

ACTIVITY RE VIH-00204627 IP-00060212
Baby MRINAL PRADVI
23-06-2025 0 Y 11 M 10 D (F)
Dr. PREETHAM KUMAR

Name: -----  -----

UHID No : ----- Consultant : ----- Dept : -----

Date of Admission : ----- Time : ----- Date of Discharge : ----- Time: -----

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
2/6/26	12:25 AM	ER	102	Jan

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
2/6/26	IV placement	1	3086516	[Signature]
3/6/26	neb - Hyperneb	3	3086716	[Signature]
4/6/26	nebs	3	3086777	[Signature]
cross checked by Lealpon, 4/6 @ 8AM				
	nebs	1	3086836	[Signature]

ANY OTHER INFORMATION

Covid test → positive

3/6/26 no food till breakfast - started food from lunch → 3/6/26 12pm

Date : _____ Time : _____ Prepared By : _____

Staff Nurse	Shift / Ward [Signature] 4/6 @ 12:40 pm	Billing Assistant	Billing Supervisor
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102

Ref. No. F/INPR/12



VIH-00204627 IP-00060212
Baby MRINAL PRADVI
23-06-2025 0 Y 11 M 11 D (F)
Dr. PREETHAM KUMAR

Patient Name : _____

Registration No.: _____



NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
3/6/26	00:00	1Am - Hyperneb	Bevonika	Ashwini P
	1.00	9Am - hyperneb	manasa	Ashwini P
	2.00	5PM - Hyperneb	Subham	[Signature]
	3.00	(3) 03086716		
	4.00	9pm - Levoflo	Bevonika	Ashwini P
4/6	5.00	1Am - Hyperneb	Bevonika	Ashwini P
	6.00	3am - Levoflo	Bevonika	Ashwini P
	7.00	(3) 3086777		
	8.00	9am - Levoflo + hyperneb	Rendu	[Signature]
	9.00	(1) 3086836		
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

9.6-01
9.5

116-17

pt-70

07-100-10

ADMISSION SHEET

Registration Details :



Admission No : IP-00060212 Admit Date : 02-Jun-2026 Admit Time : 11:04 PM UHID : VIH-00204627

Patient Details :

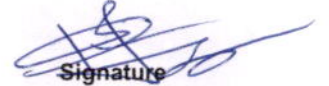
Patient Name : Baby MRINAL PRADVI Age : 0 Y 11 M 10 D
Guardian : Mr PRADEEP UPPALETI DOB : 23-06-2025 01:00 AM
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : 8-7-32/1/17/A, SAI NARAYANAPURI COLONY,
ROAD NO.10,RR NAGAR,BOWENPALLY Phone No : 9030333750/ 9030624625
Bowenpally Hyderabad Telangana INDIA E-mail : NA@GMAIL.COM
500011

Admission Details :

Bed Type : SHARED WARD Bed No : ER 102 Ward Name : N 0 GF-EMERGENCY
Room No : ER 102 Admission Type : First Visit

Contact Details :

Name : Mr PRADEEP UPPALETI Relationship : D/O
Contact Address : 8-7-32/1/17/A, SAI NARAYANAPURI Phone No : 9030333750
COLONY,ROAD NO.10,RR
NAGAR,BOWENPALLY Bowenpally Hyderabad
Telangana INDIA 500011


Signature

Doctor Details :

Doctor Name : Dr. PREETHAM KUMAR Specialisation : GENERAL PEDIATRICS
Referral Doctor : Dr Ashwin Kumar Phone No : 9030259996
Co-Consultant : 

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : VIDAL HEALTH INSURANCE TPAPVT
LTD

11 M

VIH-00204627 IP-00060212
 Baby MRINAL PRADVI
 23-06-2025 0 Y 11 M 10 D (F)
 Dr. PREETHAM KUMAR



wt : -8.41kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Baby. Mrinal Pradvi Age : 11M Gender: Male Female

Date : 2/6/26 Time of Arrival : 10:50pm

Allergies: No Yes Food Medications Blood Transfusion Other (Specify): Not known

Source of Information : Parents Others (Specify)

Mode of Arrival : Ambulatory Wheelchair Ambulance

Initial Vital Signs: Temp: 99.5°F PR: 134b/m BP: Crying RR: sub/m SpO₂: 100% vom: withy's
 Chief Complaints: Fever x 5 days, Jaxal intake, cold & cough x 2 days, loose stools

INITIAL PHYSIOLOGICAL CATEGORIZATION Appearance <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sick Looking Circulation / Colour <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding		INITIAL PHYSIOLOGICAL STATUS <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Unstable : <input type="checkbox"/> Not - Life - Threatening <input type="checkbox"/> Life - Threatening	
Work of Breathing <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea			

Triage Classification	CTAS
<input type="checkbox"/> Level 1 : Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2 : EMERGENT : Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	<input type="checkbox"/> 30 min
<input checked="" type="checkbox"/> Level 4 : LESS URGENT : Significant illness but not life threatening	<input checked="" type="checkbox"/> 60 min
<input type="checkbox"/> Level 5 : NON - URGENT : May receive care when convenient	<input type="checkbox"/> 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
 All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian
 Triage Completion Time : 10:54pm

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

1. Have you had fever (elevated temperature) in the past 2 weeks Yes No
2. Have you had cough or a rash in the past 2 weeks Yes No
3. Have you had shortness of breath or difficulty breathing in the past 2 weeks Yes No

PART B. For patients reporting fever and respiratory/rash symptoms: Not applicable

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? Yes No
 If yes, State Location:
2. Are your parents / close contacts at home is/a healthcare worker? (please encircle the choices) (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? Yes No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- The patient should be given a surgical mask immediately, if not already wearing one.
- Both patient and triage staff should perform hand hygiene.
- The staff should use PPE (as appropriate).

