

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP : _____ Patient : _____ Dept : _____

Date of Admission: _____ Discharge : _____ Time: _____

Room / Bed No : _____ Billable bed type : _____

BAH-00660997 IP5-00176106
Master KRISHNA SAINATH
10-12-2019 6 Y 6 M 28 D (M)
Dr. NALLA ANURAG REDDY



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/1/20	2:30pm	ER	125	

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
8/7	In placement	①	3237	Samsky

ANY OTHER INFORMATION

.....

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.....

.....

.....

Date : 11/1/16

Time : 12pm

Prepared By :

Staff Nurse Samsky	Shift / Ward analog morning	Billing Assistant	Billing Supervisor
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ADMISSION SHEET
Registration Details :


Admission No : IP5-00176106 Admit Date : 08-Jul-2026 Admit Time : 01:49 PM UHID : BAH-00660997

Patient Details :

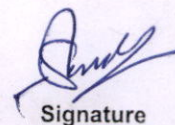
Patient Name : Master KRISHNA SAINATH NILAMKAR Age : 6 Y 6 M 28 D
 Guardian : Mr SAINATH NARAYAN NILAMKAR DOB : 10-12-2019
 Gender : Male Religion :
 Occupation : Martial Status : Single
 Address (H) : VANJAR GALLI , BILOLI , Kundalwadi Nanded Phone No : 9689686801/ 9542451980
 Maharashtra INDIA 431711 E-mail : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : FOUR SHARING Bed No : FSW 125 Ward Name : 1F-HEMATO-ONCOLOGY
 Room No : FSW 125 Admission Type : First Visit

Contact Details :

Name : Mr SAINATH NARAYAN NILAMKAR Relationship : Father
 Contact Address : VANJAR GALLI , BILOLI , Kundalwadi Nanded Phone No : 9689686801 / 9542451980
 Maharashtra INDIA 431711



Signature

Doctor Details :

Doctor Name : Dr. NALLA ANURAAG REDDY Specialisation : HEMATO ONCOLOGY
 Referral Doctor : Self Phone No :
 Co-Consultant : Dr. SIRISHA RANI

Payment Details :

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

BAH-00660997 IP5-00176106
Master KRISHNA SAINATH
10-12-2019 6 Y 6 M 28 D (M)
Dr. NALLA ANURAAG REDDY


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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 Diarrhea 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: d

Name of the Doctor: harani

Date & Time: 8/7/26 @ 1:29pm

BAH-00660997 IP5-00176106
Master KRISHNA SAINATH
10-12-2019 6 Y 7 M 1 D (M)
Dr. NALLA ANURAAG REDDY


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DISCHARGE CRITERIA – ONCOLOGY

Discharge to:

☐ HDU / Step down ICU ☐ Ward ☐ Outside Facility ☐ Others:

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:

Name of the Doctor :

Date & Time:



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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

N. Krishna Nilankar

UHID ID:

Department:

Consultant:

BAH-00660997 IP5-00176106
Master KRISHNA SAINATH
10-12-2019 6 Y 6 M 28 D (M)
Dr. NALLA ANURAAG REDDY





Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Fever on & off since 15 days.

Nausea.

History of present illness :

Child was apparently well 20 days ago. Child developed above mentioned complaints.

Fever - Intermittent fever spikes.

Reduces with Crocin Syrup.

Child was admitted & given IV medication from 23/6 to 26/6/26.

↓
Child has heavy recurrence of fever with elevated leucocytes $\bar{c}$
85% blasts

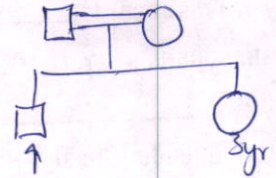
USA Abdomen - Splenomegaly (+).



Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:



Birth & Socio Economic History:

About Father : _____ } Middle class -
About Mother : _____
Any additional Information : _____

Developmental History :

④ development

Immunization History :

vaccination history



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): 111.5 cm (Centile _____)
Weight (kgs) : 16.45 kg (Centile _____)

On Examination :

Temperature : 98.5°F Pulse Rate : 116/min B.P. 101/54(63) SP02 100% on RA

Resp. rate and type of breathing : _____

Rash _____ Palos (+)

Lymphadenopathy Cervical lymph nodes (+)

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L AE (+)

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S1 S2 (+)

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Soft, NT., splenomegaly (+)

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 : _____

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Plantars _____

Superficials:

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Acute Leukemia In Evolution.

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

Tumor lysis panel - 1
 LDH
 2 extra EDTA } collect & give
 2 Heparin } in ward.
 CXR

N.B
 Shambhu
 8/7/26

Planned Management

1/2 DNS @ 65mg/hr
 Tab Atropine 100mg @ 1-1/2-1/2

Signature of the Doctor: Dr. Ramya

Name of the Doctor: Dr. Ramya

Date & Time: 8/7/26, 1:pm

Signature of the Consultant: Dr. Sandhya Vaddadi

Name of the Consultant: Dr. N. Anurag

Date & Time: 9/7/26 @ 10am

DR. SANDHYA VADDADI
 Registration No: 71664



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/20	Evening rounds	
3 PM	Newly diagnosed Acute leukemia	Adv
	No issues	1) Hydration
	Alert, active	2) Tasis, rest
	V, full @	as per chart
	Stable PRW, CRT 42%	3) (RN) Rasmussen
	CNS	4) monitor vitals
	PLS	5) Inform S.O.S.
	PIO	
		Ahmedab
		— start carbimazole today.
		2/B
		Sonam
		6 PM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/20 8:50 AM	Newly diagnosed acute leukemia / High counts / Pts. Afebrile, Alert UO $\rightarrow$ 4.3 u/hg/hr. Vitals (N) SLE-SPPWFT (FTL) etc. WBC Hb Plt (N) Splenomegaly (+)	Adv. 1) cont drugs as per chart 2) cont hydration 3) monitor vitals 4) Inform Svs. Shankar 1) Dexta 0.5 mg IV today Continue IV fluids PRBC today evening - after CBP - TLS-2 today @ 1 pm. IT Phosphate. DR. SANKAR ANAND Registration No: 71094 9/7/20 @ 10 am n/b Rajamani 9/7/20 @ 11 AM

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIK
 11-02-2022 4 Y 4 M 28 D (F)
 Dr. SIRISHA RANI



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Consulting notes</u>	
	<pre> graph TD Root(()) --- R Root --- W Root --- P R --> SC[S.C] W --> Stake((Stake)) P --> 36000[36,000] </pre>	
	→ Leukemia / blood cancer <pre> graph TD LC[Leukemia / blood cancer] --- ALL LC --- AML ALL --- B ALL --- T((T)) </pre>	
	T-ALL	Standard med high risk
	How? → ?? Stage? → CR5. R?	



