TMU HOSPITAL

(A Hospital of Teerthanker Mahaveer Medical College & Research Centre, Moradabad)
Delhi Road, Moradabad-244001 (U.P.)

Accredited with NAAC A Grade
12-B Status from UGC

PICU INITIAL ASSESSMENT

Admitted through: OPD/EMERGENCY

UHID: 40828244 IPD NO.: 240828159

PATIENT Name: Aradhna

Age: 3.2 yr. gender:

Father Name: Father Phone No:

Date and Time of admission:

DETAILS

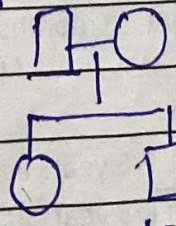
PRESENTING COMPLAINTS:

1) ~~Altered Sen.~~ Fever x 2 day
2) Abnormal body movements
3)

HISTORY OF PRESENT ILLNESS: PT informant is Father. PT was asymptomatic 10 days back when he developed fever which was gr. high grade, UNdocumented, continuous, relived with Medications. pt also had altered sensorium for 2 ~~do~~ day when pt was taken to Hospital in Rampur where

PAST HISTORY: he was admited for 2 day. Pt also had abnormal body movements with increased tone in upper and lower limbs, uprolling of eyes, tongue movement, Not associated ↑ urine discharge, Stool discharge, loss of consciousness. Then the Patient was taken to Sai Hospital where she was admitted for 6 days.

Family History: H/O Consanguinous Marriage
→ No H/O Similar complaints in Family



3y

TREATMENT HISTORY: Meronem + Dexamethasone - 2 days
Vancomycin + Levera,
Acyclovir + Valproate,
Pantop + Mannitol, Methyl prednisolone (Pulse therapy) 2 given (30 mg/kg)

Antenatal/Natal/Post Natal History:

T1: Iron, Folic acid, Calcium taken

T2: Both doses of Tetanus toxoid taken

T3: No H/O LPV, BPV, m

Any PIH/Anemia/DM/ Any other illness during antenatal period NO

Birth weight and gestation age at birth 3 kg, 9 months, Term delivery

Any natal/ postnatal problems NO EXC BF x 6 month, after that complimentary feed started

IMMUNIZATION HISTORY: BCG Scar ✓ Age appropriately immunized till Date
No Document available

SOCIOECONOMIC HISTORY: Total No of Members ⇒ 10, No of Rooms ⇒ 3, Kacchha
Father studied till 5th, work as labourers Mother illiterate is a Housewife
Monthly Income → 6-7k/month Belongs to lower class family

DEVELOPMENT HISTORY:

Gross motor, Fine motor, Key Social, Language — All milestones achieved till Date

NUTRITIONAL HISTORY: calorie

protein

Examination

Anthropometry:

		Obs	Exp	
1)	Weight	10 kg	13.9 kg	-3SD to -2SD
2)	Length/Height	94 cm	95.1 cm	-1SD to Med
3)	MUAC (6 months to 5 year age group)	13 cm		
4)	HC	48.5 cm	48.5 cm	at median
5)	H/A			
6)	W/L (<5 years age)	<-3SD		
7)	BMI (>5 years age)			

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Consultant Progress Notes

radhana Age/Sex: 3.2 yrs/ Bed No.: (3) Date 28/8/24
28/244 IPD No.: 240828/55 Ward/Unit: PICU DOA: 28/8/24
t's: III 29

PROGRESS	TREATMENT

c/s/o Unit III PG

Patient came to casualty c/o.
fever x 10 days back
fever 2 days, high grade, undocumented, not a/w chills & rigor, relived on taking medication

abnormal body movement x 7 days back.
2-3 episodes, tonic posturing, lip & tongue movement, a/w upwalling of eyes & urinary incontinance.

Patient was first admitted Rampur after which patient had abnormal body movements & referred to higher center.

fever 2 days
20/8/24
Hb:- 9
TLC:- 28,900
Plt :- 2.36

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Consultant Progress Notes

Patient Name: Ms. Aradhna Age/Sex: 3y/F Bed No.: (3) Date: 28/2/24
UHID No.: 40828/244 IPD No.: 240828/59 Ward/Unit: PICU DOA: 28/01/24
Treating Consultant's: PICU