Name of Triage Nurse : Swathi

Signature of Triage Nurse :

Date & Time : 2/6/26 @ 10:54pm

Patient Name : Baby. MRINAL PRADVI UHID : VIH-00204627 IPD : IP-00060212 Gender : Female Age : 0 Y
11 M 10 D

VIH-00204627
Baby MRINAL PRADVI
23-06-2025 0 Y 11 M 10 D (F)
Dr. PREETHAM KUMAR

Rainbow
Children's
Hospital

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 21/6/26 Time of arrival : 10:58 pm 2 days loose stools
Chief Complaints : Fever x days, ↓our intake, cold, cough x RBS: -
Height : - Weight : 8.4 kg BMI : - Head Circumference (<2 years) : -
Allergies: Yes No Medications Blood Transfusion Food Other: -

If yes, identify

Pain Screening: Yes No If Yes, Pain Score: "0" Pain Tool Used: N Pass FLACC Wong Baker
 Character Location Frequency Duration

RISK FOR FALL:

- If patient is < 6 years
tick below fall risk intervention directly
- If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months Yes No

Ambulatory Aids:

- Wheelchair Yes No
- Uses furniture for support Yes No

Gait/Transferring:

- Bedrest / immobile Yes No
- Weak Yes No
- Impaired Yes No

Mental Status: Forgets limitations Yes No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- Escort while ambulating
- Assist Patient
- Educate patient and family on fall precautions/prevention

Functional Screening: No Abnormalities Detected

- Mobility Problem
- Walking Problem
- Developmental Delay
- Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

Nutritional Screening: No Abnormalities Detected

- Underweight
- Overweight
- Feeding Problem
- Special diet
- Special feeding method

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With family

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

Time of Initial assessment completed by ER Nurse : 11:02 pm

Patient Name : Baby. MRINAL PRADVI UHID : VIH-00204627 IPD : IP-00060212 Gender : Female Age : 0 Y
11 M 10 D

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

Time	Nursing Notes
10:50pm	* patient come to ER
10:54pm	* vital checked & Recorded
10:58pm	* Doctor seen the Advised Admission
11:2pm	* Admission process done
11:40pm	* IV placement done * chest x-ray done
11:50pm	* blood sampler collect set to lab
11:42pm	* covid Rat → Positive
	* patient shifted to ward (102)

Samples collected by:

Samples sent by:

} Rajyalaxmi

Time: @ 11:40pm

Time: @ 11:50pm

Medication given in ER:

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

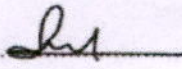
Condition of patient at time of shift - out :	Details of Shift - out
HR: 105b/m BP: 105/60 CFT: 3.35cm RR: 24b/m SPO ₂ : 100% GCS: 15/15 Temperature: 98.2°F Pain Score: 0 Repeat RBS (if applicable): -	Shift - out from ER to: 102 Time of Shift - out: 2/6/26 @ 12:25AM Handover given to: Sr. Benonika (Nurse's Name) Br. Sabin

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any):

IV placement done

Name of the Nurse : Sabin

Signature of the Nurse : 

Date & Time : 2/6/26 @ 12:25AM

Nursing General Admission Assessment Form For Pediatrics

Diagnosis: ADJ 2 UTS
Arrival Time: 12:25 AM **Mode of Arrival:** by mother lifting **Admitting From:** ER OPD Direct
Allergy / Adverse Reaction **Body Weight:** 8.4 Kg
 **Height:** cm
 NIL

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

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

Family History:
 NIL

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:
PTL / LSCS / 2.8kg / CIAB
 Are the child's immunization up to date? Yes No

Current Medication: None Yes, If Yes, fill reconciliation form
Observations: Weight: 8.4 kg Length: Head Circumference (< 2 years):
 Temp.: 98.0° F HR: 108 b/min RR: 28 b/min BP: 96/71(80)
Pain Score: 0 **Specify Site:** NIL (Follow Pain Assessment Sheet & Document)
Fall Risk Assessment: Yes No **Score:** 11 (Document in the Humpty Dumpty Sheet)
Risk of Pressure Sore (Braden Q Score 27) (Document in the Braden Q Assessment Sheet)

Pain Screening: Yes No If Yes, **Pain Score:** NIL **Pain Tool Used:** N Pass FLACC Wong Baker
Character of Pain NIL **Location** NIL **Frequency** NIL **Duration** NIL

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):

Social History: Lives With *Parents*

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

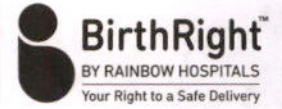
Others


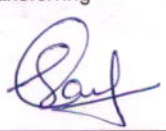
Patient Rights & Responsibilities: Yes No

Information given to *mothers*

Nurse's Name: *Beronica* Date: *8/6/26* Time: *at 12:45* Signature: *[Signature]*