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	As - chemo Rx 3 1/2 ④ - 6 months - Intensive chemotherapy hunger, anger, BP ↑ ✓ denials hair loss VCR - 4 (weekly one) Saline - 4 (weekly one) By sy - 2 (2 weekly) 3 - 1 1/2 nausea, loose motion constipation ulcers, pain infection paronychia, clot	1 stable ⑥ → ①
	→ BM → MRN → T cell → 100 15% 20%	<0.01% 80-85%



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/20 9 AM	Morning rounds J.D. ETP ALL Newly Diagnosed Acute Leukemia/ high count. Afebrile, Alert Vital (N) No fresh issues S/E → PPWF, CFT, L200 C/S R/S P/A	Asw 1) PRBC today/TM 2) count rest 3) monitor vitals 4) encourage orally 5) Inform S/S CBS, S/E TIM Inj Dexa 0.5mg IV stat. <i>[Signature]</i> SANDHYA VADDADI Registration No: 71664
10/7/20 11 AM	CLUB Resident. Dr: ETP ALL. Newly diagnosed Acute Leukemia. O/S Check alert & behavior Vital stable. C/S R/S P/A CM	N/B Rajanna 10/7/20 11 AM <u>plan</u> - CBS, S/E - TM. - PRBC - TM. - monitor vitals - C & S (N/S).



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/07/25 8:30 AM	Morning rounds SES ETP ALL	plan
	O/E - Alert & Active No Fresh Concerns	CPR ser. XPRBC Today
	CUS re (2) PID CHS - NO FMD	Monitor vitals Inform SOS Continue IV fluids
		→ Dena 1mg IV BD.
	Dr. Anuraag Reddy 43498 noted by M. Srin	XPRBC today. Z Macei

BAH-00650997
 Masur KRISHNA SAINATH
 10-12-2019 8 Y 6 M 28 D (M)
 Dr. NALLA ANURAAG REDDY

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RESULT SHEET

Date	8/2/20	9/7	11/7			
Time			8am			
Hb	5.6	6.0	6.1			
PCV	18.4	10.3	19.8			
RBC	2.49	2.63	2.69			
WBC	2,72,960	254,000	213,07			
N/L		6.78	6.977			
Platelets	63,000	52000	57,000			
CRP						
ESR						
PCT						
RBS		128				
Na	135	136	137			
K	4.2	4.3	4.5			
Cl	103	104	101			
Ca/Mg	9.7					
Phosphate	5.4	4.6				
Urea						
Creatinine	0.3					
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid	7	10.7				
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR	15/1.2					
APTT	35					
CSF Protein / Sugar						
Cells						
LDH	2387	d	d			

DRUG CHART

Date of Admission: 8/7/20 Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES
 (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

Signature
 VERIFIED BY : Name

Weight. 16454 Ward.

DRUG: Tcb ALLOPURINOL

Date	8/29/2021
Time	11:17

Dose	Route	Frequency	Start Date
	PO	TID	8/7/26

Name & Signature of the Doctor
Starting the Drugs:

Additional Instructions:

$$1 \text{ feb} = 100 \text{ mg}$$

$$\rightarrow 1 \text{ feb} = \frac{1}{2} \text{ feb} + \frac{1}{2} \text{ feb}$$

Daily Doctor's Endorsement by a Sign

DRUG: 1mg Furosemide

Date	8/7	9/7	10/2	11/2
Time				

Dose	Route	Frequency	Start Date
3 mg	IV	BD	8/7

Name & Signature of the Doctor
Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG: Iny TRANEXAMIC

Date	8/7/17	10/21/17
Time		

Dose	Route	Frequency	Start Date
250 mg	iv	BD	8/7

Name & Signature of the Doctor
Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG: Tab Ir. Lanrole

Date	
Time	

Dose 166	Route PO	Frequency OD	Start Date 1/9/7
-------------	-------------	-----------------	---------------------

Name & Signature of the Doctor
Starting the Drugs: *[Signature]*

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
9/7/26	2pm	1ij RASBURICASE	0.8mg	IV	d	Rajam Rao, Anil Korth, Rajam Rao
9/7/26	11am	1ij DEXAMETHASONE	0.5mg in 100ml NS	IV over 3 hours	d	Rajam Rao, Rajam Rao
10/7	11AM	1ij DEXAMETHASONE	0.5mg in 100ml NS	IV over 3 hours	Ally	Rajam Rao, Rajam Rao
10/7	2pm	1ij RASBURICASE	0.7mg	IV	Ally	Rajam Rao, Rajam Rao
10/7	10pm	1ij DEXAMETHASONE	0.5mg in 100ml NS	IV over 3 hours	Ally	Rajam Rao, Rajam Rao
11/07		PRBC	1 Unit over 4hrs	IV	Zi.	Rajam Rao, Rajam Rao
11/07		Tri LASIX	8mg	IV	Zi.	Rajam Rao, Rajam Rao
11/07		Tri AVIL	0.3ml	IV	Zi.	Rajam Rao, Rajam Rao
11/7	10AM	2ij DEXAMETHASONE	1mg in 100ml NS over 3 hrs.	IV	Ally	Rajam Rao, Rajam Rao



Weight. 16.45 kg Ward.

[illegible]

Signature

BAH-00660997 IP5-00176106
Master KRISHNA SAINATH
10-12-2019 6 Y 6 M 28 D (M)
Dr. NALLA ANURAAG REDDY

Patient



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MEDICATION RECONCILIATION FORM

Drug Allergies: ☐ Not known any Drug Allergies

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

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

Shifting From: ER Shifted to: Ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ 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: Dr. Ramy

Date & Time: 8/7/26; 1:45pm

Nurse Name & Signature: Nr. Sushmita

Date & Time: 8/7/26 @ 2pm

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
8/7/20	2pm	0	nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	nil/nil	[Signature]
8/7	10PM	0	nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	nil/nil	[Signature]
9/7	8AM	0	nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	nil	[Signature]
9/7	2pm	0	nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	nil	[Signature]
9/7	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	QUD	[Signature]
10/7	6am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
10/7	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
10/7	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
11/7	6am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

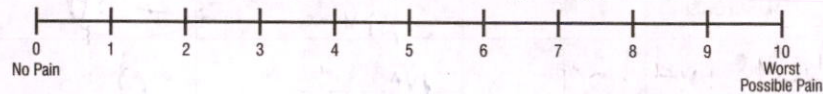
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

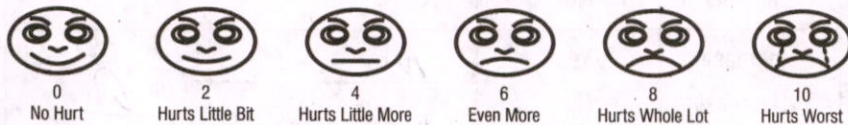
Numerical Pain Scale (Obstetric and Gynecology)



