



Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad
,Telangana, India ,500034.
TEL NO : +91-40-4466 5555
WEB : <https://rainbowhospitals.in>

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176055

Admit Date : 06-Jul-2026

Admit Time : 09:52 PM UHID : BAH-00450602

Patient Details :

Patient Name : Baby Of DIVYA REDDY

Age : 5 Y 7 M 16 D

Guardian : MR K PRASHANTH REDDY

DOB : 20-11-2020

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : HNO 314/A, MLA COLONY, ROAD NO 12
Himayat Sagar Hyderabad Telangana INDIA
500034

Phone No : 9000420012/

E-mail : RAKESH@SAIPRAGATHI.IN

Admission Details :

Bed Type : PICU

Bed No : PICU 210

Ward Name : 2F-PICU I

Room No : PICU 210

Admission Type : First Visit

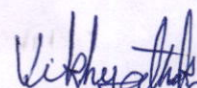
Contact Details :

Name : MR K PRASHANTH REDDY

Relationship : Father

Contact Address : HNO 314/A, MLA COLONY, ROAD NO 12
Himayat Sagar Hyderabad Telangana INDIA
500034

Phone No : 9000420012


Signature

Doctor Details :

Doctor Name : Dr. DINESH KUMAR CHIRLA

Specialisation : PEDIATRIC INTENSIVE CARE

Referral Doctor : Self

Phone No :

Co-Consultant : Dr. KAPIL BHAGWATRAO SACHANE

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELF PAY

MFC

B3

ACTIVITY RECORD FOR BILLING

Name : _____ BAH-00450602 IP5-00176055
Baby Of DIVYA REDDY
UHID No. : _____ IP No. 20-11-2020 5 Y 7 M 16 D (M)
Dr. DINESH KUMAR CHIRLA
Date of Admission: _____ Discharge : _____ Time: _____



Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
06/04/26	10 PM	ER.	PIU.	[Signature]
7/4/26	7 PM	PIU	Ward	[Signature]

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
06/07	TV placement	①	9690902	Salah
7/7	MLC	①	9690252	men

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor

PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor :

Date : 6/7/2026

Type of Admission: ☒ OPD ☐ ER ☐ Referral (if referral, Doctor's Name:

Start Time of Assessment: 9:10pm

Weight: 21 kg

Allergic History:

Chief Complaints:

elo Paracetamol
 consumption ~ 3gms
 at 4pm.

Pediatric Assessment Triangle

A Appearance - TICLS alert, conscious
 B Breathing
 C Circulation ☒ Normal
☐ Abnormal
☐ Pallor
☐ Cyanosis
☐ Mottling
☐ Bleeding
☒ Normal
☐ Gasping / Apnea

Initial Physiological Status: ☒ Stable ☐ Unstable
☐ Life Threatening
☐ Non Life Threatening

Any urgent interventions needed: ☐ Yes ☐ No

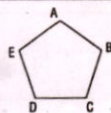
If Yes

Significant Past History: No Adenoidectomy 1 yr back

Medication History: No medications

Relevant Investigations:

Primary Assessment



Airway

☒ Open
☐ Maintainable
☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☐ No

If Yes

Breathing

Rate: 24/min SpO₂ on FiO₂ 100% RA

Rhythm: normal

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR
☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: B/L AEC+

Palpation Findings (If necessary)

Any urgent interventions needed: ☐ Yes ☐ No

If Yes



Circulation

HR: 93/min

CFT ☐ Central 13sec ☒ Peripheral 13sec

Any urgent interventions needed: ☐ Yes ☐ No

BP: 117/69 mmHg

Pulse Volume: ☐ Central Normal ☒ Peripheral Normal

If in Shock: ☐ Compensated ☒ Hypotensive

Muffled Heart Sound: ☐ Yes ☒ No

Engorged Neck Veins: ☐ Yes ☒ No

Murmurs: ☐ Yes ☒ No

Liver Span: ☒

ECG: ☒

Any Signs of Heart Failure: ☐ Yes ☒ No

If Yes



Disability

GCS: 15/15

AVPU: Alert

Pupils: ☒ Responsive ☐ Non-Responsive

Size: ☒ Right 2mm ☒ Left 2mm

Active Seizures: ☐ Yes ☒ No Sugars: ☒

Signs of Neurological compromise ☒

Any urgent interventions needed: ☐ Yes ☐ No

If Yes

Exposure



Temp: 98.4 F

Any Rash: ☐ Yes ☒ No

If yes describe the rash ☒

Active bleed ☒

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: ☒

Any urgent interventions needed: ☐ Yes ☐ No

If Yes

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest
☐ Shock - Compensated ☐ Hypotensive ☐
☐ Cardiopulmonary Arrest ☒ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings: ☒

Labs Planned:

- RPT
- PT-INR APTT
- Paracetamol levels
- VBG

Treatment Planned:

NPO
N-acetyl cysteine
iv fluids

Need for Oxygen: ☐ Yes ☒ No if yes Low Flow ☐ High Flow ☐ PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): Paracetamol overdosing

Assessment done by

Name of the Doctor: Dr. Rashmi R

Signature:

Date & Time: 6/7/26, 9:40 pm

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor:

Signature:

Date & Time:

BAH-00450602
Baby Of DIVYA REDDY IP5-00176055
20-11-2020 5 Y 7 M 16 D
Dr. DINESH KUMAR CHIRLA (M)

Rainbow
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Hospital
It takes a little more time to be a little better.

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EDIATRIC INTENSIVE CARE ADMISSION RECORD

Date: 6/7/26 Time: 10pm

Patient Assessment Form:

Informant: ☐ Father ☒ Mother ☐ Other

Presenting Complaints / Chief Complaints :

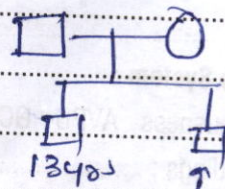
c/o alleged history of accidental Ingestion
of Syrup Paracetamol (5ml/250mg) 60ml today
at around 4 PM at home
i.e., 142 mg/kg.
(Toxic DOSE - 150 mg/kg)
no H/o Pain Abdomen/Vomiting/nausea.
mild cough (+)
no other complaints.

Past History (Including previous treatment and investigations) :

Nil. Significant.

Birth and Developmental History :

Late PreTerm/NICU stay
for 10 days



Immunization History :

Immunized till date

H / O Allergy :

No H/o any allergies

Family History :

Nil. Significant

INITIAL ASSESSMENT

RBS:

Temperature: 98.4°F Weight (kg): 21kg

Respiratory System Findings:

Air Way: ☒ Open ☐ Maintainable ☐ Not Maintainable Intubated, If Intubated, size & position of ETT:

Respiratory Examination Finding: (Air entry, breath sounds, s/o distress etc.): Respiratory Rate: 20/min

BAE @, clear

SPO₂: 100% - @ RA O by NC / FM / NRB mask / Oxyhood, at L / min

Ventilatory Support: Yes ☒ No - Day # of Vent: Respiratory Efforts:

Ventilatory Settings: Leak around ETT: Delivered Vt:

ABG: EtCO₂: P/F ratio: O.I.:

Any Nebs: ICD? Yes ☒ No, if Yes, details:

CXR:

Cardio Vascular System Clinical Exam: Heart Rate: 90/min Cardiac Rhytho:

(Heart sounds, murmur etc.):

Quality of Pulses: good cap refill Time: < 3sec Liver Edge: cm below Rt costal margin

