

ACTIVITY RECORD FOR BILLING

Name : _____ IP5-00176493
UHID No. : _____ Baby MADIA SULTHANA 12 Y 10 M 12 D (F)
04-09-2013 Dr. ABHISHEK RAVINDRA JAIN
Date of Admission : _____ Date of Discharge : _____ Time : _____
Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
17/7/26	1805am	ER	ward	Abhishek

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	De Nances Sarah	17/7/26	9708252	Sushma
2	Dr. Chandana	18/7/26	9711159	Meelin
3	Dr. Prashant Bachina	18/7/26		Meelin
4	Dr. Prashant Bachina	19/7/26		Meelin
5	Dr. Akhila Venkatesh	19/7/26	9712330	Sueen
6	Dr. Vidhi	19/7/26	9712417	Sueen
7				
8				
9				
10				

[illegible]

Investigations

Order No.

Signature

CBP, ERP, S/S, even,
exact, LFT, GRAG

7499

Samshy

1212

Sr Amnoria ; Blvd ch
crp (VBW)

21491

Sushu

1212

(EEG)

035611
~~035611~~

Sushru

1817

ICXR AD

035726



187

USG And

035760

9

19/7

X-ray Abdomen. erect

035968

nl

1917

Flu panel, cue, wineck
and pet

26072438

Martin

[illegible][illegible]

[illegible]

Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176493 Admit Date : 16-Jul-2026 Admit Time : 11:47 PM UHID : BAH-00288190

Patient Details :

Patient Name	: Baby MADIA SULTHANA	Age	: 12 Y 10 M 12 D
Guardian	: MR.M.A.ZAMEER	DOB	: 04-09-2013
Gender	: Female	Religion	:
Occupation	:	Marital Status	: Single
Address (H)	: H.NO.7-126, ABDUL KALAM NAGAR, Hanmanpura Hyderabad Telangana INDIA 509001	Phone No	: 9985824171/ 9704212696
		E-mail	: na123@rainbowhospitals.in

Admission Details :

Bed Type : SEMI PRIVATE Bed No : SPVT 111 Ward Name : 1F-VIBGYOR
 Room No : SPVT 111 Admission Type : First Visit

Contact Details :

Name	: MR.M.A.ZAMEER	Relationship	: Father
Contact Address	: H.NO.7-126, ABDUL KALAM NAGAR, Hanmanpura Hyderabad Telangana INDIA 509001	Phone No	: 9985824171


 Signature

Doctor Details :

Doctor Name	: Dr. ABHISHEK RAVINDRA JAIN	Specialisation	: PEDIATRIC NEUROLOGY
Referral Doctor	: Self	Phone No	:
Co-Consultant	:		

Payment Details :

Payment Mode	: Cash	Deposit Amount	: 0.00
		Payor Name	: ICICI LOMBARD GENERAL INSURANCE CO LTD

BAH-00288190 IP5-00176493
 Baby MADIA SULTHANA
 04-09-2013 12 Y 10 M 16 D (F)
 Dr. ABHISHEK RAVINDRA JAIN



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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	5			
7	Nursing plan of care and handover sheets	6			
8	Consultation sheet	5			
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation	2			
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia & post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist	1			
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	5			
30	Intake and Out take chart (fluid chart)	3			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list <i>Thermometer</i>	1			
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
45	<i>Extra</i>				
Total No. of Pages		39			

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /

2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00288190 IP5-00176493
Baby MADIA SULTHANA
04-09-2013 12 Y 10 M 12 D (F)
Dr. ABHISHEK RAVINDRA JAIN



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

clot tightening of lower jaw : 2 hrs

History of present illness :

child is k/clo seizure disorder

ARGinine deficiency

liver transplant — MS UD Graft wt 2278 gm in
march 2021

Now presented with clot tightening
of mouth at : 2 hrs w seizure episodes

4-5 episodes / day for : 3 days.

clot difficulty in swallowing : 2 hours.

→ child on T-Sizodon 0.5mg. 1 tab OD

→ as sup lacosamide 2.5ml OD Dose.



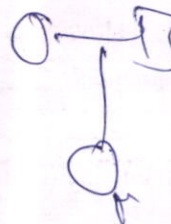
Pediatric Multiorgan History & Physical Examination

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

Port liver transplant for MSUD

Birth & Neonatal History:

FT / CSCS / C/PAB / 2.5 kg
suction stimulation.



Birth & Socio Economic History:

About Father : Upper Middle class.

About Mother :

Any additional Information :

Developmental History :

Global Developmental Delay

Immunization History :

As per Age.



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 28 kg. (Centile _____)

On Examination :

Temperature : 99.1°F Pulse Rate : 125/min B.P. _____ SPO2 99%

Resp. rate and type of breathing : B/L AET

Rash No Rash over Left part of chest 2 days

Lymphadenopathy _____

Oedema : Not noted

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L AET

Any added sounds : No Added sounds

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S1 S2

Any murmur : _____

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

Per Abdomen :

Inspection Surgical Scar (+) (Post Liver Transplant)

Palpation : Soft Liver (+)

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 : 2

Motor System:

Nutrition : moderately nourished

Tone : 4

Power : used in hip joint.

Co-ordinator : _____

Posture : Sitting

Involuntary Movements : Dystonia

Reflexes : Exaggerate.

DTR

Superficials:

Plantars

Sensory System :

Bladder / Bowel : 2

Clinical Summary & Diagnostic:

Seizure. Oro mandibular Dystonia
Seizures (prob MSUD - Post liver transplant)

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Prevent complication

Desired goals of the treatment: H¹ stability

Planned Labs:

CBP

Sr. Electrolytes

LEFT

RFT

~~NTB~~
~~Abhishek~~

Planned Management

→ Inj. lorazepam stat

→ NG tube insitu

→ Syp. Lacosamide
 (from morning)

→ Continue remaining
 oral medications.

→ Backup with levetiracetam
 for next seizures

→ IVF D5W 25ml/hr (1/2 MP)

Signature of the Doctor: Dr. T. Pawani

Name of the Doctor: T. Pawani

Date & Time: 16/07/26 14:00

Signature of the Consultant: Dr. Abhishek Ravindra Jain

Name of the Consultant: Dr. Abhishek Ravindra Jain

Date & Time: 17/07/26 11:00

BAH-00288190
 Baby MADIA SULTANA
 04-09-2013 12 Y 10 M 12 D (F)
 Dr. ABHISHEK RAVINDRA JAIN

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	17/09/18 14:30 <u>Neurotears</u> <u>seizures</u> with breakthrough No further episodes of seizures Neuroanatomical distortions. Speech, extreme sleep vitals - stable not sleeping comfortably. CV - ECG full ok myk (12) U - Hypertonia (+) dystonia spastic ataxic gait Asymmetric tonic rigidity movements No cerebellar signs. (Dr. 118 more forward)	Spice spike post admission.

Admission
 = ASD plan!