DATE	PROGRESS	TREATMENT
	P/A:- soft, non distended. no organomegaly. BS (+)	CVS:- S_1S_2 heard
	S/O:- last pass 1 week back	
	R/S:- B/L Air entry (+) no added sound.	
	C/S/B Dr Harsh Sir	
	Advice	
+-10.6 kg	- Admit in PICU under unit III	
Inves	- NGT / Foley's in situ	
CBC, PBS, RBG	- IVF DNS (75% maintaince).	
RFT/LFT	(+) ~~AAV~~ Inj MVI (1:100) (Inj KCl (1:100)	
Doing R/M	- Inj ~~Meronem~~ Taxtaz Monocef. - ~~Syp Lactolose~~	
Blood c/s	- Inj Vancomycin	
Urine c/s.	- Inj Acyclovir	
2d x ray	- Inj Pantop.	
	- Inj Dexa	
	- Inj Levera	
	- Inj Valproate	

TMUH/DOC/3
TR2.

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Consultant Progress Notes

Accredited with NAAC A Grade
2-B Status from UGC

Patient Name: Ardhna Age/Sex: 3 yr/F Bed No.: (3) Date: 28/8/24
UHID No.: 40821244 IPD No.: 240828159 Ward/Unit: PICU DOA: 28/8/24
Treating Consultant's: AT

DATE	PROGRESS	TREATMENT
	Treatment plan.	Wt-10kg
–	N/S + Foley's Insitu.	
①	IVF DNS 200ml iv 6hourly + Inj. KCl (1:100) + Inj. MVI (1:100) [75% maintainence]	
②	Inj. ~~CEFOTAXIME~~ CEFTRIAXONE 500mg iv 12 hourly in 10ml NS slowly over 20mins [@100mg/kg/day]	
③	Inj. VANCOMYCIN 150mg iv 6hourly in 10ml NS over 1hour [@60mg/kg/day]	
④	Inj. ACYCLOVIR 100mg iv 8hrly [@10mg/kg/dose]	
⑤	Inj. DEXAMETHASONE 1.5mg iv 6hourly (@0.15mg/kg/dose) (1vial = 4mg)	
⑥	Inj. PANTOP 20mg iv 24hrly	
⑦	Inj. LEVERA 60mg iv 12hrly (@20mg/kg/day) (1vial = 100mg)	

TMUH/DOC/3

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Accredited with NAAC A Grade
12-B Status from UGC

Consultant Progress Notes

Patient Name: Aradhna Age/Sex: 3 yr Bed No.: (3) Date: 28/8/24
UHID No.: 408281244 IPD No.: 2408285 Ward/Unit: PICU DOA: 28/8/24
Treating Consultant's: [illegible]

DATE	PROGRESS	TREATMENT
28/08/24 5:30pm	C/S/B Ophthal JR/	

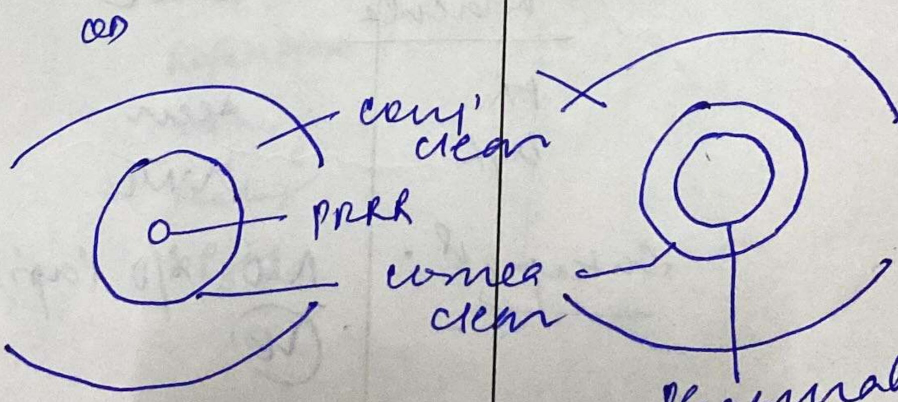
TKR

Pt Aradhna 3 y/F came c̄ fever x 10 day & abnormal body movements x 7 days.
Ref done i/v/o papilloedema.