Blood Pressures: NIBP: 106/77 mmHg IBP: CVP:

Infusion of any Inotropes?: Yes ☒ No - If yes, then details:

Any Other Infusions:

Last 2D Echo Findings:

Size of the heart and lung fields in latest CXR:

Arterial line in Situ: Yes ☒ No Place of art, line & its condition:

Central line in Situ: Yes ☒ No Place of central line & its condition:

Infection and Antibiotics:

Febrile ☒ Afebrile Current Antibiotics Details (antibiotic name and day #):

Cultures Done outside? Yes ☒ No - If yes, details:

Describe c/s Reports:

Other Labs (Latex, Serology, etc):

Ongoing Antibiotics:

Abdominal Exam: soft, mild tenderness in

@ subcostal area

ENT Exam: normal

Central Nervous System:

Level of Consciousness: AVPU / GCS score: 15/15

Neurological Findings: Alert & active

pupils reactive B/L 2mm/2mm

Relevant data from outside (Neuro imaging any ongoing medications etc):

Special Needs Screening: (If any of the below are Positive, Please fill "Cross Consultation Form" to Concerned Department)
(Please select and 'tick mark' [✓] the boxes as applicable)

- a. Nutritional Screening Criteria: Screening is ☒ Positive ☐ Negative
- | | | | |
|--|--|---|--|
| ☐ Diabetes Mellitus | ☐ Needs Therapeutic Diet. | ☐ Diarrhoea > 4days | ☐ Food Allergy |
| ☐ Overweight | ☐ Psychological Eating Disorder | ☐ Major Surgery | ☒ Patient in ICU |
| ☐ Under Weight | ☐ Difficulty swallowing / Chewing | ☐ Hyperemesis gravidarum | ☐ Tube Feeding |
| ☐ Poor Appetite > 3days | ☐ Unplanned Change in Weight | | |

- b. Psychological Screening Criteria: Screening is ☐ Positive ☒ Negative
- ☐ Non-compliance to offered treatment Over weight ☐ Suspected Drug Abuse
- ☐ Emotional / Behavioural Problem (Tearful, uncooperative)

- c. Functional Screening Criteria: Screening is ☐ Positive ☒ Negative
- ☐ Patient cannot position himself in bed ☐ Change in Muscle Power
- ☐ Restricted ROM ☐ Impaired Daily Living Activities

- d. Socio-economic Screening Criteria: Screening is ☐ Positive ☒ Negative
- ☐ Living alone ☐ Suspected abuse or neglect
- ☐ Cultural or religious background that would need to know for the plan of care ☐ Unable to assess due to lack of family

- e. Need for Interpreter Screening is ☐ Yes ☒ No If Yes then plan

6. Patient needs additional specialized assessments: ☐ Yes ☒ No

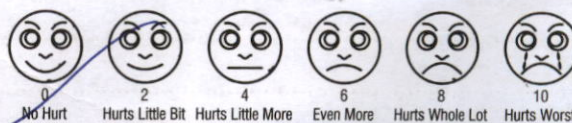
If yes, Please fill Individualized Initial Assessments Form for Special Populations

Others

Pain Screening:

Pain Scale used Wong Baker (Scale 0-10) FLACC (Scale 0-10)

Pain Score "Whenever Applicable"



Location:

Duration: days / weeks / months (Strike Out that is not applicable)

Character: ☐ localized ☐ diffuse ☐ sharp ☐ aching ☐ referred ☐ vague ☐ burning / soreness

Frequency: ☐ constant ☐ intermittent ☐ occasional

Pain Management done ☐ Yes ☐ No

Nutritional Evaluation: Well nourished.

Current Medications: None.

Provisional Diagnosis : Paracetamol Poisoning.

Prism III score at 24 hrs of admission : Worse SOFA Score :

☐ Referred Patient - ☒ Self Referral - ☐ Rainbow Patient "

Transferring Unit : ☐ Ward ☐ OT - Transported? ☐ Yes ☐ No - If yes : ☐ Long (> 30 kms) ☐ Short (< 30 kms)

Referring Consultant :

Admitting Consultant : As per note.

Indication for PICU referral : Paracetamol ingestion.

PLAN OF CARE

Preventive aspects of the treatment : To prevent Hepatic Toxicity / Encephalopathy

Desired goals of the treatment : For Hemodynamic stability.

PLANNED INVESTIGATIONS

- 1) RPT.
- 2) PT, aPTT, INR
- 3) Venous Blood gas

*Noted by
Abhinav*

PLANNED MANAGEMENT

- 1) N-Acetylcysteine
4.2g over 4 hours
↓
2.1g in 250ml NAD
over 16 hrs

- 2) IV esomeprazole
- 3) GRRS monitoring 8th hourly.
- 4) Monitor Vitals

*Noted by
Abhinav
4/2/26*

Final Diagnosis : Paracetamol Poisoning.

Doctor's Signature : JN

Name : Jayashri

Date : 6/07/26

Time : 10:00 PM

Consultant's Signature : Dr. Dinesh Kumar Chiruvu

Name : Dr. Dinesh Kumar Chiruvu

Date : 6/7/26

Time : 12pm

BAH-00450602
Baby Of DIVYA REDDY
20-11-2020 5 Y 7 M 18 D (M)
Dr. DINESH KUMAR CHIRLA

IP5-00176055

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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+1			
4	Patient Transfer form	1+1			
5	In-patient Medical record				
6	Doctors progress sheets	7			
7	Nursing plan of care and handover sheets	5			
8	Consultation sheet				
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				
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				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
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)	2+1			
36	Consent for Admission in PICU / NICU	1			
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note	1			
43	BP Monitoring chart				
44	RBS monitoring chart				
		2			
		2+2			
	Total No. of Pages				

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



PROGRESS NOTES AND DOCTOR'S ORDER

Date
 & Time

Progress Notes

Doctor's Order

6/7/2026
 9:50PM

C/S/B Plw Team

Plan

Alleged history of ingestion of syrup Paracetamol.
 60ml of 5m (250mg) Syrup
 142mg/kg

N-Acetylcysteine
 4200mg in 250ml NaCl
 IV over 4 hours

↓
 N-Acetylcysteine
 2100mg in 250ml NaCl

No A/O Vomiting/pain/Abdomen. IV over 16 hours

O/E child is Alert/Active. Nid per oral for Now.

HR - 90/min
 SpO₂ - 100% ↓ to room air
 RR - 20/min
 BP - 104/70mmHg

③ Send RP,
 PT, aPTT, INR
 Venous Blood Gas

U/S - SIS, ⊕ m
 ELA - cyst

④ Allms Poisoning cell
 consultation.

Mild Right subcutaneous
 tenderness ①

⑤ To send paracetamol
 levels to tenet.

No organomegaly
 CNs: GCS - 15/15

pupils - 3mm and
 Reacts to light

⑥ CRBS Monitoring 8 hourly.