PATIENT TRANSFER FORM



Patient Name & UHID No. VIH-00204627 IP-00060212 Baby MRINAL PRADVI 23-06-2025 0 Y 11 M 10 D (F) Dr. PREETHAM KUMAR 		Date & Time of Admission 2/06/26 @ 11:04 PM	Date & Time of Transfer Order 3/06/26 @ 12:25 AM
		Transfer Ordered by Dr. Nikesh	Reason for Transfer For Admission
From Unit ER	To Unit 102	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File (21)	Number of Imaging Films -	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Swathi 		Name of Person Ordered Transfer Dr. Nikesh	
Patient & Clinical Records Received by : Dr. Bevonika			
Date & Time of Patient Received : 3/6/26 @ 12:30 AM			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

Unavailable Bed

Nurse not Available

Available Bed not ready



**Rainbow[®]
Children's
Hospital**
It takes a lot to treat the little.

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

Patient Name: _____

VIH-00204627 IP-00060212

Baby MRINAL PRADVI

23-06-2025 0 Y 11 M 10 D (F)

Dr. PREETHAM KUMAR

UHID ID: _____



Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

fever x 5 days cough & cold x 5 days
vomiting intermittently
Loose stools x 3 days

History of present illness :

- fever, high grade, intermittent, without rigors
relieved on taking medications
for last 5 days

- cough & cold,
dry cough x 5 days

- vomiting, intermittent, mostly after taking feeds
NP, NB, Non bloody since last 3 days

- Loose stools, watery, without blood, 4-5/day
since last 3 days

- Not taking orally well x 2 days

went to nearby pediatrician — advised for admission

Travel Hx ().



Pediatric Multiorgan History & Physical Examination

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

Not significant

Birth & Neonatal History:

FT / LSCS (2-8kg) CSAB

Birth & Socio Economic History:

About Father : _____
About Mother : _____
Any additional Information : _____

Developmental History :

Appropriate for age

Immunization History :

Completed



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____
Weight (kgs) _____ (Centile _____)

On Examination :

Temperature : 99.6 F Pulse Rate : _____ B.P. _____ SPO2 100% on room air
Resp. rate and type of breathing : 28/min

Rash _____ no
Lymphadenopathy _____ no
Oedema : _____ no
Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : nil heard
Air entry & breath sounds : _____
Any added sounds : _____ no
Relevant data from outside (Chest X-Ray, ABG, etc.,) _____

Cardiovascular System :

Inspection of precordium : st2 M
Heart Sounds : _____
Any murmur : _____ no murmur
Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : _____

Per Abdomen :

Inspection _____ soft non tender
Palpation : _____
Auscultation : _____
Spine : _____ External Genitalia : _____
Relevant data from outside (CT, USG etc.,) _____



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15/5

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: (N)

Power good All movements

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR +2

Plantars flexor

Superficials:

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Acute febrile illness (UTI)



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____


Planned Labs:


- CBPV ✓
- CRP ✓
- CUE ✗
- S. Strep. titers ✓
- S. Creatinine ✓
- RI culture ✓
- Urine culture & chest X ray ✓

Planned Management

- IV fluid
- Dro. ceftriaxone
- Neb C hydrocort
- H. Zinc
- ~~IV. H. paracetamol~~
- H. ondansetron

~~Noted by Dr. Rajyalakshmi on 2/06/26 @ 11:45 PM~~

Signature of the Doctor: 
Name of the Doctor: Dr. Nikesh
Date & Time: 2/6/26

Signature of the Consultant: 
Name of the Consultant: Dr. Preetham
Date & Time: 2/6/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6/26 5:30 AM	<p><u>Child Resident</u></p> <p>As I + evaluation</p> <p>1 fempike @ kam (103.3f)</p>	
Oral intake (↓)	<p>No vomitings or loose stools ∴ Admission.</p>	
u/o (↓)	<p>o/e</p>	<p>ord (ent)</p>
Child Alert	<p>Vital stable</p>	<p><u>plan</u></p>
Oral - present	<p>CV: S1/2 (⊕)</p>	<p>- Ij. cephalosporins-D +</p>
	<p>M: B/LA (⊕)</p>	<p>- Hypocarb nebulation.</p>
	<p>P/A: Wt</p>	<p>- sup. zincana.</p>
	<p>CNS: NAD.</p>	<p>- mouthwashes</p>
<p>3/6/26 SA Dr. Preetham</p>	<p>noted by Manasa 3/6 8PM</p>	<p>- Ijfm (601)</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6/26	<u>C/S/B Resident</u>	
4:20 pm	Dis: LRTI.	
	No fevers.	
	No new concerns.	
	<u>0/e</u>	
Send out CBD film CRP	Child Acting Alert vital stable CU: S.M. (+) M: B/LAC (+) P/A: HT CNS: A.D.	- Add levulin. Trace concs y/d.
for	3/6/26 A.P.M.	
		Noted by Subham
		3/6/26 @ 7:30 pm

VIH-00204627 IP-00060212
 Baby MRINAL PRADVI
 23-06-2025 0 Y 11 M 11 D (F)
 Dr. PREETHAM KUMAR



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		AFI? [R11]
4/6/26		
8:10 AM		No fevers > 24hrs.
		- No RD on RA.
		- No other localizing signs
		- @ u.o, ↓ intake
		CVS
B/Ck → No growth		CVS @
apx 24hrs.		RS - B/C conducted
		PA - safe.
		Plan
		- Trace Cultures
		- Ceftriaxone
CRP - 32		- fluvir } DL
CUE @		- vitals cont'd
		- inform Sec.
		d.c. [signature]
4/6/26 9 AM		
↓ [signature]		
		noted by
		Manasa
		4/6/26
		9:20 PM



