

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No. : _____ Consultant: _____ Dept : _____

Date of Admission: _____ Discharge : _____ Time: _____

Room / Bed No : _____ Billable bed type : _____

VIH-00202257
Baby K CHAITRIKA
07-01-2026 1 Y 6 M 16 D (F)
Dr. SRUTHI BALLA



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
22/7/26	8:23 AM	ER	142	Kaella

Cross Consultation Visit

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

[illegible]

Signature

Substrate

[illegible]

Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
22/7/20	IV placement	①	5844	Chapman
22/7	Kidney Biopsy	②	9716222	Salah
	Conscious Sedation			
	USG Guided Procedure			
22/7	NHA	1	17564	meeloh

ANY OTHER INFORMATION

Credit

Date: 23/8/20

Time: 10am

Prepared By: Shariff

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Shariff	Ward 4		

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176750

Admit Date : 22-Jul-2026

Admit Time : 08:10 AM UHID : VIH-00202257

Patient Details :

Patient Name : Baby K CHAITRIKA

Age : 1 Y 6 M 15 D

Guardian : Mr K NAVEEN KUMAR

DOB : 07-01-2025 01:00 AM

Gender : Female

Religion :

Occupation :

Marital Status : Single

Address (H) : #4-83, JAGGAN GUDA SAMPANBOLE MC
PALLY MANDAL Medchal Ranga Reddy
Telangana INDIA 501401

Phone No : 8977085624

E-mail : nomailid@gmail.com

Admission Details :

Bed Type : GENERAL WARD

Bed No : GW 142

Ward Name : 1F-GENERAL WARD II

Room No : GW 142

Admission Type : First Visit

Contact Details :

Name : Mr K NAVEEN KUMAR

Relationship : Father

Contact Address : #4-83, JAGGAN GUDA SAMPANBOLE MC
PALLY MANDAL Medchal Ranga Reddy
Telangana INDIA 501401

Phone No : 8977085624


Signature

Doctor Details :

Doctor Name : Dr. SRUTHI BALLA

Specialisation : PEDIATRIC NEPHROLOGY

Referral Doctor : Self

Phone No :

Co-Consultant : Dr. DR.V.V.R.SATYA PRASAD

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELFPAY



PEDIATRIC IN-PATIENT MEDICAL RECORD

VIH-00202257 IP5-00176750
Baby K CHAITRIKA
07-01-2025 1 Y 6 M 16 D (F)
Dr. SRUTHI BALLA



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

History of present illness :

SR ns for P/V now

planned for Revd Brophy
to H. M. C. P. H. G.

VIH-00202257 IP5-00176750
Baby K CHAITRIKA
07-01-2025 1 Y 6 M 16 D (F)
Dr. SRUTHI BALLA



Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :



Immunization History :

as perched - to



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 11.96 (Centile _____)

On Examination :

Temperature : 98.4 Pulse Rate : 110/hr B.P. 91/65 SP02 100% on RA

Resp.rate and type of breathing : 28/hr

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : RA = @, 116/hr

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S1 S2

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : S1 S2

Ausculation : M @

Spine : _____ External Genitelia : _____

Relevant data from outside (CT, USG etc.,) _____

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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

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

no Ig on Conclusions
All B Absolute

Planned Management

- ① Inf, CEFIRAXONE
- ② NBM
- ③ IUF NRS (20ml/hr)
- ④ Renal Bsgn - (11am)
(PICU)

Signature of the Doctor: _____

Name of the Doctor: Dr. K. S. 22/7

Date & Time: _____

Signature of the Consultant: _____

Name of the Consultant: Dr. S. S.

Date & Time: _____



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/3/2025 11:30 AM	S/B Dr. Sullin <u>Renal biopsy note</u> Under aseptic Precautions ports painted & draped. (2) sided lower pole renal Biopsy done and Sample sent for LM & IF. No immediate post procedural complication noted. <u>Adv</u> 1) Strict bed rest till 7/11 10 AM 2) Watch for Hematuria, Swelling 3) vitals 3 hourly 4) APO over after child is fully conscious 5) Stop IV after 4 pm today 6) Ifo chalking 7) Lufen 800	<i>(Signature)</i>