No jaundice
 chest - clear

⑦ Puj. Esomeprazole

note by
 abhim
 6/12/26
 4:50pm

[Signature]
 Dr. Dinesh

BAH-00450602
DIVYA

IP5-00176055

BAH-00450602
Baby Of DIVYA REDDY
5 Y 7

20-11-2020

5 Y 7 M 16 D

(M)

20-11-2020
Dr. DINESH KUMAR CHIRLA



Birthright

BY RAINBOW

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Date & Time	Progress Notes	Doctor's Order
6/7/26 10:00PM	<u>A</u> = Paracetamol Poisoning wt = 21kg. Toxic Dose = 150mg/kg. → child took 3g at 3pm i.e. 142mg/kg.	<u>D/W ADMS Poisoning.</u> → To start NAC Infusion and continue for 48 hours → No role of gastric lavage = activated charcoal → No role of Hemodialysis → Monitor LFT & INR Q12H. → If no further symptoms to stop NAC after 48 hours.
		Dr. Jayashree noted by Rohini 10:00pm

[illegible]

PROGRESS NOTES AND DOCTOR'S ORDER

Date
 & Time

Progress Notes

Doctor's Order

6/7/26

10:30pm.

Counselling Notes

→ Parents were explained regarding the paracetamol poisoning causing toxicity involving liver

→ child took around 1842 mg/kg of paracetamol - which is toxic for his weight

→ Explained about Antidote - N-acetyl cysteine

→ Paracetamol level, Liver function test will be sent now

→ Jaundice, Vomiting, symptoms might develop within 24 hours

→ Liver Injury might effect after 48 hours so, we have to monitor the child in ICU

→ Liver failure, Renal failure complications were explained & monitoring of labs were explained.

→ Initial Blood gas was normal

→ R/O



(Father)

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Birth Fight

[illegible]

BAH-00450602 IP5-00176055
Baby Of DIVYA REDDY
20-11-2020 5 Y 7 M 16 D (M)
Dr. DINESH KUMAR CHIRLA



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DAILY ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 06/07/2020 Day of Admission : Day 1 Today's Date & Time : 7/7/2020 8 am

PRISM - III Score in first 24hrs. of Admission : 0 Today's SOFA Score : 0

OVERVIEW	Diagnosis : <i>Acute Paracetamol Toxicity.</i>	Current Issues : <i>Mild tenderness @ subcostal region.</i>
	VITAL SIGNS Today's Wt. (kg) : <i>21 kg</i> Temp.: <i>98.4 F</i> Blood sugar issues : <i>93 mg/dl</i>	
RESPIRATORY SYSTEM	Respiratory System Findings : (Air entry, breath sounds, s/o distress etc.) : <i>BAE @ clear</i>	
	CXR : _____	
	SPO ₂ : <i>99% on RA</i> O ₂ by NC / FM / NRB mask / Oxyhood, at _____ L / min	
	Ventilatory Support : ☐ Yes ☒ No - Day # of Vent : _____ Nitric Oxide : ☐ Yes ☒ No - If Yes, details : _____	
	Ventilatory Settings : Leak around ETT : _____ Delivered Vt : _____ ABG : <i>pH: 7.37 / HCO₃: 21 / Lac: 1.5</i> EtCO ₂ : _____ P/F ratio : _____ O.I. : _____ Chest Physiotherapy Plan : _____ Suctioning Needs : _____ Any Nebbs : _____ ICD ? ☐ Yes ☒ No, if Yes, details : _____ Plan of care : _____	
CARDIO VASCULAR SYSTEM	Cardio Vascular System Clinical Exam. (Heart sounds, murmur etc.) : <i>HR: 90/min</i>	
	Quality of Pulses : <i>epod</i> cap refill Time : <i>2.3 sec</i> Liver Edge : _____ cm below Rt costal margin	
	Blood Pressures : NIBP : <i>110/69 mmHg</i> IBP : _____ CVP : _____	
	Infusion of : ☐ Dopamine _____ mcg / kg / min - ☐ Dobutamine _____ mcg / kg / min ☐ Epinephrine _____ mcg / kg / min - ☐ Nor Epinephrine _____ mcg / kg / min ☐ Milrinone _____ mcg / kg / min	
	Any Other Infusions : _____ Last 2D Echo Findings : _____ Size of the heart and lung fields in latest CXR : _____ Arterial line in situ : ☐ Yes ☒ No Place of art, line & its condition : _____ Central line in situ : ☐ Yes ☒ No Place of central line & its condition : _____ Day of arterial line : _____ Day of Central line : _____ Plan of Care : <i>cannula @ hand</i>	
CNS	Neuro Exam : <i>GCS: 15/15 (E4V5M6)</i>	
	Pupils : <i>2mm/2mm B/L reactive</i> Sedation Used ? ☐ Yes ☒ No Any paralysis ? ☐ Yes ☒ No	
	Types of Sedation : _____ Types of Paralysis : _____	
	Relevant CT Scan, MRI EEG, Neurosonogram etc. : _____ Plan of Care : _____ Ramsay Sedation Score : _____	

FLUIDS STATUS NUTRITION AND G.I	☐ NPO ☒ PO feeds ☐ NG Feeds ☐ NJ Feeds ☐ GT Feeds I / O / Balance : / (+/-) Input : ml/k/d UO : ml/kg/hr Stools : NG output : PO intake : Feed Formula : Feed Schedule : IV Fluids - Type of IVF : @ ml / hr (..... times maintenance) TPN : ☐ Yes ☐ No - If yes, details : % of Dext, Glu Inf Rate (mg/kg/min) Amino Acids (gm/kg/day) Lipids (gm/kg/day) Cal/kg/d Nitrogen Trace elements & MVI Labs : Na <u>136</u> K <u>4.2</u> Cl <u>105</u> Ca <u>10.2</u> Mg P <u>6.2</u> HCO3 <u>21</u> Sr. Amylase : Sr. Lipase : Latest LFT : Abd Exam : <u>soft</u> Any organomegaly ? ☐ Yes ☒ No - If yes, describe : Plan (G.I. & Liver) :		
	☐ Febrile ☒ Afebrile Current Antibiotics Details (antibiotic name and day #) : Cultures Sent ? ☐ Yes ☒ No - If yes, details : Describe c/s Reports : Other Labs (Latex, Serology, etc) : Ongoing Antibiotics :		
	Sr. Creat : <u>0.3</u> Bld. Urea : <u>21</u> Other Relevant Labs : P.D. ☐ Yes ☒ No - If yes, details : Diuretics : ☐ Yes ☒ No - If yes, details : Catheterized : ☐ Yes ☒ No - If yes, then day of Catheter : Relevant Radiology (USC, MCUG radioisotope scan etc) : Plan of Care :		
	Relevant Labs (CBP etc) : <u>6.7 ÷ 12.4</u> <u>61700</u> <u>4.03</u> Any Coagulopathy : Relevant Transfusion History : Plan of Care :		
	CARE PROTOCOLS	VAP Bundle Used ? : ☐ Yes ☐ No ☒ NA CRBSI Bundle Used ? : ☐ Yes ☐ No ☒ NA CA - UTI Bundle Used ? : ☐ Yes ☐ No ☒ NA Patient Managed as per Relevant Protocols : ☐ Yes ☐ No ☐ NA If yes, then details :	
		Pending Lab Results : ☒ Yes ☐ No If yes, then details : <u>PCM levels</u> Pending Consultations : ☐ Yes ☒ No If yes, then details :	
	FINAL COMMENTS	<u>-Trace Blood paracetamol levels</u>	

Doctor's Name (Handover given) : Jayashri
 Signature : Jayashri
 Date & Time : 21/12/20 @ 8AM

Doctor's Name (Handover taken) : Mr. Kethu
 Signature : Kethu
 Date & Time : 07/01/20 9AM





PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/26 11:18 am	cl/B Dr. Dineesh	Plan
	As:- accidental ingestion of paracetamol on room air hemodynamically stable systemic exam ⁿ - (N).	1) paracetamol levels to trace 2) continue NAC levels. 3) LFT, VBA @ 4pm.
		Noted by Nitish Poo 07/06/26 8:11:22 AM Dr. Pratyusha
7/6/26 Bedside counseling notes 11:20 am		- Dr. Dineesh
	Patient's attendants have been counseled about the condition of the child i.e, → child has ingested high levels of paracetamol. → we are awaiting the paracetamol blood levels based on which we will decide further management. → As of now, he is asymptomatic and his initial blood investigations are normal.	