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: AFI ? UTI		Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: Nil					
	Surgery / Procedure:		Post OP Day:					
BACKGROUND	Date	02/06/26	01/06/26	3/6	3/6/26	3/6/26	4/6/26	
	Shift	N	NIGHT	M	Evening	N	M	
	Medical Condition (Any special condition to be noted):	nil	nil	nil	nil	Nil	nil	
ASSESSMENT	Diet:	s.diet		s.diet	soft diet wearing	s.diet	s.diet	
	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA	RA	RA	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	99.6F	98.6F	98.1F	98.6F	98.6F	98.3F
		Res:	28b/r	26b/r	28b/m	28b/m	20b/m	22b/m
		SpO ₂ :	99%	98%	97%	96%	97%	98%
		Pulse:	125b/m	126b/m	120b/m	114b/m	112b/m	110b/m
		BP:	-	-	100/60(76)	92/60(75)	76/63(71)	100/60(70)
		LOC:	conscious	conscious	conscious	conscious	conscious	conscious
		Fall Risk Score:	11	11	11	11	11	11
	Pain Score:	0	0	0	0	0	0	
	Skin Integrity	Intact	Intact	intact	intact	Intact	Intact	
	Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		Physiotherapy:	nil	nil	nil	nil	nil	nil
Others Specify:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Special Diet:		s.diet	s.diet	s.diet	s.diet	s.diet	s.diet	
Critical Lab Test / Values:		nil	nil	nil	nil	nil	nil	
Other Special Orders / Medications:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
PU Prophylaxis:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
DVT Prophylaxis:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
ADL (Dependent / Non Dependent):	dependent	dependent	dependent	dependent	dependent	dependent		
Post Operative Procedure Special Orders:	nil	nil	nil	nil	nil	nil		
Handed Over By Name :	Subhram	Beraniqa	Manasa	Subhram	Beraniqa	Indu		
Signature / ID :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]		
Date:	3/6/26	3/6/26	3/6/26	3/6/26	4/6/26	4/6		
Time:	@ 12AM	@ AM	@ 2PM	@ 8PM	@ 8AM	@ 2PM		
Taken Over By Name :	Beraniqa	Subhram	Subhram	Beraniqa	Indu			
Signature / ID :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]			
Date:	3/6/26	3/6	3/6/26	3/6/26	4/6/26			
Time:	12:25 AM	8AM	@ 2PM	@ 8PM	@ 8AM			

Noted by
 Indu
 4/6/26
 2:45pm

VIH-00204627 IP-00060212
 Baby MRINAL PRADVI 0 Y 11 M 11 D (F)
 23-06-2025
 Dr. PREETHAM KUMAR



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date							
	Shift							
	Medical Condition (Any special condition to be noted):							
	Diet:							
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):							
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
		LOC:						
		Fall Risk Score:						
Pain Score:								
Skin Integrity								
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:							
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:							
	Critical Lab Test / Values:							
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	ADL (Dependent / Non Dependent):							
	PU Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	DVT Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Post Operative Procedure Special Orders:							
	Handed Over By Name :							
	Signature / ID :							
	Date:							
	Time:							
	Taken Over By Name :							
	Signature / ID :							
	Date:							
	Time:							