O/E (torch light)

VA }
EOM } PNC

DT ↑ ? (N)



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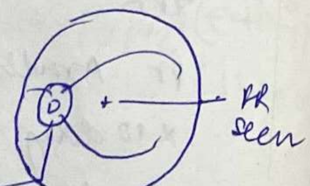
Consultant Progress Notes

Accredited with NAAC A Grade
12-B Status from UGC

Patient Name: Aradhna Age/Sex: 3 yr Bed No.: 3 Date: 28/...
UHID No.: 40828244 IPD No.: 240828159 Ward/Unit: PICU DOA: 28/...
Treating Consultant's: IIIrd

DATE	PROGRESS	TREATMENT
	Dilated fundus	
	OD	OS
	↓	
RE	cannot	Margins well defined
be	assessed	View media: Just clear
as	not	Optic disc
	dilated	Colour: normal
		Margin: well defined
		C:D ~0.2:1
		Vessels, Macula: WNL
		FR: seen
		Bgk: WNL
		Interpret: No s/o Papilloedema (LE)
		Dr Neha

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Consultant Progress Notes

Accredited with NAAC A Grade
12-B Status from UGC

Patient Name: Aradhna Age/Sex: 3 yr Bed No.: 3 Date: 28/8/24
UHID No.: 40828244 IPD No.: 240828159 Ward/Unit: PICU DOA: 28/8/24
Treating Consultant's: IIIrd

DATE	PROGRESS	TREATMENT
	Cognitive:	
	Level of consciousness - conscious	
	Orientation: Absent	
	Attention & concentration - N/A	
	Memory - N/A	
	Intelligence - N/A	
	Insight Absent	
	Mood -	
	Speech & language	
	Fluency, Comprehension, Repetition, Naming, Reading, Copying } Absent	

Duplicate Copy

DEPARTMENT OF MICROBIOLOGY

Patient Name	Ms. ARADHNA	**Lab No**	2167689
UHID/IP No	408281244 / 240828159	**Sample Date**	28/08/2024 4:09PM
Age/Gender	3 Yrs/Female	**Ackn. Date**	28/08/2024 6:29PM
Bed No/Ward	PICU	**Report Date**	02/09/2024 12:32PM
Referred By	Dr. PAEDIA UNIT 3	**Report Status**	Final
Manual Lab No		**Report Revised**	N

BACTERIOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
BLOOD CULTURE AND SENSITIVITY(BACT/ALERT 3D)				
TYPE OF REPORT	FINAL			
Specimen	BLOOD			
Culture Method	BACT/ALERT 3D (automated Culture)			
Organism Isolated	Sterile after 5 Days of aerobic incubation at 37ºC			

REMARKS:
1.Low levels of organisms may not be detected in the incubation interval of the culture.

2.Other diseases can present similarly to bacteremia, since there are many causes of fever of unknown origin.

3.Bacterial metabolism may not produce sufficient CO2 for detection in automated systems.

4.There are number of fastidious microorganisms that infect the blood but can not be grown in routine blood culture.

--End Of Report--

TECHNOLOGIST

RESIDENT

DOCTOR

Dr. Shweta R Sharma Professor Reg No 63564

Printed on 02/09/2024 13:10

Select

DEPARTMENT OF MICROBIOLOGY

Patient Name	Ms. ARADHNA	**Lab No**	2167689
UHID/IP No	408281244 / 240828159	**Sample Date**	28/08/2024 4:09PM
Age/Gender	3 Yrs/Female	**Ackn. Date**	28/08/2024 6:29PM
Bed No/Ward	PICU	**Report Date**	28/08/2024 9:45AM
Referred By	Dr. PAEDIA UNIT 3	**Report Status**	30
Manual Lab No		**Report Revised**	N

BACTERIOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
BLOOD CULTURE AND SENSITIVITY(BACT/ALERT 3D)				
TYPE OF REPORT	SECOND PROVISIONAL			
Specimen	BLOOD			
Culture Method	BACT/ALERT 3D (automated Culture)			
Organism Isolated	Sterile after 48 hrs of aerobic incubation at 37ºC			

--End Of Report--

TECHNOLOGIST

RESIDENT JR2

DOCTOR

DEPARTMENT OF MICROBIOLOGY

Patient Name	Ms. ARADHNA	**Lab No**	2168570
UHID/IP No	408281244 / 240828159	**Sample Date**	29/08/2024 12:23PM
Age/Gender	3 Yrs 1 Days/Female	**Ackn. Date**	29/08/2024 2:13PM
Bed No/Ward	PICU	**Report Date**	30/08/2024 10:15AM
Referred By	Dr. PAEDIA UNIT 3	**Report Status**	
Manual Lab No		**Report Revised**	N

BACTERIOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
CULTURE/SENSITIVITY(CSF)				
TYPE OF REPORT	FIRST PROVISIONAL			
Specimen	CSF			
Culture Method	BACT/ALERT 3D (automated Culture)			
Organism Isolated	Sterile after 24 hrs of aerobic incubation at 37°C			