Date & Time	Progress Notes	Doctor's Order
7/7/26 5:45 pm	ds/B Dr. Dinesh accidental paracetamol ingestion. on room air hemodynamically stable systemic exam? (N). asymptomatic	Plan 1) Send VBG and paracetamol drug levels tomorrow morning @ 7am 2) Stop NAC infusion. 3) encourage orally 4) Stop IV fluids 5) Shift to room.
		Noted by N. J. Poyt 5/1/26 @ 5:50pm



(P.T.O)

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00450602 IP5-00176055
 Baby Of DIVYA REDDY
 20-11-2020 5 Y 7 M 16 D (M)
 Dr. DINESH KUMAR CHIRLA



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RESULT SHEET

Date	6/7/26	7/7/26			
Time	10:30 PM	5 PM			
Hb	12.4				
PCV	37.1				
RBC	4.79				
WBC	6,700				
N/L	35.6/51.9				
Platelets	4,03,000				
CRP					
ESR					
PCT					
RBS					
Na	136				
K	4.2				
Cl	105				
Ca/Mg	10.2/				
Phosphate	6.2				
Urea	21				
Creatinine	0.3				
ALP	207	156 ↓			
SGPT	20	19			
SGOT	32	24 ↓			
T.Bill/Conj	0.4/0.1	0.3/0.1			
T.Protein	7.4	7.3			
S.Albumin	4.4	4.3			
S.Globulin	3	3.0			
A/G Ratio	1.4	3			
Uric Acid	4.5				
S.Amylase	61				
Sr.Lipase					
Blood Lactate					
S.Cholesterol	137				
PT/INR	15/1.1				
APTT	42				
CSF Protein / Sugar					
Cells					
N/L					



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: EP

Shifted to: Pw

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

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: JN (Jayan)

Date & Time: 6/7/26 @ 10 PM

Nurse Name & Signature: Anand

Date & Time: 06/07/26 @ 10 pm



MEDICATION RECONCILIATION FORM

Drug Allergies: NA ☒ 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: ICU 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	ENT ESOPIRAZOLE	20mg	IV	OD	7/10/26	☒ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Nyoti

Date & Time: 07/10/26 5:50 pm

Nurse Name & Signature: Niksh Roy

Date & Time: 07/10/26 @ 6 pm

DRUG CHART

Date of Admission: 6/12/2020 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

REGULAR PRESCRIPTIONS

Weight. 21kg Ward. PICU



DRUG : <u>Amoxicillin 201E</u>				Date Time
Dose <u>20mg</u>	Route <u>IV</u>	Frequency <u>OD</u>	Start Date <u>6/7</u>	<u>6/7 2/7 8/2</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Vikas</u>				<u>GAM</u> <u>sub</u> <u>Patu</u> <u>me</u>
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				

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				



		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.		

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]

Weight. 21 kg. Ward. Puro

Page: 4/4



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Pa

 Patients / 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		
6/12	10pm	2	Treatment and Care plan.	M	1	0	1	1	nil	Chir
7/12/20	8am	9	Soft diet	M, F	1	0	1	1	-	Mounice

Part - III: CODES

Who was taught:		PT: Patient	F: Father	M: Mother	S: Spouse	Sn: Son	D: Daughter	C: Caregiver	O: Other (Specify)
Learning Barriers:									
1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations		10. Financial Difficulties		13. Cultural/Religion Practice			
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home		11. Beliefs and Values		14. Others (Specify)			
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences		12. Impaired Vision/ or Hearing					
Teaching Tools Used:									
A: Audio	D: Demonstration	V: Video	O: Oral	P: Printed					
Mechanism/s to overcome barrier/s:									
1. None	3. Reassurance & Support	5. Respect values & beliefs		7. Other, Specify					
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference							
Understanding:									
1. Verbalizes Understanding		2. Demonstrates Understanding		3. Needs Review					



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis.

Persony (PCM).

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
6/2 9:30 AM	☒ Medical ☐ Nursing ☐ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	PCM hyposth 6ml.	H Study	- IVF - NAAE	[Signature]	☒ Nursing ☐ Others:
6/2 10 PM	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	PCM poisoning	H Study	- IV planit - IVF	[Signature]	☐ Medical ☐ Others:
7/2/26 8 AM	☐ Medical ☐ Nursing ☒ Others: Dietition	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	PCM poisoning	Encourage orally	Soft diet	Mounica	☐ 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:

BAH-00450602
Baby Of DIVYA REDDY
20-11-2020 5 Y 7 M 16 D
Dr. DINESH KUMAR CHIRLA (M)

Rainbow®
Children's
Hospital
It takes a village to raise the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EMERGENCY ROOM TRIAGE FORM

Patient's Name : B/o Divya Reddy Age : 5 yrs Gender : ☒ Male ☐ Female
Date : 6/2/26 Time of Arrival : 9:10pm Triage Completion Time : 9:12pm
Allergies : ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify) : nil ☐ Not known any drug Allergies
Source of Information : ☒ Parents ☐ Others (Specify) :
Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance

- ☒ Normal
☐ Sick Looking

Circulation / Colour

- ☒ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing

- ☒ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

- ☒ Stable
☐ Unstable :
☐ Not - Life - Threatening
☐ Life - Threatening

Initial Vital Signs: Temp: 98.4°F PR: 93bpm BP: 112/69mmHg RR: 24bpm SpO₂: 100% RA

Complaints: Alleged Ingestion of Pasa syrup 60ml @ 19pm

Triage Classification

- ☐ Level 1 : Resuscitation
☐ Level 2 : EMERGENT : Life or limb threatening
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening
☐ Level 4 : LESS URGENT : Significant illness but not life threatening
☐ Level 5 : NON - URGENT : May receive care when convenient

CTAS

- ☐ Immediate
☐ < 15 min
☒ 30 min
☐ 60 min
☐ 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Communicable Disease Triage Screening

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

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
3. Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☒ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☒ Not applicable

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☐ No
If yes, State Location: _____
2. Are your parents / close contacts at home healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☐ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
☐ The patient should be given a surgical mask immediately, if not already wearing one.
☐ Both patient and triage staff should perform hand hygiene.
☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Nr. Rachel

Date & Time : 6/2/26 @ 9:12pm

Docu. No. : RCHBH / FRM / CLINICAL / 085

Signature of Triage Nurse : [Signature]

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

NURSING INITIAL ASSESSMENT FOR PICU

Date of Admission: 06/01/2026
 Source of Admission: ☒ OPD ☐ Ward ☐ Other: ER
 Reason for Admission: Ingestion of soap powder
 Admission Diagnosis: paracetamol poisoning
 Accompanied By: ☒ Parent ☐ Guardian ☐ Other Name: _____
 Primary Language: ☒ Telugu ☒ English ☐ Hindi ☐ Other Specify _____
 Do you require an interpreter? ☐ Yes ☒ No
 Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: _____
 If yes, identify _____