PROGRESS NOTES AND DOCTOR'S ORDER

Date
& Time

Progress Notes

Doctor's Order

Δ: Acute febrile illness
 ? Dystonic crisis
 ? Epileptic event
 Encephalopathy

Plu

① Sr Ammonia, Blood ch
 CRP, VRS, LVE
 Extra plain ②
 Extra EDTA ①

17/7

8pm

elS/B Neutecam

→ No fresh issues

Child conscious
 vitals - stable

HMF

Adv

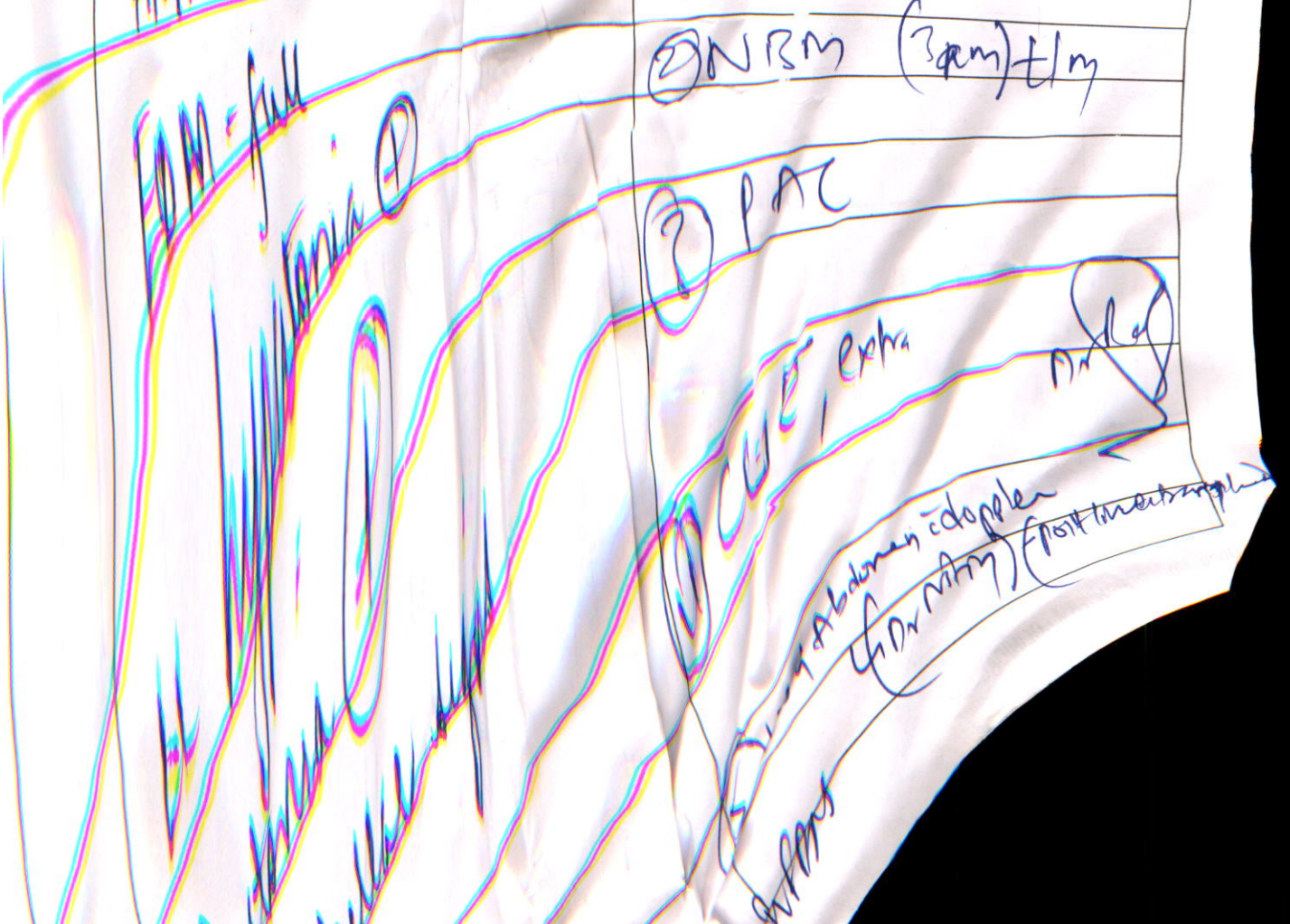
① MRI Brain plain
 ↓ sedation Hm

② NRM (3am) Hm

③ PAC

④ CUE, extra

Abdomen icteric
 (Dr Mm) (Post lunch)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	clb <u>Neurotrans</u> <u>17/08</u> clb epilepsy with breakthrough seizures. No further episodes of seizures. No neurodisability. No tonic clonus. I speak, extreme sleep. of: vitals - stable. - HNF - sleeping comfortably. - CN - EOM full of myopia (R). - Uthya (R) (F) dystonia. Exaggerated reflexes. Asymmetrical as gravity mercurials. No cerebellar signs. (Dryll @ move forward)	spike spike post admission. Adv: Asm plan! Asm plan! - Dryll - R IV 60mg in 20 mins over 20 mins. Gastroenterology review PTT - cap the throat Pulmonology review

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Δ: Acute febrile illness ? Dystonic crisis ? Epileptic event Encephalopathy	
		Plu ① Sr Ammonia, Bloods CRP, VBG, CUE Extra plain ② Labs EDTA ①
17/7 8pm	elS/B Neuroteam → No fresh issues	
	Child conscious vitals - stable HMF EDM - full LE hypotonia ⊕ Dystonia ⊕ No Cerebellar signs	Adv ① MRI Brain plain ↓ sedation t/m ② NRM (3am) t/m ③ PAC ④ CUE, extra ⑤ USG Abdomen & Doppler (for vtm) (front line sample) ⑥ Infors

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	ckd <u>Neuroteam</u>	
<u>11/1/22</u> <u>9.20 AM</u>	Epilepsy with breakthrough seizures with Aute febrile onset. Issues: ① Febrile spikes → 2-3 mild to moderate grade, today → D₂ off febrile illness. Focus → started off as URTI → cough, cold, sore throat. ② Paroxysms of mouth deviation → lasting for few seconds, 4-5 episodes. ③ No further prolonged seizures. Vitals → Stable. - Afebrile → following command - Eyes full, pupils equal reactive - Unrestrained hyperreflexia - Exaggerated reflexes. - Symmetrical outpouring movements - No nuchal or cerebellar signs <u>Dr. Arvind</u>	
		<u>Dr. Arvind</u> - vitals - Add Sp. Ag. Hb - Infuse - ECG, PCT, for panel.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22 Feb 10 AM	de <u>Neurotrans</u> Epilepsy with breakthrough seizures with acute febrile illness. No further paroxysms. No more spikes. <u>SE</u>: stable → stable. - Hct → @ baseline serum - CNS exam full. - Cerebral hypotonia. - Exaggerated reflexes. - No meningeal or cerebellar signs. - Trace flu panel. - PCR. - X-ray	Adv. - monitor for seizures, pre & post transplant changes - monitor & physio today. ↓ Start orally. - continue - tacrolimus - Add tab. Paracetamol. - Biv - clozapine

DR. ABHISHEK R JAIN
Registration No: 2757

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/11/18		
6:30 PM	4/13 Neuroteam	
	No new issues	
	MRI Brain: Normal basal ganglia	
	Prominent optic nerve sheaths 1/2 IOP.	
	ECG: vitals stable	
	Amf (N) baseline dysrhythmia.	
	Seizure.	
	Generalised hypotonia.	
	Exaggerated reflexes.	
	<u>Pre-op</u>	<u>Post-op</u>
	Motor - sitting independently	-(+)
	- walking with hand support (-)	(-), mild weight bearing after TA release
	- Significant U spasticity	- Improved after TA release
	- Good grip reaching for objects.	(-)
	Language Babbling biphables	(-)
	No meaningful words	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Pre-op</u>	<u>Post-op</u>
	Appropriate - good understanding of common objects	Regeneration
		<u>Adv:</u>
		- ophthal examination
		studies for
		- current opinion
		- continue all
		medicines,
		vitals, fowls
		<u>plan</u>
		(1) cont. NG feeds
		(2) physiotherapy, (continue)
		oromotor exercises

Date & Time	Progress Notes	Doctor's Order
		(3) Dietitian review
		(4) D/c today
		(5) Review 1 week
		(6) Bup T. clonazepam
		(7) Goudus today
		(8) Dermat opinion today
		(9) Syp. Melatonin - sleep
		(10) (800) T. clonazepam/ Syp. Pedicology/ for irritability
		(11) Syp. Orafel Syp. Bevon
		(12) Azithro x 3 days
		(13) cefixime oral x 3 days Syp. Piptaz

[illegible]



CROSS CONSULTATION FORM

Doctor Name : Abhishek Venkatesh Date : 20/7/26 Time : 11am

Diagnosis : Klefo Epilepsy & Anath through surgery

Hospital : RCH

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

Referred for : ☒ Opinion ☐ Co-Management ☐ Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Physiotherapy

Signature: _____

Findings and Recommendations :

s/o physiotherapist

Klefo Epilepsy & Anath through surgery

→ ↑ tone ⊕ in Bk L.L.

H/o → Adductor delay, or dilator
 line transposed.

on NA mbe feeding

→ Stretching for Bk L.L.

→ oromotor stric ex's,

→ PROM ex's for Bk L.L.

Consultant :

Name : Abhishek Venkatesh Signature : Abhishek Date & Time : 20/7/26 11am



CROSS CONSULTATION FORM

Doctor Name : Buddhi Date : 20/7/26 Time : 1:00 pm

Diagnosis : (1) Feeding difficulties secondary to GDD

Hospital : RCH; Bangalore

Type of Referral :

- ☐ Emergency
☐ Urgent
☒ Non Urgent

Referred for : ☒ Opinion ☐ Co-Management ☐ Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Feeding & swallowing Assessment Signature: Buddhi

Findings and Recommendations : Thanks for referral.

* OPME was assessed & revealed structurally adequate & functionally adequate

* Initiated with oral feeds using spoon
idly; dal & rice; like warm water were
child was able to chew, bite & swallow
adequately

* No choking, coughing, aspiration/
vomiting observed during & after feeding

* Plan: (1) maintain posture (90°)
(2) slow paced feeding method
(3) Parents were trained & counselled.