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



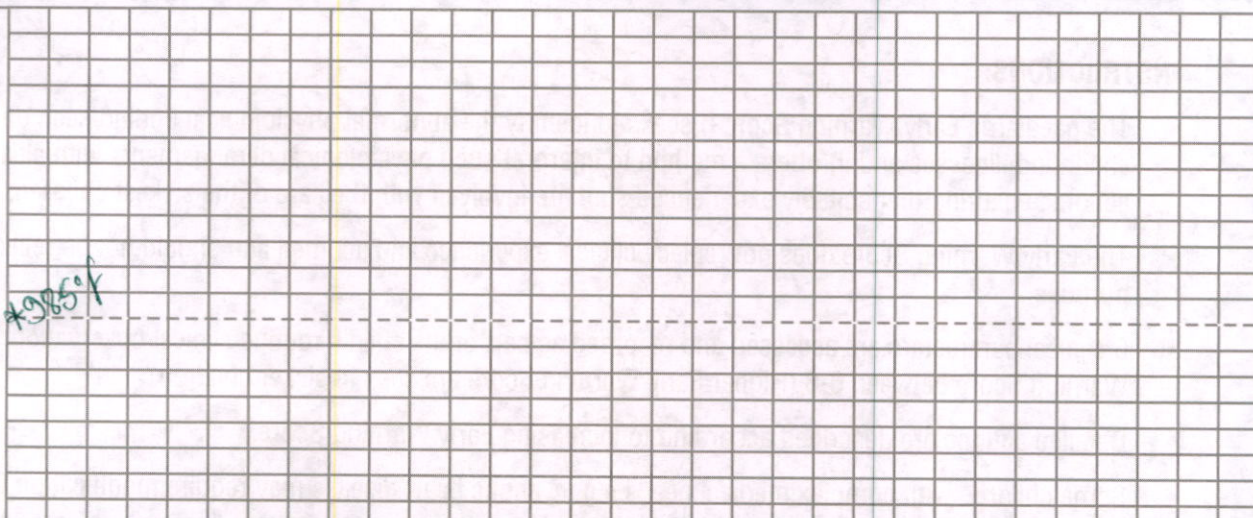
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/7/2019 Time: 10AM

Doctor / Nurse / Family Concern?

Temperature (°F)

104
103
102
101
100
99
98
97
96
95
94



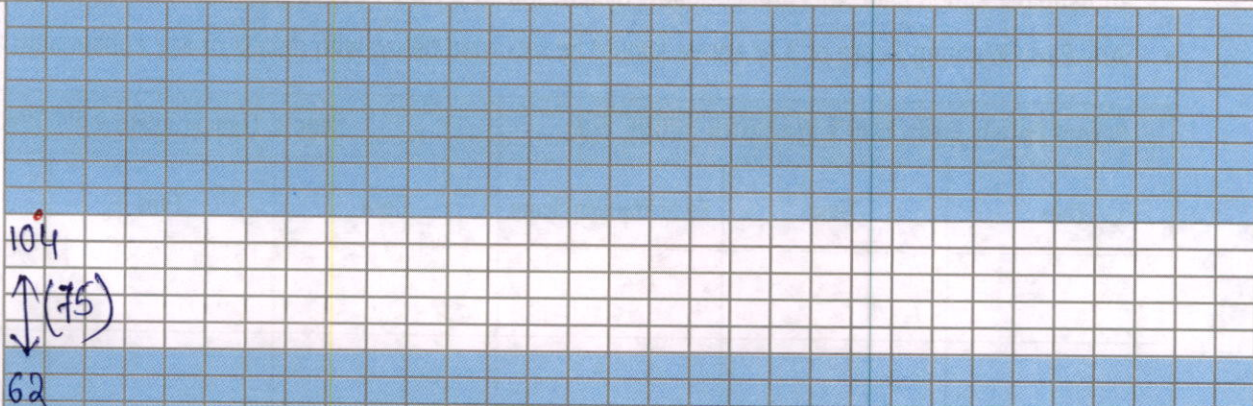
Heart Rate (bpm)

and

Blood Pressure (mmHg) *

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

Note:
BP does not score in early warning scoring



Heart Rate (Number) 120b/m

Resp. Rate (bpm) (Over 1 Minute) *

70
60
50
40
30
20
10



Resp Rate (Number) 24b/m

Resp Distress Mod/ Severe None / Mild

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



Conscious Level Normal Altered

GCS *

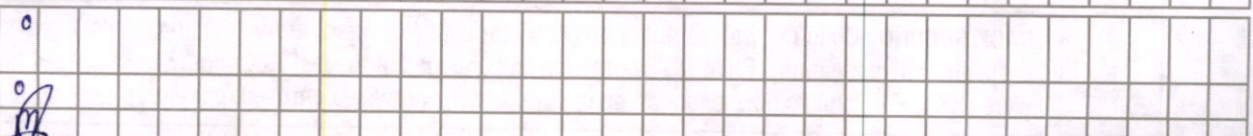


TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials



ACTIONS

NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
- Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
- Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

- If at any time additional help is required, call help – regardless of the Early Warning Score!
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The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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)



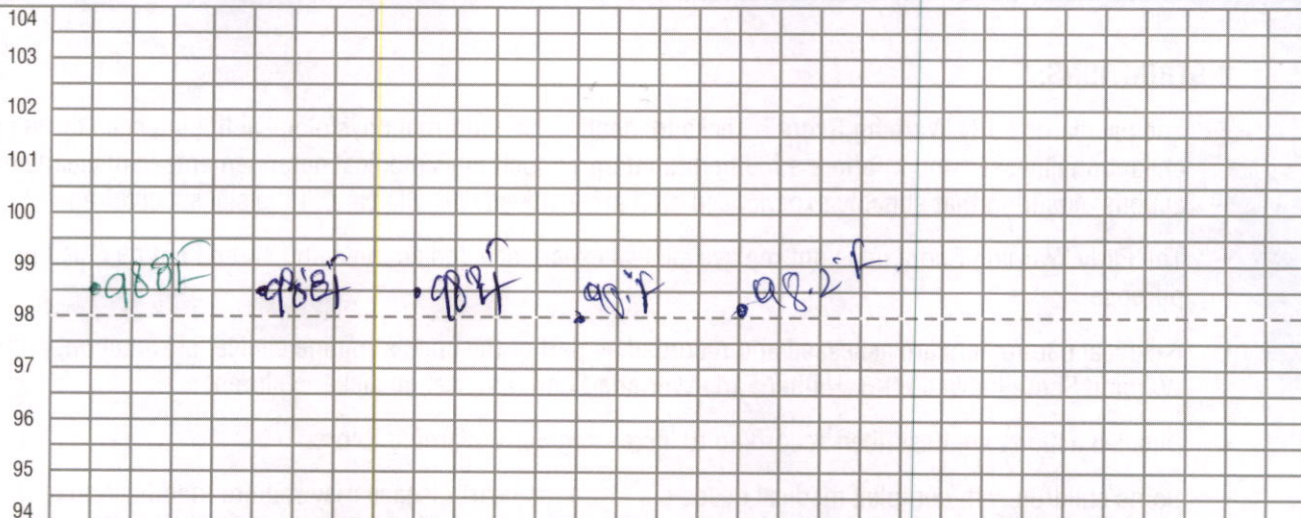
SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/9 Time: 9am 1pm 4pm 7pm 10pm
Doctor / Nurse / Family Concern?