Source of Information: ☒ Family ☐ Patient ☐ Others, Specify _____			
SIGNIFICANT HISTORY	Past Medical History	Past Surgical History	Last Hospital Admission
	no past medical history	no past surgical history	no -
	Family History: No significant family history		
	Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☒ No		
	If yes please list, _____		
CURRENT MEDICATIONS	Was the child's birth normal? ☒ Yes ☐ No If No, please describe problems: _____		
	Are the child's immunization up to date? ☒ Yes ☐ No		
	Taking Medications? ☒ Yes ☐ No		
	If yes, Fill the reconciliation form		
Medicine brought to the hospital? ☐ Yes ☒ No			
Observations: Weight: 21kg Length: _____ Head Circumference (< 2 years): _____			
Temp.: 98.5°F HR: 98 RR: 25 BP: 98/62			
Pain Score: 0 Specify Site: ALA (Follow Pain Assessment Sheet & Document)			
Fall Risk Assessment: ☒ Yes ☐ No Score: 11 (Document in the Humpty Dumpty Sheet)			
Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)			



Behavioural Status on Admission :

☐ Sleeping ☒ Crying ☐ Calm ☐ Distressed/Console ☐ Drowsy

FUNCTIONAL SCREENING: If a patient needs assistance with any of the following inform consultant

☐ Mobility problem ☐ Walking Problem ☒ No Abnormality Detected
☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

☐ Underweight ☐ Overweight ☐ Special Feeding Method
☐ Feeding Problem ☐ Special diet ☒ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☒ No

If Yes Consultant Notified: (Date/Time): 06/07/2026

Social History: Lives With Parents

Siblings in household ☒ Yes ☐ No (if yes How Many?) ONE

Orientation has been given regarding the following aspects:

☒ ID Band in situ
☒ Bedside safety explained
☒ PICU Routine: Doctor's rounds/Medication time
☒ Visiting policy explained

Orientation given to: ☒ Family ☐ Others specify

Name of Person Orientation was given to: Mrs. Divya Reddy

Orientation not given Reason:

Nurse Name: Abhinavathasan

Nurse Signature: [Signature]

Date & Time: 6/7/2026 @ 15 pm

DISCHARGE PLAN

Source of Information: ☒ Family ☐ Friend

Will patient require transportation arrangements to go home: ☐ Yes ☒ No

Will Physiotherapy require at home: ☐ Yes ☒ No

Is home medical equipment anticipated: ☐ Yes ☒ No

Is home oxygen therapy anticipated: ☐ Yes ☒ No

Are dressing needs at home anticipated: ☐ Yes ☒ No

Any other needs anticipated: ☐ Yes ☒ No If Yes Specify

Discharge Medications: ☒ Yes ☐ No

Details:

Final Diagnosis: PCM Poisoning

Nurse Name: Abhinav

Nurse Signature: [Signature]

Date & Time: 06/07/26 @ 16:30 pm

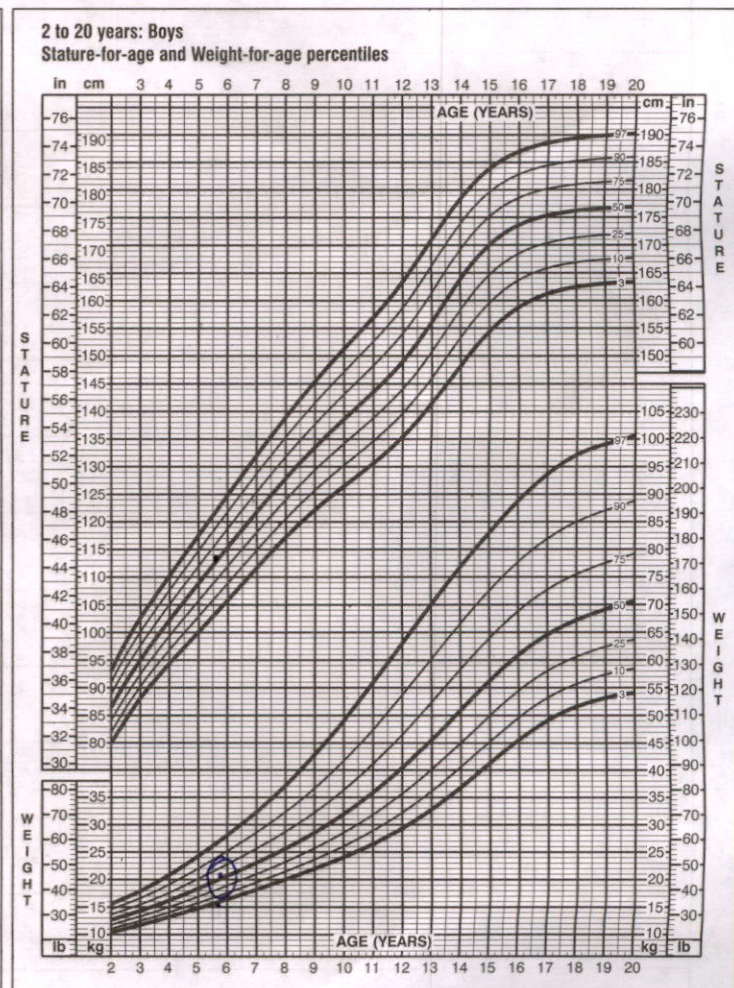
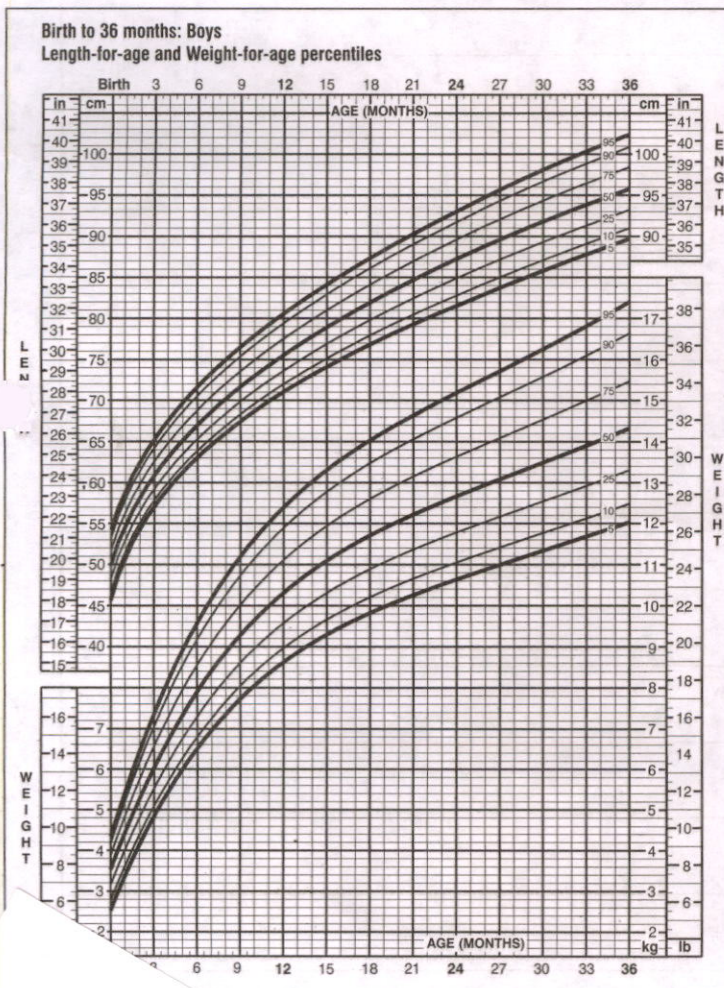
330

