

ADMISSION SHEET

Registration Details :



Admission No : IP25-00020521 Admit Date : 19-May-2026 Admit Time : 04:17 PM UHID : FDH-00046039

Patient Details :

Patient Name : Baby DHRUVIKA Age : 1 Y 7 M 16 D
Guardian : Mr VENKATESH DOB : 03-10-2024 01:00 AM
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : etla eruvalli Rangareddy District Court Phone No : 9618915263
Hyderabad Telangana INDIA 500074 E-mail :

Admission Details :

Bed Type : TWIN SHARING Bed No : TS-301B Ward Name : 3F -TWIN SHARING
Room No : TS-301B Admission Type : First Visit

Contact Details :

Name : Mr VENKATESH Relationship : Father
Contact Address : etla eruvalli Rangareddy District Court Phone No :
Hyderabad Telangana INDIA 500074


Signature

Doctor Details :

Doctor Name : Dr. KALYAN CHAKRAVARTHY KONDA Specialisation : GENERAL PEDIATRICS
Referral Doctor : Phone No :
Co-Consultant :

Payment Details :

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



FDH-00046039



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Baby Dhruvika Age : 1 y 7 m Gender: Male Female

Date : 19/05/26 Time of Arrival : 3:35 pm

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: 98.0 F PR: 129b/m BP: 83/49 RR: 26b/m SpO₂: 100%

Chief Complaints: elo - loose stools x 15 days (multiple episode) 2 episode of vomiting 2 days back elo fever

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		Work of Breathing <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea	
INITIAL PHYSIOLOGICAL STATUS <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Unstable : <input type="checkbox"/> Not - Life - Threatening <input type="checkbox"/> Life -Threatening			

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 checked="" type="checkbox"/> 30 min
<input type="checkbox"/> Level 4: LESS URGENT: Significant illness but not life threatening	<input 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: Vericalesh
 Triage Completion Time: 3:37 pm

Communicable Disease Triage Screening

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

- Have you had fever (elevated temperature) in the past 2 weeks? Yes No
- Have you had cough or a rash in the past 2 weeks? Yes No
- 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

- 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:
- 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).

Signature of Triage Nurse: Ayam

Signature of Triage Nurse: Ayam

Date: 19/05/26 @ 3:37 pm



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 19/15/24 Time of arrival : 3:35 pm

Chief Complaints: Loose stools, vomiting, fever RBS:

Height : Weight : 7.58 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: 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 parent

Siblings in household Yes No (if yes How Many?) 1

Time of Initial assessment completed by ER Nurse : 3:49 pm

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

Time	Nursing Notes
	→ Assessed the pt condition
	→ vitals checked and occurs
	→ informed to doctor
	(58) at 5:20 pm
	7/1/19

Samples collected by: / Rupak
 Samples sent by :

Time: 4:40 pm
 Time: 4:50 pm

Medication given in ER:

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

Condition of patient at time of shift-out :	Details of Shift - out
HR: 120 bpm BP: 79/49 CFT: 2.5cm	Shift - out from ER to: 301-B
RR: 26 bpm SPO ₂ : 98%	Time of Shift - out: 5:48 pm
GCS: 15 Temperature: 98.2 F	Handover given to: S. Susha
Pain Score: 0/10	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any): ny placement

Name of the Nurse: Aminul Signature of the Nurse: [Signature]

Date & Time: 19/05/26

ACTIVITY RECORD FOR BILLING

Name: -----
 UHID No : -----
 Date of Admission : -----
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

FDH-00046039 IP25-00020521
 Baby DHRUVIKA
 03-10-2024 1 Y 7 M 16 D (F)
 Dr. KALYAN CHAKRAVARTHY KONDA

Consultant : ----- Dept : -----
 Date of Discharge : ----- Time: -----



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
19/15/26	5:48pm	ER	301-B	- Arjan

Cross Consultation Visit

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

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
19/5/26	IV placement	1	7236	Arjan
20/5/26	NHA	1	7552	Kusma

Check of level
 for 7236
 22-05
 @ 9:45

ANY OTHER INFORMATION

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.....

.....

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Date: 19/5/ Time: 5:48pm Prepared By: Arjan

Staff Nurse Arjan	Shift / Ward 301-B	Billing Assistant	Billing Supervisor
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**Rainbow[®]
Children's
Hospital**
It takes a lot to treat the little.

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

FDH-00046039 IP25-00020521

Baby DHRUVIKA

03-10-2024

1 Y 7 M 16 D

(F)

Dr. KALYAN CHAKRAVARTHY KONDA





Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

loose stools :: (10) days
↓ oral acceptance & dull activities :: (1) day

History of present illness :

loose stools :: (10) days
15-20 episodes/day
Small - quantities
- Watery
Non foul smelly

↓ oral acceptance No Vomits

↓ dull activities

↓ Urine Output

H/o recent travel ⊕

No H/o similar episode in family

~~18/5/24~~ CSE - 5-6 per day

Hb - 9.4

CRP - 4.4

TLC - 10.7

PLT - 4.8



Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

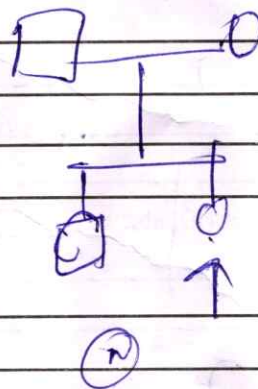
PT / EUS / RUEN / ACN / RL - 3h

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____



Developmental History :

Immunization History :

Immunized upto date



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile _____)
Weight (kgs)) 7.5 kg (Centile _____)

On Examination :

Temperature : 98°F Pulse Rate : 124 bpm B.P. 82/48 (mmHg) SPO2 98%
(60)
Resp. rate and type of breathing : RR - 26 / min

Rash _____ }
Lymphadenopathy _____ } ⊖
Oedema : _____ }
Allergies (if any): _____ } Signs of some dehydration ⊕