Temperature
(F)

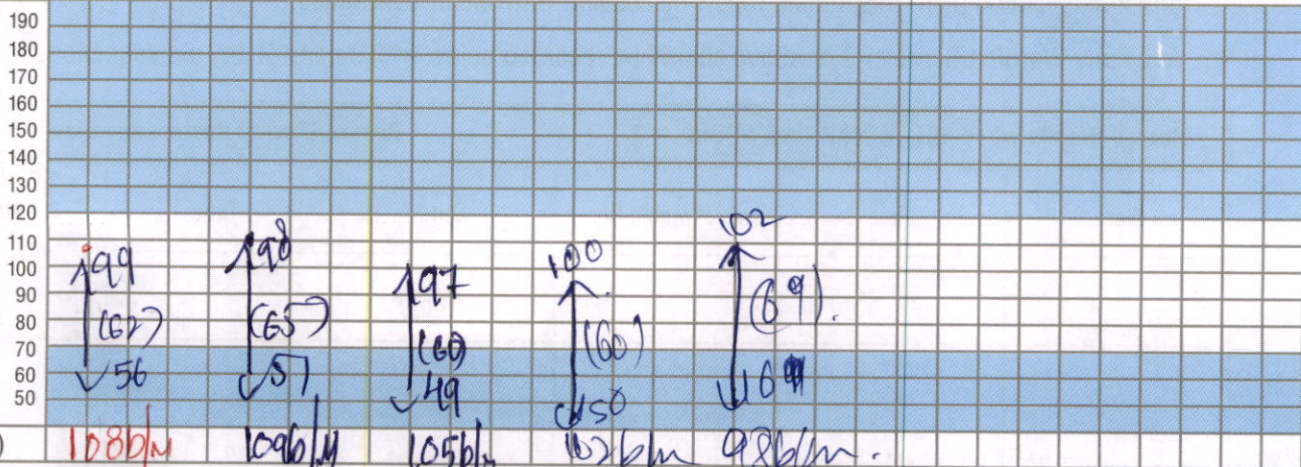


Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring



Heart Rate (Number)

108b/m 109b/m 105b/m 102b/m 98b/m

Resp. Rate (bpm)
(Over 1 Minute) *



Resp Rate (Number)

26b/m 26b/m 25b/m 28b/m 25b/m

Resp Mod/ Severe
Distress None / Mild

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

Conscious Normal
Level Altered

GCS *

100% 100% 100% 100% 100%
15/15 15/15 15/15 15/15 15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0 0 0 0 0
0 0 0 0 0
E E E E E

ACTIONS

NB: Scores 3 should be
recorded overleaf

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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

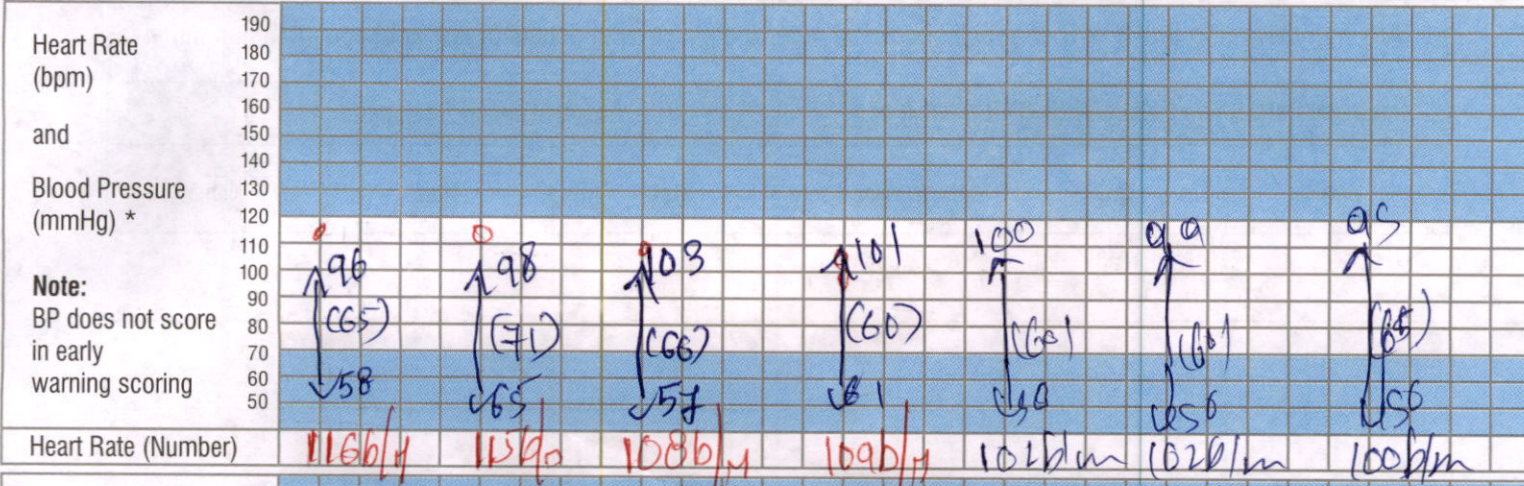
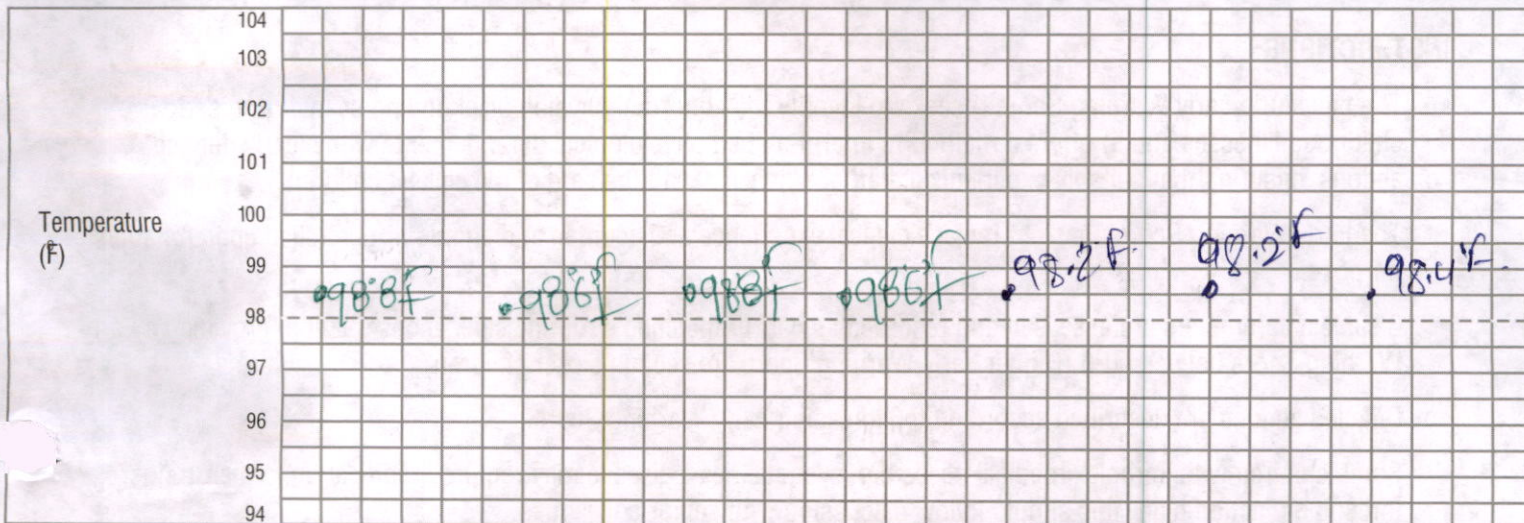
SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9/2/20 Time: 8:40 AM 1 PM 4 PM 7 PM 10 PM 3 AM 6 AM
Doctor / Nurse / Family Concern?