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 8/7/26 Time: 9:30am

Weight: 21kg Centile: >50th
 Height: 114cm Centile: >50th
 Inference: well child
 RDA: — Calories: 1500Kcal/d Protein: 24gm/d
 Diet Recommendations: soft diet
 Re-Assessment: avoid spicy, chilled and outside foods
 Food Allergies: NO Veg/Non-veg: Non-veg
 Diagnosis: paracetamol poisoning
 Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral
 Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Signature: Saima

Daily Notes:



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time: 7	10pm	2pm	6am	
Doctor / Nurse / Family Concern? <i>PN</i>					
Temperature (F)	104				
	103				
	102				
	101				
	100				
	99	<i>98.2 F</i>	<i>98.0 F</i>	<i>97.5 F</i>	<i>97.0 F</i>
	98	<i>*</i>	<i>*</i>	<i>*</i>	<i>*</i>
	97				
	96				
	95				
94					
Heart Rate (bpm) and Blood Pressure (mmHg) *	190				
	180				
	170				
	160				
	150				
	140				
	130				
	120				
	110				
	100				
90					
80					
70					
60					
50					
Note: BP does not score in early warning scoring					
Heart Rate (Number)	<i>86b/min</i>	<i>92b/min</i>	<i>96b/min</i>	<i>108b/min</i>	
Resp. Rate (bpm) (Over 1 Minute) *	70				
	60				
	50				
	40				
	30				
	20				
	10				
		<i>*</i>			
Resp Rate (Number)	<i>28b/min</i>	<i>24b/min</i>	<i>28b/min</i>	<i>24b/min</i>	
Resp Distress	<i>N</i>	<i>N</i>			
Mod/ Severe None / Mild					
Receiving O ₂ (l/min)					
O ₂ Saturations (%)	<i>100</i>	<i>99%</i>	<i>100%</i>	<i>99%</i>	
Conscious Level	<i>N</i>				
Normal / Altered					
GCS *	<i>15/15</i>	<i>15/15</i>	<i>15/15</i>	<i>15/15</i>	
TOTAL SCORE	<i>0</i>	<i>1</i>	<i>1</i>	<i>1</i>	
Number of shaded boxes					
Pain score	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>	
Initials	<i>dt</i>	<i>dt</i>	<i>dt</i>	<i>dt</i>	

- 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.
 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)

BAH-00450602 IP5-00176055
 Baby Of DIVYA REDDY
 20-11-2020 5 Y 7 M 17 D (M)
 Dr. DINESH KUMAR CHIRLA



FLUID CHART

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Sheet No. :

8/17/20

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 :						
8/17	08:00 pm										0	Shih
	09:00 pm	water								✓	0	Shih
	10:00 pm										0	Shih
	11:00 pm										0	Shih
	12:00 am										0	Shih
	01:00 am										0	Shih
Total Intake :						Total Output : 0 - 1 M - 0						
8/17	02:00 am										0	Shih
	03:00 am										0	Shih
	04:00 am										0	Shih
	05:00 am										0	Shih
	06:00 am						✓			✓	0	Shih
	07:00 am	water									0	Shih
Total Intake :						Total Output : 0 - 1 M - 0						
Total 24 hrs. Intake		Total 24 hrs. Output										

BAH-00450602 IP5-00176055
 Baby Of DIVYA REDDY
 20-11-2020 5 Y 7 M 17 D (M)
 Dr. DINESH KUMAR CHIRLA




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.

		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						

BAH-00450602 IP5-00176055

Baby Of DIVYA REDDY

20-11-2020 5 Y 7 M 16 D (M)

Dr. DINESH KUMAR CHIRLA



NURSING CARE RECORD

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

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/12/26

Assessment: Paracetamol Poisoning

Goals

- ☒ Maintain Airway and Oxygenation
☒ Maintain Personal Hygiene
☐ Identify Potential Complications

- ☐ Relieve Pain & Discomfort
☒ Prevent Infection
☐ Any Others. Specify.....

- ☐ Maintain Fluid Balance
☒ Meet Elimination Needs

- ☐ Improve Activity Tolerance
☐ Ensure Safety

- ☐ Maintain Good Nutritional Status
☐ Early Ambulation Reduce Anxiety

- ☐ Maintain Skin Integrity
☐ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
10 pm	⇒ Assess the body neurological condition	10 pm	⇒ Assessed the body neurological condition	All plan implemented
11 pm	⇒ maintain I/O chart	11 pm	⇒ maintained I/O chart	
	⇒ monitor vitals & signs		⇒ monitored vitals & signs	
2 Am	⇒ Blood sampled sending	2 Am	⇒ checked recorded	
4 Am	⇒ CRBS monitoring hourly	4 Am	⇒ Blood sampled & send in lab	
7 Am	⇒ continue I/O chart ⇒ Administer medication given to acc per doctor's order	7 Am	⇒ orally offered ⇒ continue I/O chart & vitals ⇒ Administer medication given to acc per doctor's order	

Re-Assessment: DONE

Special Notes: with poor level activity

Nurse Signature: Abhinav

Nurse Name: Abhinav

Date & Time: 7/12/26 9:14 AM

BAH-00450602 IP5-00176055
Baby Of DIVYA REDDY
20-11-2020 5 Y 7 M 16 D (M)
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NURSING CARE RECORD

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Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 7/07/2026

Assessment: Assess the general condition

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
9 AM	Assess the child general condition	10 AM	Assessed the child general condition.	All Plan are implemented.
11 AM	Monitor vitals and record.	12 PM	Monitored vitals and recorded.	
1 PM	Maintain I/O chart.	2 PM	Maintained I/O chart.	
3 PM	Planning to Give Continue fluid.	4 PM	Given Continue fluid as Per doctor order.	
5 PM	Encourage orally intake	6 PM	Encouraged orally intake.	
7 PM	GRBS 8th hourly.	8 PM	Done GRBS 8th hourly	

Re-Assessment: Done

Special Notes:

Send IBU & Paracetamol levels to check.