Date & Time	Progress Notes	Doctor's Order
22/9/2016 2:30pm	S/P Dr. Lullini	
	Case Reviewed	<u>Adv</u>
	S/P Renal Biopsy	- Stop IVF after 4pm
	No Hematuria now	- Continue ceftriaxone
	Passed clear urine	- Allow orally soft diet
	Biopsy site clean	- If v/o less, Juy Laris 10mg IV stat
	Hemodynamically stable	- Juyora v/o @ 6pm +
		- vitals 3 hourly
		- Watch for Worsening periorbital edema
		- Check wt 7/M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/7 9 AM	Seen by Resident. A&S - SD&NS → SRNS. hematuria resolved. T. wt - 11.1 kg (12 kg). U/O - 925 ml @ 24 hrs ~ 3.47 cc/kg/hr. oral intake fair Vitals stable. BP-95/50 (64) Chest clear abdomen soft hydration fair.	Plan 1. Plan Discharge today. S. Saluti
23/7 10 AM	Seen by Dr. Sruthi Balla.	Discharge today • Syp Ziprax 4 X 4d. • Syp OMNACORTIL FORTE 7.5 ml Daily x 3d ↓ 5.5 ml A/D x 4 weeks • Syp Calcimax ⑦ 5ml OD } to continue • T. LANZOL 15mg OD. • T. Enalapril 1 tab HS 2.5mg • Plan to add Tacrolimus @ P/V • R/V & Biopsy report on Monday • Plan genetic testing after Biopsy report

r. SRUTHI BALLA



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VIH-00202257 IP5-00176750
 Baby K CHAITRIKA
 07-01-2026 1 Y 6 M 16 D (F)
 Dr. SRUTHI BALLA

Patient S



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RESULT SHEET

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

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI

 Others (ECG, Contrast Studies etc..) :

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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: EL

Shifted to: ward

Sl. No.	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Sup-OMNACORTIL FORTE	25ml	PO	OD		☒ C ☐ DC
2	T-GANZOLE	15mg	PO	OD		☐ C ☐ DC
3	Sup-GALCINAPLUS	5ml	PO	OD		☒ C ☐ DC
4	T-ENAGAPRIL	2.5mg	PO	OD Night		☒ C ☐ DC
5						☐ C ☐ DC
						☐ 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. Balaji

Date & Time: 22/7/26, 8:20 AM

Nurse Name & Signature: Abhishek

Date & Time: 22/7/26 @ 8:20 AM

VIH-00202257
 Baby K CHAITRIKA
 07-01-2025 1 Y 6 M 15 D (F)
 Dr. SRUTHI BALLA

IP5-00176750



DRUG CHART

Date of Admission: Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG : Inj PARACETAMOL				Date Time															
Dose	Route	Frequency	Start Date																
150mg	IV	SOS	22/7																
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:																			

VERIFIED BY : Name Signature



REGULAR PRESCRIPTIONS

Weight. 12kg Ward.

DRUG : <u>2g CEFTRIAXONE</u>				Date Time <u>22/2/23</u>
Dose <u>500mg</u>	Route <u>IV</u>	Frequency <u>BD</u>	Start Date <u>22/2/23</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. K. S. Prasad</u>				
Additional Instructions: <u>10mg/kg/day</u>				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				



		(F)	
Dr. BRUTHI BALLA T T G M 16 D 		ate me	
		Nurse Sig.	Nurse Sig.
		Nurse Sig.	Nurse Sig.
DRUG :	Dose		Dose
	Dr. Sign.		Dr. Sign.
Route Start Date	Dose		Dose
	Dr. Sign.		Dr. Sign.
Name & Signature of the Doctor	Dose		Dose
	Dr. Sign.		Dr. Sign.
Additional Instructions:	Dose		Dose
	Dr. Sign.		Dr. Sign.

VARIABLE DOSE		Date Time ↓							
			Nurse Sig. ↓		Nurse Sig. ↓		Nurse Sig. ↓		Nurse Sig. ↓
DRUG :			Dose		Dose		Dose		Dose
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.
Route	Start Date		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.

STAT / ONCE ONLY DRUGS[illegible]

07-01-2026

1 Y 6 M 16 D

(F)

I.V. FLUIDS CHART

Weight. 12 kg. Ward.



