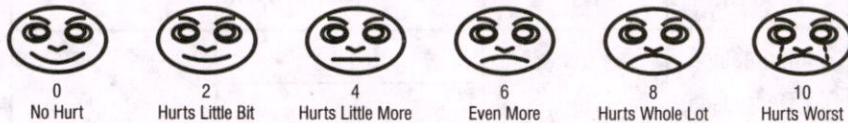
Numerical Pain Scale (Obstetric and Gynecology)



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, SaO₂	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

Wong - Baker (Pediatrics) Above 7 Years





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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 2/7 Time: 10 AM

Doctor / Nurse / Family Concern?

Temperature (F)	104	
	103	
	102	
	101	
	100	
	99	98.5 F
	98	*
	97	
	96	
	95	
	94	

Heart Rate (bpm)	190	
	180	
	170	
	160	
	150	
	140	
	130	
	120	
	110	
	100	100
	90	91
and Blood Pressure (mmHg) *	80	
	70	
	60	60
	50	
	Note: BP does not score in early warning scoring	
	Heart Rate (Number) 106b/min	

Resp. Rate (bpm) (Over 1 Minute) *	70	
	60	
	50	
	40	
	30	
	20	
	10	
	Resp Rate (Number) 23b/min	

Resp Distress	Mod/ Severe	
	None / Mild	0
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		100%

Conscious Level	Normal	
	Altered	C
GCS *		15/15

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

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.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT : I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 10 AM Mode of Arrival: By father Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction

Body Weight: Kg

Height: cm

NA

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:

Healthy family

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: 98.6 F HR: 102 b/m RR: 24 b/m BP: 100/60 (H) mmHg

Pain Score: Specify Site: (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☒ Yes ☐ No Score: 9 (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: 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

PHW-00110942 IP5-00175961
 Master ANUMANDLA KARTHIK
 05-01-2015 11 Y 5 M 29 D (M)
 Dr. SIRISHA RANI



Patient Sticker

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm			60ml								
Total Intake :			60ml			Total Output :						
	02:00 pm			60ml					200ml			
	03:00 pm	H ₂ O 200ml		60ml								
	04:00 pm			60ml								
	05:00 pm			60ml								
	06:00 pm								200ml			
	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						

Patient Sticker

FLUID CHART

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	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											
	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						



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date:

Assessment: *patient having weakness*

Goals

- | | | | | | |
|---|--|--|---|---|---|
| ☒ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☒ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☒ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☐ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☒ Early Ambulation Reduce Anxiety | ☐ Patient & Family Education |
| ☐ Identify Potential Complications ☐ Any Others. Specify..... | | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
10am	→ Assess the pt ^{condition} condition	10:30 Am	→ Assessed the pt ^{condition} condition	<i>pt feels better</i>
11am	→ Monitor the vital Sign	11:30 Am	→ TO check & Recorded the vital sign	
12pm	→ provide the supportive ^{care}	12:30 Am	→ TO given the oral med ^{-on}	
1pm	→ Ensure the safety needs	2pm	→ provided the side rails	
3pm	→ plan LP, PRBC → Administer the medication	4pm	→ LP DONE & PRBC onflow → Administered the medication	

Re-Assessment: *pt feels better*

Special Notes:

Nurse Signature: *Un*

Nurse Name: *Un*

Date & Time: *17/12 @ 5pm*

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

- | | | | | | |
|---|--|---|---|---|---|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☐ Maintain Personal Hygiene | ☐ Prevent Infection | ☐ Meet Elimination Needs | ☐ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☐ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis: <u>Bre Au</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time	FR 10:40 am	OWO 5pm				
	Medical Condition (Any special condition to be noted):		<u>NO</u>	<u>NO</u>				
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:	<u>98.2°</u>	<u>98.6°</u>				
		Res:	<u>22b</u>	<u>26b</u>				
		SpO ₂ :	<u>100%</u>	<u>100%</u>				
		Pulse:	<u>98.1°</u>	<u>100.1°</u>				
		BP:	<u>107/66</u>	<u>96/56</u>				
		Fall Risk Score:	<u>10</u>	<u>10</u>				
Pain Score:		<u>0/10</u>	<u>0</u>					
Recommendations	Safety Needs:		<u>yes</u>	<u>sick daily</u>				
	Physiotherapy		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:		<u>NO</u>	<u>NA</u>				
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:		<u>NO</u>	<u>NA</u>				
Post Operative Procedure Special Orders:		<u>NO</u>	<u>NA</u>					
Handed Over By Name :		<u>Anne</u>	<u>Jeany</u>					
Signature :		<u>[Signature]</u>	<u>[Signature]</u>					
Date:		<u>9/10/20</u>	<u>4/7/20</u>					
Time:		<u>10:40 am</u>	<u>5pm</u>					
Taken Over By Name :		<u>Gowda</u>	<u>[Signature]</u>					
Signature :		<u>[Signature]</u>	<u>[Signature]</u>					
Date:		<u>4/7/20</u>	<u>4/7/20</u>					
Time:		<u>10:30 Am</u>						

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:							



CONSENT FOR BLOOD TRANSFUSION

Name: Karthik Reddy Age: 11Y Gender: Male ☒ Female ☐
UHID.No : 110942 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 A. Madan Mohan Reddy hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immuno-deficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

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

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: [Signature]
Name: A. Madan Mohan Reddy
Date & Time: 4/7/26 @ 1pm

Doctor (Who is talking the consent)

Signature: [Signature]
Name: Dr. Sparani
Date & Time: 4/7/26 @ 1pm

Witness

Signature: [Signature]
Name: A. Madan Mohan Reddy
Date & Time: 4/7/26 @ 1pm

రోగి పేరు: వయస్సు: లింగము ☐ పురుషుడు ☐ స్త్రీ

UHID. సంఖ్య: తేదీ:

రక్త ఉత్పత్తి రకాలు:

- | | | |
|---|---|---|
| ☐ తాజా ఘనీభవించిన ప్లాస్మా | ☐ ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు | ☐ Random Donor Platelets |
| ☐ క్రయోప్రెసిపిటేట్ | ☐ ఒకే ధాత ప్లేటిలెట్స్ | ☐ Whole Blood |
| ☐ మొత్తం రక్తం | ☐ ఎర్ర రక్త కణం | ☐ ఇతరులు..... |

నేను ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. ధాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడిస్, హైపటెటిస్ జి సర్వేస్ యాంటిజన్, హైపటెటిస్ యాంటిబడిస్, మలేరియా మరియు సిఫ్లిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణీత కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలెత్తవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు

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

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకం

పేరు

పేరు

తేదీ మరియు సమయము

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు



BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 4/7/26 Time: 1 pm

Blood Group of the Patient: A+ve Blood Group on the Blood Bag: A+ve

Blood Bank Issue No: BAA 26-01502 Date of Collection: 23/6/25 Date of Expiry: 2/8/26

Date & Time of Starting Transfusion: 4/7/26 @ 1 pm Planned duration of Transfusion: 4 hours