Consultant : (1) encourage oral feeds.

Name : _____ Signature : _____ Date & Time : _____



CROSS CONSULTATION FORM

Doctor Name: Dr. Naveen Saradhi Date: 17/7/26 Time:

Diagnosis:

Hospital: RCH Banjara

Type of Referral :

☐ Emergency

☐ Urgent

☒ Non Urgent

Referred for: ☒ Opinion ☐ Co-Management ☐ Transfer of care

Reason for Referral: If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

Findings and Recommendations :

12y 10 mon / F

KICLO Epilepsy ± breakthrough seizures / s/p liver transplant for Anginase deficiency
+ GDD

Issue : Stridor & supra-sternal retractions since last 3yrs.
Snoring ⊕, mouth breathing ⊕, ? apneic episodes
Dystonia ⊕

O/E Alert

Vitals stable, SpO₂ - 99% (RA)

Chest - B/L crepts, B/L AE +

On NG tube feeds

@

16/7 Hb - 8.6 / TLC - 15460 / N₇₀ L₂₃ / Plt - 5.07L

Pt on Tacrolimus / Sizodon / lacosamide / Ceftriaxone

Consultant :

Name: Dr. Naveen Saradhi Signature: Date & Time: 17/7/26

Adv

- Chest x ray AP view
- Nasal endoscopy (Dr Chandana / Dr Santosh)
- Sleep study
- IV Augmentin
- Flomist-F nasal spray — 1 spray in each nostril BD

7/10/10

① master breathing ② ③ apnoea

④

(1) (2) (3) (4)

1/1/10

1/1/10

1/1/10

Consultant

Dr. Santosh

Dr. Santosh



CROSS CONSULTATION FORM

Doctor Name : Dr. Pralant B Date : 15/02/2021 Time : 1:30

Diagnosis :

Hospital :

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

Referred for : ☐ Opinion ☐ Co-Management ☐ Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: _____

Findings and Recommendations : K140 - Arginine deficiency.

SP OCT - MSUD - March 2021.

c/o oromotor dystonia = tightening of mouth $\approx$ 2 hrs $\times$ 1 week
seizure episode - 4-5 episode/day.

also difficulty swallowing $\approx$ 2 hrs

on Lixodon 0.5mg $\times$ 1/2 tab/OD.

lyp Lacosamide 2.5mg/OD

c/o fever $\times$ 1 week - mainly during
paroxysmal events
 $\approx$ once/twice per day.
low grade.

on laxative $\leftarrow$ Empty - 30ml/OD $\times$ 3 months
colon - 15ml/OD

Consultant :

Name : Dr. Pralant B Signature : _____ Date & Time : _____

Ammonia = 23

CXR - clear
vix abdomen -
B/lys - (17/07) - 2
CER - 15

CBP = 8.6 / 15.460 / 5.072
+ 0.23

LFT = .17 | 4.84 | 0.3 < 0.2 | 4.2
| 8.6

on. ceftriaxone - D2

Plan
ix To send. CUE, urine with

ix To Rate Blood with

ix To evaluate for cause of

levu.
passionate
dyspnea.

2. impetive

ix empty - 30ml/or to continue

ix color - 10ml/or - x

ix To ~~report~~ ~~report~~ ~~report~~

ix To upgrade
ix To upgrade
ix To upgrade

ix Monitor for levu.

ix x 101F - to

ix void to continue Dr. Kumpf

ix Trace facolimus levu
Sum
old report.
ix cmv & EBV
old report

ix Repeat LFT
on Monday

ix stop empty / color.
ix X-ray abdomen.

ix sand cue, v/ls, etc, PCT
CBP, voided

ix upgrade to piplog
ix empty / 187.

ix Reduce facolimus dose to small
ix today - 1-2 episode, yesterday
ix 2-3 episode, partly shock

ix 2-3 episode, partly shock

ix 2-3 episode, partly shock

ix 2-3 episode, partly shock

ix 2-3 episode, partly shock

ix 2-3 episode, partly shock

ix 2-3 episode, partly shock

ix 2-3 episode, partly shock

ix 2-3 episode, partly shock

ix 2-3 episode, partly shock

ix 2-3 episode, partly shock

ix 2-3 episode, partly shock

ix 2-3 episode, partly shock

ix 2-3 episode, partly shock

ix 2-3 episode, partly shock

ix 2-3 episode, partly shock

ix 2-3 episode, partly shock



CROSS CONSULTATION FORM

Doctor Name : Dr. Prachant B Date : 19/07/26 Time :

Diagnosis :

Hospital :

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

Referred for : ☐ Opinion ☐ Co-Management ☐ Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

Findings and Recommendations :

Plan

- 1x TO send CUE, U/Ls, PLT, ~~WBC~~, flu panel
- 2x Trace B/Ls, CRP weekly
- 3x Dulcoflex rectal suppositories 10mg. 1 PR / stat
↓
fib
→ Empty 30ml / once daily. 2 to contin
- Colox. 10ml / once daily
- 4x Tadalafil 0.75mg / BD, repeat LRT on Tuesday.

Consultant :

Name : Dr. Prachant Signature : Date & Time :



CROSS CONSULTATION FORM

Doctor Name : Dr. Chandana Date : 18/7/26 Time : 4:30pm
Diagnosis : Seizure Disorder / Arginase Deficiency

Hospital :

Referred for : ☐ Opinion ☐ Co-Management ☐ Transfer of care

Type of Referral :

- ☐ Emergency
☐ Urgent
☐ Non Urgent

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: _____

Findings and Recommendations :

OE
Afebrile
Grade - 3-4 tonsils
congested.
nose - mild
congestion.
uncooperative for
awake nasal / has
endoscopy / fever spikes.
plan: X-ray - Nasopharynx
and s/s
c sleep Video.

Thanks for referral
c/o snoring / month
breathing
since years
has sleep disturbance
on and off throat pain

plan for
Adenotonsillectomy
if having
apnoea
- cont. Flomist - F N/S.

Consultant :

Name : Dr. Chandana Signature : [Signature] Date & Time : 4:30pm

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

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

RESULT SHEET

Date	16/7/23				
Time	11:57 AM				
Hb	8.6				
PCV	30.4				
RBC	5.0				
WBC	15.46				
N/L	10/23				
Platelets	5.07L				
CRP					
ESR					
PCT					
RBS	117				
Na	139				
K	3.7				
Cl	107				
Ca/Mg					
Phosphate					
Urea	14				
Creatinine	0.3				
ALP	485				
SGPT	11				
SGOT	17				
T.Bill/Conj	0.3 < 0.2				
T.Protein	8.6				
S.Albumin	4.2				
S.Globulin	4.4				
A/G Ratio	0.9				
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

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04-09-2013 12 Y 10 M 12 D (F)
Dr. ABHISHEK RAVINDRA JAIN



MEDICATION RECONCILIATION FORM

Drug Allergies:

☐ Not known any Drug Allergies

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

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

Shifting From: ER

Shifted to: Ward

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: T. Parani

Date & Time: 15/07/20 11:20 AM

Nurse Name & Signature: Abhishek

Date & Time: 16/7/20 11:20 AM

Patient

BAH-00288190
Baby MADIA SULTHANA
04-09-2013 12 Y 10 M 12 D (F)
Dr. ABHISHEK RAVINDRA JAIN

IP5-00176493

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DRUG CHART

Date of Admission: 16/7/26 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 : SYR CROCAN DS (240/5)				Date Time	17/7
Dose	Route	Frequency	Start Date		
8.5ml	PO	SOS	16/7	3:30 PM	
Doctor's Signature		Valid Period	Pharm.		
Sureshree					
Additional Instructions:					
temp > 99.5°F					

DRUG : MIDAZ SPRAY				Date Time	
Dose	Route	Frequency	Start Date		
1 puff each	P/N	(SOS)	16/7		
Doctor's Signature		Valid Period	Pharm.		
T. Ravani					
Additional Instructions:					
1 puff 1-125mg If convulsion					

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

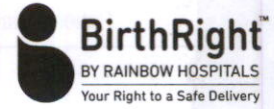


REGULAR PRESCRIPTIONS

Weight. ... 28 kg ... Ward.