Composition of I.V. Fluid
(on, mention ml./hr = Mcg/kg/min. etc)

Route

Flow Rate	ml/hr
-----------	-------

Doctor
Sign

Nurse
Sign

Date of Stopping

Doctor
Sign

Nurse
Sign

227

9:10am

ONS



20

S. Chandrasekhar

22/7

2012

VERIFIED BY : Name

VIH-00202257
Baby K CHAITRIKA
07-01-2025 1 Y 6 M 15 D (F)
Dr. SRUTHI BALLA



RCH/ FRM / CLINICAL / 125

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

Pratiksha
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 22/12	Time:	5 Pm	10pm	2Am	5:30Am	
Doctor / Nurse / Family Concern?						
Temperature (F)	104	97.8 F	97.8 F	96.7 F	96.5 F	97.9 F
Heart Rate (bpm)	190	126 bpm	120 bpm	128 bpm	102 bpm	116 bpm
Blood Pressure (mmHg) *	120	107/61	107/81	99/63	90/50	95/64
Note: BP does not score in early warning scoring						
Resp. Rate (bpm) (Over 1 Minute) *	70	29 bpm	28 bpm	27 bpm	28 bpm	
Resp Rate (Number)						
Resp Mod/ Severe Distress None / Mild						
Receiving O ₂ (l/min) O ₂ Saturations (%)		100%	99%	99%	100%	
Conscious Level Normal / Altered		15/15	15/15	15/15	15/15	
GCS *						
TOTAL SCORE						
Number of shaded boxes	0	1	0	0	0	
Pain Score						
Observer's Initials	Qy		m	m	pa	
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.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

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

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

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

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

Patient No.

VIH-00202257

IP5-00176750

Baby K CHAITRIKA

1 Y 6 M 16 D

(F)

07-01-2025

Dr. BRUTHI BALLA



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FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am	1											
	09:00 am												
	10:00 am	Das										Ch	
	11:00 am											Ch	
	12:00 pm	1		20ml								Ch	
	01:00 pm	1		20ml						200ml		Ch	
Total Intake :						Total Output : m=0 u=200							
	02:00 pm			20ml									
	03:00 pm	Das		20ml									
	04:00 pm												
	05:00 pm	No											
	06:00 pm	1/4											
	07:00 pm									150			
Total Intake :						Total Output : m=D u=333							
22/7	08:00 pm	↑								285ml			
	09:00 pm	↑	Wile									Merlin	
	10:00 pm	NO											
	11:00 pm	1/4											
	12:00 am	Wile										Merlin	
	01:00 am	↓											
Total Intake :						Total Output : M= u=285ml							
23/7	02:00 am	↑											
	03:00 am	↑										Merlin	
	04:00 am	NO											
	05:00 am	1/4											
	06:00 am	↓										Merlin	
	07:00 am	↓	Wile							107ml			
Total Intake :						Total Output : M=0 u=107ml							
Total 24 hrs. Intake													
Total 24 hrs. Output			3.47 cc/kg										

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FLUID CHART

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Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 22/12

Assessment: pt came for Renal Biopsy

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
9am	→ Assess the pt General Condition	9am	→ Assessed the pt General Condition	
10pm	→ Check the Vital signs		→ Checked the Vital signs	
	→ plan for Administration medication	11:10pm	→ providing medication as per doctor Order	
2pm	→ plan for I/O Chart	12:10pm	→ strictly I/O Chart	
	→ plan for Renal Biopsy	2:10pm	→ Renal Biopsy done	
			→ continue I/O Chart	

Re-Assessment: Re-Assessment every 4th hrs

Special Notes:

Nurse Signature: [Signature] Nurse Name: Chandane Date & Time: 22/12/2024

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 22/7/26

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2m	Assess the general Condition of the patient	2:30 p	Assessed the general Condition of the patient	Baby Condition is good
3m	Monitor the vitals signs		monitored the vitals signs	
4m	maintain Ilo chart	3:30 p	maintained Ilo chart	
5m	Administer medication as per as chart	4:30 p	Administered medication as per as chart	
6m	maintain personal Hygiene	5:30 p	maintained personal Hygiene	

Re-Assessment:

Re-Assessment

Special Notes:

Ilo chart

Nurse Signature: lls

Nurse Name: nikita

Date & Time: 22/7/26 8 pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 02/7/20

Assessment: Baby having discomfort.