Check for Correct Unit: ☒ Correct Patient: ☒

Blood products cross checked by: Nurse 1: Uday Nurse 2: Bhuvan

Before starting transfusion vitals: Temp: 98.6 F HR 106 bpm RR: 26 bpm BP: 100/60 mmHg SpO₂ 100%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
<u>4/7/26</u>	15 Min	<u>106 bpm</u>	<u>98.6 F</u>	<u>100/60</u>	<u>100%</u>	<u>No</u>	<u>No</u>	<u>No</u>	<u>No</u>
	15 Min	<u>96 bpm</u>	<u>98.6 F</u>	<u>96/56</u>	<u>100%</u>	<u>No</u>	<u>No</u>	<u>No</u>	<u>No</u>
	30 Min	<u>93</u>	<u>98.6 F</u>	<u>90/60</u>	<u>100%</u>	<u>No</u>	<u>No</u>	<u>No</u>	<u>No</u>
	30 Min	<u>99</u>	<u>98.6 F</u>	<u>93/57</u>	<u>100%</u>	<u>No</u>	<u>No</u>	<u>No</u>	<u>No</u>
	30 Min	<u>101</u>	<u>98.6 F</u>	<u>95/61</u>	<u>100%</u>	<u>No</u>	<u>No</u>	<u>No</u>	<u>No</u>
	1 Hr	<u>106</u>	<u>98.6 F</u>	<u>98/60</u>	<u>100%</u>	<u>No</u>	<u>No</u>	<u>No</u>	<u>No</u>
	1 Hr	<u>109</u>	<u>98.6 F</u>	<u>100/60</u>	<u>100%</u>	<u>No</u>	<u>No</u>	<u>No</u>	<u>No</u>

Comments: NA

Name of the Incharge-Nurse: Uday

Signature of the Incharge-Nurse: Uday

Date & Time: 4/7/26 @ 5 pm

Name of the Nurse: Uday

Signature of the Nurse: Uday

Date & Time: 4/7/26 @ 5 pm

Rainbow Hospital Blood Centre, Rainbow Childrens I.
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road
Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

LEUCO REDUCED BLOOD CELLS I.P

Qty. 275 ml. Prepared from Whole human blood collected in 63 ml. of C.P.D.A.
Solution.



Rh Positive

HIV I & II/ HBsAG/ HCV - Non
reactive
VDRL - Non reactive
MP - Negative
NAT(HIV I & II/ HBsAG/ HCV)- Non
reactive

Unit No.: BAH26-01502
Blood Group: A Rh Positive
Collection Date: 23/Jun/2026
Expiry Date: 04/Aug/2026

1) Administer Without Warming. 2) Shake Gently Before Use.
Add Any Medication. 4) Check Blood Group and Name Before Administration.
With Filter. 6) Do Not Mix with Any Other Blood.
There is Any Visible Clot or Sediment.
Appropriate Compaction Test.
Antibodies in Recipient Blood.

Issue Label / Cross Matching Report

Patient : MASTER.KARTHIK REDDY -
Patient's Blood Group : A Rh Positive
Hosp/Dr : Rainbow Childrens Hospital, dr sandhya
UHID No.: PHW-00110942 Wd-Bed No.:
Product : LR-PRBC
Blood Group : A Rh Positive
Unit No.: BAH26-01502
X Matching Report: Compatible
X-matched by: Premalatha

Issue Dt : 04/Jul/2026
Colln. Dt : 23/Jun/2026
Exp. Dt : 04/Aug/2026
Issued By : Premalatha

Rainbow Hospital Blood Centre, Rainbow Childrens
Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road
No.2, Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

CONSENT FOR PROCEDURAL SEDATION

Authorization By: ☐ Patient ☒ Patient Attendant

I, the undersigned do hereby acknowledge the following:

- I have been made aware by the doctors in language known to me the details of sedation planned for the procedure
Short sedation.
- I have been made aware of the possible complications from the procedure of sedation as follows:
 - Changes in heart rate, blood pressure, need for oxygen supplementation, allergic reactions, upper airway obstruction, laryngospasm, conversion to general anaesthesia
- I have been made aware that the sedation is being advised to relieve pain and anxiety during the procedure. It will help me remain calm, comfortable, and cooperative, allowing the procedure to be performed smoothly and safely.
have been clearly explained about the benefits, risk, and alternative of the sedation which is General Anaesthesia.
- I authorize Dr. Sandhya and his / her team to perform the procedural sedation upon the patient / myself.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: Ch. Yamuna
Name: Ch. Yamuna
Relationship with patient: Mother
& Time: 4/7/26 @ 12:30pm

Witness:

Signature: Ch. Yamuna
Name: Ch. Yamuna
Date & Time: 4/7/26 12:30pm

Doctor (who is taking consent):

Signature: Dr. Praveen Name: Dr. Praveen Date: 4/7/26 Time: 12:30pm

ప్రాసేజరల్ సెడేషన్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, క్రింది విషయాలను అంగీకరిస్తున్నాను:

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

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

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

PHW-00110942 IPS-00175961
Master ANUMANDLA KARTHIK
05-01-2015 11 Y 5 M 29 D (M)
Dr. SIRISHA RANI

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CONSENT FOR SPECIAL PROCEDURES

Patient Name : Karthik Gender: ☒ Male ☐ Female

UHID No : PHW-00110942 Department : Hematology Date : 4/7/26

I Yamuna S S/D/W/O MADAN MOHAN

Here by give consent for procedure of : Lp + IT chemotherapy

For my patient, Named :

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

Bleeding, pain, Headache.

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

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

Name of the Doctor performing the procedure: DR. Soorani

Patient Attendant :

Signature : Chye

Name : Ch. Yamuna

Relationship with Patient: mother

Date & Time : 4/7/26 @ 12:30p

Witness :

Signature : Chye

Name : Ch. Yamuna

Date & Time : 4/7/26 @ 12:30p

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. prakash

Date & Time : 4/7/26 @ 12:30p

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

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

.....

.....

.....

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

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

PROCEDURE SAFETY CHECK LIST (TIMEOUT OUTSIDE OT)

Procedure Name: Lumbar puncture Date: 4/7/26 In-Time: 12:30pm Out-Time: 1pm
Doctor Performing Procedure: Dr. Sravan Doctor Giving Sedation: Dr. Sandhya Assisting Nurse: Heen

SIGN IN		Time: <u>12:30p</u>	TIME OUT		Time: <u>12:40p</u>	SIGN OUT		Time: <u>1pm</u>			
	Yes	No	NA		Yes	No	NA				
Patient is verified using two identifiers (Name & UHID)	☒	☐	☐	Correct Patient	☒	☐	☐	Name of the Surgical / Invasive Procedure is recorded	☒	☐	☐
All required documents, images, studies are available	☒	☐	☐	Correct Site	☒	☐	☐	Instrument, Sponge and Needle Count Completed	☒	☐	☐
NPO Status Checked from Patient / Patient Attendant	☒	☐	☐	Correct Procedure	☒	☐	☐	Specimens are labeled	☒	☐	☐
Consent is Signed	☒	☐	☐	All the team members introduced	☒	☐	☐	Any equipment problems are addressed	☒	☐	☐
Any need for blood products	☒	☐	☐								
If Yes Comment:											
Any Risk of Hemodynamic Compromise	☐	☒	☐								
If Yes Comment:											
Any drug or food allergy	☐	☒	☐								
If Yes Comment:											
Correct Site of Procedure Marked	☒	☐	☐								
All resources required are correct, available and functioning	☒	☐	☐								
Signature of the Doctor: <u>Dr. Sravan</u>				Signature of the Nurse: <u>Heen</u>				Signature of the Nurse: <u>Heen</u>			
Name of the Doctor: <u>Dr. Sravan</u>				Name of the Nurse: <u>Heen</u>				Name of the Nurse: <u>Heen</u>			

Any Adverse / Unexpected Events

NA

Moderate Sedation Flow-Sheet

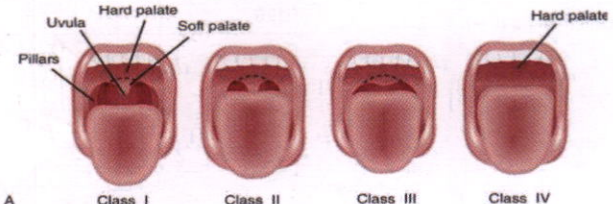
Immediate Pre-Sedation Assessment

B.P	PR	R.R	Temp	SPO ₂	Pain Score	Weight
100/60/61	102 b/m	20 b/m	98.6 F	100%	—	39 kg.