Respiratory System :

Inspection (any s/o distress) : _____ }
Air entry & breath sounds : _____ } ↑/normal
Any added sounds : _____ }
Relevant data from outside (Chest X-Ray, ABG, etc.,) _____

Cardiovascular System :

Inspection of precordium : _____ }
Heart Sounds : _____ } S1 ⊕, M ⊕
Any murmur : _____ }
Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : _____

Per Abdomen :

Inspection _____ }
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 / 15

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Plantars _____

Superficials:

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

_____ Acute GE & some _____
_____ dehydrate _____

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Sepon

Desired goals of the treatment : M. Stabils

Planned Labs:

~~VGG~~
 Blood c/s
 Stool c/s
 Stool for Rota Virus
 CUE

Noted by Amrith

Planned Management

Adm

- Inj ceftriaxone 80
- Pro Gb 80
- Redvit sachet 100
- Inj pan
- gastro diet
- loperamide stat dnr
- IVF - full mxy
- 2yd dry

Signature of the Doctor: [Signature]
 Name of the Doctor: Dr. Lalhan
14/10/24
 Date & Time: 7pm

Signature of the Consultant:
 Name of the Consultant:
 Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/5/26 8:20pm	<p>CUHB Dr. Aishwarya</p>	
	<p>Δ Acute gastroenteritis with dehydration.</p>	
	<p>Child had 7 episodes of loose stools since admission No vomiting/excessive irritability passed urine once. Had 1-2 idlis</p>	
	<p>O/E: HR - 136/min RR - 24/min BP - 97/72 mmHg.</p>	<p>Tongue - moist.</p>
	<p>PE: P/A: Soft, Non tender. CVS: S1, S2 ⊕, No Murmur RU: BIL AEC ⊕, NUBS CNS: WNL</p>	
	<p><i>Aishwarya</i></p>	<p>Plan - Wf oral intake - Wf urine output/stools - Monitor HR/BP O&K - Trace reports</p> <p>Noted by <i>N. B. Srinivas</i> 19/5/26 @ 8:20pm</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/5/26		
8:30am	clisly noted	
	- 15-16 clis laan	
	stet = aden	
	- u/s - 2-3 nodules	R
	- droplet	1) wait for some measles
	- H. pylori	2) Probiotic (R)
	- oral probiotics	
		3) Tm 6am
		<div style="border: 1px solid black; padding: 5px; display: inline-block;"> f CRP, WBC, WIDAL blood gas, chest xray </div>
	Noted by Kalyana 20/5/26	
		R
		- To give lepra mtd stat

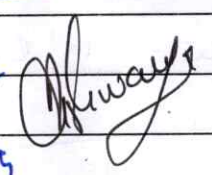
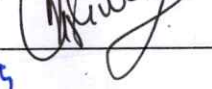
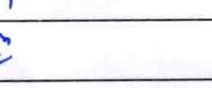
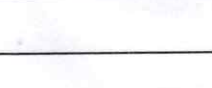


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/10/24 11 pm	cls for <u>Orphanine</u>	
	a episodes of loose stools. oral intake poor. Uo - good. No fever spikes.	Alert with dehydration.
	ok Child is sleeping. vitals stable. stable CURS, S, H, O NIB (Acid) NBS +	<u>Advice</u>
	PA Toff CURS - N FAVO.	- continue rehydration Trace stool for lacto virus. - continue rest of medication as charted. - Send CBP, CRP, W/BAL, urea, creat, Blood gas, and urine of dehydration. Noted by mural 20/10/24



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/5/2026	Child Dr. Ashwarya	
4:15pm	AGE 2 dehydration	
	Child asleep	
	No further loose stools today	
	Oral intake - improved	
	AF: HR-108/min	
	RR-22/min	
	SE: PA: Soft, Non tender.	
	CV: S ₂ ⊕, No murmurs	
	RU: BIL AE ⊕, NUBS	
	CNS: WNL	
		Plan
		- Reduce fluids to 20ml/hour
		- W/A oral intake / loose stools
		- Continue medication as charted
		
		
		
		



RESULT SHEET



outside

Date	18/5/26	21/05			
Time					
Hb	9.4	9.6			
PCV		31.8			
RBC		4.59			
WBC	10.7	13.15			
N/L		17.8/77.4			
Platelets	4.8	52L			
CRP	4.4	5.0			
ESR					
PCT					
RBS					
Na		135			
K		5.3			
Cl		107			
Ca/Mg					
Phosphate					
Urea		4			
Creatinine		0.3			
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein/Sugar					
Cells					
N/L					

Date	19/04					
Time						
CUE-Alb						
CUE-Sugar						
CUE - Ketones						
CUE-PUS Cells	2-4					
CUE - RBC Cells	Occasional					
CUE <u>casts</u>	Granular casts present+++					
Stool Pus Cell						
OVA/Cyst						
Occult Blood						
<u>CUE</u>						
<u>Stool Bata</u>	Positive					

Culture and Sensitivities : "Blood culture shows No growth"
 US hrs no growth.

Radiology: USG :
 X-Ray:.....
 ECHO:
 CT:
 MRI
 Others (ECG, Contrast Studies etc.) :