--End Of Report--

TECHNOLOGIST

RESIDENT

DOCTOR

DEPARTMENT OF RADIOLOGY

Patient Name	Ms. ARADHNA	**RIS No**	2167700
UHID/IP No	408281244 / 240828159	**Order Date**	
Age/Gender	3 Yrs/Female	**Ackn. Date**	29/08/2024 11:07AM
Bed No/Ward	PICU	**Report Date**	29/08/2024 11:07AM
Referred By	Dr. PAEDIA UNIT 3	**Report Status**	
Manual Lab No		**Report Revised**	N

RADIOLOGY - MRI

MRI BRAIN WITH CONTRAST

History:- Abnormal body movements, altered sensorium. Recent history of fever.

Findings:-
Motion artifacts present.
Non enhancing altered signal intensity lesion appearing iso to hypointense on T1W, hyperintense on T2/IR and showing mild diffusion restriction in lateral borders on DWI without any evidence of blooming is noted involving bilateral thalami. Subtle FLAIR hyperintensities also seen in midbrain and right temporal subcortical white matter.
Mild diffuse cerebral atrophic changes are seen in the form of prominent cerebral cortical sulci and ventricles.
Rest of the visualized brain parenchyma show normal signal intensity.
No abnormal meningeal enhancement is noted.
Bilateral lateral, third & fourth ventricles are otherwise normal.
Bilateral basal ganglia appear normal.
Bilateral cerebellar hemispheres and rest of the brainstem are normal in signal intensity.
Posterior pituitary bright spot is present.
Mild prominence of bilateral perioptic nerve sheaths.

IMPRESSION:
-Altered signal intensity lesions in bilateral thalami with mild diffusion restriction along with subtle lesions in right temporal lobe and midbrain. Possibilities are :
1. Viral encephalitis (Flaviviral etiology in differentials).
2. Acute disseminated encephalomyelitis (ADEM) is less likely.
Suggested clinical correlation and CSF analysis.

DR. ARCHI
JR-III

DR. MOHIT
JR-III

DR. SUBHASISH
ASSISTANT PROFESSOR

DR. SHRUTI CHANDAK
PROFESSOR

--End Of Report--

TECHNOLOGIST **RESIDENT** **RADIOLOGIST**

Patient Name	Ms. A
UHID/IP No	4082
Age/Gender	3 Yrs
Bed No/Ward	PICU
Referred By	Dr. F
Manual Lab No	

8570
08/2024 12:23PM
08/2024 1:32PM
08/2024 5:48PM
al

Test Name | thod

CSF FLUID ROUTINE &

Physical Examination
Volume
Color
Appearance
Clot
Reaction

Chemical Examinatio
Glucose
Micro Protein

Microscopic Examina
TOTAL COUNTS.

Differential Count
NEUTROPHILS
Mononuclear Cells

RED BLOOD CELLS

TECHNOLOGIST

DOCTOR

Page: 2 Of 2

ABL835 TMU HOSPITAL
PATIENT REPORT — Syringe - S 95uL — 05:58 PM 8/28/2024 — Sample # 3381

Identifications

Patient ID	408281244
Patient Last Name	ARADHNA
Sex	Female
Sample type	Arterial
$FO_2(i)$	21.0 %
Age	0 years

Blood Gas Values			
pH	7.442		[7.350 - 7.450]
↓ pCO_2	28.6	mmHg	[35.0 - 45.0]
↑ pO_2	113	mmHg	[83.0 - 108]
Acid Base Status			
↓ $cHCO_3^-(P)_c$	19.2	mmol/L	[20.0 - 28.0]
↓ $cBase(Ecf,ox)_c$	-4.3	mmol/L	[-3.0 - 3.0]
↓ $cBase(B,ox)_c$	-3.7	mmol/L	[-3.0 - 3.0]
Electrolyte Values			
cK^+	4.0	mmol/L	[3.5 - 4.5]
↓ cNa^+	131	mmol/L	[135 - 145]
↓ cCa^{2+}	1.02	mmol/L	[1.15 - 1.29]
cCl^-	105	mmol/L	[98 - 110]
Metabolite Values			
$cGlu$	107	mg/dL	[70 - 140]
↑ $cLac$	3.2	mmol/L	[0.5 - 1.5]
Oximetry Values			
↓ $ctHb$	10.0	g/dL	[11.5 - 16.5]
sO_2	98.2	%	[95.0 - 100.0]
FO_2Hb	96.2	%	[92.0 - 100.0]
↓ $FCOHb$	1.2	%	[92.0 - 98.0]
↓ $FHHb$	1.8	%	[95.0 - 98.0]
↓ $FMetHb$	0.8	%	[91.0 - 100.0]
Calculated Values			
Anion Gap_C	6.2	mmol/L	
$AnionGap,K^+_C$	10.1	mmol/L	
BO_{2C}	13.6	Vol%	
$cBase(B)_c$	-3.7	mmol/L	
$cBase(Ecf)_c$	-4.3	mmol/L	
$ctCO_2(B)_c$	39.6	Vol%	
$ctCO_2(P)_c$	44.9	Vol%	
RI_e	-1	%	
$mOsm_C$	267.0	mmol/kg	
ABE_C	-3.7	mmol/L	
SBE_C	-4.3	mmol/L	