DRUG : T. SIZODONOR				Date Time	16/7/2019
Dose	Route	Frequency	Start Date		
1/2 tab	PO	OD	16/7		
Name & Signature of the Doctor Starting the Drugs:				100% Home Som Long Som	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : SYR LACOSAMIDE				Date Time	17/7/2019
Dose	Route	Frequency	Start Date		
2.5ml	PO	BD	17/7	100% Home Som Long Som	
Name & Signature of the Doctor Starting the Drugs:				100% Home Som Long Som	
Additional Instructions:				1ml = 15mg	
Daily Doctor's Endorsement by a Sign					
DRUG : T. TACROLIMUS (1.5mg)				Date Time	16/7/2019
Dose	Route	Frequency	Start Date		
1 tab	PO	BD	16/7	100% Home Som Long Som	
Name & Signature of the Doctor Starting the Drugs:				100% Home Som Long Som	
Additional Instructions:				9 AM	
Daily Doctor's Endorsement by a Sign					
DRUG : SYR EMTY				Date Time	16/7/2019
Dose	Route	Frequency	Start Date		
30ml	PO	OD	16/7	100% Home Som Long Som	
Name & Signature of the Doctor Starting the Drugs:				100% Home Som Long Som	
Additional Instructions:				100% Home Som Long Som	
Daily Doctor's Endorsement by a Sign					

BAH-00288190 IP5-00176493
 Baby MADIA SULTHANA
 04-09-2013 12 Y 10 M 12 D (F)
 Dr. ABHISHEK RAVINDRA JAIN



Sheet No:

REGULAR PRESCRIPTIONS

Weight 28 kg Ward

DRUG : SYR COLAX				Date Time	16/7/26
Dose 15ml	Route PO	Frequency OD	Start Dt. 16/7		
Name & Signature of the Doctor Starting the Drugs: <i>Srinivashree</i>				stop 18/07/26 10/07/26	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

DRUG : JIGGLEMELOS R Gummies				Date Time	17/7/26
Dose 1 gummy	Route Oral	Frequency OD	Start Dt. 17/7		
Name & Signature of the Doctor Starting the Drugs: <i>T. Ravani</i>				10pm	
Additional Instructions: <i>(metatomin)</i>					
Daily Doctor's Endorsement by a Sign					

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

DRUG : Inj, CEFTRIAXONE				Date Time	18/7/26
Dose 1.2 gram	Route IV	Frequency BD	Start Dt. 17/7		
Name & Signature of the Doctor Starting the Drugs: <i>Dr. K. S. Srinivas</i>				10pm 18/07/26	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

Weight Ward

VERIFIER Name Signature

Sheet No:

REGULAR PRESCRIPTIONS

Weight 28.6 Ward

DRUG : <u>Syp. LACOSAMIDE</u>				Date/Time	<u>18/7 10/7</u>
Dose	Route	Frequency	Start Dt.		
<u>4.5ml</u>	<u>PO</u>	<u>Q12H</u>	<u>18/7</u>		
Name & Signature of the Doctor Starting the Drugs:				<u>Dr. Abhishek Ravindra Jain</u>	
Additional Instructions:				<u>5mg/kg/day</u>	
Daily Doctor's Endorsement by a Sign					
DRUG : <u>T. TACROLIMUS</u>				Date/Time	<u>18/7 10/7</u>
Dose	Route	Frequency	Start Dt.		
<u>0.75mg</u>	<u>PO</u>	<u>BD</u>	<u>18/7</u>		
Name & Signature of the Doctor Starting the Drugs:				<u>Dr. Kunal</u>	
Additional Instructions:				<u>9am some</u>	
Daily Doctor's Endorsement by a Sign					
DRUG : <u>INJ PIPERACILLIN + TAZOBACTAM</u>				Date/Time	<u>18/7 10/7</u>
Dose	Route	Frequency	Start Dt.		
<u>2.8gm</u>	<u>IV</u>	<u>TID</u>	<u>18/7</u>		
Name & Signature of the Doctor Starting the Drugs:				<u>Dr. Kunal</u>	
Additional Instructions:				<u>10am some</u>	
Daily Doctor's Endorsement by a Sign					
DRUG : <u>Tab. CLOBAZAM</u>				Date/Time	<u>19/7 20/7</u>
Dose	Route	Frequency	Start Dt.		
<u>7 Tab</u>	<u>PO</u>	<u>Q12H</u>	<u>19/7</u>		
Name & Signature of the Doctor Starting the Drugs:				<u>Dr. Kunal</u>	
Additional Instructions:				<u>stop 21/7</u>	
Daily Doctor's Endorsement by a Sign					



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
1 Tab	PO	OD	19/7	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : TAB PARITANE				Date Time 20/7
1 Tab	PO	BD	20/7	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : SYR RELENT PLUS				Date Time 20/7
5ml	P/O	BID	20/7	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

VERIFIED

Signature

VERIFIED BY : Name

Name:

Weight: kgs

Sheet No:

Docu. No. : RCHBH /FRM / CLINICAL / 136

IP5-00176493
Baby MADIA SULTHANA
04-09-2013 12 Y 10 M 12 D (F)
Dr. ABHISHEK RAVINDRA JAIN



Weight. Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
16/07/26	11:55pm	Inj LORAZEPAM	2.5mg	IV	Zi	Poonj
16/07/26	11:55pm	Inj LACOSAMIDE	37.5mg in 20ml (Neurolemin)	IV	Zi	Poonj
16/07/26		Inj LEVIPIL	600mg (For next Convulsion)	IV	Zi	
17/7	12:40am	MIDAZ SPRAY	2 puffs			prony
17/07	12:40am	MIDAZ SPRAY	2 PUFFS in both nostrils	IV	Zi	prony Sundhu
17/7		Inj BRIV	60mg	IV		X
		Inj PARALAL	20mg			
17/7	11:30am	Inj AVIL	10mg	IV		Some Sundhu
17/7	11:30am	Inj PEDICHAZYL	10mg	IV		Some Sundhu

18/7 6pm Inj PARACETAMOL - 450 mg

Amir
Sundhu

Weight. Ward.

[illegible]

TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 2017	Time:	6pm	10pm	2Am	6Am		
Doctor / Nurse / Family Concern?		10am	1pm	4pm	10pm	2Am	6Am
Temperature (°F)	104						
	103						
	102						
	101						
	100						
	99						
	98	98.4	97.5	97.0	98.8	97.2	96.7
Heart Rate (bpm)	190						
	180						
	170						
	160						
	150						
	140						
	130						
Blood Pressure (mmHg) *	120	120	101	118	106	95	99
	110	(66)	(85)	(71)	90	72	82
	100						
	90						
	80						
	70						
	60						
Heart Rate (Number)	110b/m	106b/m	110bpm	100bpm	98bpm	92bpm	
Resp Rate (bpm) (Over 1 Minute)	70						
	60						
	50						
	40						
	30						
	20						
	10						
Resp Rate (Number)	26b/m	25b/m	24bpm	26bpm	27bpm	28bpm	
Resp Mod/ Severe Distress None / Mild							
Receiving O ₂ (l/min) O ₂ Saturations (%)							
	99%	100%	100%	97%	98%	98%	
Conscious Level Normal / Altered							
	15/15	15/15	15/15	15/15	15/15	15/15	
GCS *							
	15/15	15/15	15/15	15/15	15/15	15/15	
TOTAL SCORE							
	1	1	0	0	0	0	
Pain Score							
	0	0	0	0	0	0	
Observer's Initials							
	0	0	0	0	0	0	