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: 301-B

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

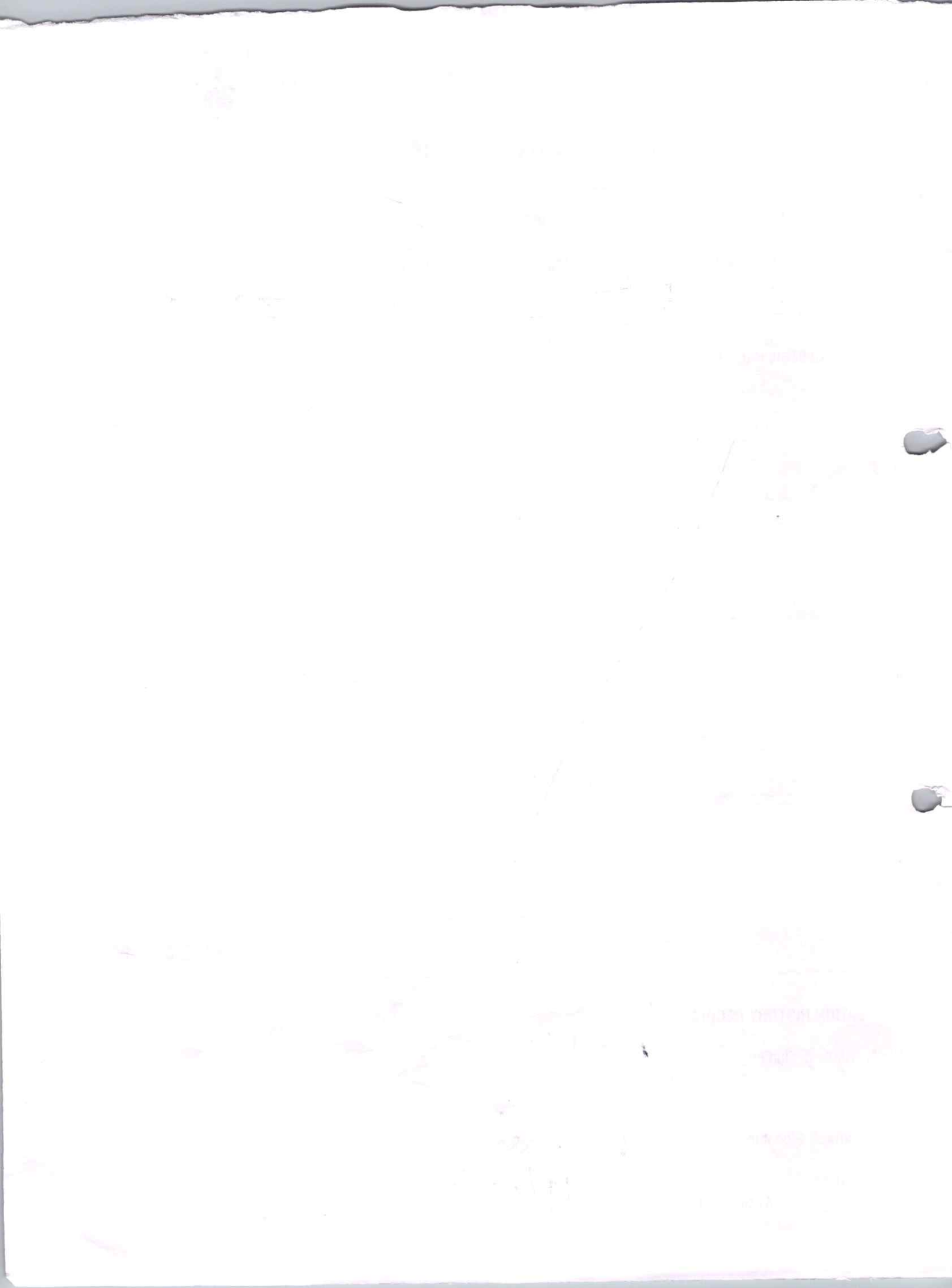
Doctor Name & Signature : Dr. Lakshmi

Date & Time : 19/05/26

Nurse Name & Signature: [Signature]

Date & Time : 19/05/26

Docu. No. : RCH / FRM / GENERAL / 090





REGULAR PRESCRIPTIONS

Weight. 7.5kg Ward. 3A

VERIFIED

DRUG : INJ. CEFTRIAXONE				Date Time	19/5	20/5	21/5	22/5													
Dose	Route	Frequency	Start Date																		
375mg	IV	BD	19/5	6 AM	X	Kalab Nabi	Kalab Nabi	Kalab Nabi	Kalab Nabi												
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG : INJ PANTOP				Date Time	19/5	20/5	21/5	22/5													
Dose	Route	Frequency	Start Date																		
8mg	IV	OD	19/5	6 AM	6:30 PM	Kalab Nabi	Kalab Nabi	Kalab Nabi	Kalab Nabi												
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG : PROGH SACHET				Date Time	19/5	20/5	21/5	22/5													
Dose	Route	Frequency	Start Date																		
1 sachet	PO	BD	19/5	10 AM	6:30 PM	Kalab Nabi	Kalab Nabi	Kalab Nabi	Kalab Nabi												
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG : REDOTIL SACHET				Date Time	19/5	20/5	21/5	22/5													
Dose	Route	Frequency	Start Date																		
1 sachet	PO	TID	19/5	6 AM	10 PM	Kalab Nabi	Kalab Nabi	Kalab Nabi	Kalab Nabi												
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					



Sheet No: **REGULAR PRESCRIPTIONS** Weight 7.5 kg Ward 3A

DRUG :				Date
Dose	Route	Frequency	Start Dt.	Time
290 DROPS				19/5
1ml	PO	OD	19/5	6:20 PM
Name & Signature of the Doctor Starting the Drugs:				6:20 PM
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				X
RASHFREE OINTMENT				19/5
1A		TDS	19/5	6 AM
Name & Signature of the Doctor Starting the Drugs:				6 AM
Additional Instructions:				10 AM
Daily Doctor's Endorsement by a Sign				X
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				