Notes
↑ Value(s) above reference range
↓ Value(s) below reference range
c Calculated value(s)
e Estimated value(s)
1035: One or more derived parameters cannot be calculated

Printed 6:00:28PM 8/28/2024

BS-100mg/dl

DEPARTMENT OF MICROBIOLOGY

Patient Name	Ms. ARADHNA	**Lab No**	2168570
UHID/IP No	408281244 / 240828159	**Sample Date**	29/08/2024 12:23PM
Age/Gender	3 Yrs 1 Days/Female	**Ackn. Date**	29/08/2024 1:32PM
Bed No/Ward	PICU	**Report Date**	29/08/2024 5:48PM
Referred By	Dr. PAEDIA UNIT 3	**Report Status**	Final
Manual Lab No		**Report Revised**	N

CLINICAL PATHOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
CSF FLUID ROUTINE & MICROSCOPY				
Physical Examination				
Volume	2.0	ml		
Color	Colorless			
Appearance	Clear			
Clot	Absent			
Reaction	Alkaline			
Chemical Examination				
Glucose	55.2	mg/dl	40 - 80	
Micro Protein	25.7	mg/dl	(15 - 45))	
Microscopic Examination				
TOTAL COUNTS.	30	cells/cumm		
Differential Count				
NEUTROPHILS	20	%		
Mononuclear Cells	80	%		
RED BLOOD CELLS	0-1	/hpf		

RBS-109mg/dl

--End Of Report--

TECHNOLOGIST **RESIDENT** **DOCTOR**

Dr. PARUL

Printed on 29/08/2024 19:09

DEPARTMENT OF MICROBIOLOGY

Patient Name	Ms. ARADHNA	**Lab No**	2168570
UHID/IP No	408281244 / 240828159	**Sample Date**	29/08/2024 12:23PM
Age/Gender	3 Yrs 1 Days/Female	**Ackn. Date**	29/08/2024 2:13PM
Bed No/Ward	PICU	**Report Date**	29/08/2024 5:54PM
Referred By	Dr. PAEDIA UNIT 3	**Report Status**	Final
Manual Lab No		**Report Revised**	N

BACTERIOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
GRAMS STAINING				
Specimen	CSF			
REPORT	NO BACTERIA SEEN			
AFB/ ZN STAIN				
Specimen	CSF			
Report	NO ACID FAST BACILLI SEEN			

--End Of Report--

TECHNOLOGIST **RESIDENT** **DOCTOR**

Dr. Dr Pinaki Patil 97142

Select

DEPARTMENT OF MICROBIOLOGY

Patient Name	Ms. ARADHNA	**Lab No**	2167689
UHID/IP No	408281244 / 240828159	**Sample Date**	28/08/2024 4:09PM
Age/Gender	3 Yrs/Female	**Ackn. Date**	28/08/2024 6:29PM
Bed No/Ward	PICU	**Report Date**	29/08/2024 2:59PM
Referred By	Dr. PAEDIA UNIT 3	**Report Status**	Final
Manual Lab No		**Report Revised**	N

BACTERIOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
CULTURE/SENSITIVITY(URINE)				
TYPE OF REPORT	FINAL			
Specimen	URINE			
Culture Method	Automated			
Organism Isolated	Sterile after 24 hrs of aerobic incubation at 37ºC			