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

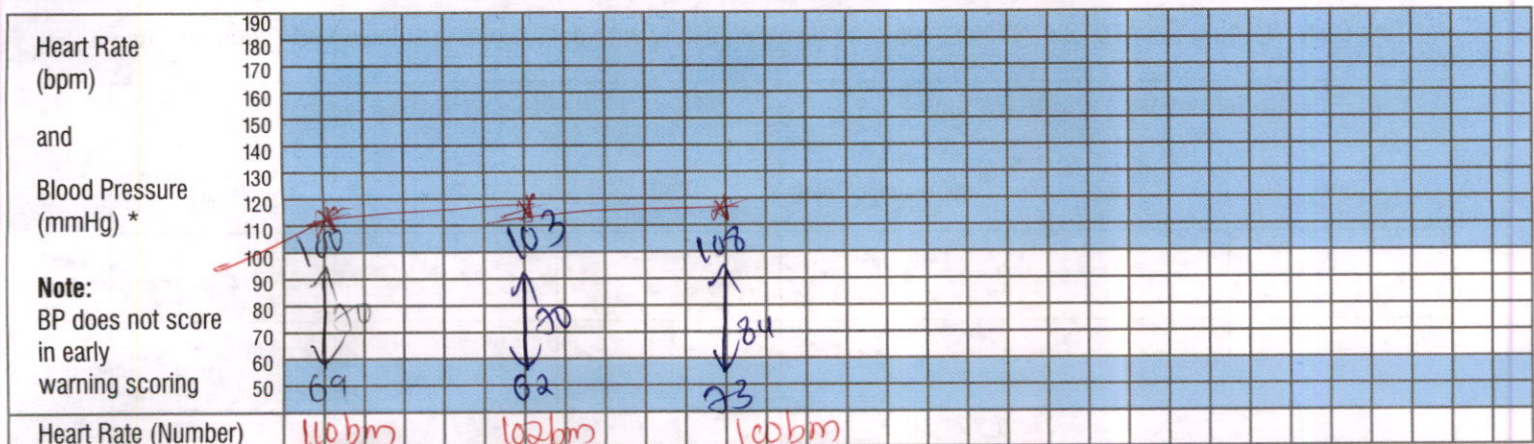
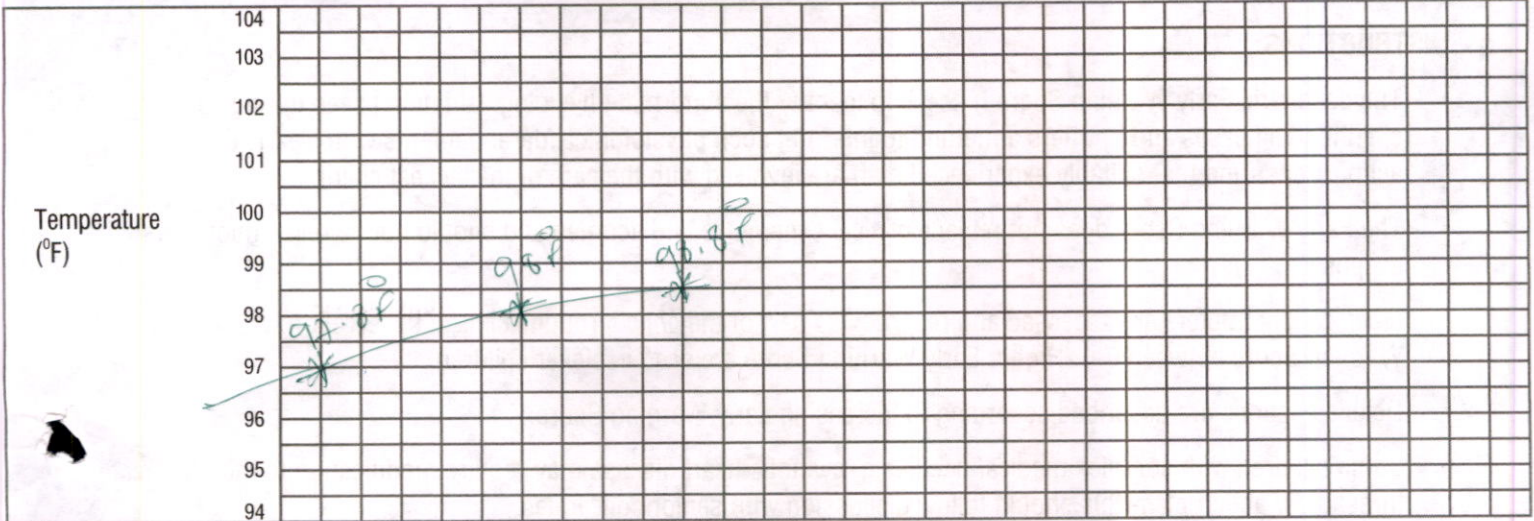
I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection).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

TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 19/12 Time: 10pm 2am 6am

Doctor / Nurse / Family Concern?



Resp Distress Mod/ Severe
 None / Mild

Receiving O₂(l/min)
 O₂Saturations (%)

Conscious Level Normal
 Altered

GCS *

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

ACTIONS

NB: Scores 3 should be
 recorded overleaf

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
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Patient Sucker

Doc. No. : RCHB/ FRM / CLINICAL / 127

TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

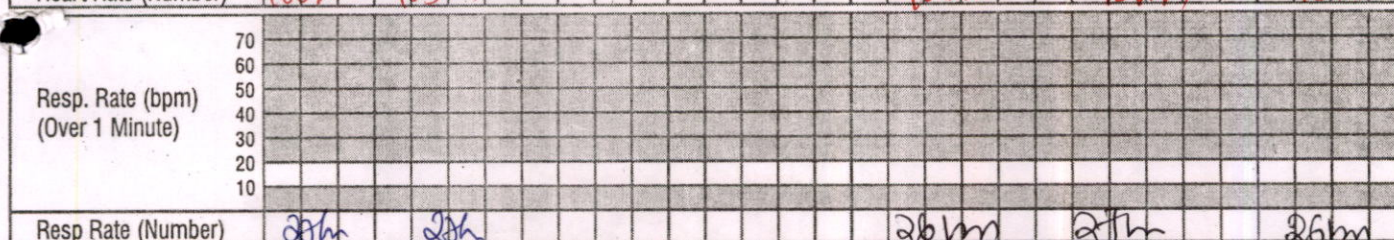
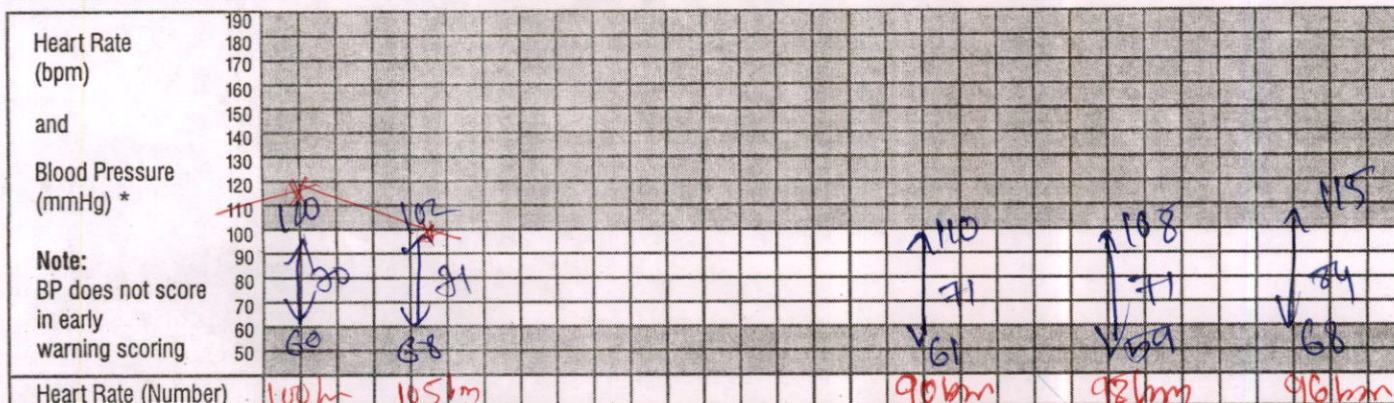
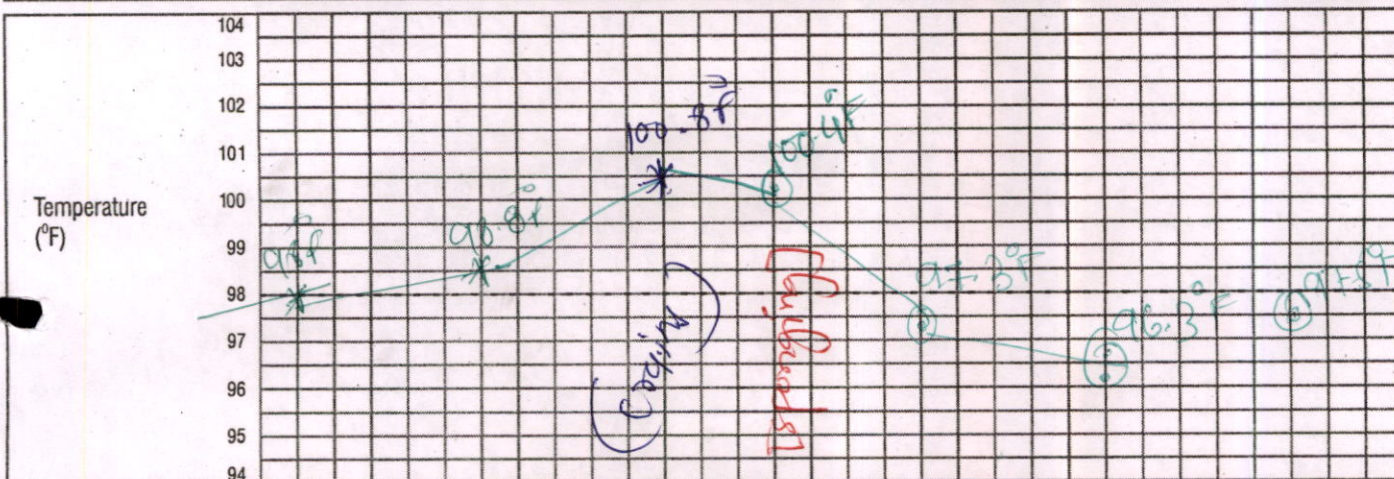
Rainbow
 Children's
 Hospital
 It takes a lot to treat the kids.