VERIFIED

Signature
 VERIFIED BY : Name



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

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

STAT / ONCE ONLY DRUGS

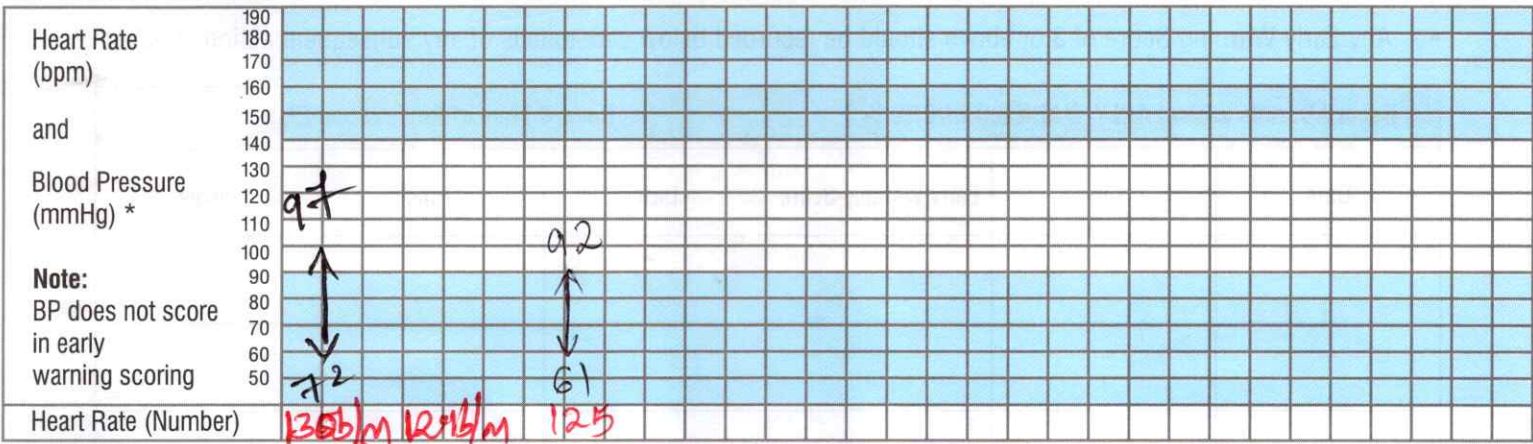
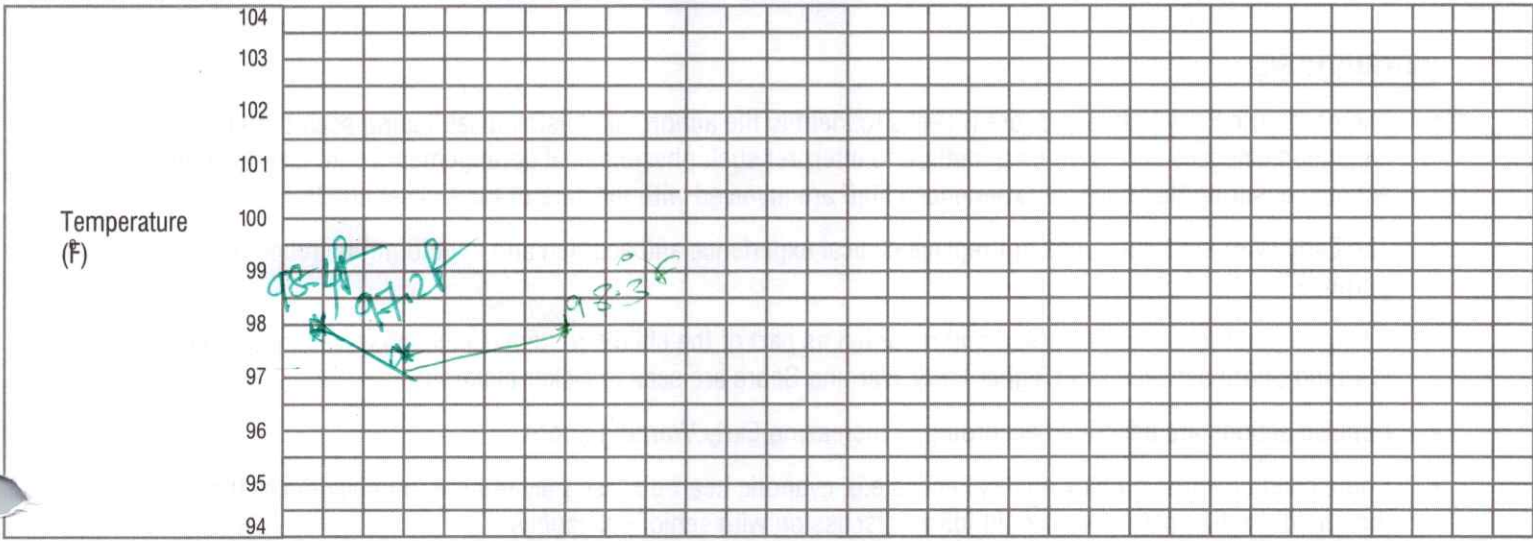
Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
19/5	4:14 PM	TAB LOPERAMIDE 2mg	0.1mg/kg (0.7mg) [1/4 tab in 5ml water] 1/4 tablet in 5ml of water	PO	L	Amirul Rupak
19/05	5:08 PM	NS bolus	75ml	IV	L	Amirul Rupak
20/5	2:45 PM	Tab. LOPERAMIDE 2mg	0.1mg/kg (0.7mg) [1/4 tab in 5ml water] 1/4 th tablet in 5ml of water	PO	[Signature]	Smeeta Mishra
21/5/24	11:15 AM	Tab. Loperamide (2mg) 1/4th tablet in 5ml of water and (0.7mg)	give	PO	[Signature]	Mishra Tuhin

VERIFIED BY: Nurse Signature

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 9:00 AM 11

Doctor / Nurse / Family Concern? Par



Resp. Rate (bpm) (Over 1 Minute) *	25b/m	25b/m	25
Resp Rate (Number)	25b/m	25b/m	25

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

TOTAL SCORE			
Number of shaded boxes	0	0	0
Pain Score	0	0	0
Observer's Initials	[Signature]	[Signature]	[Signature]

ACTIONS

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

NB: Scores 3 should be recorded overleaf

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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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.