Nurse Signature:

Roy

Nurse Name:

Nitish Roy

Date & Time:

07/07/2026 @ 8 PM

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 Baby Of DIVYA REDDY
 20-11-2020 5 Y 7 M 17 D (M)
 Dr. DINESH KUMAR CHIRLA



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 7/12/20

Assessment:

observation

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 pt general condition & vitals	8 ³⁰ pm	→ Assessed the pt general condition	Future safety
12Am	→ wlf for any pain	12 ²⁰ Am	→ wlf for any pain	
3Am	→ Maintain fluid balance	3 ³⁰ Am	→ Maintain fluid balance	
5Am	→ Encourage orally medication	5 ¹⁰ Am	→ Encourage orally medication	
7Am	As per chart	7 ⁴⁰ Am	→ Administered medication as per chart	

Re-Assessment:

Special Notes: Send paracetamol level sample + VBG Tlm 7Am

Nurse Signature: Shilpa Nurse Name: Shilpa Date & Time: 8/12/20 @ 8Am

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Department: P.W. Date of Admission: 06/01

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known					
	<u>Pneumonia</u> <u>Pneumonia</u>		If Yes Specify:					
BACKGROUND	Area	Shift Time	EP 10M	3000	3000	3000	3000	3000
	Medical Condition (Any special condition to be noted):		NA	NA	NA	NA	NA	NA
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:	98.0F	98.2F	98.0F			
		Res:	28bpm	24bpm	28			
		SpO2:	100%	99.1	99			
		Pulse:	95bpm	96bpm	101			
		BP:	98/62	92/60	100/59			
	Fall Risk Score:	11	11	11				
	Pain Score:	0	0	0				
	Recommendations	Safety Needs:	Yes	Yes	Yes			
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Others Specify:		NA	NA	NA				
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:			VBG 8	VBG 8				
Post Operative Procedure Special Orders:			NA	NA				
Handed Over By Name :			Shilpa	Shilpa				
Signature :			Shilpa	Shilpa				
Date:			11/1/26	11/1/26				
Time:			10:10P	@8pm	@8am			
Taken Over By Name :			Shilpa	Shilpa				
Signature :			Shilpa	Shilpa				
Date:			11/1/26	11/1/26				
Time:			10:30pm	@8pm	@8pm			



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							
BACKGROUND	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:							
Recommendations	Pain Score:							
	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	
Recommendations	Other Special Orders / Medications:							
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature :								
Date:								
Time:								
Taken Over By Name :								
Signature :								
Date:								
Time:								

BAH-00450602
Baby Of DIVYA REDDY
20-11-2020 5 Y 7 M 16 D (M)
Dr. DINESH KUMAR CHIRLA

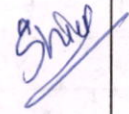
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NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA : PCMP 1		Diagnosis : PCMP poisoning		Surgery / Procedures :	
	Allergies : NA				Post OP Day :	
	Date : 6/12/26		7/12/20	07/07/26		
	Area		PICU	PICU		
	Shift Time		NIGHT	DAY		
	Diet :		NA	Orally		
INVASIVE LINES	Ventilation (RA, NP, NIV, VENTI)		RA	RA		
	1.					
	2.		cannula ①	Cannula ①		
	3.					
	4.					
ASSESSMENT	Infusions / Transfusions		NAC	NAC		
			DNS	DNS		
	PU Prophylaxis		NA	NA		
	DVT Prophylaxis		NA	NA		
	Vitals	BP	98/62	109/60		
		PR	102	98		
		RR	23	24		
		SpO ₂	100%	100%		
		Temp	98.5°F	98.6°F		
	Pain Score		0/10	0/10		
	LOC (Alert, Conscious, Confusion, Unconscious)		Alert	Alert		
	Skin Integrity (Intact / Bedsore / Any other condition)		Intact	Intact		
Restraints If any		NA	NA			
Fall Risk (Vulnerable (Y/N) if yes score)		Yes	yes			
(Ambulation, walking, moving with assistance, bed ridden)		moving	Moving			
ADL (Dependent / Non-Dependent)		Dependent	Dependent			
Critical Lab Test / Values (if any)		NA	NA			

Note : RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Investigations Procedures	Date :	7/1/26	07/07/26					
		Area	PCU	PCU					
		Shift Time	NIGHT	DAY					
		Ordered / Planned	Followed	Followed					
			Doctor	Doctor					
			order	order					
		Due	No	No					
			due	due					
		Reports Pending	No	No					
			Reports	Reports					
			Pending	Pending					
		Referrals (If any)	No	No					
			Referrals	Referrals					
Remarks (Special Interventions like, Drainage Tube flushing etc.)	No	No							
Handed Over By Name :	Abhinav	Nitish ROY							
Signature :									
Date :	7/1/26	07/07/26							
Time :	7 AM	8 PM							
Taken Over By Name :	Nitish								
Signature :	Nitish								
Date :	7/1/26	07/07/26							
Time :	8 AM	8 PM							



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
06/07/20	10pm	0	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	nil nil	(Curand)
6/7	12AM	0	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	abhis
7/7	4PM	0	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	abhis
7/7	7PM	0	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	abhis
07/07/26	10 AM	0	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	ROY
07/07/26	12 PM	0	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	ROY
07/07/26	4 PM	0	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	ROY
07/07/26	6 PM	6	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	N.ROY
2/8/26	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shy
8/8/26	6am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shy

Re-assessment Frequency:

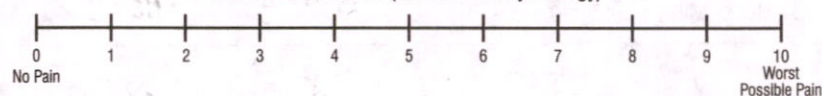
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





BRADEN 'Q' SCALE

				Date :	06/07	7/7	8/7	
				Time :	10 PM	4 AM	5 AM	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	2	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23								
Docu. No. : RCHBH/FRM / CLINICAL / 119								
					TOTAL SCORE	28	28	28
					Evaluator's Name	Heena	Abhy	Shy

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



THE HUMPTY DUMPTY SCALE

ML

06/11 11/11 8/11

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old						
	3 to less than 7 years old		3	3	3		
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2		
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1		
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1		
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2		
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1		
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1		
TOTAL			11	11	11		

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		yes	yes	yes		
Call device within reach		yes	yes	yes		
Wheels Locked		yes	yes	yes		
Room free of clutter		yes	yes	yes		
Adequate Lighting		yes	yes	yes		
Wheel Chair Support		yes	yes	yes		
Other Intervention(s) Specify		no	no	no		
Nurse's Name :		Parvathi	Abhinav	Divya		
Signature :		[Signature]	[Signature]	[Signature]		
Date :		06/11	11/11	8/11		
Time :		10:15	11:00	8:00		

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						Abhishek	NROD	NROD	NROD				

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

Signature of Shift In Charge :

Signature : Palash Name : Palash

Signature of Ward In Charge :

Signature : [Signature] Name : [Signature]

Date:	7/7								
Doctor's Orders	Followed orders								
Carried out or not	Carried out								
Bed Side									
Structured Handover done	done								
IV Site	yes								
Central Lines	no								
Arterial Lines	no								
Feeding Catheter	no								
Urinary Catheter	no								
Skin Care	given								
Eye Care	given								
Mouth Care	given								
Sterillum Bottle, Stethoscope	bed side clean								
Suction Bottle (Should be clean & empty)	clean								
Intubation Tray	NA								
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	loaded								
Ventilator Tubing, (Any Water, Blood)	NA								
Humidification	NA								
Check all Infusion (Labelling, Correct Preparation)	checked								
Chest Physio & Neb	NA								
Handed Over By Name :	Abhinav								

Date & Time : 7/7/26 2:40



CONSENT FOR ADMISSION IN PEDIATRIC INTENSIVE CARE UNIT

Name: Shriyaan (B/o Divya Reddy) Age: 5 yrs Gender: Male ☒ Female ☐

UHID.No : _____ Date: 6/7/26

I _____ S/o, D/o, W/o, _____ hereby
declare that our patient Master/Baby _____ who is related to me as _____
is getting admitted in the Pediatric Intensive Care Unit of Rainbow Children's Hospital on _____

The doctors have explained to me in a language understood by me that my child has following health related issues :

Paracetamol Poisoning.

The doctors have clearly explained to me that my patient Master / Baby _____ during his /
her stay in the Pediatric Intensive Care Unit may undergo various medical and surgical procedures like airway management,
mechanical ventilation, Central Line Insertion, Peripherally Inserted Central Catheter Line and arterial line placements, chest drain,
or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure
shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is implied
that I give consent for various invasive procedure to save the life of my child. I understand that a sick child in Pediatric Intensive Care
Unit has life threatening medical conditions.

I understand that when a child is sick in the Pediatric Intensive Care Unit with multiple medical and surgical procedures performed
upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of infections,
bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child Master / Baby : _____
_____ in the Pediatric Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved
from various procedures, high risk medications and infections in the Pediatric Intensive Care Unit and treat him/her with all
necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant :

Signature: [Signature]

Name: K. Divya

Relationship with Patient: Mother

Date & Time: 6/7/26 10:30 PM

Witness :

Signature: [Signature]

Name: Abhim

Date & Time: 6/7/26 10:30 PM

Doctor (who is taking the consent) :

Signature: [Signature]

Name: Jayabhi

Date & Time: 6/7/26 @ 10:30 PM

**పిల్లల ఇంటెన్సివ్ కేర్ యూనిట్ లో
అడ్మిషన్ కొరకు సమ్మతి**

రోగి పేరు వయస్సు లింగం ☐ పు ☐ స్త్రీ

యు.హెచ్.డి.

నేను శ/ం. d/o. w/o.

..... అనే బాలుడు / బాలిక యొక్క బికిత్త మేరకు రెయిన్స్ పిల్లల అనుపత్తి లోని పిల్లల ఇంటెన్సివ్ కేర్ యూనిట్
తేదీ నాడు పూర్తి సమ్మతితో చేర్చితిని.

మా బాలుడి / బాలిక లో ఈ కింద తెలిపిన ఆరోగ్య సమస్యల గురించి విద్య నిపుణుడు నాకు అర్థమగు భాషలో వివరించితిరి.

.....

.....

రెయిన్ బో బిల్డ్స్ హాస్పిటల్ లోని పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో చేరించి జిడ్డుకు ఆరోగ్య సంబంధిత సమస్యలు ఉన్నాయని వైద్యులు నాకు అర్థమయ్యే భాషలో వివరించారు. రోగి _____ పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో ఉన్న సమయంలో ఆతను వివిధ వైద్య మరియు శస్త్ర చికిత్సలకు లోనవుతారని వైద్యులు నాకు స్పష్టంగా వివరించారు. ఎయిర్ వే మేనేజ్ మెంట్, మెకానికల్ వెంటిలేషన్, బొడ్డు ధమని కాథెటర్, బొడ్డు సీర మరియు ధమనుల కాథెటర్ వంటి . పెరిపెరల్లి ఇన్ఫ్యూజన్ చేయబడిన సెంట్రల్ కాథెటర్ టైన్ మరియు ఆర్థరీ టైన్ ప్లేస్ మెంట్స్, చాతీ డ్రైయిన్ లేదా పెరిటోనియల్ డ్రైయిన్ ఇన్ఫర్షన్ మొదలైనవి.

అటువంటి ప్రక్రియలు చేస్తున్నప్పుడు నాకు సమాచారం ఇవ్వబడుతుందని మరియు దీనికి ప్రత్యేక సమ్మతి ఉంటుందని వైద్యులు నాకు చెప్పారు. ఏదేమైనప్పటికీ, ఏదైనా ప్రాణాంతక అత్యవసర పరిస్థితుల్లో సమాచారం తీసుకోవడానికి సమయం లేకపోతే నా జిడ్డు ప్రాణాన్ని కాపాడేందుకు ఇతర వైద్య ప్రక్రియలకు నేను సమ్మతి ఇస్తున్నాను.

పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో అనారోగ్యంతో ఉన్న పిల్లవాడికి ప్రాణాంతకమైన వైద్య పరిస్థితులు ఉన్నాయని అర్థం చేసుకోవడమైనది.

ఒక జిడ్డు అనారోగ్యంతో పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో ఉన్నప్పుడు అతని/ఆమె పై నిర్వహించబడు అనేక వైద్య మరియు శస్త్రచికిత్సా విధానాలతో ఈ అధిక ప్రమాదకరమైన విధానాల వల్ల సంభవించు సస్పాలు మరియు అధిక ప్రమాదకరమైన మందుల రూపంలో అంటువ్యాధులు, రక్తస్రావం, శ్వాసపరమైన, చర్మం మరియు ఇతర కణజాల నష్టం మొదలైనవి కలగవచ్చు. డాక్టర్లు నాకు బాగా అర్థమయ్యే భాషలో వివరించారు.

మా బాలుడు / బాలిక ను ఇంటెన్సివ్ కేర్ యూనిట్ (పి.ఐ.సి.యు) లో చేర్చుకొని అవసరమయ్యే వైద్యం చేయుటకు నేను వైద్య బృందానికి నా సమ్మతి ధృవపరుస్తున్నాను.

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

DOCU.No.: RCHBH/FRM/CLINICAL/013

సాక్షి ను ఇంటెన్సివ్ కేర్ యూనిట్ (పి.ఐ.సి.యు) లో చేర్చుకొని
సంతకము
పేరు
తేదీ మరియు సమయము

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00450602 IP5-00176055 Baby Of DIVYA REDDY (M) 20-11-2020 5 Y 7 M 17 D Dr. DINESH KUMAR CHIRLA  Dr. Dinesh Kumar Chirala		Date & Time of Admission 06/07/26 @ 9:52pm	Date & Time of Transfer Order 7/07/26 @ 7pm
		Transfer Ordered by Dr. Dinesh Kumar Chirala	Reason for Transfer Shifting
From Unit P100	To Unit 330	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 29 pages	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what?		Patient shifted with ID band: Yes ☒ No ☐ If No:
Number of Imaging Films NA			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	OP - File	①	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Nishan Roy		Name of Person Ordered Transfer Dr. Dinesh Kumar Chirala	
Patient & Clinical Records Received by : Sushma 7:15pm			
Date & Time of Patient Received : 7/7/26 @			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

PATIENT TRANSFER FORM

BAH-00450602 IP5-00176055
Baby Of DIVYA REDDY
20-11-2020 5 Y 7 M 16 D (M)
Dr. DINESH KUMAR CHIRLA



Date & Time of Admission <i>06/07/20 @</i>		Date & Time of Transfer Order <i>06/07/20 @ 10pm</i>
Treating Consultant Name	Transfer Ordered by <i>Dr. Rashmi</i>	Reason for Transfer <i>Admission.</i>
From Unit <i>ER</i>	To Unit <i>PW</i>	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File <i>19</i>	Number of Imaging Films <i>Nil</i>	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If yes, what ?
Medications / Consumables / Surgicals / Hand over		
Sl.No.	Item Name	Quantity
1.	<i>DNR 500</i>	<i>100</i>
2.		
3.		
4.		
5.		
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐		
Name & Signature of Person who is Transferring <i>Rashmi</i>		Name of Person Ordered Transfer <i>Dr. Rashmi</i>
Patient & Clinical Records Received by : <i>Abhinav @ 10pm</i>		
Date & Time of Patient Received : <i>10:30pm</i>		

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

- ☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: Expected date

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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

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: Explained about Care

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

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: K. Suresh

Nurse Name: K. Suresh

Date and Time: 7/7/26 @ 7:15pm