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 19/12 Time: 2am 6am 7am 9am 10:30am 1pm 6:30pm

Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)		
O ₂ Saturations (%)	100%	100%
Conscious Level	Normal	Altered
GCS *	15/15	15/15
TOTAL SCORE		
Number of shaded boxes	1	1
Pain Score	0	0
Observer's Initials	P	P

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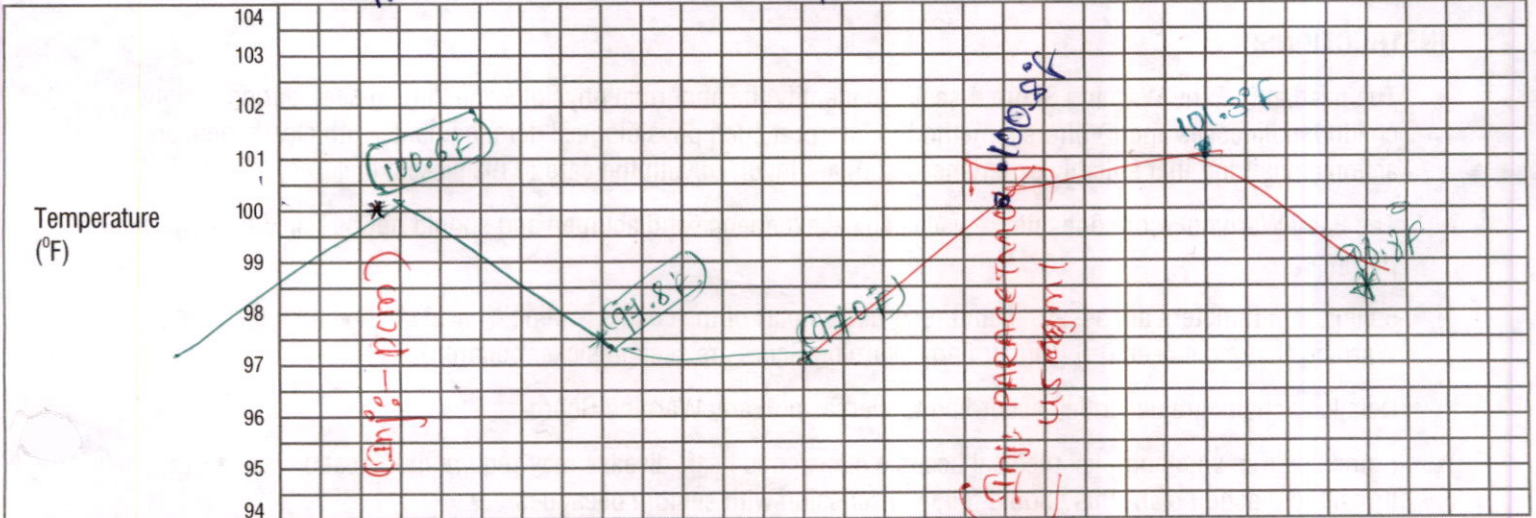
* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 18/7 Time: 9:44 PM 11:00 AM 2:00 PM 6:00 PM 11:30 PM 9:40 PM 10:00 PM

Doctor / Nurse / Family Concern?



Heart Rate (bpm)

and

Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring

Heart Rate (Number)

Time	Heart Rate (bpm)	Blood Pressure (mmHg)
11:00 AM	152	111/63
6:00 PM	144	114/74
10:00 PM	178	102/68

Resp. Rate (bpm) (Over 1 Minute)

Resp Rate (Number)

Time	Resp. Rate (bpm)
11:00 AM	26
6:00 PM	28
10:00 PM	28

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

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

ACTIONS

NB: Scores 3 should be recorded overleaf

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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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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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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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.
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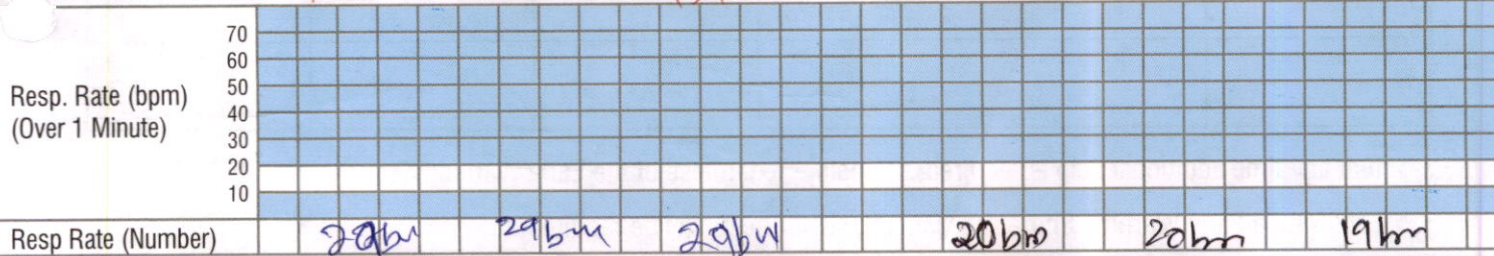
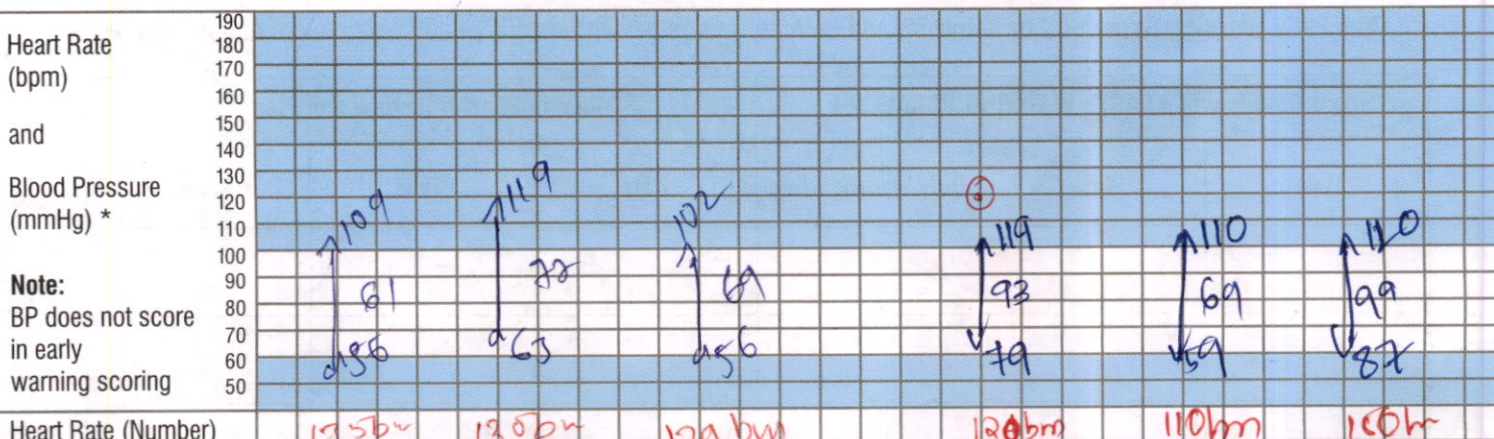
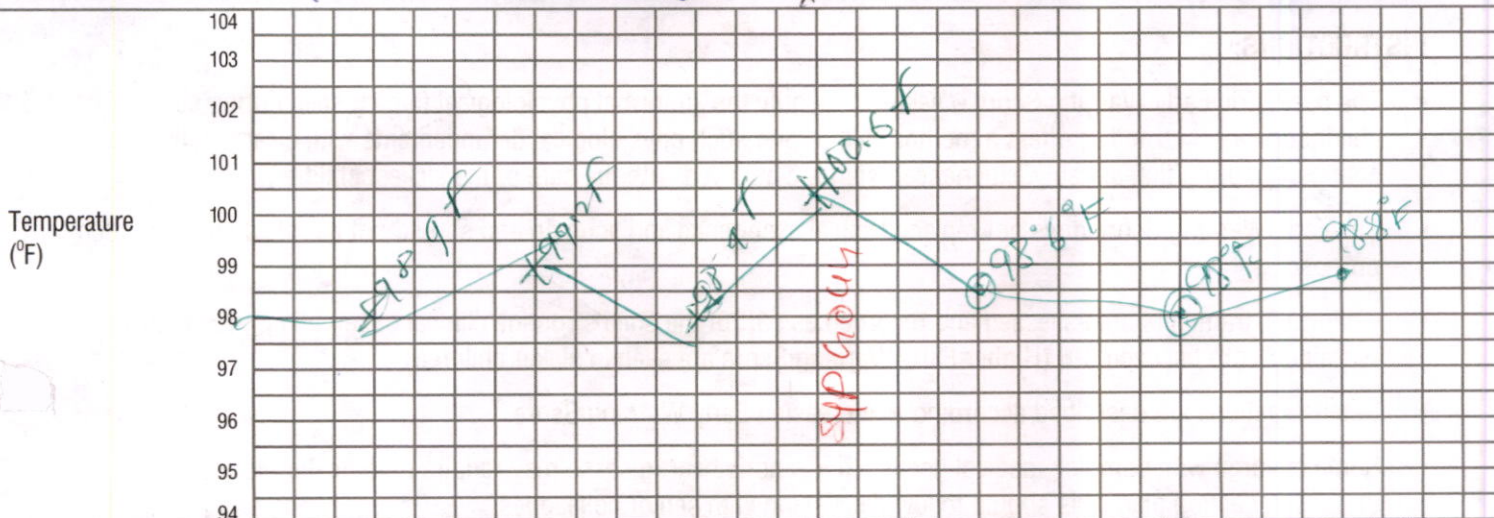
TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 12/09/13 Time: 10 AM 1 PM 6 PM 7:50 PM 10 PM 2 AM 6 AM
 Doctor / Nurse / Family Concern?