--End Of Report--

TECHNOLOGIST

RESIDENT

DOCTOR

Dr. Dr Imran Ahamad Assistant Professor
Reg No 30873

Printed on 29/08/2024 15:51

Select

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DEPARTMENT OF PATHOLOGY

Patient Name	Ms. ARADHNA	**Lab No**	2167689
UHID/IP No	408281244 / 240828159	**Sample Date**	28/08/2024 4:09PM
Age/Gender	3 Yrs/Female	**Ackn. Date**	28/08/2024 5:02PM
Bed No/Ward	PICU	**Report Date**	28/08/2024 8:49PM
Referred By	Dr. PAEDIA UNIT 3	**Report Status**	Final
Manual Lab No		**Report Revised**	N

HAEMATOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
CBC				
HAEMOGLOBIN	**10.7 L**	gm/dl	11.0 - 14.0	
Total Leukocyte Count	13.0	10^3/uL	5 - 15	
Differential Count				
Neutrophils	64	%	40.00 - 80.00	
Lymphocytes	27	%	20.00 - 40.00	
Eosinophils	01	%	1.00 - 6.00	
Monocytes	08	%	2.00 - 10.00	
Basophils	00	%	0.00 - 1.00	
	100	%		
PLATELET COUNT	370	10^3/uL	150 - 450	
PCV	**33.9 L**	%	36.0 - 48.0	
TOTAL RBC COUNT	4.7	millions/cu. mm	4.0 - 5.2	
MCV	**71.4 L**	fl	80 - 100	
MCH	**22.6 L**	pg	26 - 34	
MCHC	31.6	gm/dl	31.0 - 35.5	
RDW	**16.4 H**	%	4 - 16	
MPV	8.6	fl	7.8 - 11.0	

PBF(GBP)

PERIPHERAL BLOOD SMEAR

RBCs	MILD ANISOPOIKILOCYTOSIS PREDOMINANTLY NORMOCYTIC NORMOCHROMIC RBCs ALONG WITH FEW MICROCYTIC HYPOCHROMIC RBCs AND OCCASIONAL ELLIPTOCYTES.
WBCs	TOTAL COUNT IS NORMAL WITH NORMAL MORPHOLOGY FOR AGE.
PLATELETS	ADEQUATE ON SMEAR.
PARASITES	NOT SEEN ON SMEAR.

--End Of Report--

TECHNOLOGIST **RESIDENT** **DOCTOR**

Dr. AVYAYA VERMA TMU07042

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Delhi Road, Moradabad-244001 (U.P.)
: 0591-2360777
URL : www.tmu.ac.in

DEPARTMENT OF PATHOLOGY

Patient Name	Ms. ARADHNA	**Lab No**	2167689
UHID/IP No	408281244 / 240828159	**Sample Date**	28/08/2024 4:09PM
Age/Gender	3 Yrs/Female	**Ackn. Date**	28/08/2024 5:02PM
Bed No/Ward	PICU	**Report Date**	28/08/2024 9:49PM
Referred By	Dr. PAEDIA UNIT 3	**Report Status**	Final
Manual Lab No		**Report Revised**	N

CLINICAL PATHOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
ROUTINE URINE ANALYSIS				
Physical Examination				
Volume	20	ml		
Color	Pale Yellow			
Appearance	Clear			
PH.	6.0		4.6 - 8.0 (PH)	
Chemical Examination				
ALBUMIN	NEGATIVE			
SUGAR	NEGATIVE			
Microscopic Examination				
RED BLOOD CELLS	NIL			
PUS CELL	0-1	/hpf		
EPITHELIAL CELLS	0-1	/hpf		
BACTERIA	NOT SEEN			
CRYSTALS	NIL			
CAST	NIL			

--End Of Report--

TECHNOLOGIST

RESIDENT

DOCTOR

Dr. AVYAYA VERMA TMU07042

TMU HOSPITAL
(A Hospital of Teerthanker Mahaveer Medical College & Research Centre)
Delhi Road, Moradabad-244001 (U.P.)
: 0591-2360777
URL : www.tmu.ac.in

DEPARTMENT OF BIOCHEMISTRY

Patient Name	Ms. ARADHNA	**Lab No**	2167689
UHID/IP No	408281244 / 240828159	**Sample Date**	28/08/2024 4:09PM
Age/Gender	3 Yrs/Female	**Ackn. Date**	28/08/2024 6:42PM
Bed No/Ward	PICU	**Report Date**	28/08/2024 7:50PM
Referred By	Dr. PAEDIA UNIT 3	**Report Status**	Provisional/Interim
Manual Lab No		**Report Revised**	N

BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Range	Method
LFT/LIVER FUNCTION TEST				
Bilirubin Total	0.3	mg/dl	0.2 - 1.0	
Bilirubin Direct	0.1	mg/dl	0.0 - 0.4	
Bilirubin Indirect.	0.2	mg/dl	0.0 - 0.7	
AST/SGOT	38.0	IU/L	5.0 - 40.0	
ALT/ SGPT	20.3	IU/L	5.0 - 40.0	
Alkaline Phosphatase	104.0	U/L	50.0 - 126.0	
GGTP (GAMMA GT)	21.0	U/L	5.0 - 36.0	
Protein Total	**5.7 L**	g/dl	6.6 - 8.3	
Albumin	**3.4 L**	g/dl	3.5 - 5.5	
Globulin	**2.3 L**	g/dl	2.8 - 4.5	
A/G Ratio (Albumin/Globulin Ratio).	1.48		1 - 2	
RENAL FUNCTION TEST/RFT				
UREA	17.4	mg/dl	13.0 - 45.0	
Creatinine	0.66	mg/dl	0.50 - 1.20	
Uric Acid	**2.1 L**	mg/dl	3.5 - 7.2	
Calcium	9.0	mg/dl	8.2 - 10.5	
Phosphorus	3.6	mg/dl	2.5 - 6.2	
Alkaline Phosphatase	104.0	U/L	50.0 - 126.0	
Sodium	137.0	mEq/L	135.0 - 155.0	
Potassium	4.8	mEq/L	3.50 - 5.50	
Chloride	108.0	mEq/L	90.0 - 120.0	

--End Of Report--

TECHNOLOGIST **RESIDENT** **DOCTOR**

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Consultant Progress Notes

Patient Name: _____ Age/Sex: _____ Bed No.: _____ Date: _____
UHID No.: _____ IPD No.: _____ Ward/Unit : _____ DOA: _____
Treating Consultant's : _____

DATE	PROGRESS	TREATMENT
3/9/24 12PM	C/S/I/B JR4 Unit III Adv: • SYP SODIUM VALPROATE 2.5mL 12 hourly (5mL/200mg) • SYP LEVERA 1ml P/O 12 hourly (1ml/100mg)	wt→ kg @ 20mg/kg/day @ 20mg/kg/day

Patient Name: Aradhna
UHID No.: 4082 3124 IPD
Treating Consultant's : PT.

DATE	PR
3.9.24 Evening 3:44pm	PR tip knee Ank Sho E

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NURSING INITIAL ASSESSMENT

Name: Aradhna Age/Gen: 34/F DOA: 28/08/24
UHID: 40828124 Ward: PICU Bed No. 02
Department: Pediatric Speciality: PICU Unit: III
Diagnosis : Seizures Time of Arrival : 3:40pm Time of Assessment 3:55pm
Mode of Admission : Walking / Wheelchair / Stretcher Patient accompanied on admission : Yes / No. (as app).
If yes, Name Rohit Relation Father Contact No. :
Primary language spoken (Hindi) Interpreter needed : Yes / No. No
Cultural/religious barriers ☐ Yes ☐ No If Yes, describe No

Vitals Signs

Temp. 98.6F Pulse : 75bm BP : 90/60 Resp. : 28bm RBS : 116 SPO2 : 98%

Patient Vulnerability Status: Yes ☑ No ☐

☐ Elderly>65 yrs ☑ Minors<14 yrs ☐ Subnormal Intelligence ☐ Chronic/Intense
☐ Pain Patient with Psychiatric Illness ☐ Physically Challenged ☐ Patient Under Intensive Care
☐ Pregnant Women ☐ Immuno-suppressed/Compromised ☐ Comatose ☐ Periatic/Neaonate ☐ Others

Medications: Includes PCA/Opiates, Anticonvulsants, Diuretics, Hypnotics, Laxatives, Sedatives and Antipsychotics (select as applicable)

☒ On one high risk drug ☒ On two or more high risk drugs ☒ Se dated procedure within last 24 hours

Allergies / Adverse Reaction Known ☐ Not Known ☑

If known / suspected allergies to : No

Name of medication and description of reaction

No

Reaction to previous transfusion : Yes ☐ No ☑

If yes, brief description of reaction :