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 general condition of the baby.	8.30pm	Assessed the general condition of the baby.	Implemented all the procedure
9pm	Administer medication as per doctor order.	9.30pm	Administered medication as per doctor order.	
10pm	Monitor vital signs.	10.30pm	Monitored vital output signs	
12Am	Monitor urine output	11Am	Monitored urine output.	
2Am	Provide comfortable position.	3Am	Provided comfortable position.	
4Am	Watch for worsening periorbital edema.	5Am	Watched for worsening periorbital edema.	
6Am	Encourage to take soft diet.	7Am	Encouraged to take soft diet.	

Re-Assessment:

Special Notes: Monitor urine output

Nurse Signature: Merlin

Nurse Name: Merlin

Date & Time: 03/7/20 @ 2am

VIH-00202257 IP5-00176750
Baby K CHAITRIKA
07-01-2025 1 Y 6 M 15 D (F)
Dr. SRUTHI BALLA



NURSING CARE RECORD


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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sruthi Balla Department: Pediatric Date of Admission: 22/7/26

SITUATION	Diagnosis: <u>Renal biopsy.</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:			
	Area	Shift Time				
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
		<u>8:23 AM</u>	<u>1st floor</u>	<u>2nd floor</u>	<u>3rd floor</u>	<u>4th floor</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>98.0F</u>	<u>98.3F</u>	<u>98F</u>	<u>96F</u>	
	Res: <u>20b/m</u>	<u>26b/m</u>	<u>23b/m</u>	<u>28b/m</u>		
	SpO ₂ : <u>100.1</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>		
	Pulse: <u>125b/m</u>	<u>121b/m</u>	<u>120b/m</u>	<u>128b/m</u>		
	BP: <u>90/58</u>	<u>98/60</u>	<u>100/60</u>	<u>94/50</u>		
	Fall Risk Score: <u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>		
	Pain Score: <u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>		
	Recommendations	Safety Needs:	☒ Yes	☒ Yes	☒ Yes	☒ Yes
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No
Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Keerti</u>	<u>Chandam</u>	<u>Nikita</u>	<u>Keerti</u>	
Signature :		<u>Keerti</u>	<u>Chandam</u>	<u>Nikita</u>	<u>Keerti</u>	
Date:		<u>22/7</u>	<u>22/7/26</u>	<u>22/7</u>	<u>22/7</u>	
Time:		<u>8:23 AM</u>	<u>2:23 PM</u>	<u>8 PM</u>	<u>8 AM</u>	
Taken Over By Name :		<u>Chandam</u>	<u>Nikita</u>	<u>Meen</u>	<u>Shiraj</u>	
Signature :		<u>Chandam</u>	<u>Nikita</u>	<u>Meen</u>	<u>Shiraj</u>	
Date:		<u>22/7/26</u>	<u>22/7</u>	<u>22/7</u>	<u>23/7</u>	
Time:		<u>9 AM</u>	<u>2 PM</u>	<u>8 PM</u>	<u>8 AM</u>	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area							
	Shift Time							
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:						
	Res:							
	SpO ₂ :							
	Pulse:							
	BP:							
	Fall Risk Score:							
	Pain Score:							
	Recommendations	Safety Needs:						
Physiotherapy		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Others Specify:								
Special Diet:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Other Special Orders / Medications:								
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature :								
Date:								
Time:								
Taken Over By Name :								
Signature :								
Date:								
Time:								

VIH-00202257
Baby K CHAITRIKA
07-01-2025 1 Y 6 M 16 D (F)
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THE HUMPTY DUMPTY SCALE 22/7 23/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	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			
Cognitive Impairments	Not Aware of Limitations	3		3			
	Forget Limitations	2					
	Oriented to own Ability	1	1				
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	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			
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			
TOTAL			11	13			

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	yes			
Call device within reach		✓	yes			
Wheels Locked		✓	yes			
Room free of clutter		✓	yes			
Adequate Lighting		✓	yes			
Wheel Chair Support		✓	no			
Other Intervention(s) Specify		✓	no			
Nurse's Name :			Keethu			
Signature :			Ki			
Date :			22/7	23/7		
Time :			8pm	8am		

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 Baby K CHAITRIKA
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BRADEN 'Q' SCALE

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				Date : 22/7/2025			
				Time : 9 AM	6 PM		
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.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	9	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	
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.	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	
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	
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	
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	
				TOTAL SCORE	28	28	
				Evaluator's Name	Colt		

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

VIH-00202257 IP5-00176750
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PAIN ASSESSMENT FORM