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

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

ACTIONS	
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.

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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)

BAH-0060997 IP5-00176106
Master KRISHNA SAINATH
10-12-2019 6 Y 6 M 28 D (M)
Dr. NALLA ANURAAG REDDY



No. : RCHBH/ FRM / CLINICAL / 126

①

SCHOOL AGE (5-12 years)

Children's Observation &
Early Warning Scoring Chart

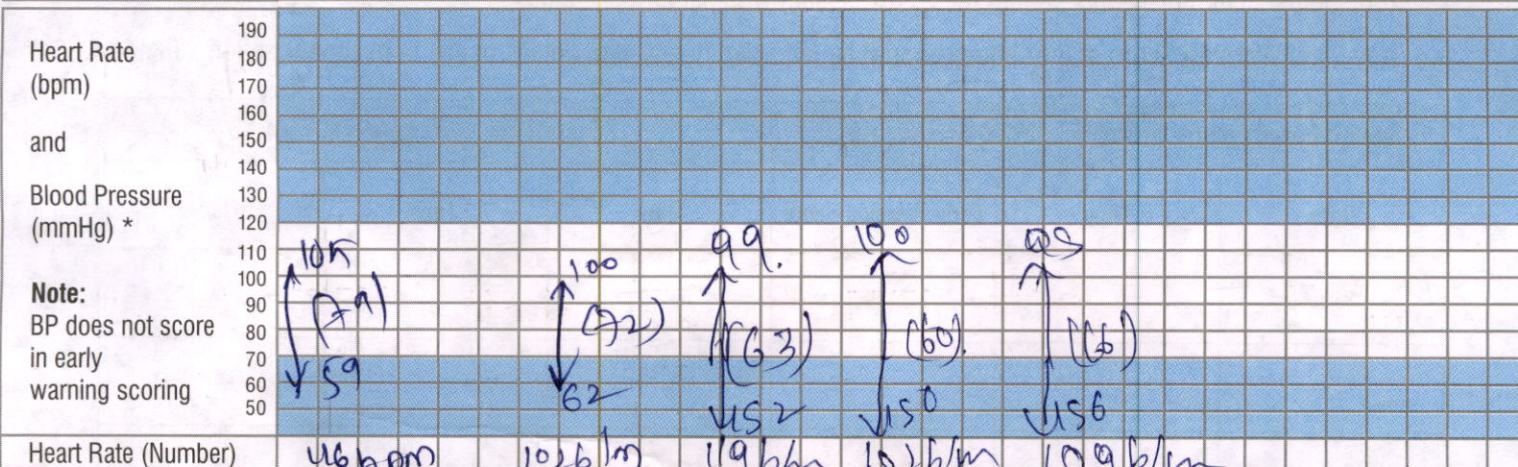
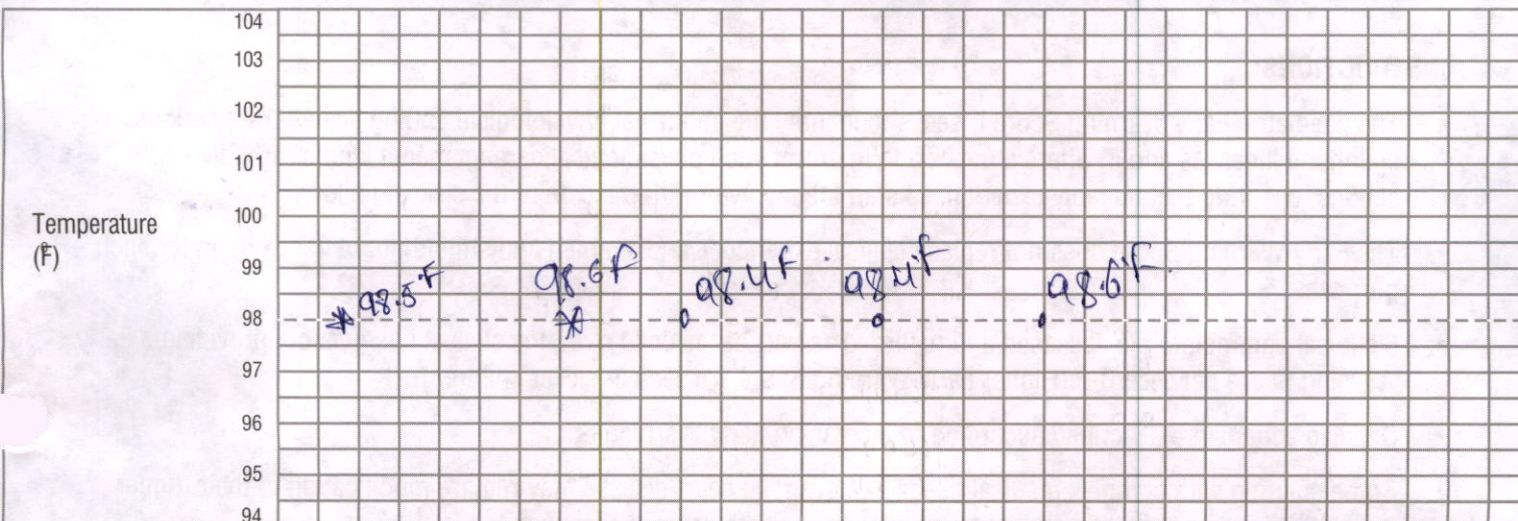
Rainbow
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Hospital
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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 8/2 Time: 9pm 7pm 10pm 3Am 6Am

Doctor / Nurse / Family Concern?