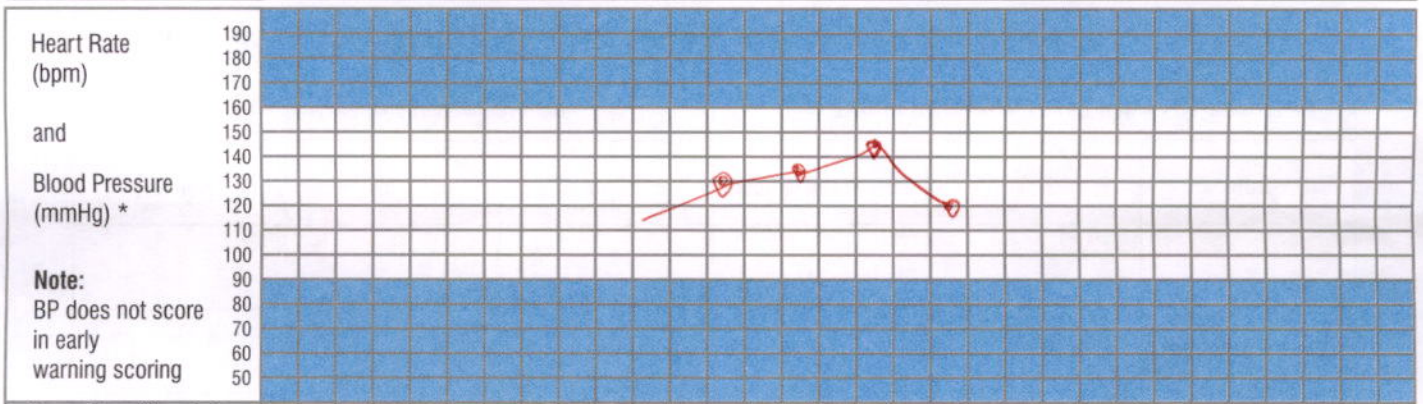
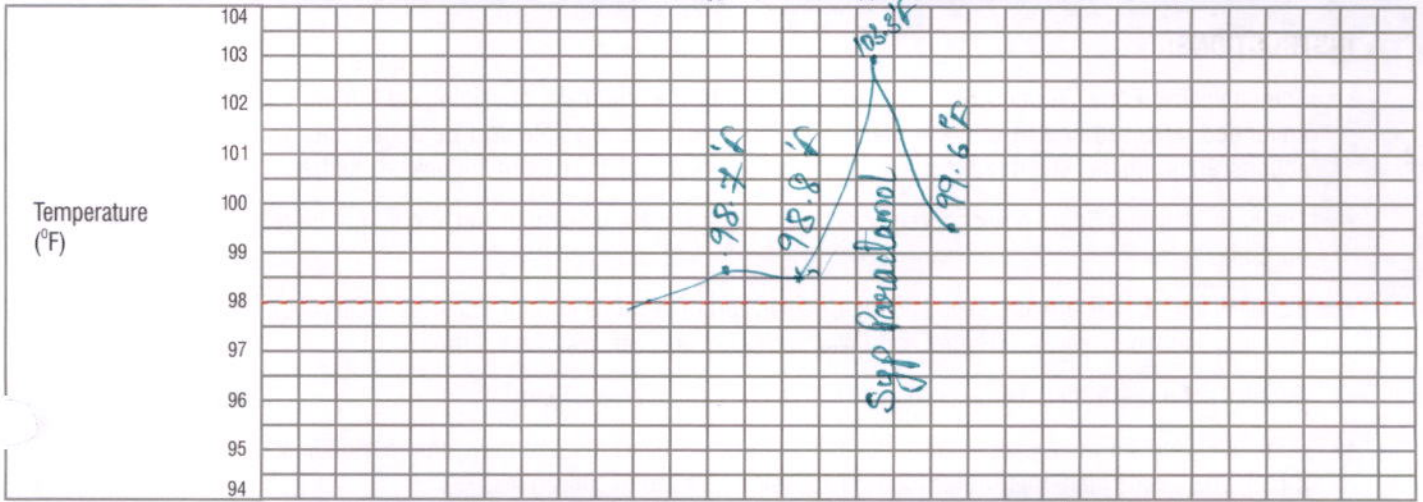
INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart



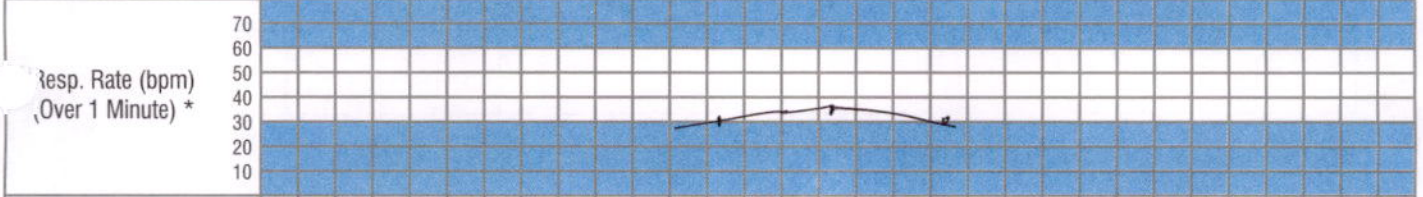
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 26/06/25 Time: _____

Doctor/Nurse/Family Concern? _____



Heart Rate (Number) _____



Resp Rate (Number) _____

Resp Distress: Mod/ Severe / None / Mild

Receiving O₂ (l/min) / O₂ Saturations (%)

Conscious Level: Normal / Altered

GCS *

TOTAL SCORE
 Number of shaded boxes

Pain Score

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 incharge and PICU /NICU fellow or PICU/NICU 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.

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)