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Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
22/7	8Am	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Relief
22/7	11am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chendane
22/7	8pm	0/10		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Meslin
23/7	4Am	0/10		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Meslin
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

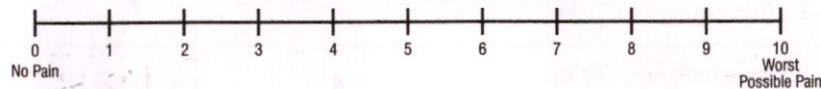
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

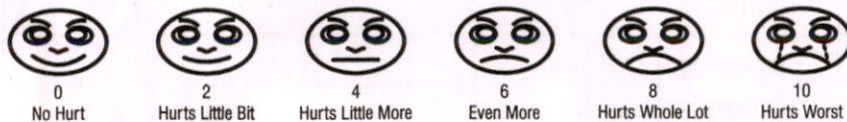
Numerical Pain Scale (Obstetric and Gynecology)



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





CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0						
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-	-						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-						
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-	-						
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-	-						
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-						
Signature of the Nurse				[Signature]			[Signature]						

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personnel ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : Sourav Name : Sourav

Signature of Ward In Charge :

Signature : Neeraja Name : Neeraja

VIH-00202257 IPS-00176750
 Baby K CHAITRIKA
 07-01-2025 1 Y 6 M 16 D (F)
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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Patient's / Learner Language: English Patient / Learner Literacy: ☒ Read ☒ Write ☒ Speak Willingness to Learn: ☐ Yes ☐ No Healthcare Literacy: ☐ Yes ☐ No

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
22/7	8 AM	2	Treatment & care plan	F	1	1	1	0	-	Chaitri
22/7/25	8:30 AM	9	Child is on NPO	F	1	0	1	1	-	Moulin

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									

Patient Sticker
 V14-00202257
 Baby K CHAITRIKA
 07-01-2025 1 Y 6 M 16 D (F)
 Dr. SRUTHI BALLA

MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagn

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
22/7 8am	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Renal Biopsy	Hemodynamic Stable	Providing NPO	Day	☐ Nursing ☐ Others:
22/7/26 8am	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Renal biopsy,	H. stability	procedure	Keerthi	☒ Medical ☐ Others:
22/7/26 9:30 am	☐ Medical ☐ Nursing ☒ Others: DBL...	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	Renal Biopsy	Child is on NPO	NPO till Further Advised	M... ..	☐ 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:

Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 9am Mode of Arrival: Wheel chair Admitting From: ☐ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Body Weight: 12 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>NA</u>	<u>NA</u>	<u>NA</u>

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.: 98.9°F HR: 116b RR: 28b BP: 98/60

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 28) (Document in the Braden Q Assessment Sheet)

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

Character of Pain Location Frequency Duration

FUNCTIONAL SCREENING:☒ No Abnormalities Detected☐ Mobility Problem☐ Walking Problem☐ Developmental Delay☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:☒ No Abnormalities Detected☐ Underweight☐ Overweight☐ Special Feeding Method☐ Feeding Problem☐ Special diet☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening:☒ No Significant FindingsUnusual concerns about patient's Psychological Status: ☐ Yes ☐ No

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify Inform consultant for positive criteria.

Social History: Lives With

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 ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump : ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ NoInformation given to ParentsNurse Signature: ChandaNurse Name: ChandaDate: 22/7Time: 2:20

VIH-00202257 IP5-00176750
Baby K CHAITRIKA
07-01-2025 1 Y 6 M 16 D (F)
Dr. SRUTHI BALLA

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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DISCHARGE PLANNING FORM

Nationality: Indian

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: As per doctor Order

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☐ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication ☒ Yes ☐ No

☐ Bathing ☐ Yes ☒ No

☐ Eating ☐ Yes ☒ No

☐ Walking ☐ Yes ☒ No

☐ Dressing ☐ Yes ☒ No

☐ Toileting ☐ Yes ☒ No

Explain to Parent

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Hand hygiene

☐ Patient's Educational Topic/s discussed with the:

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Chandana

Date and Time: 22/7/26 2:20 PM

CONSENT FOR SPECIAL PROCEDURES

Patient Name : Chaitrika Gender: ☐ Male ☒ Female
UHID No : V1H-00202257 Department : Ped. Nephrology Date : 22/7/26