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

NB: Scores 3 should be recorded overleaf

Score 1 : Continue normal observation by staff nurse

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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. : 4

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

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	H2O	150ml	70ml							0	
	09:00 am	Idli	1 piece	70ml			✓			200ml	0	
	10:00 am	Milk	50ml	70ml							0	
	11:00 am	upma										
	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						



FLUID CHART

Sheet No. : 3

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	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	N.G							
10/12	08:00 am	Roti		70ml			✓			250ml	0	Day 3
	09:00 am			70ml							0	
	10:00 am	H2O	140ml	70ml							0	
	11:00 am	ml	100ml	33.3							0	
	12:00 pm			33.3						280ml	0	
	01:00 pm			33.3							0	
Total Intake :			550ml			Total Output :			580ml			
10/12	02:00 pm	Rice		50ml							0	Day 3
	03:00 pm			50ml						250ml	0	
	04:00 pm	H2O	140ml	70ml							0	
	05:00 pm			70ml							0	
	06:00 pm			70ml						200ml	0	
	07:00 pm			70ml							0	
Total Intake :			470ml			Total Output :			450ml			
10/12	08:00 pm	chapatti		70ml							0	Day 3
	09:00 pm	dal.		70ml							0	
	10:00 pm		270ml	70ml							0	
	11:00 pm			70ml						400ml	0	
	12:00 am	H2O		70ml							0	
	01:00 am			70ml							0	
Total Intake :			690ml			Total Output :			400ml			
10/12	02:00 am			70ml							0	Day 3
	03:00 am			70ml							0	
	04:00 am			70ml							0	
	05:00 am			70ml						300ml	0	
	06:00 am			70ml							0	
	07:00 am			70ml						100ml	0	
Total Intake :			420ml			Total Output :			400ml			
Total 24 hrs. Intake		2130 ÷ 133.1cc/kg										
Total 24 hrs. Output		1780 ÷ 4.63cc/kg										

BAH-00660997 IP5-00176106
Master KRISHNA SAINATH
10-12-2019 6 Y 6 M 28 D (M)
Dr. NALLA ANURAAG REDDY



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FLUID CHART

Sheet No. : 29

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

		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	200ml		70ml			✓			200ml	0	Rajamani
	09:00 am			70ml							0	
	10:00 am	H2O	200ml	70ml							0	
	11:00 am			70ml							0	
	12:00 pm			70ml						210ml	0	
	01:00 pm			70ml							0	
Total Intake :				440ml						410ml		M-1
	02:00 pm	Rice		70ml							0	Rajamani
	03:00 pm			25ml							0	
	04:00 pm	H2O	40ml	25ml						250ml	0	
	05:00 pm			25ml							0	
	06:00 pm			70ml							0	
	07:00 pm			70ml						150ml	0	
Total Intake :				425ml						400ml		M-1
	08:00 pm			70ml						200ml	0	Sany
	09:00 pm	chapti		70ml							0	
	10:00 pm		100ml	70ml							0	
	11:00 pm	H2O		70ml							0	
	12:00 am			70ml							0	
	01:00 am			70ml						50ml	0	
Total Intake :				520ml						250ml		
	02:00 am			70ml						200ml	0	Sany
	03:00 am			70ml							0	
	04:00 am			70ml							0	
	05:00 am			70ml							0	
	06:00 am			70ml							0	
	07:00 am			70ml						200ml	0	
Total Intake :				420ml						400ml		

Total 24 hrs. Intake

1802° - 109,216kg

Total 24 hrs. Output

1,460° - 3,756kg

m-1

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



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.

Docu. No. : RCHBH/FRM/CLINICAL/092



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/7/20

Assessment: Baby having ct hydration

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
8am	* Assess the child General condition	9am	* Assessed the child General condition	* Baby is good
10am	* monitor vital signs	11am	* monitor vital signs	
12Am	* maintain I/O chart	1Am	* maintained I/O chart	
2Am	* Administer medication given as per doctor order	3Am	* Administer medication as per doctor order	
5am	* ct some feeding	6am	* ct some feeding with hourly breast feeding	

Re-Assessment:

Special Notes: watch for dot & any alarm.

Nurse Signature: [Signature]

Nurse Name: Shuan

Date & Time: 11/7/20 @ 07



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 10/7

Assessment: Baby has poor oral intake

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
8 AM	Assess General condition of the baby	8 am	assessed General condition of the baby	Baby has eating well.
8:10 AM	Monitor vital signs	8:10 am	monitored vital signs	
12 PM	administer medications as per chart	12 PM	administered medications as per chart	
2 PM	to maintain fluid balance	2 PM	administered fluids	
4 PM	to encourage oral intake	4 PM	Encouraged oral intake	
6 PM	Ensure safety	6 PM	monitored side rails	
7 PM	Maintain I/O chart	7 PM	Maintained I/O chart	

Re-Assessment: Baby has improved his oral intake

Special Notes:

Nurse Signature:

Nurse Name: Rajani

Date & Time: 10/7/2020 8 PM



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/20

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
8pm	→ Assess the patient General condition	8:30pm	→ Assessed the patient condition.	Patient feel Better
10pm	→ Maintain personal hygiene.	10:30pm	→ Maintained personal hygiene.	
12am	→ Ensure Safety.	12:30am	→ Provided Side rails	
2am	→ Maintain fluid Balance.	2:30am	→ Maintained fluid Balance	
6am	→ Monitor I/O chart	6:30am	→ monitored I/O chart	

Re-Assessment: Patient is active

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Savitha

Date & Time: 9/7/2020



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 9/12/16

Assessment: Baby has poor oral intake

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess General condition of the baby	8am	assessed General condition of the baby	Baby has eating well
8:10am	Monitor vital signs	8:10am	Monitored vital signs	
10am	administer Medications as per chart	10am	administered medications as per chart	
1pm	to maintain hand hygiene	1pm	performed hand hygiene	
3pm	to ensure safety	3pm	provided oral care	
6pm	Maintain I/O chart	6pm	Maintained I/O chart	

Re-Assessment: Baby has improved his oral intake

Notes:

Nurse Name: Rajamma

Date & Time: 9/12/16 @ 8pm

BAH-00660997 IP5-00176106
Master KRISHNA SAINATH
10-12-2019 5 Y 6 M 28 D (M)
Dr. NALLA ANURAAG REDDY



2

NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/7/26

Assessment: Baby having cough hyaline loam

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the child present condition	9pm	* Assessed the child present condition	
1pm	* monitor vital signs	11pm	* monitor vital signs	
12Am	* maintain D/o chart	12:40Am	* maintain D/o chart	
1Am	* Administer medication as per doctor's order	2Am	* Administer medication as per doctor's order	
3am		4am		
5am	* monitor cough & sputum	7am	* monitor cough & sputum	

Re-Assessment: with hourly vital monitoring

Special Notes: watch for fever & any changes

Nurse Signature: [Signature]

Nurse Name: Shree

Date & Time: 8/7/26

①

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 8/7/26

Assessment: patient is anxious

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
3:00pm	Assess general condition of the patient	3:30pm	Assessed general condition of the patient	Patient is stable
4pm	monitor vital signs	4:30pm	monitored vital signs	
5pm	maintain hygiene.	5:30pm	maintained hygiene.	
6pm	Administer medications as per order.	6:30pm	Administered medications as per order	
7pm	maintain I/O chart	7:50pm	maintained I/O chart	

Re-Assessment: patient is stable

Special Notes:

Nurse Signature: [Signature]