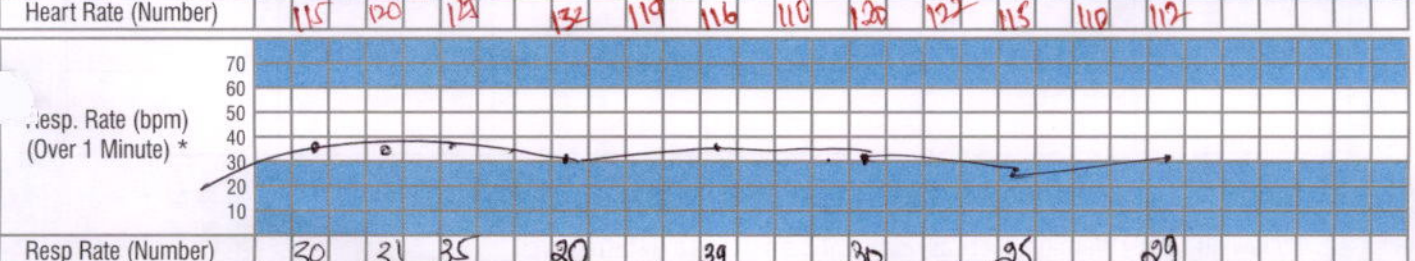
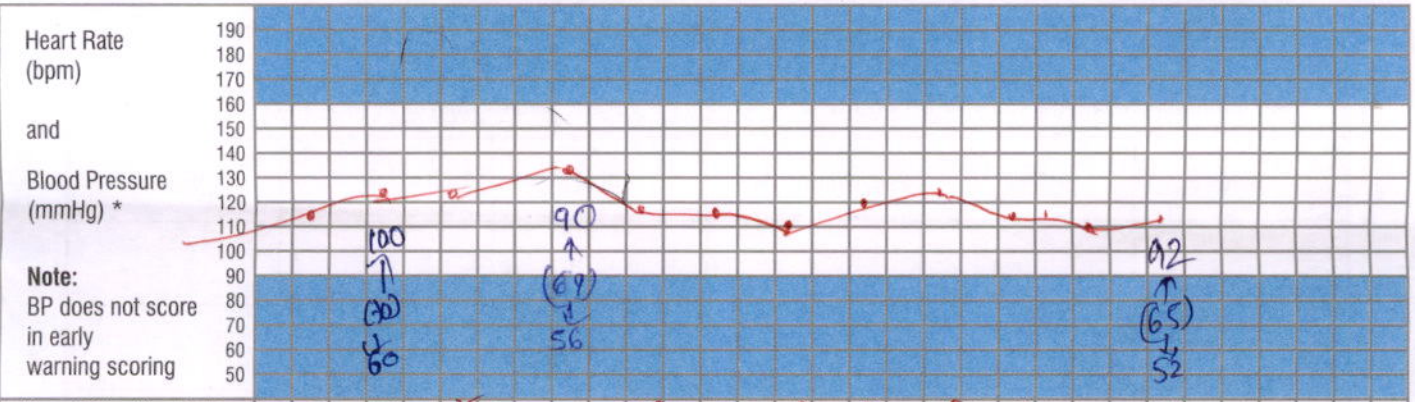
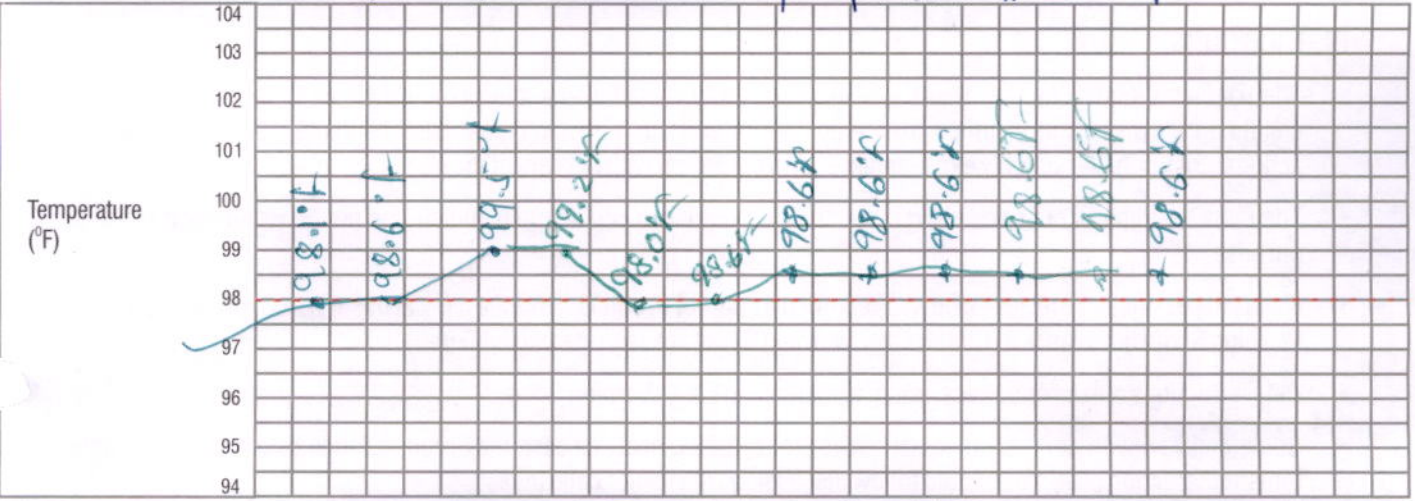
INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 3/6 Time: 9 11 2 3:15 5 7 9 11 1 3 5 7

Doctor/Nurse/Family Concern? AM AM PM PM PM PM PM PM PM AM AM AM PM



Resp Distress	Mod/ Severe None / Mild	Receiving O ₂ (l/min)	O ₂ Saturations (%)	Conscious Level	Normal Altered	GCS *
		07	98	N	N	15
		08	98	N	N	15
		08	98	N	N	15
		07	97	N	N	15
		09	99	N	N	15
		06	96	N	N	15
		09	99	N	N	15
		09	99	N	N	15
		08	98	N	N	15
		07	97	N	N	15
		09	99	N	N	15
		08	98	N	N	15

TOTAL SCORE	Number of shaded boxes	Pain Score	Observer's Initials
	0	0	PK
	0	0	M
	0	0	M
	0	0	SK
	0	0	SK
	0	0	SK
	0	0	B
	0	0	B
	0	0	B
	0	0	B
	0	0	B
	0	0	B

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 /NICU fellow or PICU/NICU 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.

VIH-00204627 IP-00060212
 Baby MRINAL PRADVI
 23-08-2025 0 Y 11 M 11 D (F)
 Dr. PREETHAM KUMAR

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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- 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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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)

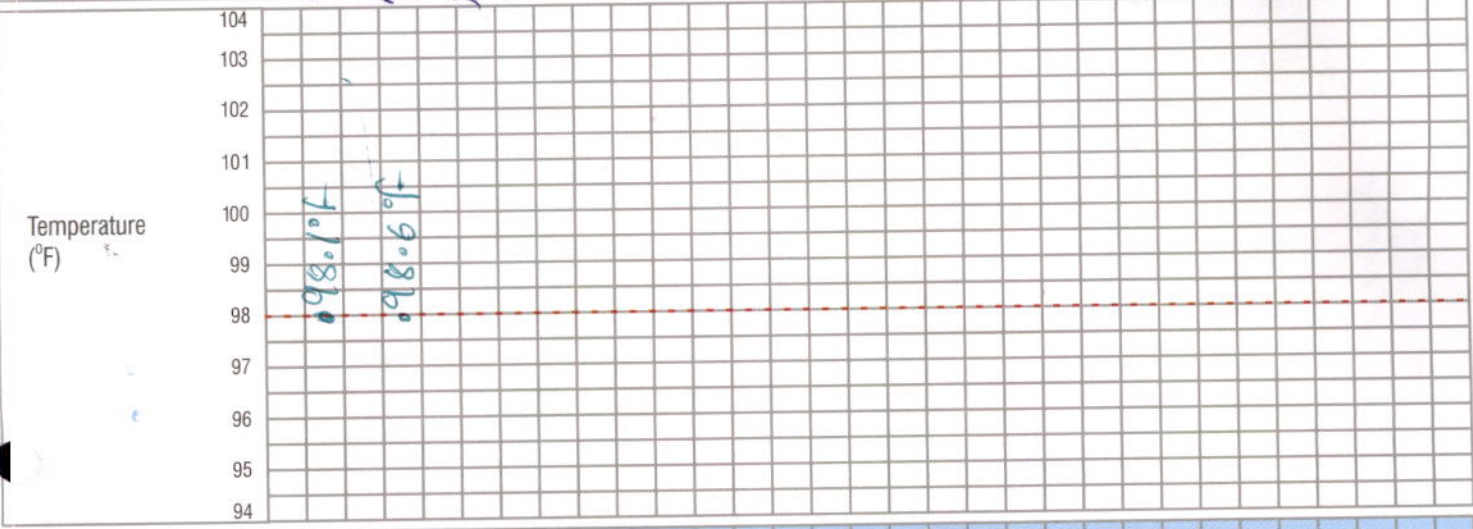
INFANT (<1 year)
 Children's Observation &
 Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 23/8 Time: 8 11 PM

Doctor/Nurse/Family Concern? Am Am Pm



Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		98 97
Conscious Level	Normal	r r
	Altered	
GCS *		5 5

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

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 incharge and PICU /NICU fellow or PICU/NICU 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.

noted by
 Indu
 4/8
 pm

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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Date	Time	Early Warning Score	Date	Time	Name

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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)



FLUID CHART

Sheet No. :

26/26

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 Thrombophlebitis 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												
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				DNS								
Total Intake :						Total Output :							
31/6/26	02:00 am												
	03:00 am												
	04:00 am	OBF		30ml									
	05:00 am			30ml									
	06:00 am			30ml									
	07:00 am			30ml									
Total Intake :						Total Output :							

Total 24 hrs. Intake 150ml

Total 24 hrs. Output 1 time



FLUID CHART

Sheet No. :

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

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
3/6	08:00 am											3/6 @ 7pm
	09:00 am	30ml	similac	30ml					✓			
	10:00 am	30ml										
	11:00 am	30ml	DBM									
	12:00 pm	30ml										
	01:00 pm	30ml	similac						✓			
Total Intake : 120ml					Total Output :							
4/6	02:00 pm			30ml								3/6 @ 7pm
	03:00 pm	30ml	similac	30ml								
	04:00 pm	30ml										
	05:00 pm		DBM						✓			
	06:00 pm											
	07:00 pm											
Total Intake : 90ml					Total Output :							
5/6	08:00 pm											3/6 @ 7am
	09:00 pm		DBM						✓			
	10:00 pm											
	11:00 pm		DBM									
	12:00 am											
	01:00 am											
Total Intake :					Total Output :							
6/6	02:00 am								✓			4/6 @ 7am
	03:00 am		DBM									
	04:00 am											
	05:00 am		DBM									
	06:00 am											
	07:00 am		DBM						✓			
Total Intake :					Total Output :							

Total 24 hrs. Intake 210 ml

Total 24 hrs. Output 6 time



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
4/6/26	08:00 am										0	Indu 4/6	
	09:00 am		DBF										
	10:00 am												
	11:00 am		DBF										
	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							

*noted by
 Indu
 4/6/26
 8:20 PM*



DRUG CHART

Date of Admission: 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.