Diagnosis: Reflex Brachial Plexus Block.

Procedure: L.P.

Comorbidities: _____

☒ Risk, benefits & alternatives discussed; ☒ Patient understand & elects to proceed ☒ Consents for procedure and sedation signed and dated ASA Physical Status ☐ ASA PS 1: Healthy Patient ☒ ASA PS 2: Mild Systemic Disease, no functional limitations ☐ ASA PS 3: Severe Systemic Disease, functional limitations ☐ ASA PS 4: Severe Systemic Disease, constant threat to life ☐ ASA PS 5: Moribund Patient unlikely to survive 24 hrs. ☐ ASA PS 6: A declared braindead patient whose organs are being removed for donor purposes ☐ E: Emergency procedure GCS: E 4 M 6 V 5 ☒ IV Site: Gauge: Sedation Plan: Allergies:	AIRWAY EVALUATION Mouth: ☐ Normal ☒ Loose Teeth ☐ Small Mouth ☐ Protruding Incisors ☐ Receding Lower Jaw ☐ Dentures Neck: ☒ Normal ☐ Decreased ROM ☐ Thyromental Distance Less Than 6 cm ☐ Short Neck  Mallampati Class: ☐ I ☐ II ☐ III ☐ IV
---	---

Monitoring of Patient Intra – Procedure

Procedure Monitoring

Heart Rate (HR), Respiratory Rate (RR), Oxygen Saturation (O₂ Sat) continuously monitored, and Level of Consciousness (LoC) to be monitored and recorded minimally every 15 minutes until 15 minutes after the last administration of any sedation, then every 30 minutes, then every 1 hour until stable. Respiratory status to be monitored continuously.

Level of Consciousness (LOC):

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

TIME	BP	PR	RR	O ₂ Sat%	O ₂ Supplementation	Comments / Initials
Baseline	105/65	104b/m	22B/m	100% PA		
12:30p	100/60/4	101b/m	25b/m	100%		

Doctor Notes:

Doctor Name: Dr. praveen. Signature: R.

12:30 pm

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

Signature:

Patient



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	2				
	13 years old and above	1					
Gender	Male	2	2				
	Female	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			10				

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 :	Anil				
Signature :	[Signature]				
Date :	4/12				
Time :	9:0				



BRADEN 'Q' SCALE

					Date :			
					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.	9			
"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.	9			
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.	9			
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.	9			
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."	9			
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 of 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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.	9			
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.	9			
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28		
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	AO		

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



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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 | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 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		
4/1/20	9:15 AM	10	fall Risk Education	mother	1	one	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 4. Language Barrier 7. Impaired Thought Process/Cognitive limitations 10. Financial Difficulties 13. Cultural/Religion Practice 2. Physical Impairment 5. Educational Level 8. Responsibilities at Home 11. Beliefs and Values 14. Others (Specify) 3. Emotional Barriers 6. Desire / Motivate to Learn 9. Cultural Differences 12. Impaired Vision/ or Hearing									
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed									
Mechanism/s to overcome barrier/s: 1. None 3. Reassurance & Support 5. Respect values & beliefs 7. Other, Specify 2. Obtain translator 4. Teach Family / Others 6. Respect Cultural / Religion Preference									
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review									



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
4/21/26	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	B-ALL	Hemodynamic stability	LP SOS PRBC	N. [Signature]	☐ Nursing ☐ Others:
4/21/26 9:40 on	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	B-cell ALL	H. Stable	LP	[Signature]	☒ 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:

PHW-00110942 IP5-00175961
Master ANUMANDLA KARTHIK
05-01-2015 11 Y 5 M 29 D (M)
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RESULT SHEET

Date	4/7					
Time	1PM					
Hb	7.5 PRBC					
PCV	24					
RBC	2.58					
WBC	2.50					
N/L	57/37					
Platelets	177					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