I S/D/W/O

Here by give consent for procedure of : Renal Biopsy

For my patient, Named : Chaitrika

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

Pain, bleeding, hematuria

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

0

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

Name of the Doctor performing the procedure: Dr. Sruethi Balla

Patient Attendant : [Signature]
Signature :
Name : Swami
Relationship with Patient: Uncle
Date & Time : 22/7/26 10am

Witness :
Signature : [Signature]
Name : Chandan
Date & Time : 22/7/26 011am

Doctor (who is taking the consent) :
Signature : [Signature]
Name : Sruethi
Date & Time : 22/7/26 10am

CONSENT FOR SPECIAL SEDATION

Patient Name: Chaitrika Gender: ☐ Male ☒ Female

UHID No: VIH-00202257 Department: Ped. Nephrology Date: 22/7/26

I S / D / W / O

Here by give consent for procedure for my patient : Renal Biopsy + Sedation

The doctors have explained to me in language known to me the details of sedation as follows:

- Type of Sedation : Short IV sedation
- Possible complications from the procedure of sedation:
Bradycardia, hypotension

The doctors have explained to me about the benefits, risk, alternative of the procedure.

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

Patient Attendant :

Signature : [Signature]

Name : Swami

Relationship with Patient: Under

Date & Time : 22/7/26 10am

Witness :

Signature : [Signature]

Name : Chandan

Date & Time : 22/7/26 @ 11am

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Savitri

Date & Time : 22/7/26 10 Am.

ప్రత్యేక మత్తు కోసం సమ్మతి

రోగి పేరు : వయస్సు లింగం పు స్త్రీ

యు.హెచ్.ఐ.డి. విభాగము

తేదీ

నేను కుమారుడు / కుమార్తె / భార్య

..... అను విధానంపై పూర్తి అంగీకారం తెలుపుతున్నాను.

వైద్యులు నాకు తెలిసిన భాషలో మత్తుమందు వివరాలను ఈ క్రింది విధంగా వివరించారు:

● సెడేషన్ రకం

● మత్తు ప్రక్రియ నుండి తలెత్తు సమస్యలు:

.....

.....

ప్రక్రియ యొక్క ప్రయోజనాలు, ప్రమాదం, ప్రత్యామ్నాయం గురించి వైద్యులు నాకు వివరించారు.

నేను పైన పేర్కొన్న విషయాన్ని నాకు తెలిసిన భాషలో అర్థం చేసుకున్నాను మరియు మత్తుమందు ఇవ్వడానికి సమ్మతిని ఇచ్చాను.

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకము

పేరు

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

తేదీ మరియు సమయము

సంతకము

పేరు

Moderate Sedation Flow-Sheet

Immediate Pre-Sedation Assessment

B.P	PR	R.R	Temp	SPO ₂	Pain Score	Weight
110/70	130	30/m	98.6	100%	3	12 kg

Diagnosis:

Procedure: Kidney Biopsy

Comorbidities:

- ☒ Risk, benefits & alternatives discussed;
- ☐ Patient understand & elects to proceed
- ☐ Consents for procedure and sedation signed and dated

ASA Physical Status

- ☒ ASA PS 1: Healthy Patient
- ☐ ASA PS 2: Mild Systemic Disease, no functional limitations
- ☐ ASA PS 3: Severe Systemic Disease, functional limitations
- ☐ ASA PS 4: Severe Systemic Disease, constant threat to life
- ☐ ASA PS 5: Moribund Patient unlikely to survive 24 hrs.
- ☐ ASA PS 6: A declared braindead patient whose organs are being removed for donor purposes

☐ E: Emergency procedure

GCS: E 4 M 6 V 5

☒ IV Site: Gauge: 22G

Sedation Plan: Ketamine

Allergies:

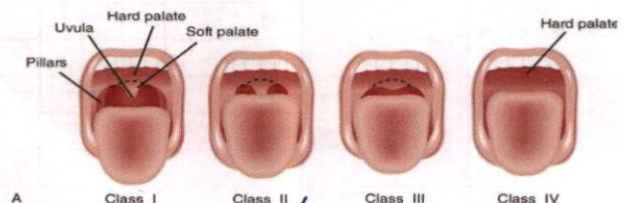
AIRWAY EVALUATION

Mouth:

- ☒ Normal
- ☐ Loose Teeth
- ☐ Small Mouth
- ☐ Protruding Incisors
- ☐ Receding Lower Jaw
- ☐ Dentures

Neck:

- ☒ Normal
- ☐ Decreased ROM
- ☐ Thyromental Distance Less Than 6 cm
- ☐ Short Neck



Mallampati Class: ☒ I ☐ II ☐ III ☐ IV

Monitoring of Patient Intra – Procedure

Procedure Monitoring

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

Level of Consciousness (LOC):

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

TIME	BP	PR	RR	O ₂ Sat%	O ₂ Supplementation	Comments / Initials
Baseline	110/68	140/min	34/min	100%		
1200pm	108/66	142/min	34/min	100%		

Doctor Notes: unclear

Post Sedation Care Room

[illegible]

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

Activity :	Consciousness:	Respiration:	Oxygen Saturation:	Circulation:
Four extremities = 2	Fully awake = 2	Breathe Deep= 2	Sat O ₂ >92 % on room air = 2	BP +/- 20 mm hg of pre-op = 2
Two extremities = 1	Arousal on calling=1	Dyspnea, limited breathing = 1	Needs oxygen to maintain Sat O ₂ >90% = 1	BP +/- 20-50 mm hg of pre-op = 1
No extremities = 0	Unresponsive=0	Apnea = 0	Saturation <90% with oxygen = 0	Bp +/-50 mm hg of Pre-Op = 0

Stamp

PROCEDURE SAFETY CHECK LIST (TIMEOUT OUTSIDE OT)

Patient Name: Gender: ☐ Male ☐ Female UHID. No: Age:

Date: In-Time: 11:45am Out-Time: 12pm

Doctor Performing Procedure: DR. Senthil Doctor Giving Sedation: DR. Vikas Assisting Nurse: Br. Subrata

SIGN IN		Time: <u>11:45am</u>	TIME OUT		Time: <u>11:50am</u>	SIGN OUT		Time: <u>12pm</u>			
	Yes	No	NA		Yes	No	NA				
Patient is verified using two identifiers (Name & UHID)	☒	☐	☐	Correct Patient	☒	☐	☐	Name of the Surgical / Invasive Procedure is recorded	☐	☒	☐
All required documents, images, studies are available	☒	☐	☐	Correct Site	☒	☐	☐	Instrument, Sponge and Needle Count Completed	☒	☐	☐
NPO Status Checked from Patient / Patient Attendant	☒	☐	☐	Correct Procedure	☒	☐	☐	Specimens are labeled	☒	☐	☐
Consent is Signed	☒	☐	☐	All the team members introduced	☒	☐	☐	Any equipment problems are addressed	☐	☒	☐
Any need for blood products	☐	☒	☐								
If Yes Comment:											
Any Risk of Hemodynamic Compromise	☒	☐	☐								
If Yes Comment:											
Any drug or food allergy	☐	☒	☐								
If Yes Comment:											
Correct Site of Procedure Marked	☒	☐	☐								
All resources required are correct, available and functioning	☐	☐	☐								
Signature of the Doctor: <u>[Signature]</u>				Signature of the Nurse: <u>Subrata</u>				Signature of the Nurse: <u>Subrata</u>			
Name of the Doctor: <u>Dr. Senthil</u>				Name of the Nurse: <u>Subrata</u>				Name of the Nurse: <u>Subrata</u>			

Any Adverse / Unexpected Events

nil

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 22/7/28 Time: 8:30am

Weight: 11.9 kg Centile: 50th

Height: 82cm Centile: 75th

Inference: well fueled

RDA: — Calories: 1200 kcal/d Protein: 20g/d

Diet Recommendations: child is on NPO

Re-Assessment:

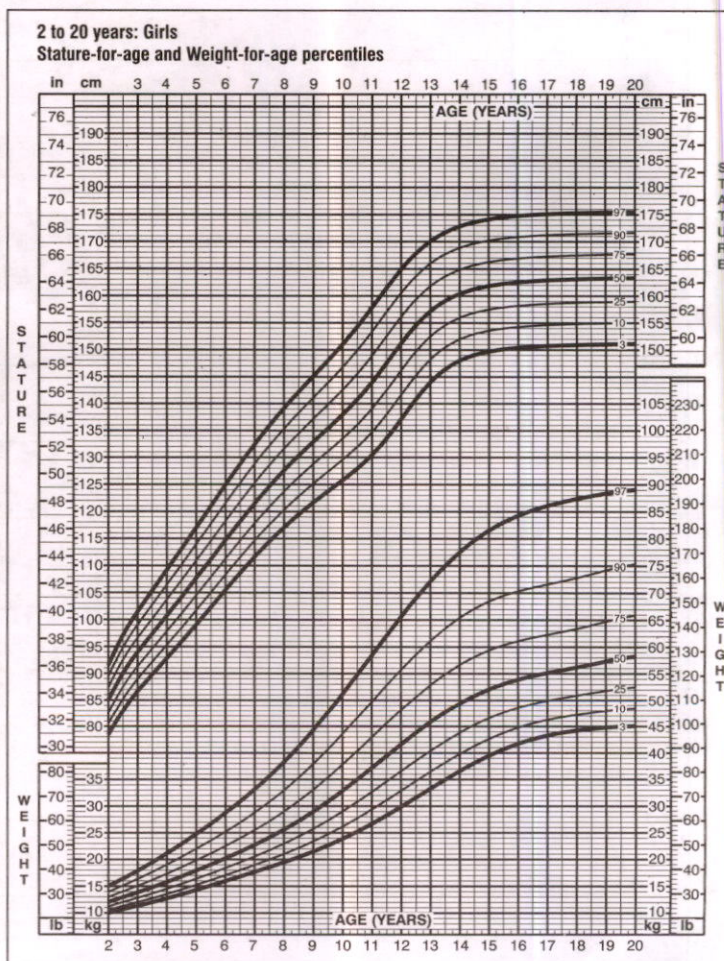
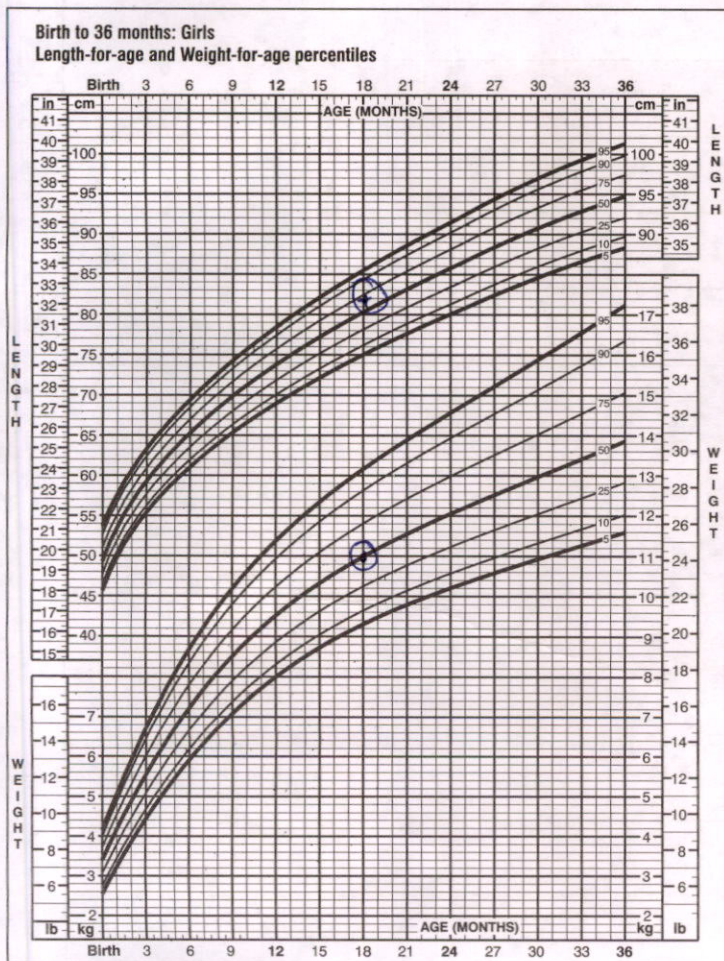
Food Allergies: NO Veg/Non-veg: non-veg

Diagnosis: F/V/C of SRNS & Renal Biopsy

Nutritional Intervention - ☐ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (GIRLS)



Dietician's Name: Mounica

Dietician's Signature: Mounica

Daily Notes:

~~23/2/20~~
8am

child is stable. Entake is fair

continue $\bar{c}$ soft low salt diet

Nikol