Nurse Name: SONIA

Date & Time: 8/7/26 @ 8pm



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Nalla Anuraag Reddy Department: ICU Date of Admission: 8/7/20

SITUATION		Diagnosis: <u>Acute leukemia & Evaluation</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known		If Yes Specify: _____		
BACKGROUND	Area	ER 2:30 pm	ICU 8pm	ICU 8pm	ICU 8pm	ICU 8am	ICU 8pm	
	Medical Condition (Any special condition to be noted):	<u>nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</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>98.5°F</u>	Res: <u>22b/m</u>	SpO ₂ : <u>100%</u>	Pulse: <u>116b/m</u>	BP: <u>111/54(63)</u>	Fall Risk Score: <u>11</u>	Pain Score: <u>0</u>
		<u>98.6°F</u>	<u>28b/m</u>	<u>100%</u>	<u>102b/m</u>	<u>100/62(2)</u>	<u>11</u>	<u>0</u>
		<u>98.8°F</u>	<u>24b/m</u>	<u>99%</u>	<u>112b/m</u>	<u>100/61</u>	<u>11</u>	<u>0</u>
		<u>98.6°F</u>	<u>28b/m</u>	<u>100%</u>	<u>101b/m</u>	<u>100/61</u>	<u>11</u>	<u>0</u>
		<u>98.6°F</u>	<u>28b/m</u>	<u>100%</u>	<u>103b/m</u>	<u>100/61</u>	<u>11</u>	<u>0</u>
Recommendations	Safety Needs:	<u>yes</u>	<u>Side rail</u>	<u>Side rail</u>	<u>Side rail</u>	<u>Side rail</u>	<u>Side rail</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Sesurika</u>	<u>Savillera</u>	<u>Shel</u>	<u>Rajamani</u>	<u>Swathi</u>	<u>Raji</u>	
Signature :		<u>8/7/20</u>	<u>8/7</u>	<u>8/7</u>	<u>8/7</u>	<u>8/7</u>	<u>8/7</u>	
Date:		<u>8/7</u>	<u>8/7</u>	<u>8/7</u>	<u>8/7</u>	<u>8/7</u>	<u>8/7</u>	
Time:		<u>2:30 pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8am</u>	<u>8pm</u>	
Taken Over By Name :		<u>Sugam</u>	<u>Subramaniam</u>	<u>Rajamani</u>	<u>Sugam</u>	<u>Raji</u>	<u>Raji</u>	
Signature :		<u>8/7</u>	<u>8/7</u>	<u>8/7</u>	<u>8/7</u>	<u>8/7</u>	<u>8/7</u>	
Date:		<u>8/7</u>	<u>8/7</u>	<u>8/7</u>	<u>8/7</u>	<u>8/7</u>	<u>8/7</u>	
Time:		<u>2:30pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8am</u>	<u>8pm</u>	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. NALLA ANURAAG Department: PAEDIATRICS Date of Admission: 17/7/26

SITUATION	Diagnosis: <u>1st - Acute Wilms</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify: <u>NK</u>				
BACKGROUND	Area	Shift Time	<u>Once AM</u>				
	Medical Condition (Any special condition to be noted):		<u>NK</u>				
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:	<u>98.2</u>				
		Res:	<u>24</u>				
		SpO ₂ :	<u>100%</u>				
		Pulse:	<u>112</u>				
		BP:	<u>10/6</u>				
		Fall Risk Score:	<u>10</u>				
Pain Score:		<u>side 000</u>					
Recommendations	Safety Needs:		<u>NK</u>				
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:		<u>NK</u>				
	Special Diet:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:		<u>NK</u>				
Post Operative Procedure Special Orders:		<u>NK</u>					
Handed Over By Name :		<u>Shree</u>					
Signature :		<u>[Signature]</u>					
Date:		<u>17/7/26</u>					
Time:		<u>8AM</u>					
Taken Over By Name :		<u>Moornitha</u>					
Signature :		<u>[Signature]</u>					
Date:		<u>17/7/26</u>					
Time:		<u>8AM</u>					



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 1:49pm Mode of Arrival: with parent Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction

No Reaction

Body Weight: 13.28kg Kg

Height: — cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>not significant</u>	<u>not significant</u>	<u>not significant</u>

Family History: No family history

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.: 98.5°F HR: 116b/min RR: 22 bpm BP: 101/54 (63)

Pain Score: 0 Specify Site: nil (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: 0 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

BAH-00660997 IP5-00176106

Master KRISHNA SAINATH

10-12-2019 5 Y 6 M 28 D (M)

Dr. NALLA ANURAAG REDDY



①

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CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

Type of Line: ☐ PICC Line ☐ UAC ☐ UVC

☒ Other *Arterial*

Date of Initial Line Insertion: Duration of Central Line:

- Always perform hand hygiene before accessing central line
- Use Sterile gloves for handling central line
- Clean the hub with antiseptic solution every time before & after it is accessed
- Consider – antibiotic via central line before removal of the line
- Inspect Central line in each shift for the following

Parameters	Date	Shift Time	8/7 8pm	9/7 8pm	10/7 8am	11/7 8am		
Can we remove Central Line today (Discuss in the clinical round)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Evidence of any inflammation at insertion site (Redness / Swelling (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Blood at insertion site (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Any peeling of dressing? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Is dressing clean and dry? (If no inform the doctor)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any leakage at insertion site? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there any obstruction to the infusion flow? (If yes inform the doctor)			☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing intact and labelled properly			☐ Yes ☒ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Central line changed on								
Name of the Nurse			<i>Savitree</i>	<i>Shree</i>	<i>Dayanar</i>	<i>Savitree</i>	<i>Shree</i>	
Signature of the Nurse			<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	

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	3	3	3	3	
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	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	1	1	1	
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	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	2	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	1	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	1	1	1	
TOTAL			11	11	11	11	

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes	yes	no
Call device within reach	yes	yes	yes	no
Wheels Locked	yes	yes	yes	no
Room free of clutter	yes	yes	yes	no
Adequate Lighting	yes	yes	yes	no
Wheel Chair Support	no	no	no	no
Other Intervention(s) Specify	no	no	no	no
Nurse's Name :	Susana	no	Susana	no
Signature :	[Signature]	[Signature]	[Signature]	[Signature]
Date :	8/12/20	8/12/20	10/12/20	11/12/20
Time :	2pm	8pm	8am	8am



BRADEN 'Q' SCALE

				Date :	8/12/2019	10/12/2019	11/12/2019
				Time :	2 PM	8 AM	11 AM
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 e. extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	6	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4
				TOTAL SCORE	28	28	28
				Evaluator's Name	[Signature]	[Signature]	[Signature]

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

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

BAH-0060997
Master KRISHNA SAINATH
10-12-2019 6 Y 6 M 28 D (M)
Dr. NALLA ANURAAG REDDY

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Part - I.