No

Food Allergy : Known ☐ Not Known ☑

Glasgow Coma Scale Scoring - E 4 **V** 3 **M** 6

Psychological Status & Level of Consciousness

Calm ☑ Anxious ☐ Withdrawn ☐
Agitated ☐ Depressed ☐ Sleep Disorder ☐

Behavior	Response	Score	Behavior	Response	Score
Eye Opening Response	Spontaneously	(4)	Best Motor Response	Obeys commands	(6)
	To speech	3		Moves to localized pain	5
	To pain	2		Flexion withdrawal from pain	4
	No response	1		Abnormal flexion (decorticate)	3
Best Verbal Response	Oriented to time, place and person	5		Abnormal flexion (decerebrate)	2
	Confused	4		No response	1
	Inappropriate words	(3)	Total score:	Best response	15
	Incomprehensible sounds	2		Comatose client	8 or less
	No response	1		Totally unresponsive	3

Fall Risk Assessment :

Variables	Numeric Values	
1. History of falling	No	0
	Yes	25
2. Secondary diagnosis / Elimination Problem	No	0
	Yes	15
3. Ambulatory Aid		
None / bed rest / nurse assist		0
Crutches / cane / walker		15
Furniture		30
4. CNS/CVS Medication	No	0
	Yes	15
5. Gait		
Normal / bed rest / wheelchair		0
Weak		10
Impaired		20
6. Mental Status		
Oriented to own ability		0
Overastimates of forgets ilimiations		15

0-24 (low risk) 25-44 (medium risk) Above 45 (high risk)

Modified Morse Fall Scale Score = Total 25

Functional Assessment :

Activity	Independent	Dependent
Bathing	☑	☐
Dressing	☑	☐
Eating	☑	☐
Mobility	☑	☐
Climbing Stairs	☑	☐
Toilet Use	☑	☐
Walking	☑	☐

Pain Rating (0-10) : 0-6 Location : 0 Sharp/Dull/Aching/Burning (as a

Nursing Assessment	Nursing Intervention
1	

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Shift Wise Nursing Record

Name: Aradhya Age/Gen: 5y1 f DOA: 28/8/24 Date: 01/9/2024

UHID: 40828124 IPID: 24082815 Ward: Pedia Bed No.

Vitals	Morning Record
BP - Pulse Rate - Resp Rate - Temp - SPO2 - GCS - RBS - Diet - Pain Score - O2 Support -	
	Hand Over Given By Staff Name & ID:
	Hand Over Taken By Staff Name & ID:

Vitals	Evening Record
BP — Pulse Rate 90/min Resp Rate 20/min Temp - 98.4°F SPO2 - 96% GCS - 15 RBS - N/A Diet Breastfeed Pain Score - 0 O2 Support - RA Urine	A new patient received in Pedia ward from PICU at 1PM on 01/09/24 Rly GIC is done P + VS checked & recorded
	Hand Over Given By Staff Name & ID: Yadwinder 2024
	Hand Over Taken By Staff Name & ID: Jasvinder 2224

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Shift Wise Nursing Record

Name: Aradhna Age/Gen: 34/F DOA: 28/8/24 Date: 2/9/24
UHID: 40828144 IPID: 24082859 Ward: Pedia. Bed No.

Morning Record

Vitals	
BP -	—
Pulse Rate -	88/m
Resp Rate -	22/m
Temp -	98.9 °F
SPO2 -	95%
GCS -	15
RBS -	NIT
Diet -	Breastfeed
Pain Score -	0
O2 Support -	NO

- Pt G/c is stable.
- Pt V/s checked and record.
- Pt all NSG Care done.
- Pt all due to medication are given as per Dr. order.

Hand Over Given By Staff Name & ID: Komalpal 3474
Hand Over Taken By Staff Name & ID: 8372

Evening Record

Vitals	
BP -	—
Pulse Rate -	87b/m
Resp Rate -	21b/m
Temp -	98.8°F
SPO2 -	96%
GCS -	15
RBS -	NIL
Diet -	Breastfeed
Pain Score -	0
O2 Support -	NO

Pt G/c is stable
Pt V/s Check & record
all due medication given as per Dr Order
All NSG Care Done

Hand Over Given By Staff Name & ID: 8372
Hand Over Taken By Staff Name & ID: 8167

Night Record

Vitals	
BP -	—
Pulse Rate -	86/m
Resp Rate -	22/m
Temp -	98.2°F
SPO2 -	99%
GCS -	15
RBS -	NIL
Diet -	BF
Pain Score -	No
O2 Support -	No

- Pt G/c is stable
- Pt V/s checked & recorded.
- All due medicine are given as per dr. order
- All NSG care done.

Hand Over Given By Staff Name & ID: 8167
Hand Over Taken By Staff Name & ID: Jageshwari 3149

Jageshwari 3149
Verified By Ward Incharge Name & ID

TMUH/NURS/3