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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)
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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)

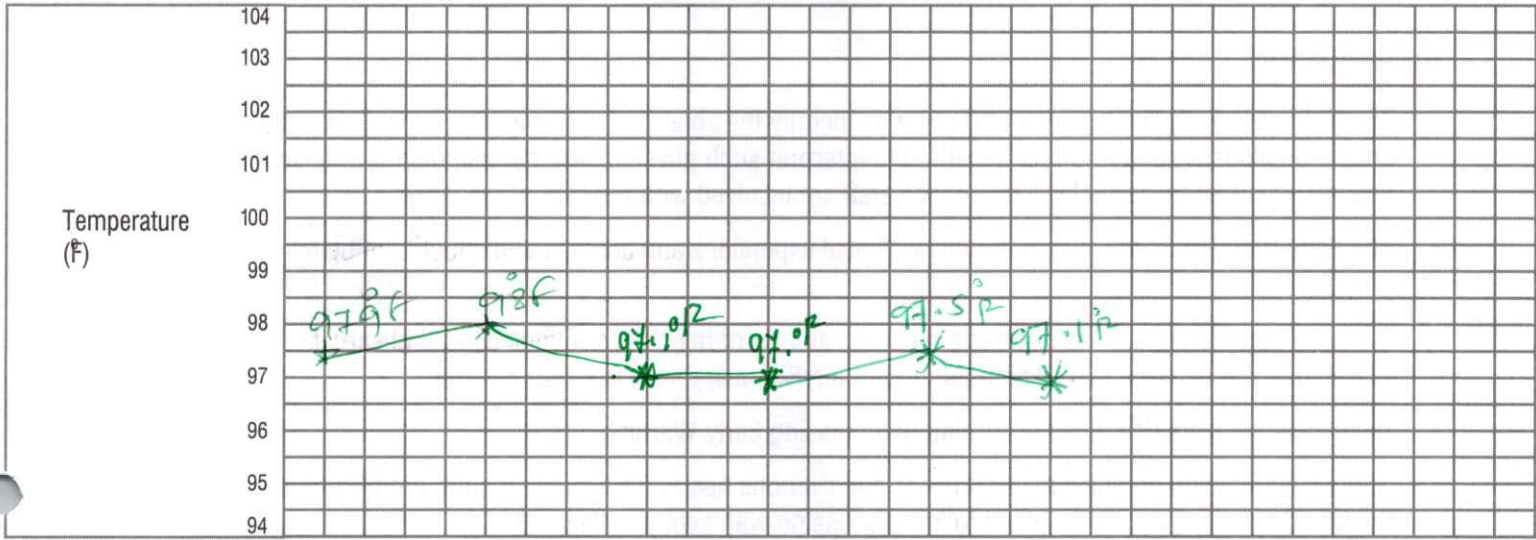
20/5/26

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time: 3	7	10.30Am	1.20pm	5	8
Doctor / Nurse / Family Concern?	AM	AM			PM	PM



Heart Rate (bpm)						
Blood Pressure (mmHg) *						
Heart Rate (Number)	107	103	110b/m	106b/m	102s/m	110s/m

Note: BP does not score in early warning scoring

Resp. Rate (bpm) (Over 1 Minute) *						
Resp Rate (Number)	25	26	26b/m	26b/m	22s/m	22s/m

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

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

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.

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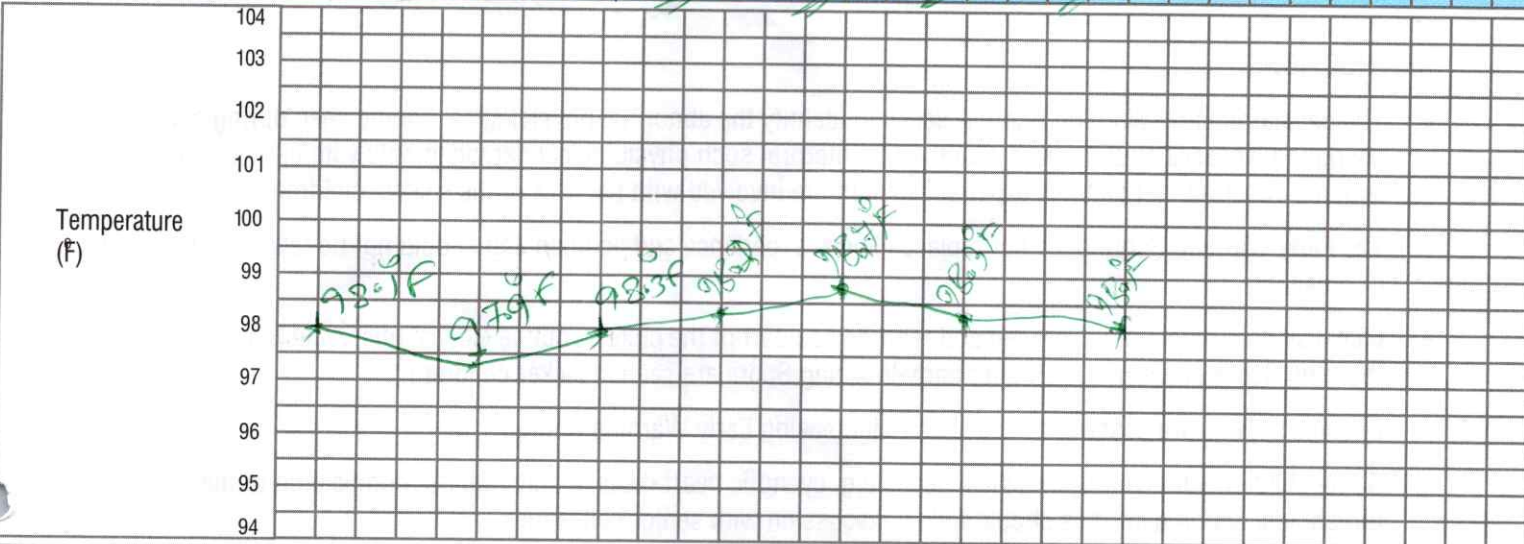
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 12:37 AM 1:03 AM 1:37 AM 2:03 AM 2:37 AM 3:03 AM 3:37 AM
 Doctor / Nurse / Family Concern? AM AM AM AM AM AM AM



Heart Rate (bpm)	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50
and															
Blood Pressure (mmHg) *															
Note: BP does not score in early warning scoring															
Heart Rate (Number)	89	91	101	100	103	103	103	103	103	103	103	103	103	103	103

Resp. Rate (bpm) (Over 1 Minute) *	70	60	50	40	30	20	10
Resp Rate (Number)	24	23	24	24	23	25	25

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

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

ACTIONS

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
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- Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
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NB: Scores 3 should be recorded overleaf

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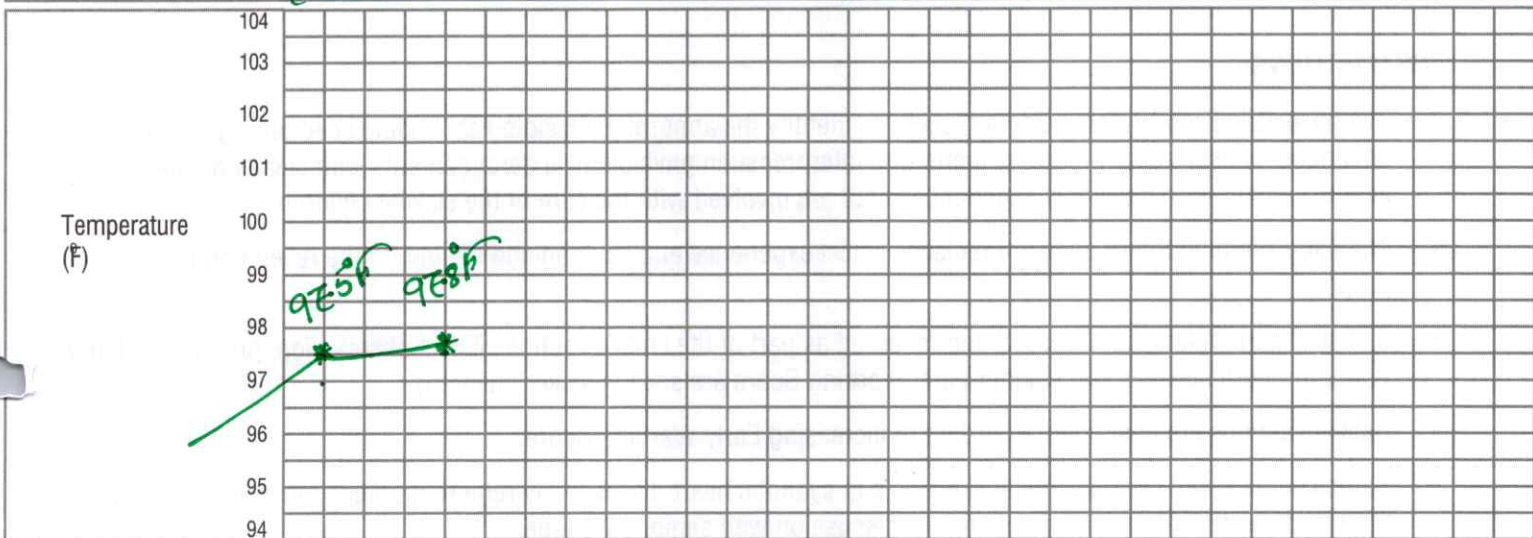


22/05/22

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time:

Doctor / Nurse / Family Concern? *San* *Fan*



Heart Rate (bpm)	190	
	180	
	170	
	160	
and	150	
	140	
Blood Pressure (mmHg) *	130	
	120	
	110	
	100	
	90	
	80	
	70	
	60	
	50	
Heart Rate (Number)	<i>108 bpm</i>	<i>110 bpm</i>

Note:
BP does not score in early warning scoring

Resp. Rate (bpm) (Over 1 Minute) *	70	
	60	
	50	
	40	
	30	
	20	
	10	
Resp Rate (Number)	<i>24 bpm</i>	<i>25 bpm</i>

Resp Distress	Mod/ Severe	
	None / Mild	
		<i>N</i> <i>N</i>

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

Conscious Level	Normal	
	Altered	
GCS *		<i>15</i> <i>15</i>

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

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1	: Continue normal observation by staff nurse
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19/5/26

FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												

Total Intake :

Total Output :

E 19/5	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm	← Admission →											
	06:00 pm	DNS	32ml	NO	NO	✓+✓		NO		0			
	07:00 pm	DNS	32ml	NO	NO	✓		NO	✓	0			

Total Intake : 64ml

Total Output : M-02V-1

N	08:00 pm	DNS	32ml	NO	NO	✓		NO		0			
	09:00 pm	+	32ml	NO	NO			NO		0			
	10:00 pm	MVI	32ml	NO	NO	✓		NO		0			
	11:00 pm	DNS	32ml	NO	NO			NO	✓	0			
	12:00 am	+	32ml	NO	NO			NO		0			
	01:00 am	MVI	32ml	NO	NO			NO		0			

Total Intake :

Total Output :

N	02:00 am	DNS	32ml	NO	NO	✓		NO		0			
	03:00 am	+	32ml	NO	NO	✓	✓	NO		0			
	04:00 am	MVI	32ml	NO	NO			NO		0			
	05:00 am	DNS	32ml	NO	NO			NO		0			
	06:00 am	MVI	32ml	NO	NO	✓	✓	NO	✓	0			
	07:00 am	"	"	NO	NO	✓	✓	NO		0			

Total Intake : 320ml + 50ml

Total Output : M-9 U-2

Total 24 hrs. Intake : 370ml

Total 24 hrs. Output : M-19 U-3

20/5/26 2/2/07

FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
20/5	08:00 am	DNS+		32	NO	NO	✓		NO		0	Phu	
	09:00 am	MVI	eddy	32	NO	NO	✓		NO	✓	0	Phu	
	10:00 am	DNS+	pho	32	NO	NO	✓		NO		0	Phu	
	11:00 am	MVI	boord	32	NO	NO	✓		NO		0	Phu	
	12:00 pm	RL		32	NO	NO	✓		NO	✓	0	Phu	
	01:00 pm	RL		32	NO	NO	✓		NO		0	Phu	
Total Intake : 100ml + 192ml = 292ml						Total Output : M-6 U-2							
	02:00 pm	RL		32	NO	NO			NO		0	Phu	
	03:00 pm	RL		32	NO	NO	✓		NO	✓	0	Phu	
	04:00 pm	RL	san	32	NO	NO	✓		NO		0	Phu	
	05:00 pm	RL	+	32	NO	NO			NO		0	Phu	
	06:00 pm	RL	idzo	32	NO	NO			NO		0	Phu	
	07:00 pm	RL		32	NO	NO			NO		0	Phu	
Total Intake : 192ml + 100 = 292ml						Total Output : M-3 U-2							
20/5	08:00 pm	RL	Curd	32	NO	NO			NO		0	Phu	
	09:00 pm	RL	rice	32	NO	NO	✓		NO		0	Phu	
	10:00 pm	RL	idzo	32	NO	NO	✓		NO	✓	0	Phu	
	11:00 pm	RL		32	NO	NO			NO		0	Phu	
	12:00 am	RL		-	NO	NO			NO		0	Phu	
	01:00 am	RL		32	NO	NO	✓		NO	✓	0	Phu	
Total Intake :						Total Output :							
	02:00 am	RL		32	NO	NO	✓		NO		0	Phu	
	03:00 am	RL		32	NO	NO			NO		0	Phu	
	04:00 am	RL		-	NO	NO			NO		0	Phu	
	05:00 am	BAS		32	NO	NO	✓		NO		0	Phu	
	06:00 am	RL		32	NO	NO			NO	✓	0	Phu	
	07:00 am	MVI		32	NO	NO			NO		0	Phu	
Total Intake : 320ml + 100ml						Total Output : M-5 U-3							
Total 24 hrs. Intake		1004ml											
Total 24 hrs. Output		M-14 U-6											



21/5/26



FLUID CHART

Sheet No. : 3

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
M	08:00 am	DNS + water	25	NO	NO				NO		0	A
	09:00 am	MVI	—	NO	NO	✓			NO	✓	0	A
	10:00 am	DNS + H ₂ O	25	NO	NO	✓			NO	✓	0	A
	11:00 am	MVI	25	NO	NO	✓			NO		0	A
	12:00 pm	DNS +	25	NO	NO				NO		0	A
	01:00 pm	MVI	25	NO	NO				NO		0	A
Total Intake : <u>T=100+200ml</u>						Total Output : <u>M-3 U-2</u>						
B	02:00 pm	DNS + rice	25	NO	NO				NO		0	A
	03:00 pm	MVI + H ₂ O	25	NO	NO				NO		0	A
	04:00 pm	DNS +	25	NO	NO	✓			NO	✓	0	A
	05:00 pm	DNS +	—	NO	NO				NO		0	A
	06:00 pm	MVI	20	NO	NO				NO		0	A
	07:00 pm	DNS	20	NO	NO	✓			NO	✓	0	A
Total Intake : <u>T=125+100ml</u>						Total Output : <u>M-2 U-2</u>						
N	08:00 pm	DNS + MVI	20ml	NO	NO	✓			NO	✓	0	A
	09:00 pm	MVI + H ₂ O	MVI	NO	NO				NO		0	A
	10:00 pm	"	"	NO	NO	✓			NO		0	A
	11:00 pm	"	"	NO	NO	✓			NO	✓	0	A
	12:00 am	DNS + MVI	20ml	NO	NO				NO		0	A
	01:00 am	"	20ml	NO	NO				NO		0	A
Total Intake : <u>60ml + 150ml</u>						Total Output : <u>M-3 U-2</u>						
N	02:00 am	DNS + MVI	20ml	NO	NO				NO		0	A
	03:00 am	"	20ml	NO	NO				NO		0	A
	04:00 am	"	20ml	NO	NO				NO		0	A
	05:00 am	"	20ml	NO	NO				NO		0	A
	06:00 am	Ceftriaxone	Ceftriaxone	NO	NO				NO		0	A
	07:00 am	"	—	NO	NO				NO	✓	0	A
Total Intake : <u>80ml + 100ml</u>						Total Output : <u>M-0 U-1</u>						
Total 24 hrs. Intake			<u>915ml</u>			Total 24 hrs. Output			<u>M-3 U-2</u>			

FDH-00046039 IP25-00020:21
 Baby DHRUVIKA
 03-10-2024 1 Y 7 M 19 D (F)
 Dr. KALYAN CHAKRAVARTHY KONDA

22/5/26



FLUID CHART

Sheet No. : a

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												
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							



19/5/26

Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 5:48pm Mode of Arrival: walking Admitting From: ER OPD Direct

Allergy / Adverse Reaction Body Weight: 7.5 Kg
 NA Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
NO	NO	NO

Family History:

No significant

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: 7.5 kg Length: Head Circumference (< 2 years):

Temp.: 98.2 F HR: 125 bpm RR: 25 BP: 97/72 mm Hg

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

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

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

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

Character of Pain Location Frequency Duration

FUNCTIONAL SCREENING: No Abnormalities Detected

- Mobility Problem Walking Problem
- Developmental Delay Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: No Abnormalities Detected

- Underweight Overweight Special Feeding Method
- Feeding Problem Special diet No Abnormality Detected

Inform consultant for positive criteria

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 Mother

Nurse's Name: Srinche Date: 19/10/20 Time: 6:10PM Signature: [Signature]



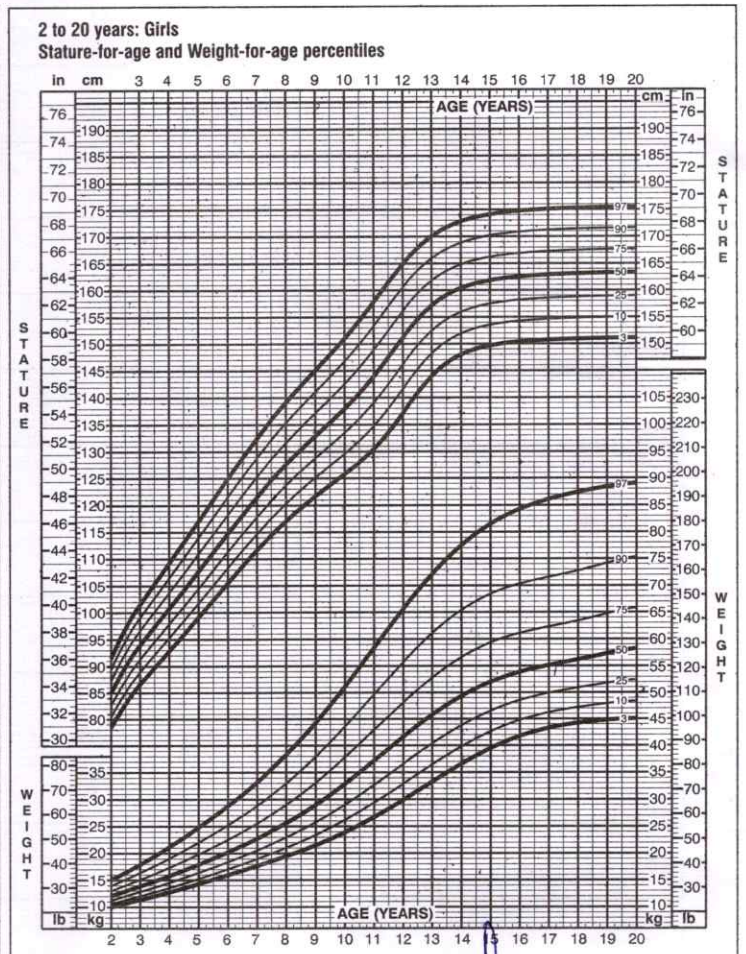
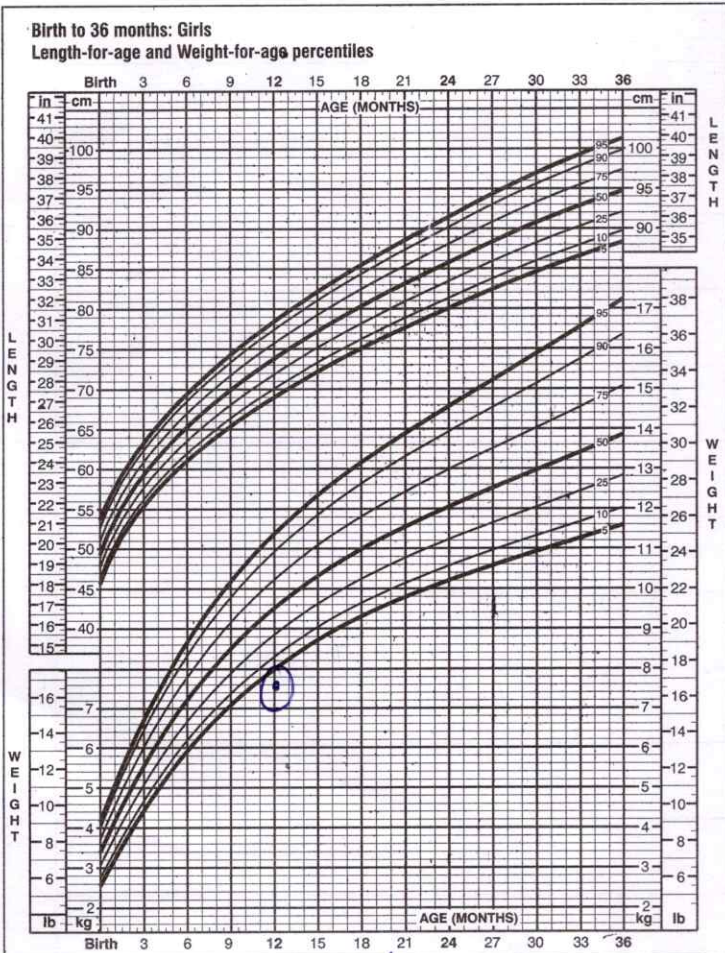
301-B

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 20/5/20 Time: 9:30

Weight: 7.5 Centile: 5th
 Height: 68 Centile:
 Inference: underweight
 RDA: 1000 Calories: 1000 kcal Protein: 10g
 Diet Recommendations: soft & bland diet & oral liquid
 Re-Assessment:
 Food Allergies: Veg/Non-veg: veg
 Diagnosis: AUC & dehydration
 Nutritional Intervention - Oral Enteral Parenteral
 Patient's Signature: Anusha

GROWTH CHART (GIRLS)



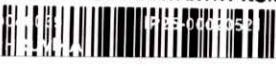
Dietician's Name: Dhani

Dietician's Signature: [Signature]

Daily Notes:

2015/26 - soft diet @ anal train

PATIENT TRANSFER FORM

Patient Name & UHID No. FDH-00046039 IP25-00020521 Baby DHRUVIKA 03-10-2024 1 Y 7 M 16 D (F) Dr. KALYAN CHAKRAVARTHY KONDA 		Date & Time of Admission 19/5/26 @ 4:17 PM	Date & Time of Transfer Order 19/5/26 @ 5:48 PM
		Transfer Ordered by DR. Uma Lahari	Reason for Transfer Admission
From Unit ER	To Unit 301B	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 14	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Venkat</i> 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 checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring <i>Ajan</i>		Name of Person Ordered Transfer DR. Lahari	
Patient & Clinical Records Received by : <i>Sireha</i> 19/5/26 @ 5:48 PM			
Date & Time of Patient Received :			

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