VERIFIED BY : Name
 Signature
 02.06.26
 02.06.26

5ml/20mg SOS / PRN (As Required Medication)

DRUG : (PARACETAMOL) HP. CROCIDIN DS				Date Time																	
Dose	Route	Frequency	Start Date																		
R.5ml	PO	SOS	2/6																		
Doctor's Signature		Valid Period	Pharm.																		
Additional Instructions:		(15mg/kg/dose) (If T > 100 F) (6 hrs)																			

DRUG : (ONDANSERON) HP. ONDERM				Date Time																	
Dose	Route	Frequency	Start Date																		
5ml	PO	SOS	2/6																		
Doctor's Signature		Valid Period	Pharm.																		
Additional Instructions:		(0.1 mg/kg/dose) (If vomiting) (stat)																			

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

REGULAR PRESCRIPTIONS

Weight. 8.4kg Ward. 1st Floor



Rajyalakshmi 20/06/2025
 VERIFIED
 Rajyalakshmi 20/06/2025
 VERIFIED
~~Rajyalakshmi 20/06/2025
 VERIFIED~~

DRUG : <u>IV. LEFTRIAXONE</u>				Date Time	<u>9/6</u>	<u>11/6</u>														
Dose	Route	Frequency	Start Date	<u>6 AM</u>	<u>1:30 PM</u>	<u>6 AM</u>	<u>6 AM</u>													
<u>600mg</u>	<u>IV</u>	<u>12 hourly</u>	<u>2/6</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nitesh</u>																				
Additional Instructions: <u>6 PM 6 AM</u> <u>office fresh dose</u> <u>(500mg/kg/dose)</u>																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Neb. with HYPERNEB</u>				Date Time																
Dose	Route	Frequency	Start Date																	
<u>1 resp</u>	<u>Neb</u>	<u>8 hourly</u>	<u>2/6</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nitesh</u>				<u>↓ see nebulization sheet</u>																
Additional Instructions: <u>(Dr. HS)</u>																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>5TP. ZINCONIA</u>				Date Time																
Dose	Route	Frequency	Start Date																	
<u>5ml</u>	<u>PO</u>	<u>one daily</u>	<u>2/6</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nitesh</u>																				
Additional Instructions: <u>5 ml = 200mg</u>																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>ZINCONIA A 00PS</u>				Date Time																
Dose	Route	Frequency	Start Date																	
<u>1ml</u>	<u>PO</u>	<u>one daily</u>	<u>2/6</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nitesh</u>																				
Additional Instructions: <u>(1 ml = 20mg)</u>																				
Daily Doctor's Endorsement by a Sign																				



Sheet No: **REGULAR PRESCRIPTIONS** Weight 8.4 Kg Ward 1st Floor

DRUG: SYP ZINCOMAX Date/Time 3/6 4/6

Dose	Route	Frequency	Start Dt.
<u>5ml</u>	<u>PO</u>	<u>once</u>	<u>2/6</u>

Name & Signature of the Doctor Starting the Drugs: [Signature]
 Additional Instructions: 5ml = 20mg

Daily Doctor's Endorsement by a Sign

DRUG: OSELTAMIVIR Date/Time

Dose	Route	Frequency	Start Dt.
<u>1ml</u>	<u>oral</u>	<u>12hly</u>	<u>3/6</u>

Name & Signature of the Doctor Starting the Drugs: [Signature]
 Additional Instructions: (1ml - 12mg)
3 mg/kg/dose

Daily Doctor's Endorsement by a Sign

DRUG: OSELTAMIVIR Date/Time 3/6 4/6 5 6 7

Dose	Route	Frequency	Start Dt.
<u>2ml</u>	<u>PO</u>	<u>12hly</u>	<u>3/6/2</u>

Name & Signature of the Doctor Starting the Drugs: [Signature]
 Additional Instructions: 1ml/12mg
3mg/kg/dose

Daily Doctor's Endorsement by a Sign

DRUG: Neb. hydrocortisone Date/Time

Dose	Route	Frequency	Start Dt.
<u>0-3mg</u>	<u>plw</u>	<u>6hly</u>	<u>3/6/2</u>

Name & Signature of the Doctor Starting the Drugs: [Signature]
 Additional Instructions: braylee = 0-3mg

Daily Doctor's Endorsement by a Sign

VERIFIED & ready to use
 2/6/26

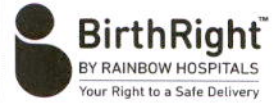
MERU Drug 3.6.26 10AM

VERIFIED

ChH 3/6/26

See the Neb's chart

VIH-00204627 IP-00060212
 Baby MRINAL PRADVI
 23-08-2025 0 Y 11 M 11 D (F)
 Dr. PREETHAM KUMAR



Sheet No: **REGULAR PRESCRIPTIONS** Weight Ward

8/16/26

Chait

Signature

VERIFIED BY : Name

DRUG :				Date
Dose	Route	Frequency	Start Dt.	Time
NAB CLEAR NATAL DROPS				3/6 4/6
2 DROPS	PO	8 times	3/6/2	AM
Name & Signature of the Doctor Starting the Drugs:				2 pm
Dr. Preetham				10 pm
Additional Instructions:				2 pm
2 DROPS IN EARLY MORNING				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date
Dose	Route	Frequency	Start Dt.	Time
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date
Dose	Route	Frequency	Start Dt.	Time
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date
Dose	Route	Frequency	Start Dt.	Time
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				



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Patient Name : Baby MRINAL PRADVI
 23-06-2025 0 Y 11 M 11 D (F)

Registration No.: VIH-00204627 IP-00060212
 Dr. PREETHAM KUMAR



MEDICATION NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
8/6/26	00.00			
	1.00	6AM PnJ CEFTRIAZONE 400mg (BD) → 1:30 AM		Ashwini.P
2.00	SYP ZINCONIA 1ml (OD) → 6AM			
	3.00			
	4.00			
	5.00			
	6.00			
	7.00	6pm PnJ CEFTRIAZONE 400mg (BD)		
	8.00			
	9.00			
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			