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

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

ACTIONS

NB: Scores 3 should be recorded overleaf

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- Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

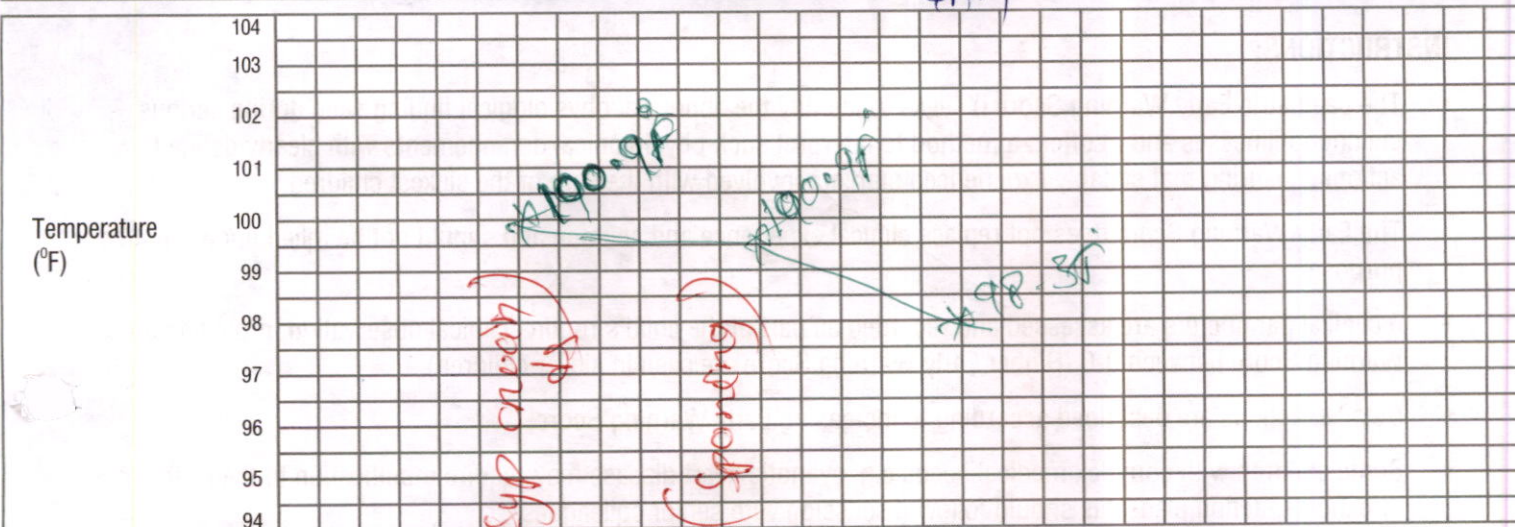
I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection).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



TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 18/7 Time: 2 AM 3.30 AM 5 AM 6 AM
 Doctor / Nurse / Family Concern?



Heart Rate (bpm)
 and
 Blood Pressure (mmHg) *

Note:
 BP does not score in early warning scoring

Heart Rate (Number)

120 bpm

Resp. Rate (bpm)
 (Over 1 Minute)

Resp Rate (Number)

24 bpm

Resp Mod/ Severe Distress None / Mild

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

99%

Conscious Level Normal Altered

GCS *

15/05

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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.
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BAH-00288190 IP5-00176493
 Baby MADIA SULTHANA
 04-09-2013 12 Y 10 M 12 D (F)
 Dr. ABHISHEK RAVINDRA JAIN



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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

FLUID CHART

1

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.

		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



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.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake			Output					IV Site	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	N.G						
17/12	08:00 am			30ml						0	
	09:00 am			30ml					✓	0	Susha
	10:00 am			30ml	150ml					0	
	11:00 am	DNS		30ml					✓	0	
	12:00 pm			30ml						0	Susha
	01:00 pm			30ml	150ml					0	
Total Intake :					Total Output :						
17/12	02:00 pm			30ml						0	
	03:00 pm			30ml					✓	0	Susha
	04:00 pm			30ml						0	
	05:00 pm	DNS			150ml					0	
	06:00 pm			30ml						0	Susha
	07:00 pm			30ml						0	
Total Intake :					Total Output :						
17/12	08:00 pm	↑		30ml					✓	0	
	09:00 pm	↑		30ml	150ml					0	Meelin
	10:00 pm									0	
	11:00 pm	DNS		30ml						0	
	12:00 am	↓		30ml	150ml				✓	0	Meelin
	01:00 am	↓		30ml						0	
Total Intake :					Total Output :						
18/12	02:00 am	↑	↑	30ml						0	
	03:00 am	↑	↑	30ml	150ml					0	Meelin
	04:00 am	DNS	NPO	30ml						0	
	05:00 am			30ml						0	
	06:00 am	↓	↓	30ml					✓	0	Meelin
	07:00 am									0	
Total Intake :					Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

FLUID CHART

3

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.

		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						
18/7	08:00 am	↑	NPO	30ml		/		-	/		0
	09:00 am	↑		30ml		/				✓	0
	10:00 am	DNLS		-		/					0
	11:00 am			-		/					0
	12:00 pm	↓		30ml		/					0
	01:00 pm	↓		30ml		/					0
Total Intake :						Total Output :					
18/7	02:00 pm			30ml		/			/		0
	03:00 pm	↑		30ml		/				✓	0
	04:00 pm			-		/					0
	05:00 pm	DNLS	Barely water	-		/					0
	06:00 pm	↓		30ml		/				✓	0
	07:00 pm		milk	30ml		/					0
Total Intake :						Total Output :					
18/7	08:00 pm			30ml	milk	/			/		0
	09:00 pm	↓		30ml	150	/				✓	0
	10:00 pm			30ml		/					0
	11:00 pm	DNLS		30ml	sup	/					0
	12:00 am	↓		30ml	150	/					0
	01:00 am					/					0
Total Intake :						Total Output :					
19/7	02:00 am	↓		30ml	milk	/			/		0
	03:00 am			30ml	150	/					0
	04:00 am	DNLS		30ml		/					0
	05:00 am			30ml	sup	/					0
	06:00 am	↓		30ml	50ml	/					0
	07:00 am			30ml	150ml	/					0
Total Intake :						Total Output :					

Total 24 hrs. Intake

Total 24 hrs. Output



FLUID CHART

Sheet No. :

1. All measurements in ml.
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		Intake			Output					IV Site	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		Thrombo-phlebitis Score
			Mouth	I.V	N.G							
19/7	08:00 am	↑		-					/		0	Ment
	09:00 am	↑		30ml	veg soup					✓	0	
	10:00 am	DNS		30ml	150ml				/		0	
	11:00 am	↓	30ml		NP				/		0	
	12:00 pm	↓	30ml	Baby's					✓		0	
	01:00 pm	↓	30ml	150ml							0	
Total Intake :					Total Output :							
19/7	02:00 pm	↑		30ml	veg soup				/		0	Ment
	03:00 pm	↑		30ml	150ml					✓	0	
	04:00 pm			30ml					/		0	
	05:00 pm	DNS		30ml	chicken				/		0	
	06:00 pm	↓	30ml	150ml					✓		0	
	07:00 pm	↓	30ml								0	
Total Intake :					Total Output :							
19/7	08:00 pm	↓		30ml	veg soup				/		0	Ment
	09:00 pm	↓		30ml	150ml						0	
	10:00 pm	DNS		30ml					/		0	
	11:00 pm	↓	30ml		NP				/		0	
	12:00 am	↓	30ml	chicken							0	
	01:00 am	↓	30ml	150ml							0	
Total Intake :					Total Output :							
20/7	02:00 am	↓		30ml					/		0	Ment
	03:00 am	↓		30ml	veg soup						0	
	04:00 am	DNS		30ml	150ml				/		0	
	05:00 am	↓	30ml		NP				/		0	
	06:00 am	↓	30ml	milk					✓		0	
	07:00 am	↓	30ml	150ml							0	
Total Intake :					Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

BAH-00288190 IP5-00176493
 Baby MADIA SULTHANA
 04-09-2013 12 Y 10 M 16 D (F)
 Dr. ABHISHEK RAVINDRA JAIN



FLUID CHART

Sheet No. : 6

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			
20/9/17	08:00 am			30ml							0		
	09:00 am			30ml							0		
	10:00 am	ONS		30ml chicken soup							0	Sure	
	11:00 am			-							0		
	12:00 pm		Jelly	-							0	Sure	
	01:00 pm			-							0	Sure	
Total Intake :						Total Output :							
20/9/17	02:00 pm			30ml							0		
	03:00 pm		Garlic water	30ml							0	Sure	
	04:00 pm	ONS		30ml							0		
	05:00 pm		chicken soup	30ml							0	Camille Chung	
	06:00 pm			-							0		
	07:00 pm			-							0	Sure	
Total Intake :						Total Output :							
20/9/17	08:00 pm			30ml							0		
	09:00 pm		Jelly	30ml							0	Meslin	
	10:00 pm	ONS		-							0		
	11:00 pm			30ml							0		
	12:00 am			30ml milk							0	Meslin	
	01:00 am			30ml	150ml						0		
Total Intake :						Total Output :							
21/9/17	02:00 am			30ml							0		
	03:00 am			30ml							0	Meslin	
	04:00 am	ONS		30ml							0		
	05:00 am			30ml							0		
	06:00 am			-							0	Meslin	
	07:00 am		water	-							0		
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							



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.
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						

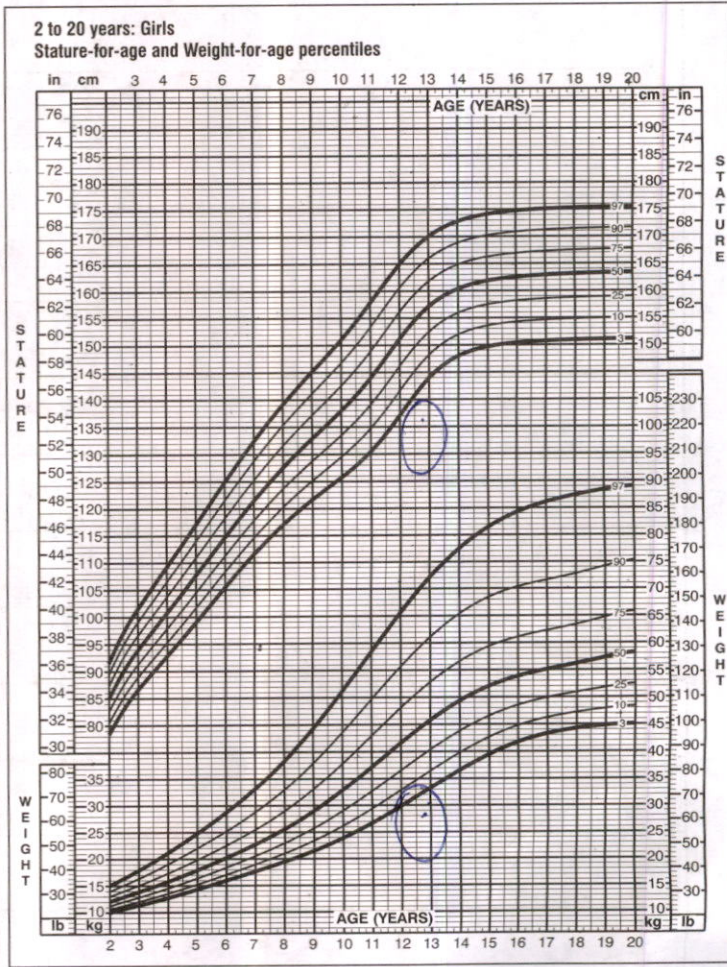
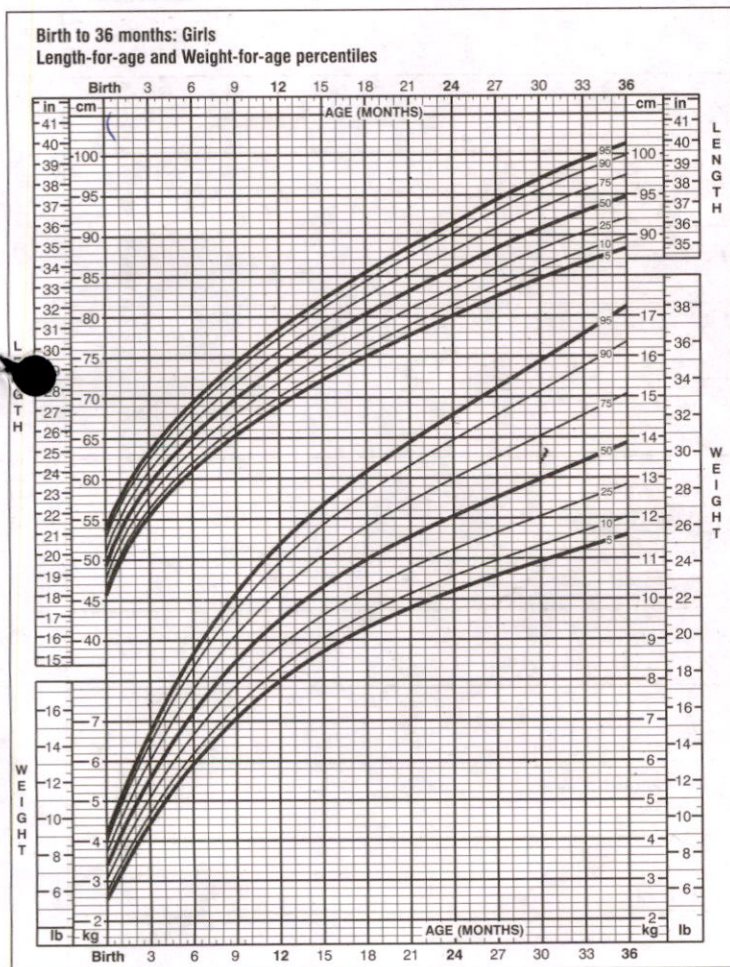


NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 12/7/26 Time: 9am

Weight: 28 kgs Centile: 65th
 Height: 136 cms Centile: 65th
 Inference: underweight child
 RDA: — Calories: 1250 kcal/d Protein: 31 g/d
 Diet Recommendations: child is on NG feeds + pedia gold (1:95ml)
 Re-Assessment: dilution 150ml / 3 hourly
 Food Allergies: No Veg/Non-veg Non-veg
 Diagnosis: oro mandibular dystonia + seizures
 Nutritional Intervention - ☐ Oral ☒ Enteral ☐ Parenteral
 Patient's Signature: [Signature]

GROWTH CHART (GIRLS)



Dietician's Name Nikitha

Dietician's Signature Nikitha

Daily Notes:

18/12/26
10am

child is stable. Intake is NG feeds (milk, soups, water)

- nicotter

19/12/26
10am

child is stable. Intake is NG feeds (milk, soups)

- nicotter

20/12/26
8am

child is stable. child is on NG feeds (milk, soups)

- nicotter