Patient's Language: Hindi 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		
8/7/20	2pm	7.	Infection Control Measures	M	4	0	1	1	-	[Signature]
9/7/20	4pm	9	Normal High protein diet	M	1	0	1	1	-	[Signature]

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
8/7/26 2pm	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Acute leukemia ↓ Evaluation	H-Global	IVF		☒ Nursing ☐ Others:
8/7/26 @ 2pm	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Acute leukemia ↓ Evaluation	H-Global	IVF		☐ Medical ☐ Others:
8/7/26 4pm	☐ Medical ☐ Nursing ☒ Others: Dietician	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Acute leukemia ↓ Evaluation	Normal Hgb Protein diet	DDA E: 1450 kcal/d P: 25g/d		☐ 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:



NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 8/7/26 Time: 3:30pm

Weight: 16.45 kgs Centile: 5th

Height: 111.50 cms Centile: 75th

Inference: Underweight child

RDA: — Calories: 1450 Kcal/d Protein: 25g/d

Diet Recommendations: Normal High protein diet

Re-Assessment: Anorexia, chilled and out of food

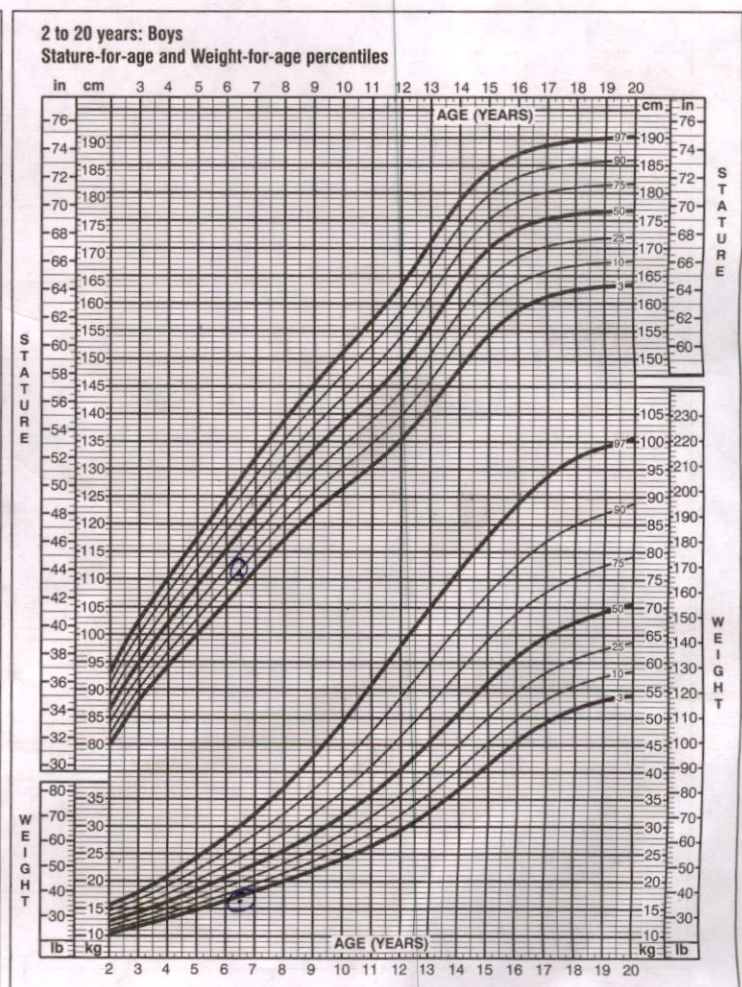
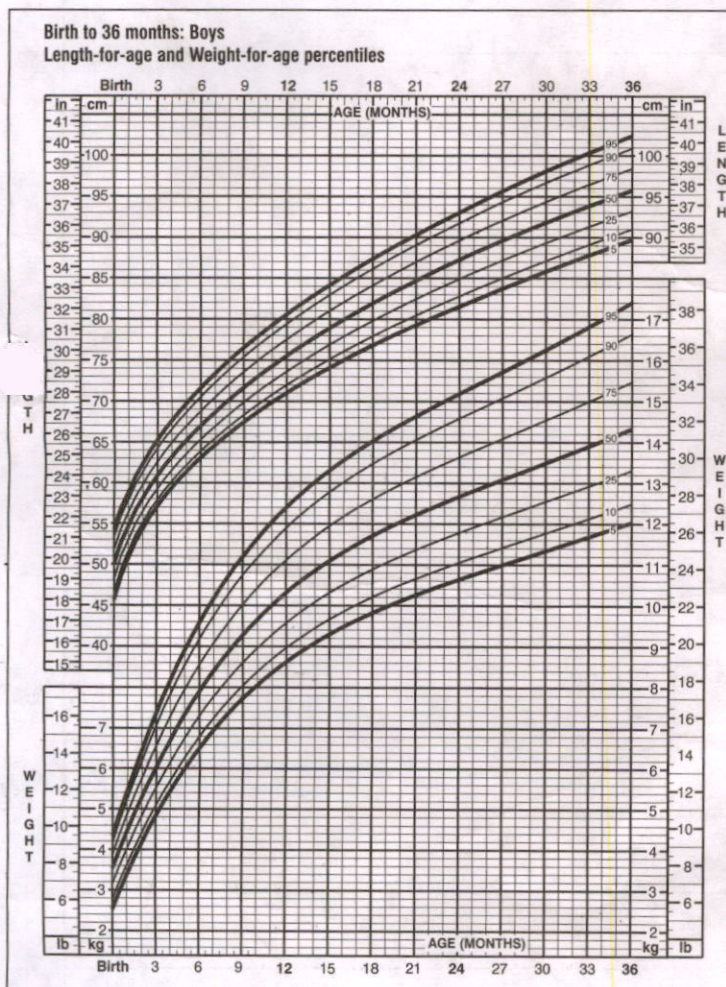
Food Allergies: NO Veg/Non-veg: non-veg

Diagnosis: Acute leukemia & Evaluation

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: Mounica

Dietician's Signature: Mounica

Daily Notes:

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

CONSENT FOR BLOOD TRANSFUSION

Name: Krishna Sainath Age: 6y Gender: Male ☒ Female ☐
UHID.No : BAH-00660997 Date: 11/07/26

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

..... 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 / Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Signature:

Name:

Date & Time

Doctor (Who is talking the consent)

Signature: Dr. T. Parani

Name: T. Parani

Date & Time 11/07/26 9:30AM

Witness

Signature:

Name:

Date & Time

రక్త మార్పిడి కొరకు అంగీకార పత్రము

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

రక్త ఉత్పత్తి రకాలు:

- | | | |
|---|---|---|
| ☐ తాజా ఘనీభవించిన ప్లాస్మా | ☐ ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు | ☐ Random Donor Platelets |
| ☐ క్రయోప్రెసిపిటేట్ | ☐ ఒకే ధాత ఫ్లేటిలెట్స్ | ☐ 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 నిర్ణయ కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడిన అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యల 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 ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ఫ్లేట్ లెట్స్, ఫ్రెష్ ఫ్రాజెన్ ప్లాస్మా, క్రయోప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకం

పేరు

పేరు

తేదీ మరియు సమయము

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు