

B2

ACTIVITY RECORD FOR BILLING

Name : _____ BAH-00660340 IP5-00175793
Master MOHAMMED ZAYAN UDDIN
24-08-2022 3 Y 10 M 9 D (M)
UHID No. : _____ IP No. : _____ Dr. KAPIL BHAGWATRAO SACHANE
Date of Admission: _____ Discharge : _____ Time: _____
Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
4/7/	6:45pm	PICU	102	Adhikari

Cross Consultation Visit

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

[illegible]

Signature

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
5/7	HHA	(1)	aur	APY
5/7				

ANY OTHER INFORMATION

CXR - (3)
 ABG - (3)
 VBG - (1)

Date : 7/7/26 Time : 10pm Prepared By : Amet

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Dubita	SPV 102		

B2

ACTIVITY RECORD FOR BILLING

Name : Zayan

BAH-00660340 IP5-00175793

Waster MOHAMMED ZAYAN UDDIN

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

24-08-2022 3 Y 10 M 7 D (M)

Dr. KAPIL BHAGWATRAO SACHANE

Date of Admission: _____ Ti _____ arge : _____ Time: _____



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

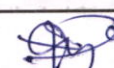
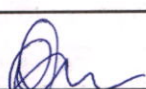
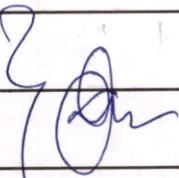
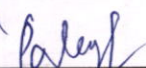
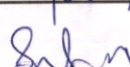
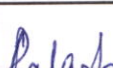
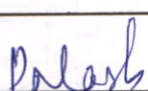
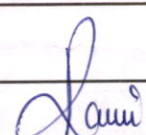
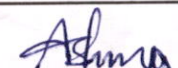
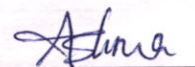
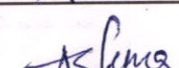
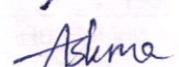
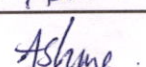
WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
01/08	5am	ER	PICU	Randy

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Abhinav Shukla	1/2	9682245	<i>[Signature]</i>
2	Dr. Sushanta Roddy	02/07	9684092	<i>[Signature]</i>
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
1/2	RR, PCT, IIOD Cls	26065742	
	CSS Stool Cls		
	WGL PT/APTT	26085887	
1/2	NSG Abdomen	32585	
1/2	Stool for rotavirus	26065902	
	Dengue. NS, IELM.		
	Scrub IELM,	26065765	
01/04	CUG	26065788	
02/7	CBP I PT/APTT I INR	26066272	
	LFT, RBS		
2/08	Mycoplasma IgM	26066152	
	5 viral panel	26066125	
	CXR	03 2799	
02/07	CAPs sepsis - PCR	26066194	
	S/E	26066292	
31/126	Electrolytes	26066391	
	RBS	26066438	
	PCT, LFT	2606651	
	ABG	2606666	
	RBS	260066733	
	RBS	260066739	
	CBP	26066669	

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature	
1/7	Inv. Monitor Inf. pump	}	STOP	9681975	}	
21/7/26	Inv. Monitor	}	STOP	9681975	}	
	Inf. pump			9681975		}
	Inf. pump			9683120		
	Sur. pump			9683120		
	O ₂ .			9684694		
31/7/26	Inv. Monitor	}	STOP	9681975	}	
	Inf. pump			9681975		}
	Inf. pump			9683120		
	Oxygen			9684694		
	Sur. pump			9683120		

[illegible]

317/26

ADMISSION SHEET

Registration Details :

Admission No : IP5-00175793

Admit Date : 01-Jul-2026

Admit Time : 04:30 AM **UHID** : BAH-00660340

Patient Details :
Patient Name : Master MOHAMMED ZAYAN UDDIN

Age : 3 Y 10 M 7 D

Guardian : Mr MOHAMMED MOIZUDDIN

DOB : 24-08-2022

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : 1-13-338, PEERBURHAN STREET NO-10
 NANDED MAHEBOOB NAGAR Nanded
 Maharashtra INDIA 431605

Phone No : 8999645220 / 9673247769

E-mail : NO@GMAIL.COM

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 MOHAMMED MOIZUDDIN

Relationship : Father

Contact Address : 1-13-338, PEERBURHAN STREET NO-10
 NANDED MAHEBOOB NAGAR Nanded
 Maharashtra INDIA 431605

Phone No : 8999645220 / 9673247769


 Signature

Doctor Details :
Doctor Name : Dr. KAPIL BHAGWATRAO SACHANE

Specialisation : PEDIATRIC INTENSIVE CARE

Referral Doctor : SELF

Phone No :

Co-Consultant : Dr. SHAIKH FARHAN A RASHID

Payment Details :
Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD

ADMISSION CRITERIA – PICU

Admission / Transfer from:

☒ Emergency ☐ Outpatient (OPD) ☐ Ward ☐ Operation Theater ☐ Others:

Tick (✓) any of the following criteria requiring admission / transfer to PICU

- ☐ All patients requiring mechanical ventilation;
- ☐ Patients with impending respiratory failure;
 - ☐ Upper airway obstruction;
 - ☐ Lower airway obstruction;
 - ☐ Alveolar disease; and
 - ☐ Unstable airway;
- ☐ All Paediatric patients after successful resuscitation;
- ☐ **Comatose Patients;**
 - ☒ Meningitis, encephalitis; ☐ Hepatic encephalopathy; ☐ cerebral malaria;
 - ☐ Head injury; ☐ Poisonings; and ☒ Status epilepticus;
- ☐ **All types of shock/hemodynamic instability:**
 - ☐ Septic shock;
 - ☐ Hypovolemic shock; (Bleeding emergencies such as gastrointestinal bleeding, bleeding diathesis, disseminated intravascular coagulation; Cardiogenic shock; myocarditis, cardiomyopathy, congenital heart disease; Neurogenic shock; and Multiple trauma;
- ☐ Cardiac arrhythmias after consulting with the treating consultant
- ☐ Hypertensive Emergencies;
- ☐ Severe acid base disorders;
- ☐ Severe electrolyte abnormalities;
- ☐ Diabetic ketoacidosis (Ph < 7.2, altered sensorium, hyperglycemia)
- ☐ Acute renal failure; Patients requiring acute hemodialysis, hemofiltration and peritoneal dialysis;
- ☐ **Post-Operative Patients;**
 - ☐ Requiring ventilation;
 - ☐ Unstable patients; and
 - ☐ Post-operative patients after open heart surgery, neurosurgery, thoracic surgery and other patients after major general surgery with potential for respiratory/haemodynamic instability;
- ☐ Patients requiring nitric oxide therapy;
- ☐ Malignant hyperpyrexia;
- ☐ Acute hepatic failure
- ☐ Severe dehydration with mental status change;
- ☐ Asthma requiring hourly nebulization/getting tired with increasing oxygen requirement/mental status change.
- "UNSTABLE" PATIENT IS DEFINED AS**
 - ☐ HR < 50 or > 160 per minute or more than upper normal limit according to age. BP < 90 systolic and < 50 diastolic and or requiring inotropic support. Arrhythmia or risk of sudden arrhythmia.
 - ☐ Signs of peripheral poor perfusion or suspicion of any type of shock.
 - ☐ Capillary refill time > 4 seconds.
 - ☐ Children Blood pressure (Syst.) < [70 + (2 × age "Years")].
- Respiratory failure or high risk of failure or airway obstruction:**
 - ☐ Respiration rate < 5 per minute below the normal or > 10-15 per minute above the normal range for age.
 - ☐ O2 Saturation < 90 % or need for O2 > 4 Litres per minute by normal face mask. Abnormal ABG: PH < 7.25, PaO2 < 60 torr, PaCO2 > 50 torr.
 - ☐ Distress and risk of exhaustion
- ☒ **Change of level of consciousness: GCS < 13.**
- ☐ **Persistent oliguria with acidosis.**

the Doctor:

Bharath

Name of the Doctor:

Bharath Reddy

Date & Time:

1/7/26
 5 AM

Patient Sticker

DISCHARGE CRITERIA – PICU

Discharge to:

- ☐ HDU / Step down ICU ☐ Ward ☐ Outside Facility ☐ Others:

Tick (✓) any of the following criteria requiring discharge / transfer from PICU

- ☐ Stable hemodynamic parameters.
- ☐ Stable respiratory status (patient extubated with stable arterial blood gases) and airway patency at least for 24 hours with no respiratory distress needing continuous monitoring.
- ☐ Minimal oxygen requirements that do not exceed patient care unit guidelines.
- ☐ Intravenous inotropic support, vasodilators, and antiarrhythmic drugs are no longer required or, when applicable, low doses of these medications can be administered safely in otherwise stable patients in a designated patient care unit.
- ☐ Cardiac dysrhythmias are controlled.
- ☐ Neurologic stability with control of seizures.
- ☐ Removal of all hemodynamic monitoring catheters.
- ☐ Routine peritoneal or hemodialysis with resolution of critical illness not exceeding general patient care unit guidelines.
- ☐ Patients with mature artificial airways (tracheostomies) who no longer require excessive suctioning.

Signature of the Doctor:

Name of the Doctor :

Date & Time:

PEDIATRIC INTENSIVE CARE ADMISSION RECORD

Date: 01/07/26 Time: 5:20 AM

Patient Assessment Form:

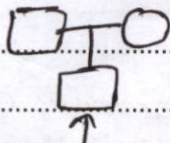
Informant: ☐ Father ☒ Mother ☐ Other

Presenting Complaints / Chief Complaints :

Fever since 2 days ; 2 episodes per day
moderate to high grade ; not relieving with medication
Loose stools 3-4 episodes since Tuesday evening
Seizures since Tuesday evening
First seizure episode on day 2 of fever i.e., Tuesday evening
as blinking of eyes, Tonic movements of all 4 limbs lasted
for 2-3 minutes
Similar another 5 episodes - seen throughout night
Vomitings (+) one episode before first seizure episode
Non bilious, non projectile, non blood stained.

Past History (Including previous treatment and investigations) : No H/O previous seizures

Birth and Developmental History : Preterm / 3.5 kg / LSCS / H/O NICU admission
for 2-3 days



Immunization History : Immunized up to date

H / O Allergy : No significant history

Family History : No H/O seizures in the family.

INITIAL ASSESSMENT

RBS : 119 mg/dl Temperature : 98.3°F Weight (kg) : 13 kg

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 : 30 bpm

SPO₂ : 100% at O by NC / FM / NRB mask / Oxyhood, at Room air 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 : 108/min Cardiac Rhytho : Regular

(Heart sounds, murmur etc.) : -

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

Blood Pressures : NIBP : 90/80 (68 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 #) : Meropenem, Amikacin

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

Describe c/s Reports : -

Other Labs (Latex, Serology, etc) : -

Ongoing Antibiotics : Ceftriaxone, Vancomycin, Azithromycin

Abdominal Exam : Soft, nontender, NO HSM

ENT Exam : Normal

Central Nervous System :

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

Neurological Findings : B/L reacting pupils 2mm

Active, alert

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

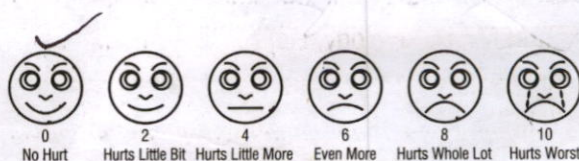
If yes, Please fill Individualized Initial Assessments Form for Special Populations

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: Moderately built

Current Medications: ceftriaxone, vancomycin, Azithromycin, Acyclovir
Levetiracetam, valproate

Provisional Diagnosis : Acute febrile encephalopathy
? Acute meningoencephalitis

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 : PICU as per Rota

Indication for PICU referral : Seizures

PLAN OF CARE

Preventive aspects of the treatment : Neurological damage

Desired goals of the treatment : Resolution of symptoms

PLANNED INVESTIGATIONS

RP,
PCT
Blood c/s

M.B.
Ref

PLANNED MANAGEMENT

Inj. ceftriaxone
Inj. Vancomycin
Inj. Azithromycin
Inj. Acyclovir
Inj. Levetir
Inj. Valproate
Syp. Ziconia
Econorm sachets
3% NS @ 1ml/kg/hr
DRS @ 50% maintenance.

Final Diagnosis : Acute febrile encephalopathy
? Acute meningoencephalitis

Doctor's Signature : Bhaleth

Name : Bhaleth Reddy

Date : 01/07/26

Time : 5:35 AM

Consultant's Signature : [Signature]

Name : [Signature]

Date : 01/07/2026

Time : 5:35 AM



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



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

[illegible]

3AH-00660340
Master MOHAMMED ZAYAN UDDIN
24-08-2022 3 Y 10 M 7 D
Dr. KAPIL BHAGWATRAO SACHANE (M)

LY ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 11-06-2022 Day of Admission : Day-1 Today's Date & Time : 11/2/26 8 AM
PRISM - III Score in first 24hrs. of Admission : Today's SOFA Score :

OVERVIEW	Diagnosis : <u>Acute febrile encephalopathy</u>	Current Issues : <u>encephalopathy seizures</u>
VITAL SIGNS	Today's Wt. (kg) :	Temp.:
RESPIRATORY SYSTEM	Respiratory System Findings : (Air entry, breath sounds, s/o distress etc.) : <u>BAC ⊕ Clear</u>	
	CXR : _____	
	SPO ₂ : <u>98%</u> O ₂ by NC / FM / NRB mask / Oxyhood, at <u>Room APD</u> L / min	
	Ventilatory Support : ☐ Yes ☒ No - Day # of Vent : _____ Nitric Oxide : ☐ Yes ☐ No - If Yes, details : _____	
	Ventilatory Settings : Leak around ETT : _____ Delivered Vt : _____	
	ABG : <u>pH - 7.2 pO₂ - 29 pO₂ - 31 EtCO₂ : <u>Lac - 6.3</u> P/F ratio : <u>4103 - 14.4</u> O.I. : _____</u>	
	Chest Physiotherapy Plan : _____ Suctioning Needs : <u>as per gap - 15.6</u>	
	Any Nebbs : _____ ICD ? ☐ Yes ☐ No, if Yes, details : _____	
	Plan of care : _____	

CARDIO VASCULAR SYSTEM	Cardio Vascular System Clinical Exam. (Heart sounds, murmur etc.) : <u> sinus HR - 107</u>	
	Quality of Pulses : <u>good</u> cap refill Time : _____ Liver Edge : _____ cm below Rt costal margin	
	Blood Pressures : NIBP : <u>110/60 (70mmHg)</u> 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 : _____	
CNS	Central line in situ : ☐ Yes ☒ No Place of central line & its condition : _____	
	Day of arterial line : _____ Day of Central line : _____	
	Plan of Care : _____	

	Neuro Exam : <u>GCS 15/15</u> <u>encephalopathy</u> <u>ig valproate 20mg/kg/dose</u> <u>ig levetiracetam 20mg/kg/dose</u>	
	Pupils : <u>2mm 2mm reacting to light</u> 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 : <u>DNS</u> @ <u>55ml/hr</u> (120% HF) 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>145</u> K <u>3.7</u> Cl <u>116</u> Ca <u>8.6</u> Mg P HCO3 Sr. Amylase : Sr. Lipase :				
	Latest LFT :				
Abd Exam : <u>soft</u> <u>TSB - 0.2</u> <u>SGOT - 94.5</u> <u>SGPT - 466</u> <u>proten - 6.2</u>					
Any organomegaly ? ☐ Yes ☒ No - If yes, describe :					
Plan (G.I. & Liver) :					
INFECTION	☐ 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) :				
NEPHROLOGY ISSUES	Ongoing Antibiotics :				
	Sr. Creat : <u>0.5</u> Bld. Urea : <u>24</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 :				
HEMATOLOGY	Relevant Radiology (USC, MCUG radioisotope scan etc) :				
	Plan of Care :				
	Relevant Labs (CBP etc) :				
	Any Coagulopathy :				
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				
FINAL COMMENTS	If yes, then details :				
	Pending Lab Results : ☐ Yes ☒ No				
	If yes, then details :				
	Pending Consultations : ☐ Yes ☒ No				
If yes, then details :					
Review URI blood.					

Doctor's Name (Handover given) : Dr. Nathan

Signature : [Signature]

Date & Time : 1/2/26

Doctor's Name (Handover taken) : [Signature]

Signature : [Signature]

Date & Time : 1/2/26 @ 9pm

Date & Time	Progress Notes	Doctor's Order
	<u>Counselling Notes.</u>	
1/7/26. 6:30am.	Dr. Avinash.	
	Child's condition is explained to parents. Child was having seizures which can be due to brain infections or any severe disorder. Currently seizures have subsided, child is stable. We will do EEG & MRI Brain later. If child remains stable, we will plan further diagnostic tests. We will take Neurology opinion today. We might plan CT scan if lab reports suggests infection to rule out CNS infection. Currently child is seizure free & stable but child needs to be in PICU for observation.	
	Sobyer Mallu	Singh

[illegible]

3AH-00660340 IP5-00175793
 Master MOHAMMED ZAYAN UDDIN
 24-08-2022 3 Y 10 M 7 D (M)
 Dr. KAPIL BHAGWATRAO SACHANE

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/7/2026 9:40AM	<u>Counselling Note</u> Do. Kapil	<u>Room-2</u>
	Parents have been Counsellled that, child had Seizures. Fts could be due to fever or due to injection. Initial Blood tests showing high injection. Child is having Abdomen injection. After the brain doctor has seen the child we will decide on lumbar puncture to do or not. We are giving medication. Sometimes during Seizures, there could be respiratory depression and should be managed in ICU. Initial CECT Brain is done. After Neurologist has seen, we will decide on MRI and lumbar Puncture. There is swelling in liver.	
	<u>Dr. Vikas</u> <u>Draper with Mouth</u>	<u>Plan</u> ① Dengue NS, IgM. ② Sepsis IgM, CRP ③ Peripher Smear ④ USG Abdomen. <u>Light</u> <u>malis</u> <u>Noted by Anam</u>



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Docu. No. : RCHBH /FRM / CLINICAL / 088

Date & Time	Progress Notes	Doctor's Order
1/7/2026 3:30pm	C/S/B Dr. Kapil plan A! - GI sepsis Acute febrile encephalopathy	① Repeat ABG ② 10:00pm
Issue	① loose stools ② Seizures ③ Worsening febrile encephalopathy	② W/F loose stools ③ MRI Reporting ④ EEG Reporting
	MRI Brain done today currently on post sedation Dr. Chins	⑤ Tomorrow morning CBP, PT, aPTT, fXr. CPT ⑥ SOS IVIG
		noted by anr

3AH-00660340
 Master MOHAMMED ZAYAN UDDIN
 24-08-2022 3 Y 10 M 7 D (M)
 Dr. KAPIL BHAGWATRAO SACHANE

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/08 @ 7pm	Informd the mrs reports and neurologist opinion	CD/w Dr Kapil Sr. Adv ① ABG, LFT CBP, ESR fentin ② Start antiedema measures noted by nurse Ch Chouch
9:30pm 17/08	Counselling room-2 Parents have been explained in detail that child is having significant edema in the brain which is caused by mrs. we have already started on antiedema measures. risk of worsening edema and need of ventilator if such spikes, need of urgent CT brain is also been explained. Risk of deterioration is explained K.B. Manoh Adv	Dr. Manoh Sobita malle

IP5-00175793

3AH-00660340
 Master MOHAMMED ZAYAN UDDIN
 24-08-2022 3 Y 10 M 7 D (M)
 Dr. KAPIL BHAGWATRAO SACHANE



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

3AH-00660340

IP5-00175793
Waster MOHAMMED ZAYAN UDDIN
24-08-2022 3 Y 10 M 7 D (M)
Dr. KAPIL BHAGWATRAO SACHANERainbow
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ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 01/07/26 Day of Admission : Day 2 Today's Date & Time : 02/07/26 8 AM
PRISM - III Score in first 24hrs. of Admission : Today's SOFA Score :

OVERVIEW	Diagnosis : GI Sepsis Acute Febrile Encephalopathy	Current Issues : Loose stools - Improving. Encephalopathy
	VITAL SIGNS Today's Wt. (kg) : 13 kg Temp.: 98.2°F Blood sugar issues :	
RESPIRATORY SYSTEM	Respiratory System Findings : (Air entry, breath sounds, s/o distress etc.) : BAE@, clear	
	CXR : SPO ₂ : 100% on 5 lit. O ₂ by NC (FM) NRB mask / Oxyhood, at 5 lit/min L / min	
	Ventilatory Support : ☐ Yes ☒ No - Day # of Vent : Nitric Oxide : ☐ Yes ☒ No - If Yes, details :	
	Ventilatory Settings : Leak around ETT : Delivered Vt : ABG : PH: 7.42/HCO ₃ : 24.1/PCO ₂ : 31.3 EtCO ₂ : P/F ratio : O.I.:	
	Chest Physiotherapy Plan : Suctioning Needs : Any Nebs : ICD ? ☐ Yes ☒ No, if Yes, details : Plan of care :	
CARDIO VASCULAR SYSTEM	Cardio Vascular System Clinical Exam . (Heart sounds, murmur etc.) : HR: 90/min	
	Quality of Pulses : Good cap refill Time : <3sec. Liver Edge : cm below Rt costal margin	
	Blood Pressures : NIBP : IBP : 89/47 mmHg 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 :	
CNS	Neuro Exam : GCS - 15/15 Levipil, Valproate	
	Pupils : 2mm 2mm reacting to light Sedation Used ? ☐ Yes ☒ No Any paralysis ? ☐ Yes ☒ No	
	Types of Sedation : Types of Paralysis : Relevant CT Scan, MRI EEG, Neurosonogram etc. : on Inj Valproate Plan of Care : Inj Levipil	
	Ramsay Sedation Score :	

FLUIDS STATUS NUTRITION AND G.I	☐ NPO ☒ PO feeds ☐ NG Feeds ☐ NJ Feeds ☐ GT Feeds I / O / Balance : <u>-30</u> / (+/-) 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>14.5</u> K <u>3.7</u> Cl <u>11.6</u> Ca Mg P HCO3 Sr. Amylase : Sr. Lipase : Latest LFT : Abd Exam : <u>soft</u> <u>IVF - DNS - 15 ml/hr</u> <u>3-1 NS - 10 ml/hr</u> Any organomegaly ? ☐ Yes ☒ No - If yes, describe : Plan (G.I. & Liver) : <u>800 ml</u> <u>(60-1)</u>		
	☐ Febrile ☒ Afebrile Current Antibiotics Details (antibiotic name and day #) : Cultures Sent ? ☒ Yes ☐ No - If yes, details : Describe c/s Reports : <u>Dongu d-2 Trace Blood c/s</u> Other Labs (Latex, Serology, etc) : <u>Acylani D2 Dengue IgM, Scrub IgM -</u> Ongoing Antibiotics : <u>Moxifloxacin D2 peripheral smear</u> <u>Vancocycl D2</u>		
	NEPHROLOGY ISSUES	Sr. Creat : <u>0.5</u> Bld. Urea : <u>24</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) : Any Coagulopathy : <u>1st CBP : 10.4 124.50 88.6/4.5 1.45/4.4</u> 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>Dengue IgM, Scrub IgM</u> Pending Consultations : ☐ Yes ☐ No If yes, then details :	
		FINAL COMMENTS <u>- MRI reporting</u> <u>- SOS IVIG</u> <u>- Trace pending labs</u>	

Doctor's Name (Handover given) : Jayab
 Signature : JM
 Date & Time : 21/12/20 @ 8am

Doctor's Name (Handover taken) : Suhay
 Signature : [Signature]
 Date & Time : 21/12/20 @ 8am

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/2022	C/S B Dr. Kapil Septic Aseptic Meningitis Plan Gen ① Loose stools - Better ② Encephalopathy - Better on facemask oxygen. Hemodynamically stable HR - 100/min SpO₂ - 100% on facemask RR - 22/min BP - 86/55 mmHg.	① chest xray ② mycoplasma ③ viral panel ④ Rota Virus stool Trace ⑤ ophthalmology examination for papilledema. ⑥ LFT tomorrow. ⑦ sepsis - PCR blood.
	Parents have been counselled that, condition is better now. Now some child's requiring oxygen full will get a chest xray. child's clinical condition and MRI findings are not correlating. we will continue medication.	note 100%
	Notes	soliga 2 marks



DAILY ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 1/7/26 Day of Admission : Day - 3 Today's Date & Time : 3/7/26 7AM
PRISM - III Score in first 24hrs. of Admission : Today's SOFA Score :

OVERVIEW	Diagnosis : Influenza A virus acute febrile encephalopathy GI sepsis		Current Issues : encephalopathy improving, one episode hypoglycemia	
	VITAL SIGNS Today's Wt. (kg) : Temp.: Blood sugar issues :			
RESPIRATORY SYSTEM	Respiratory System Findings : (Air entry, breath sounds, s/o distress etc.) : BAE @ Urea			
	CXR : SPO ₂ : 98% O ₂ by NC / FM / NRB mask / Oxyhood, at 1L NP L / min			
	Ventilatory Support : ☐ Yes ☒ No - Day # of Vent : Nitric Oxide : ☐ Yes ☒ No - If Yes, details :			
	Ventilatory Settings : Leak around ETT : Delivered Vt : ABG : 1/7/26 pH-7.4 pCO ₂ -31.3 pO ₂ -68.4 Lac-1.5 P/F ratio : 7103-24.1 O.I. :			
	Chest Physiotherapy Plan : Suctioning Needs : Any Nebbs : Budesal TID ICD ? ☐ Yes ☒ No, if Yes, details : Plan of care : off oxygen - 94%			
CARDIO VASCULAR SYSTEM	Cardio Vascular System Clinical Exam. (Heart sounds, murmur etc.) : Spms. HR-110			
	Quality of Pulses : good cap refill Time : ~2 sec Liver Edge : cm below Rt costal margin			
	Blood Pressures : NIBP : IBP : 95/60 (70) mmHg 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 : Left leg - 22g Last 2D Echo Findings : Left hand - 22g			
	Size of the heart and lung fields in latest CXR : Arterial line in situ : ☒ Yes ☐ No Place of art, line & its condition : Right radial Central line in situ : ☐ Yes ☐ No Place of central line & its condition : Day of arterial line : D3 Day of Central line : Plan of Care :			
CNS	Neuro Exam : E4 V2 M5 High level pp 20mg/kg/dose BP			
	Pupils : 2mm 2mm reacting 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 :			

Doctor's Name (Handover taken) : Dr. Kalleu
Signature : Kalleu
Date & Time : 03/07/2025 8:30 AM

3AH-00660340 IP5-00175793
 Master MOHAMMED ZAYAN UDDIN (M)
 24-08-2022 3 Y 10 M 7 D
 Dr. KAPIL BHAGWATRAO SACHANE

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
03/07/2026 10:00 AM	clsb Dr. Kapil	Plan:
	Δ Influenza A mon	1) PCT, LFT, [ABG BD]
	Issues:	↳ from morning sample
	Thrombocytopenia	2) RBS Q6H
	fever spikes	3) Encourage orally
	encephalopathy (improving)	4) IF SpO ₂ < 94% → start O ₂ (LP)
	O/E	5) Chest Xray T/m
	Hemodynamically stable	6) w/Hold LP plan
	on normal.	7) ABG & Cbp BD.
	NPO for LP.	8) Trace cultures (sterile ush)
		9) stop 3% NaCl
		10) Levon + 3% NaCl Neb Q8H
		11) B. Ashme.
		3/2/26 @ 10:00 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
03/08/26 10:35am	<u>counselling room no 1</u>	Dr. Kapil Sachane
	- Explained regarding the influenza & its effect on organs like liver, brain, lung (multiorgan) chances of increase pressure in brain are present for which treatment was started. At present ↑ pressure symptoms are resolving will take a neurological consultation for the same. Liver functions are getting normalised gradually. Since platelets are low will hold Lumbar Puncture once platelets improve, will take decision then, chances of secondary infections are present, antibiotics are being used for same. will continue in PICU for today & decide tomorrow based on clinical condition. Treatment will keep on modifying based on clinical condition.	
	consent taken by	Father's Signature:
	 <u>Dr. Kapil Sachane</u> <u>03/08/26</u> <u>10:40am</u>	 <u>03/08/26</u> <u>10:42am</u>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/2/24 4pm	CLSB Dr. Kapil	Plan
	As:- Influenza-A illness / pneumonia / MODS	1) WLF Fever spike
	o/e	2) Contre IV antibiotics
	Hemodynamically stable	3) ABC, CBP BD
	on room air	4) ABC - 8pm
	accepting orally	CBP - 6pm.
	vitals	5) If high grade fever spike, to consider optimising antibiotic.
	PR - 126 bpm BP - 88/54 (+0)	6) CXR tomorrow morning
	RR - 28 bpm	ABC, CBP @ 6am
	SpO ₂ - 99% on room air	tomorrow morning
		7) Encourage orally.
		8)
		M.B. Ashma.
		Dr. Prathap



DAILY ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 01/07 Day of Admission : Day 4 Today's Date & Time : 04/07

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

OVERVIEW	Diagnosis : Influenza A illness Acute febrile encephalopathy at sepsis	Current Issues : Encephalopathy (improving) Thrombocytopenia (improving) fever spikes - 4 spikes/day
	VITAL SIGNS Today's Wt. (kg) : 13 Temp.: Blood sugar issues :	
RESPIRATORY SYSTEM	Respiratory System Findings : (Air entry, breath sounds, s/o distress etc.) : CXR : 4/7: B/L infiltrate. B/L AC (+) Left side pleth (+) SPO ₂ : 99% T R/A ✓ 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 : 7.4 / 82 / 85 / 0.6 / 24 EtCO ₂ : P/F ratio : O.I. : PH PCO ₂ PO ₂ Lac HCO ₃ Chest Physiotherapy Plan : Suctioning Needs : Any Nebs : Budesonide TID ICD ? ☐ Yes ☒ No, if Yes, details : Plan of care : Levofloxacin + 3% NaCl TID To do chest xray today	
	Cardio Vascular System Clinical Exam. (Heart sounds, murmur etc.) : HR-102 Quality of Pulses : Good cap refill Time : < 2 sec Liver Edge : 2 cm below Rt costal margin Blood Pressures : NIBP : 93/50 (64) 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 : At we (R) Radial. Central line in situ ☐ Yes ☒ No Place of central line & its condition : Planula - 22G Rt axillary Day of arterial line : Day of Central line : Left hand Plan of Care :	
	Neuro Exam : Full VMC Pupils : 2mm B/L Reactivity to light Sedation Used ? ☐ Yes ☒ No Any paralysis ? ☐ Yes ☒ No Types of Sedation : Types of Paralysis : Relevant CT Scan, MRI EEG, Neurosonogram etc. : Plan of Care : Can make fentanyl to oral Ramsay Sedation Score :	

FLUIDS STATUS NUTRITION AND G.I	☐ NPO ☒ PO feeds ☐ NG Feeds ☐ NJ Feeds ☐ GT Feeds I / O / Balance : <u>-111</u> / (+/-) Input : ml/k/d UO : <u>3.0</u> ml/kg/hr Stools : NG output : PO intake : Feed Formula : <u>SOFT</u> Feed Schedule : IV Fluids - Type of IVF : <u>DNS</u> @ <u>2.0</u> 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 & MV Labs : Na K Cl Ca Mg P HCO3 Sr. Amylase : Sr. Lipase : Latest LFT : <u>20</u> Abd Exam : <u>soft</u> Any organomegaly ? ☐ Yes ☒ No - If yes, describe : Plan (G.I. & Liver) :	
	INFECTION ☒ 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 :	
NEPHROLOGY ISSUES	Sr. Creat : <u>0.5</u> Bld. Urea : <u>24</u> (<u>1.7</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 :	
	HEMATOLOGY Relevant Labs (CBP etc) : 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 : Pending Consultations : ☐ Yes ☒ No If yes, then details :
	FINAL COMMENTS <u>Trace Blood c/s (3/7/26).</u>	

Doctor's Name (Handover given) : Dr Kaitu

Signature : [Signature]

Date & Time : 04/07 2:00 pm

Doctor's Name (Handover taken) : Dr. Prathin

Signature : [Signature]

Date & Time : 4/7/26, 8:00 am

3AH-00660340 IP5-00175793
Waster MOHAMMED ZAYAN UDDIN
24-08-2022 3 Y 10 M 7 D (M)
Dr. KAPIL BHAGWATRAO SACHANE



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
04/10/22 11:00 AM	Child B Mr Kapil Sir	
	<u>Δ: Influenza A illness</u> <u>Pneumonia / MODS</u>	<u>Plan:</u>
	<u>Issues:</u> Fever spikes (4) Encephalopathy (improving) Thrombocytopenia (typical) @ Trace Blood C/S.	① Send LFT, INR, PCT. Ferritin (new)
	Child on room air -	② Cont antibiotic.
	SpO ₂ : 98% PR: 112/min.	③ Paper
	RR: 30/min BP: 105/70.	④ Stop iv fluid.
	Chat: Left side crept @.	⑤ Encourage oral intake
	CNS: GCS 15/15.	
	Pupil: 2+ 2+.	
		N.B. Asthma 4/7/26 11:00 AM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
04/07/26 5:40pm	<u>SHIFTING NOTES:</u> <u>Δ: INFLUENZA A ± MODS</u> → Reported ± Encephalopathy fever spikes (T) loose stools. → clinical condition improved T - 98°F P - 116/m R - 29/m BP - 100/60 mmHg SpO₂ - 98% ± LRA	<u>PLAN</u> 1) Send CBC tomorrow morning @ 6:00am. 2) ct hapt maintenance infused. 3) Encourage oral intake 4) Inform PICU team if child has fever (↑WOB) drowsy. 5) (T) Blood Cx. 6) ct Antibiotics.
	<u>Wah</u> <u>Dr VAMATH</u> <u>04/07/26</u> <u>5:42pm</u>	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/25 8 AM	CRIB PICU fellow: DSB:- Influenza A virus with MODS On room - A/C hemodynamically stable. one low grade fever - 99.6 F accepting orally well. C/o cough ⊕. Chest - crepitations present. Inj vancomycin - D5 Inj meropenem - D5 Inj Doxycycline - D5 Sip Flixir - D4 CBP: hb - 9.2 wbc - 4340 platelet - 76000	plan. 1. w/f fever spikes. 2. monitor vitals. 3. encourage oral intake. 4. continue infusions 20ml/hr maintenance. 5. Trace CBP. Dr. Nathan



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/26 12:40 PM	C/S/B Dr Kapil	plan.
	Influenza A MODS	1. Inj hydrocortisone 2mg/kg/dose TID
	on room Air	2. CXR - now
	hemodynamically stable.	3. CBP, CRP Tomorrow with
	one low grade fever	check (amb chare @8) next prick
	99.6 f at 10pm.	4. SpO ₂ without O ₂
	No cough.	5. w/f fever spikes
	Chest - wheeze (+).	6. Monitor vitals.
	SpO ₂ without O ₂ - 97%.	
		Dr. Nathan
5/7/26 3pm	C/S/B Resident	Plan
	1. Influenza A Illness MODS	1) CBP } T/m 6am
	child on Room air	CRP } (or) with change change
	Hemodynamically stable	2) Continue Inj Vancomycin (DS)
	2 low grade fever spikes.	Inj Moxifloxacin (DS)
	@ 12pm & 1pm	Inj Doxycycline (DS)
	mild cough (+).	3) Neb - Budesonide, Levofloxacin
	Resp - BAE (+).	4) Inj Hydrocortisone
	PIA - soft	5) w/f fever spikes / monitor
	Cvs - S ₁ S ₂ heard.	SpO ₂
	Vitals - stable	Inform SOS
	SpO ₂ - 97-98%.	
	Room Air.	Dr. Jagah
		Dr. Nathan (P.T.O.)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
06/08/22 8:00am	S/B New-fellow Dr. Influenza A ± MODS one fever spike yesterday afternoon (? Thrombophlebitis)	PLAN
	On RA GCS 15/15 cough ⊕ but sed relatively.	1) w/f fever spike. 2) Day 6 Vancomycin ⑥ Meropepenem ⑥ Doxycycline
	On Augmentin: Decay 1 kept ⊕. 98+ ↓ RA	3) Cont Nebt Rudecal & Insulin.
	PA 154, CRP: 5.0	<u>Dr. Kapil</u>
06/08/22	S/B Dr. Kapil Dr. Influenza A ± MODS	Adv
	On room air Hemodynamically stable chest. B/L AED Equal NRB	① continue nebulization ② continue vancomycin, Meropepenem Day 8 of fever (today)
	Cut 15/15 1 fever spike yesterday abst abse	③ continue Hydralazine ④ (Bp, CRP, LFTs after 2 days 2HR Kusum



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 5 PM	<u>C/S/B Resident</u> Δ:- Influenza A Illness/MODS	
	child on Roomair Hemodynamically stable	<u>Plan</u> 1) D6 of Vancomycin/mesoprenem/ Doxycycline
	O/E Resp P/A } (N) CVS }	2) CBP, CRP, LFT, INR 3 after 2 day
	Vitals - stable Cough - Better	3) keep discharge summary ready 4) stop IV fluids 5) Continue nebulization 6) Oral levipil.
		<i>[Signature]</i>
7/7/26 8 AM	<u>C/S/B pre-fellow</u> Δ:- Influenza A Illness/MODS	
	on room Air hemodynamically stable no fever spikes	<u>plan</u> 1. w/f fever spikes 2. Monitor vitals.
	1 episode of nasal bleed mild at 8 pm yesterday	3. encourage oral intake 4. plan discharge today.
	Chest - clear.	
	Trig vancomycin - D7	5. keep summary ready.
	Trig meropenam - D7	
	Trig Doxycycline - D7	<i>[Signature]</i> Dr. Nathan

Date & Time	Progress Notes	Doctor's Order
7/7/26	C/S/B or Kapil.	
	ASB:- Influenza A virus MONS	
	on room A90	pau
	hemodynamically stable No fever spikes.	1. Fluivir for 10 days
	2 episode of mild nose bleed at 8 pm yesterday.	2. Review on Thrombus. 3. Continue Meropenem, Vancomycin, doxycycline for total 10 days.
	Inj vancomycin - D7	4. CBP, CRP, LFT/PT/INR after 2 days.
	Inj meropenem - D7	5. Discharge.
	Inj doxycycline - D7	6. Continue nebulizations.
		M or ratheris

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00660340 IP5-00175793
Master MOHAMMED ZAYAN UDDIN
24-08-2022 3 Y 10 M 7 D (M)
Dr. KAPIL BHAGWATRAO SACHANE



2

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CROSS CONSULTATION FORM

Doctor Name: Dr. Sushan Reddy Date: 2/7/20 Time: 1 PM

Diagnosis: A.I. sepsis

Hospital: Ref. Banjara Hills

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:

Indus examination

for
Signature:

Findings and Recommendations :

Thank for referral

(O/E)

Abnorm

Phys. exam

no slo: Pabikudra

MA
SOS

Consultant :

Name: Sushan Reddy Signature: for Date & Time: 2/7/20 1 PM

liberal in energy preferences

(vor/Neuend)

3/10

① LP - 44 Andu

১৫৭

cost of a
doctors or comprehensive
PCT

② 44

3 of length

② Prior to shop valuations after
ETC if background is good
and ele chgs are serious.

not from
glanced for
(population)

$$\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$$

② c/t fricodena mo iwas

$$\frac{2}{2}$$

⑥ Ophthalmology residents
to look for papilledema.

10

Speck, Kennedy

An undigested

Proven, possible

no change

② 2/1/2020

many others @

no autonomous function

1



Date	3/7/26	04/07/26	5/7/26	06/07/26
Time	6 PM	4 AM	9 AM	6:30 am.
Hb	9.4 ↑	8.9	9.2	10.3
PCV	30.5	29.5	31.0	34.1
RBC	4.15	3.98	4.11	4.62
WBC	41,520	3000 ↓	4340 ↑	3460 ↓
N/L	80.4/15.7	58/33	54/33	43/41.
Platelets	82,000 ↑	77,000 ↓	76,000 ↓	160,000 ↑
CRP		5.0		5.0
ESR	ANC	1740		
PCT	3.1	1.37 ↓		
RBS				
Na				
K				
Cl				
Ca/Mg				
Phosphate				
Urea				
Creatinine				
ALP		107		
SGPT	289	243 ↓		198 ↓
SGOT	220	155 ↓		87 ↓
T.Bill/Conj		0.2/0.1		0.2/0.1
Protein		5.1		6.7
Alb	2.7	2.8 ↑		3.9 ↑
Glob		2.3		2.8
Urea				
Creatinine				
Glucose				
Cholesterol				
Triglycerides				
LDL				
HDL				
Uric Acid				
Ammonia				
Bilirubin				
Alkaline Phosphatase				
Aspartate Aminotransferase				
Alanine Aminotransferase				
Lactate Dehydrogenase				
Prothrombin Time				
Partial Thromboplastin Time				
Fibrinogen				
D-Dimer				
Iron				
TIBC				
Transferrin Saturation				
Vitamin B12				
Folate				
Homocysteine				
Uric Acid				
Urea Nitrogen				
Creatinine				
Glucose				
Hemoglobin A1c				
Lipid Panel				
Cholesterol				
Triglycerides				
LDL				
HDL				
Uric Acid				
Ammonia				
Bilirubin				
Alkaline Phosphatase				
Aspartate Aminotransferase				
Alanine Aminotransferase				
Lactate Dehydrogenase				
Prothrombin Time				
Partial Thromboplastin Time				
Fibrinogen				
D-Dimer				
Iron				
TIBC				
Transferrin Saturation				
Vitamin B12				
Folate				
Homocysteine				
Uric Acid				
Urea Nitrogen				
Creatinine				
Glucose				
Hemoglobin A1c				
Lipid Panel				
Cholesterol				
Triglycerides				
LDL				
HDL				
Uric Acid				
Ammonia				
Bilirubin				
Alkaline Phosphatase				
Aspartate Aminotransferase				
Alanine Aminotransferase				
Lactate Dehydrogenase				
Prothrombin Time				
Partial Thromboplastin Time				
Fibrinogen				
D-Dimer				
Iron				
TIBC				
Transferrin Saturation				
Vitamin B12				
Folate				
Homocysteine				
Uric Acid				
Urea Nitrogen				
Creatinine				
Glucose				
Hemoglobin A1c				
Lipid Panel				
Cholesterol				
Triglycerides				
LDL				
HDL				
Uric Acid				
Ammonia				
Bilirubin				
Alkaline Phosphatase				
Aspartate Aminotransferase				
Alanine Aminotransferase				
Lactate Dehydrogenase				
Prothrombin Time				
Partial Thromboplastin Time				
Fibrinogen				
D-Dimer				
Iron</				

3AH-00660340
Waster MOHAMMED ZAYAN UDDIN
24-08-2022 3 Y 10 M 7 D
Dr. KAPIL BHAGWATRAO SACHANE (M)

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	1/7/26	1/7/26	2/7/26	2/7/26	3/7/26	03/7/26
Time	6am	8 PM	6am	6pm	6 AM	10:30 AM
Hb	10.3	10.4	10.3		9.1	
PCV	35.1	33.7	34.2		30.3	
RBC	4.6	4.5	4.52		5,800 4.01	
WBC	8460	12,050	13,130		5,800 ↓	
N/L	86/11	88.6/9.5	77.3/20.6		79/18	
Platelets	1.56 lakh	1.45 lakh	1.19 lakh ↓		72,000 ↓	
CRP						
ESR						
PCT	19.4					3.10 ↓
RBS						
Na	145		130	135	136	
K	3.7		3.4	3.4	3.4	
Cl	116		105	107	106	
Ca/Mg	8.6					
Phosphate	5.6					
Urea	24					
Creatinine	0.5					
ALP	170	156	172		120	120
SGPT	466	664 ↑	467 ↓			289 ↓
SGOT	945	1315 ↑	704 ↓			220 ↓
T.Bill/Conj	0.2/0.1	0.3/0.1	0.4/0.2			0.2/0.1
T.Protein	6.2	5.6 ↓	5.2			4.9
S.Albumin	3.5	3.1 ↓	2.8			2.7
S.Globulin	2.8	2.5	2.4			2.2
A/G Ratio		2.5	2.4			
Uric Acid	5.7					
S.Amylase	86					
Sr.Lipase						
Blood Lactate						
S.Cholesterol	114					
PT/INR	22/1.7	14/1.0	17/1.3 ↑		14/1.0	
APTT	66	30	62		43	
CSF Protein / Sugar						
Cells						
Wt	for hb.					

Date	01/07/26					
Time	-					
CUE - Alb	-					
CUE - Sugar	-					
CUE - Ketones	-					
CUE - PUS Cells	2-3					
CUE - RBC Cells	1-2					
CUE	Blood - Hemolyzed Trace					
	-					
Stool Pus Cell	30-35					
OVA/Cyst	RBC 8-10					
Occult Blood	Abundant					
Protease yeast	Negative					
Fe+	NH					

Culture and Sensitivities :

- Drug
- Sensitivity] Negative

Mycoplasma IgM - Non reactive

Stool for rota virus - negative

Sepsis panel PCR :- NEGATIVE

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI :

Others (ECG, Contrast Studies etc.) :

3AH-00660340 IP5-00175793
 Master MOHAMMED ZAYAN UDDIN
 24-08-2022 3 Y 10 M 7 D (M)
 Dr. KAPIL BHAGWATRAO SACHANE



Outside

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RESULT SHEET

Date	29/6/26				
Time					
Hb	10				
PCV	32.7				
RBC	4.59				
WBC	12100				
N/L	68/27				
Platelets	5.52/lakh				
CRP	3.44				
ESR	18				
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine	0.57				
ALP					
SGPT	31				
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					



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: PIW.

Shifted to: ICU floor

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	INJ MEROPENEM	520mg	IV	TID.		☐ C ☐ DC
2	INJ VANCOMYCIN	250mg	IV	TID.		☐ C ☐ DC
3	INJ DOXYCYCLINE	30mg	IV	BD		☐ C ☐ DC
4	SUP FLUVIA (2ml=12mg)	2.5ml	PO	BD		☐ C ☐ DC
5	TAB LANZOLOL (1 tab=15mg)	1 tab	PO	OD		☐ C ☐ DC
6	INJ LEVITIL	260mg	IV	BD		☐ C ☐ DC
7	SUP ZINIDONIA	5ml	PO	OD		☐ C ☐ DC
8	ECONDRM SACHET	1 Sachet	PO	BD		☐ C ☐ DC
9	NEB LEVOLIN + 3-TAB	0.1634 + 2ml 2-TAB	Neb	TID.		☐ C ☐ DC
10	NEB BODECAL	2 resp.	Neb	TID		☐ C ☐ DC

* C - Continue, DC - Discontinue

ICATION HISTORY RECORDED / VERIFIED BY

Name & Signature: W. A. S.

me: Dr. V. A. S.

e & Signature: 04/07/24

6:00pm

3AH-00660340 IP5-00175793
 Master MOHAMMED ZAYAN UDDIN
 24-08-2022 3 Y 10 M 7 D (M)
 Dr. KAPIL BHAGWATRAO SACHANE



Sheet No:

REGULAR PRESCRIPTIONS

Weight **13Kg**

Ward **PW**

DRUG : INTJ. ESOMEPRAZOLE				Date Time	12/2/2024
Dose	Route	Frequency	Start Dt.		
15mg	IV	OD	01/07		
Name & Signature of the Doctor Starting the Drugs: Bhaleth				6AM 8/2/24 Stop Dr. Bhaleth on 01/07/24	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : INTJ. LEVITIL				Date Time	12/2/2024
Dose	Route	Frequency	Start Dt.		
260mg	IV	12hrly	01/07		
Name & Signature of the Doctor Starting the Drugs: Bhaleth				6AM 8/2/24 Stop Dr. Bhaleth on 01/07/24	
Additional Instructions:				6AM 8/2/24 Stop Dr. Bhaleth on 01/07/24	
Daily Doctor's Endorsement by a Sign					
DRUG : INTJ. VALPROATE				Date Time	12/2/24
Dose	Route	Frequency	Start Dt.		
260 mg	IV	12hrly	01/07		
Name & Signature of the Doctor Starting the Drugs: Bhaleth				10AM 8/2/24 Stop Dr. Bhaleth on 01/07/24	
Additional Instructions:				10AM 8/2/24 Stop Dr. Bhaleth on 01/07/24	
Daily Doctor's Endorsement by a Sign					
DRUG : SYP. ZINCINIA				Date Time	12/2/24
Dose	Route	Frequency	Start Dt.		
5ml	PO	OD	01/07		
Name & Signature of the Doctor Starting the Drugs: Bhaleth				6AM 8/2/24 Stop Dr. Bhaleth on 01/07/24	
Additional Instructions:				6AM 8/2/24 Stop Dr. Bhaleth on 01/07/24	
Daily Doctor's Endorsement by a Sign					

Ward *240*

DRUG : <u>Inj VITAMIN K</u>				Date: <u>11/8/24</u>	
				Time: <u>3:17 PM</u>	
Dose <u>4 mg</u>	Route <u>IV</u>	Frequency <u>OD</u>	Start Dt. <u>1/1/26</u>		
Name & Signature of the Doctor <u>Jayashri</u>				<u>12 AM</u>	
				<u>12 PM</u>	
Additional Instructions:				<u>12 PM</u>	
				<u>12 PM</u>	
Daily Doctor's Endorsement by a Sign				<u>12 PM</u>	
				<u>12 PM</u>	



Sheet No:

REGULAR PRESCRIPTIONS

Weight ... 13kg Ward puw

DRUG: SYP FLOVIR.				Date Time	2/7	03/7	4/7	5/7	6/7	7/7
Dose	Route	Frequency	Start Dt.							
2.5ml	PO	BD	2/7							
Name & Signature of the Doctor Starting the Drugs: <i>Sachane</i>				6am X <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i>						
Additional Instructions: <i>60mg/5ml.</i>				6pm <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i>						
Daily Doctor's Endorsement by a Sign				<i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i>						
DRUG: NEB BUDESAL.				Date Time	2/7	03/7	4/7	5/7	6/7	7/7
Dose	Route	Frequency	Start Dt.							
1 nebulizer	NEB	TID	2/7							
Name & Signature of the Doctor Starting the Drugs: <i>Sachane</i>				6am X <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i>						
Additional Instructions:				2pm <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i>						
Daily Doctor's Endorsement by a Sign				<i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i>						
DRUG: LEVULIN + 3% NACL				Date Time	3/7	4/7	5/7	6/7	7/7	
Dose	Route	Frequency	Start Dt.							
6	NEB	TID	03/7							
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Sachane</i>				6am X <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i>						
Additional Instructions: <i>Levulin - Ampule - 0.63</i> <i>3% NACL + 2ml.</i>				2pm <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i>						
Daily Doctor's Endorsement by a Sign				<i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i>						
DRUG: SYP POTCHLOR				Date Time						
Dose	Route	Frequency	Start Dt.							
5ml	PO	TID	3/7							
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Sachane</i>										
Additional Instructions: <i>2 mg/kg / day</i>										
Daily Doctor's Endorsement by a Sign										



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : <u>INJ HYDROCORTISONE</u>				Date Time	<u>5/7 6/7/22</u>															
Dose	Route	Frequency	Start Dt.																	
<u>26mg</u>	<u>IV</u>	<u>TID</u>	<u>5/7</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nareen</u>				<u>6 AM 5/7/22</u> <u>INPACOM</u> <u>5/7/22</u>																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Syrup LEVIPIL</u>				Date Time	<u>6/7/22</u>															
Dose	Route	Frequency	Start Dt.																	
<u>2-Sml</u>	<u>PO</u>	<u>BD</u>	<u>6/7</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Jagah</u>				<u>6 AM 6/7/22</u> <u>INPACOM</u> <u>6/7/22</u>																
Additional Instructions: <u>(1ml/100mg)</u>				<u>6 PM 6/7/22</u>																
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																				
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																				

DRUG CHART

Date of Admission: 01/07/26 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 : 2y- PARACETAMOL				Date Time
Dose 200mg	Route IV	Frequency SOS	Start Date 3/7/26	03/07/26 5/7 POX POX 3:30pm 8:pm 3:10pm Rainier
Doctor's Signature Dr. prathin		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:				

Weight. 13 Kg Ward. 940

Page: 2/4

3AH-00660340

IP5-00175793

Vlaster MOHAMMED ZAYAN UDDIN

24-08-2022 3 Y 10 M 7 D (M)

Dr. KAPIL BHAGWATRAO SACHANE



Weight. 13kg Ward. p.wd

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.			

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

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
1/2/26	7:50 AM	NS bolus	130 ml	IV over 30 mins	pratik	Raj
1/2/26	9 pm	Di Mannitol	40ml	IV	to	monali
3/2/26	7 AM	INTJ PARACETAMOL	130 ml	IV	W	Raj
3/2/26	8:00 AM	INTJ 10% Dextrose	65ml	IV	pratik	Sakshi
6/2/26	3:30 pm	INTJ PARACETAMOL	130 ml	IV	W	Nishu
						Shruti

3AH-00660340 IP5-00175793
 Master MOHAMMED ZAYAN UDDIN (M)
 24-08-2022 3 Y 10 M 7 D
 Dr. KAPIL BHAGWATRAO SACHANE

I.V. FLUIDS CHART

Weight. 18kg Ward. PW

Indication of I.V. Fluid (n ml/hr = Mcg/kg/min. etc)		Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
1/7/26	5Am	IVE DNS 50% Maintenance	IV	20ml/hr	Shalekh	1/7/26		
1/7/26	5Am	3% NS	IV	10ml/hr	Shalekh	1/7/26		
1/7/26	7am	DNS + 10 ml Kcl	IV	30 ml/hr	pratyaksh	1/7/26		
1/7/26	7:30Am	3% NS	IV	5ml/hr	Shalekh	1/7/26		
1/7/26	7:30 am	DNS + 10 ml Kcl	IV	40 ml/hr	pratyaksh			
1/7/26	8am	1/2 DNS + 35 ml NaHCO ₃ + 5 ml Kcl	IV	55 ml/hr	pratyaksh	1/7/26		
1/7/26	7pm	3% NS	IV	10	pratyaksh	2/7	Jayashree	
1/7	7pm	1/2 DNS + 35ml SODIUM BICARBONATE	IV	15	pratyaksh	2/7	J	
2/7	6am	1/2 DNS + 35ml Sodium Bicarbonate	IV					
2/7	6am	DNS	IV	15	Jayashree	3/7	Jayashree	

Signature

VERIFIED BY : Name

[illegible]



I.V. FLUID CHART

[illegible]

3AH-00660340
Waster MOHAMMED ZAYAN UDDIN
24-08-2022 3 Y 10 M 7 D (M)
Dr. KAPIL BHAGWATRAO SACHANE

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NG INITIAL ASSESSMENT FOR PICU

Date of Admission: 11/12/2025 @ 5:00am

Source of Admission: ☐ OPD ☐ Ward ☒ Other: ER

Reason for Admission: pull activity

Admission Diagnosis: seizures

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

	Past Medical History	Past Surgical History	Last Hospital Admission
SIGNIFICANT HISTORY	No past medical history	No past surgical history	No last Hospital Admission
	Family History:		
	Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☒ No		
	If yes please list, Was the child's birth normal? ☒ Yes ☐ No If No, please describe problems: Are the child's immunization up to date? ☒ Yes ☐ No		
CURRENT MEDICATIONS	Taking Medications? ☐ Yes ☒ No If yes, Fill the reconciliation form Medicine brought to the hospital? ☐ Yes ☒ No		
Observations: Weight: 13kg Length: Head Circumference (< 2 years): Temp: 98.6 F HR: 96 bpm RR: 23 BP: 98/64 Pain Score: 0/10 Specify Site: N/A (Follow Pain Assessment Sheet & Document) Fall Risk Assessment: ☒ Yes ☐ No Score: 12 (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):

Social History: Lives With

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

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: mother

Orientation not given Reason:

Nurse Name: Rajhaldar

Nurse Signature: [Signature]

Date & Time: 11/12/26 @ 5:20am

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: Seizure activity

Nurse Name: Rajhaldar

Nurse Signature: [Signature]

Date & Time: 11/12/26 @ 8:21am

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Patient's / Learner Language: Telugu 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		
01/2	5 am	9	Infection Control Measure	M	1	0	1	1	M	Am
1/2/26	8 am	9	Child is on NPO	M	1	0	1	1	-	Mamika

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: <table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>									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	
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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: <table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>									1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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MULTI-DISCIPLINARY PLAN OF CARE FORM

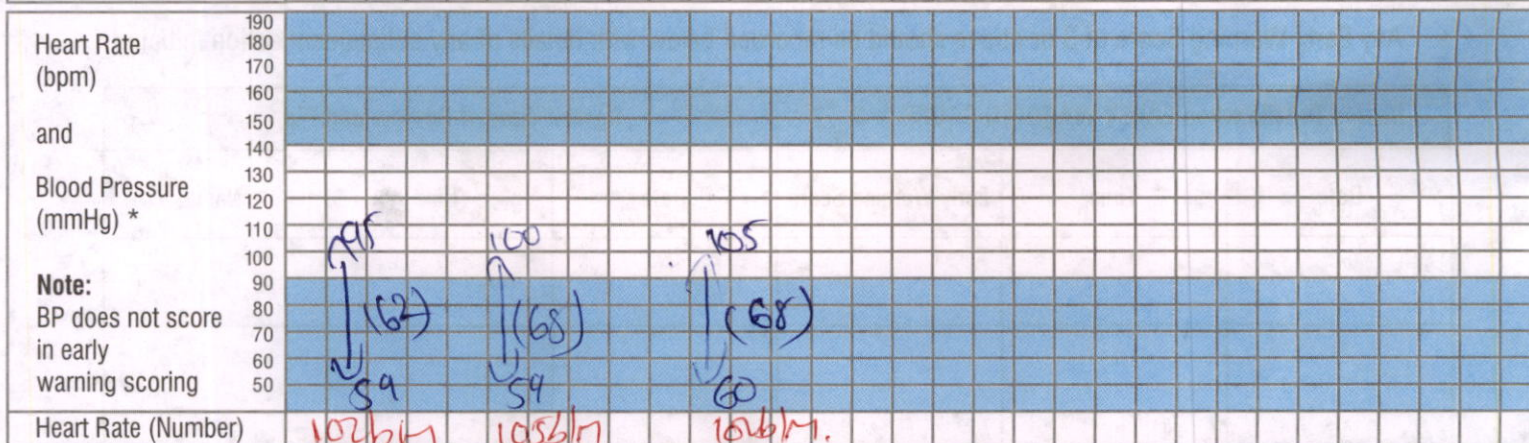
Diagnosis: Seizures

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
01/8	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	- Seizures	- H dynamic Stimulus	- RT hand	<i>[Signature]</i>	☒ Nursing ☐ Others:
01/8	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	- Seizures	- iv placemr	- iv placemr Om	<i>[Signature]</i>	☐ Medical ☒ Others:
11/7/26 8am	☐ Medical ☐ Nursing ☒ Others: Dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	AFC	Child is on NPO	Encourage orally soft diet	<i>Mounica</i>	☐ 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:

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 10PM 2AM 6AM

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	1
Pain Score	0
Observer's Initials	0

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

* NB: 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)



PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 6/8	Time: 12pm	1:40 Am	6am	10Am	12pm	1pm	5PM
Doctor / Nurse / Family Concern?							
Temperature (F)	100.8	98.8	98.8	99.4	99.1	98.6	98.8
Heart Rate (bpm)	100	100	100	100	100	100	100
Blood Pressure (mmHg) *	100/60	119/60	105/62	112/63	113/61		
Heart Rate (Number)	101bpm	98F	105bpm	112bpm	113bpm		
Resp. Rate (bpm) (Over 1 Minute) *	28bpm	23bpm	21bpm	22bpm	23bpm		
Resp Mod/ Severe Distress None / Mild							
Receiving O ₂ (l/min) O ₂ Saturations (%)	98%	92%	98%	92%	100%		
Conscious Level Normal / Altered							
GCS *	15/15	15/15	15/15	14/15	15/15		
TOTAL SCORE	1	1	1	1	1		
Number of shaded boxes	1	1	1	1	1		
Pain Score	1	1	1	1	1		
Observer's Initials	J	J	J	J	J		

ACTIONS

NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 27/08/2022	Time: 10pm	11pm	11:30pm			
Doctor / Nurse / Family Concern?	10pm	3:30pm	4:30pm	6pm		
Temperature (F)	99.4 F	100.1 F	98.8 F	99.2 F	99.3 F	99.4 F
Heart Rate (bpm)	126 bpm	104 bpm	108 bpm			
Blood Pressure (mmHg) *	100/61	93/75	113/81			
Resp. Rate (bpm)	28 bpm	28 bpm	26 bpm			
Receiving O ₂ (l/min)	0	100%	100%			
O ₂ Saturations (%)	99%	100%	100%			
GCS *	15/15	15/15	15/15			
TOTAL SCORE	1	1	1			
Number of shaded boxes	0	0	0			
Pain Score	0	0	0			
Observer's Initials						

ACTIONS

NB: Scores 3 should be recorded overleaf

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 4/7/22	Time: 5:12 AM
Doctor / Nurse / Family Concern?	10pm 2am 6am 10am 11:50am 12:55pm
Temperature (°F)	
Heart Rate (bpm)	
Blood Pressure (mmHg) *	
Note: BP does not score in early warning scoring	
Heart Rate (Number)	120bpm 110bpm 115bpm 120bpm
Resp. Rate (bpm) (Over 1 Minute) *	
Resp Rate (Number)	28bpm 24bpm 28bpm 27bpm
Resp Mod/ Severe Distress None / Mild	
Receiving O ₂ (l/min) O ₂ Saturations (%)	100% 98% 100% 98%
Conscious Level Normal / Altered	
GCS *	15/15 15/15 15/15 15/15
TOTAL SCORE	
Number of shaded boxes	1 1 1 1
Pain Score	0 0 0 0
Observer's Initials	

ACTIONS

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BAH-00660340 IP5-00175793
Master MOHAMMED ZAYAN UDDIN
24-08-2022 3 Y 10 M 10 D (M)
Dr. KAPIL BHAGWATRAO SACHANE



FLUID CHART

Sheet No. : 11

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 Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm			10ml						0		
	09:00 pm	10% Dext + 10ml KCL	10ml							0		Searcher
	10:00 pm		10ml							0		
	11:00 pm									0		Searcher
	12:00 am									0		
	01:00 am											Searcher
Total Intake :						Total Output :						
	02:00 am		10ml							0		
	03:00 am	10% Dext + 10ml KCL	10ml							0		Searcher
	04:00 am		10ml							0		
	05:00 am		10ml							0		Searcher
	06:00 am									0		
	07:00 am											Searcher
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						
5/7	08:00 am	1	20ml						✓	0	Am
	09:00 am	10% D5 + 10ml	20ml			✓				0	
	10:00 am	10% D5 + 10ml	20ml	NA		✓			✓	0	
	11:00 am	10% D5 + 10ml	20ml		✓				✓	0	
	12:00 pm	10% D5 + 10ml							✓	0	
	01:00 pm	10% D5 + 10ml				✓				0	
Total Intake :					Total Output :						
5/7	02:00 pm	1	20ml			✓			✓	0	Pr
	03:00 pm	10% D5 + 10ml	20ml							0	
	04:00 pm	10% D5 + 10ml	20ml						✓	0	
	05:00 pm	10% D5 + 10ml	20ml							0	
	06:00 pm	10% D5 + 10ml							✓	0	
	07:00 pm	10% D5 + 10ml								0	
Total Intake :					Total Output :						
5/7	08:00 pm	1	20ml							0	Pr
	09:00 pm	10% D5 + 10ml	20ml							0	
	10:00 pm	10% D5 + 10ml	20ml						✓	0	
	11:00 pm	10% D5 + 10ml	20ml		NP					0	
	12:00 am	10% D5 + 10ml							✓	0	
	01:00 am	10% D5 + 10ml								0	
Total Intake :					Total Output :						
6/7	02:00 am	1	20ml							0	Pr
	03:00 am	10% D5 + 10ml	20ml							0	
	04:00 am	10% D5 + 10ml	20ml		NP					0	
	05:00 am	10% D5 + 10ml								0	
	06:00 am	10% D5 + 10ml								0	
	07:00 am	10% D5 + 10ml								0	
Total Intake :					Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

BAH-00660340
Master MOHAMMED ZAYAN UDDIN
24-08-2022
Dr. KAPIL BHAGWATRAO SACHANE (M)
IP5-00175793
3 Y 10 M 11 D

FLUID CHART



Sheet No. :

- All measurements in ml.
- Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
- 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							
6/8/26	08:00 am			2000		/					0	
	09:00 am			2000		/	✓		✓	0	Surhar	
	10:00 am	10% PPS F		2000		/				0		
	11:00 am					/				0		
	12:00 pm	1000 ml				/	✓		✓	0	Surhar	
	01:00 pm											
Total Intake :					Total Output :							
6/8	02:00 pm			✓		/				0		
	03:00 pm			✓		/	✓		✓	0	Surhar	
	04:00 pm	1000 ml		✓		/				0		
	05:00 pm					/	✓		✓	0	Surhar	
	06:00 pm					/				0		
	07:00 pm					/	✓		✓	0		
Total Intake :					Total Output :							
6/8	08:00 pm			✓		/				0		
	09:00 pm			✓		/			✓	0	Surhar	
	10:00 pm	No WR		✓		/				0		
	11:00 pm			✓		/				0		
	12:00 am	✓		✓		/			✓	0	Surhar	
	01:00 am			✓		/				0		
Total Intake :					Total Output :							
8/8	02:00 am			✓		/				0		
	03:00 am			✓		/				0		
	04:00 am	No WR		✓		/			✓	0	Surhar	
	05:00 am	WR		✓		/				0		
	06:00 am	✓		✓		/			✓	0	Surhar	
	07:00 am			✓		/				0		
Total Intake :					Total Output :							
Total 24 hrs. Intake												
Total 24 hrs. Output												

BAH-00660340 IP5-00175793
Master MOHAMMED ZAYAN UDDIN
24-08-2022 3 Y 10 M 12 D (M)
Dr. KAPIL BHAGWATRAO SACHANE



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

FLUID CHART

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

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 4/7/26

Assessment: Assessed general condition of child

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
8AM	Assess general condition of child	9AM	Assessed general condition of child	All plans are implemented.
10AM	Send for LFT, PCT, INR, Ferritin	11AM	Send LFT, PCT, INR, Ferritin	
12PM	Encourage food orally	1PM	Encouraged food orally	
2PM	Giving nebulization	3PM	Given nebulization	
4PM	Continue fluid administration	5PM	Continued fluid administration	
6PM	Maintain I/O chart	7PM	Maintained I/O chart	

Re-Assessment: Re Assessment done

Special Notes: w/c fever spikes

Nurse Signature: Ashma

Nurse Name: Ashma

Date & Time: 4/7/26 2PM



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

BAH-00660340 IP5-00175793
 Master MOHAMMED ZAYAN UDDIN (M)
 24-08-2022 3 Y 10 M 7 D
 Dr. KAPIL BHAGWATRAO SACHANE

NURSING CARE RECORD

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Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 11/7/26

Assessment: Acute febrile encephalopathy & seizures

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
8am	Assess the general condition of the child	9am	Assessed the general condition of the child	All the plans are implemented.
10am	Maintain I/O chart	11am	Maintained I/O chart	
12pm	Monitor vital signs.	1pm	Monitored vital signs.	
2pm	Plan to send samples.	3pm	Samples sendd cue, igm, dengue, Rotavirus stool &	
4pm	Plan to do EEG & usg abdomen	5pm	EEG done & usg abdomen done	
6pm	Plan to do MRI	7pm	MRI done.	

Re-Assessment: Re-assessment done.

Special Notes:

Nurse Signature: Anu

Nurse Name: Ansu

Date & Time: 01/07/26 4pm.

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 21/7/26

Assessment: Assess the general condition.

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
8am	Assess the general condition of the child.	9am	Assessed the general condition of the child.	All the plans are implemented.
10am	Maintain I/O chart	11am	Maintained I/O chart	
12pm	Monitor vital signs.	1pm	Monitored vital signs.	
2pm	Plan to do C-Xray	3pm	C-Xray done.	
4pm	Plan to send Sepsis PCR, IgM myco	5pm	Sepsis PCR, IgM mycoplasma done	
6pm	Administer medication as per the chart	7pm	Administered medication as per the chart	

Re-Assessment: Re-assessment done

Special Notes:

Nurse Signature: Ansu

Nurse Name: Ansu

Date & Time: 21/7/26 3pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 02/07/26

Assessment: Baby Having Respiratory Distress

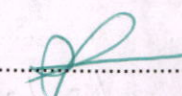
Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the General Condition of the baby.	8.10pm	→ Assessed the General condition of the baby.	→ vital are stable
10pm	→ provide comfortable position.	10.30pm	→ provided comfortable position.	
12am	→ Monitor vital signs hourly.	12.10am	→ Monitored the vital signs.	
4am	→ Administer the medication As per Doctor orders.	4.10am	→ Administered the medication As per Doctor orders.	
6am		6.10am		
7am		7.10am		

Re-Assessment: Baby Having full activity.

Special Notes:

Nurse Signature: 

Nurse Name: Nilish Ray

Date & Time: 03/07 @ 8AM

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 1/7/26

Assessment: assessed the baby 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
8pm	Assess the baby condition	10pm	Assessed the baby condition	All plans are implemented
11pm	monitor the vital signs	12pm	monitor the vital signs	
2am	maintain the Flo chart		maintained Flo chart	
3am	antibiotics givened		antibiotics givened	
7am	continue IV fluids	6am	continue IV fluids	

Re-Assessment: done

Special Notes:

Nurse Signature: [Signature]

Nurse Name: pranaliya

Date & Time: 2/7/26 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 03/07/26

Assessment: Baby Having Pyrexia

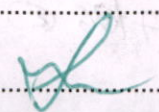
Goals

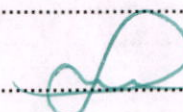
- | | | | | | |
|---|--|---|---|--|--|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☒ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☐ Maintain Personal Hygiene | ☐ Prevent Infection | ☐ Meet Elimination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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the general condition of the baby.	8:10pm	→ Assessed the general condition of the baby.	vital are stable.
10pm	→ provide comfortable position.	10:30pm	→ provided comfortable position.	
12am	→ EXR Done.	12:30am	→ EXR Done At 6am.	
4am	→ All Lab send As per Doctor order's.	4:10am	→ All Lab Done As per plan.	
6am	→ Administration of the Medication As per Doctor Order's.	6:10am	→ Administered the Medication As per Doctor Order's.	
7am		7:10am		

Re-Assessment: Baby Having full Activity

Special Notes:

Nurse Signature: 

Nurse Name: 

Date & Time: 04/07 @ 8Am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 31/7/26

Assessment: Assessed general condition of child.

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
8am	Assess general condition of child	9am	Assessed general condition of child.	All plans were Implemented.
10am	Send for PCT, LFT & TD do ABG.	11am.	Send for PCT LFT & ABG is done.	
11am	GRBS 6 th Hourly	12pm	GRBS 6 th Hourly.	
12pm	Plan. for ABG, CBP BID	1pm	ABG, CBP BD	
2pm	w/f fever spikes	3pm	w/f fever spikes	
4pm	Send for CBP	5pm	CBP is send for.	
6pm	Administer medications as per chart	7pm	Administered medications as per chart	

Re-Assessment: Re Assessment done

Special Notes:

Nurse Signature:

Nurse Name: Ashma

Date & Time: 31/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: Baby having cough

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the general condition of the baby	8:10 pm	Assessed the general condition of the baby	By done all procedure baby condition is improved.
10pm	provide comfortable position	10:55 pm	provided comfortable position	
12am	Monitor vitals signs	12am	Monitored vitals signs.	
2am	To give nebulization	5am	Levolin 0.63 + 3% NS	
6am	Maintain Ila chart	6:30 am	Maintained Ila chart	
8:30 am	Administer medication as per doctor order	8am	Administered medication as per doctor order.	

Re-Assessment:

Special Notes: Cough Levolin 0.63 + 3% NS Budecort Inespu.

Nurse Signature: [Signature] Nurse Name: Swarna Date & Time: 5/7/26 @ 8AM

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/7/26

Assessment: Baby Having cough

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
10am	→ Assess the Baby General Condition, monitor vital's record	10:30am	→ Assessed the Baby General Condition, monitored vital's & recorded	By Anthea's doc pt condition is improved
11am	→ continue 10% Dext + 10ml/kg (20ml/hr)	11:30am	→ continued 10% Dext + 10ml/kg (20ml/hr)	
12pm	→ Give nebulization's	12:30pm	→ Given nebulization's	
1pm	→ Administer medication as per doctor order plan to do CXR	2pm	→ Administered medication as per doctor order → CXR done	

Re-Assessment: CXR done

Special Notes: CBP, CRP, Tm

Nurse Signature: [Signature]

Nurse Name: Aparajita (081966)

Date & Time: 5/7/26 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/07/26

Assessment: Baby having cough

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
2pm	→ Assess the baby general condition & monitor the vital sign.	2:30 pm	→ Assess the baby general condition & monitored the vital sign	Baby condition is improved.
3pm	→ Maintain the I/O chart	3:30 pm	→ Maintained the I/O chart	
4pm	→ Administer the medication as per doctor order	4:30 pm	→ Administered the medication as per doctor order	
5pm	→ Give Nebulization	5:30 pm	→ Given nebulization.	
6pm	→ provide the comfortable position.	7:15 pm	→ provided the comfortable position.	

Re-Assessment:

spo2 without oxygen check & monitor vitals.

Special Notes:

LFT, CBP, CRP T/M

Nurse Signature: V. Rewina

Nurse Name: V. Rewina (607729)

Date & Time: 5/07/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: Baby having dull activity

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.....

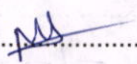
Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the general condition of the patient	9pm	Assessed the general condition of the patient	Baby condition is good
10pm	monitor the vitals signs	11pm	monitored the vitals signs	
12am	maintain I/O chart	2am	maintained I/O chart	
4am	maintain fluid Balance	5am	maintained fluid Balance	
6am	Administer medication as per as chart	7am	Administered medication as per as chart	

Re-Assessment:

Re-Assessment

Special Notes:

CBP, CRP, LFT, T/m

Nurse Signature: 

Nurse Name: Nisha

Date & Time: 5/7/26 @ 8am

BAH-00660340 IPS-00175793
 Master MOHAMMED ZAYAN UDDIN
 24-08-2022 3 Y 10 M 11 D (M)
 Dr. KAPIL BHAGWATRAO SACHANE

NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 6/7/26

Assessment: pt having dull activity

- 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
8 Am	Assess the general condition.	9 Am	Assess the general condition.	By done all implementation as per order
9 Am	monitor vital sign	10 Am	monitor vital sign	
	monitor IO chart		monitor IO chart	
10 Am	provide nebulization	11 Am	provided nebulization	
11 Am	provide comfortable position	12 pm	provided comfortable position	
12 pm	Administered medication	1 pm	Administered medication	

Re-Assessment:

Special Notes: wif fever spi' ky

Nurse Signature: 

Nurse Name: Swarna 07772

Date & Time: 6/7/26 @ 1 pm

BAH-00660340
Master MOHAMMED ZAYAN UDDIN
24-08-2022 3 Y 10 M 12 D (M)
Dr. KAPIL BHAGWATRAO SACHANE

NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 6/7/26

Assessment: Baby having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2PM	→ Assess the baby general Condition	2:10PM	→ Assessed the baby general Condition	baby Condition is improve
3PM	→ monitor the vital's	3:10PM	→ monitored the vital's	
4PM	→ maintain IV fluid's	4:10PM	→ maintained IV fluid's	
5PM	→ given nebulization	5:10PM	→ givened nebulization	
6PM	→ Administer medication as Per doctor order's	6:10PM	→ Administered medication as Per doctor order's	

Re-Assessment:

Special Notes: given nebulization

Nurse Signature: Sisil Nurse Name: Sisil Date & Time: 6/7/26 @ 8PM

BAH-00660340 IP5-00175793
Master MOHAMMED ZAYAN UDDIN
24-08-2022 3 Y 10 M 12 D (M)
Dr. KAPIL BHAGWATRAO SACHANE

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6/7/26

Assessment: Baby having all activity

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
8am	Assess the general condition of the patient	9am	Assessed the general condition of the patient	Baby Condition is good
10am	monitor the vitals signs	11am	monitored the vitals signs	
12pm	maintain I/O chart	2pm	maintained I/O chart	
4pm	Administer medication as per as chart	5pm	Administered medication as per as chart	
6pm	maintain personal hygiene	7pm	maintained Personal hygiene	
	Ensure the patient safety		Ensured the patient safe	

Re-Assessment: Re-Assessment

Special Notes:

Nurse Signature: S

Nurse Name: Savanika

Date & Time: 7/7/26 @ 8am

BAH-00680340 IP5-00175793
 Master MOHAMMED ZAYAN UDDIN
 24-08-2022 3 Y 10 M 12 D (M)
 Dr. KAPIL BHAGWATRAO SACHANE

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. K.B.S. Department: Pedia Date of Admission: 1/7

SITUATION		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:						
BACKGROUND	Diagnosis:	<u>Seizures Active</u>						
	Area	<u>5am</u>	<u>1st Floor 8am-8pm</u>	<u>1st Floor 8am-2pm</u>	<u>1st Floor 2pm-8pm</u>	<u>1st Floor 8pm-8am</u>	<u>1st Floor 8am-5pm</u>	
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
RECOMMENDATIONS	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.2</u>	<u>96.1</u>	<u>97.0</u>	<u>98.1</u>	<u>98.2</u>	<u>98.1</u>
		Res:	<u>114b/m</u>	<u>24b/m</u>	<u>26b/m</u>	<u>26b/m</u>	<u>23b</u>	<u>28</u>
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>	<u>99%</u>	<u>99</u>
		Pulse:	<u>124b/m</u>	<u>120</u>	<u>112b/m</u>	<u>102b/m</u>	<u>100b</u>	<u>101</u>
		BP:	<u>98/62</u>	<u>99/67</u>	<u>100/90</u>	<u>102/62</u>	<u>100/70</u>	<u>100/60</u>
		Fall Risk Score:	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>
	Pain Score:	<u>0</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	
Safety Needs:	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No		
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Ramya</u>	<u>Suvaral</u>	<u>Apurva</u>	<u>Ravina</u>	<u>Nikita</u>	<u>Sushma</u>	
Signature :		<u>Ramya</u>	<u>Suvaral</u>	<u>Apurva</u>	<u>Ravina</u>	<u>Nikita</u>	<u>Sushma</u>	
Date:		<u>01/7</u>	<u>5/7</u>	<u>5/7</u>	<u>5/7</u>	<u>6/7</u>	<u>6/7</u>	
Time:		<u>5am</u>	<u>8AM</u>	<u>2pm</u>	<u>2pm</u>	<u>8am</u>	<u>2pm</u>	
Taken Over By Name :		<u>Ramya</u>	<u>Apurva</u>	<u>Ravina</u>	<u>Nikita</u>	<u>Sushma</u>	<u>Sushma</u>	
Signature :		<u>Ramya</u>	<u>Apurva</u>	<u>Ravina</u>	<u>Nikita</u>	<u>Sushma</u>	<u>Sushma</u>	
Date:		<u>1/7/26</u>	<u>5/7</u>	<u>5/7/26</u>	<u>5/7</u>	<u>6/7</u>	<u>6/7</u>	
Time:		<u>5.10AM</u>	<u>2PM</u>	<u>2pm</u>	<u>3pm</u>	<u>8AM</u>	<u>2pm</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Area							
BACKGROUND	Shift Time	1st Shift 8am-5pm	1st Shift 5pm-8pm					
	Medical Condition (Any special condition to be noted):	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: 98.5°F	98.0					
	Res:	25b/m	22m					
	SpO ₂ :	99.1	99.0					
	Pulse:	102	102b					
	BP:	101/61	100/60					
	Fall Risk Score:	12	12					
Recommendations	Safety Needs:	yes	yes					
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	NA	NA					
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	NA	NA					
Post Operative Procedure Special Orders:		NA	NA					
Handed Over By Name :		Shrisha	Shravanthi					
Signature :		[Signature]	[Signature]					
Date:		6/7	7/7					
Time:		8PM	8am					
Taken Over By Name :		Shravanthi	Shrisha					
Signature :		[Signature]	[Signature]					
Date:		6/7	7/7					
Time:		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:							
Pain Score:								
Recommendations	Safety Needs:							
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:							
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:							
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature :								
Date:								
Time:								
Taken Over By Name :								
Signature :								
Date:								
Time:								

THE HUMPTY DUMPTY SCALE

5/7 6/7 8/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	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	2	2	2		
	Oriented to own Ability	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			12	12	12		

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	Yes	Yes		
Call device within reach		✓	Yes	Yes		
Wheels Locked		✓	Yes	Yes		
Room free of clutter		✓	Yes	Yes		
Adequate Lighting		✓	Yes	Yes		
Wheel Chair Support		X	No	No		
Other Intervention(s) Specify		X	No	No		
Nurse's Name :		Surek	Nelchi	msr		
Signature :		✓	✓	✓		
Date :		5/7	6/7	7/7		
Time :		6:00 AM	6:00 AM	6:00 AM		

AH-00660340
 Master MOHAMMED ZAYAN UDDIN
 24-08-2022 3 Y 10 M 7 D (M)
 Dr. KAPIL BHAGWATRAO SACHANE

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	3	3	3
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	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	1	1
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2	2	2	2	2	2
	Oriented to own Ability	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	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	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	1	1
TOTAL			12	12	12	12	12

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		Yes	✓	✓	✓	✓
Call device within reach		Yes	✓	✓	✓	✓
Wheels Locked		Yes	✓	✓	✓	✓
Room free of clutter		Yes	✓	✓	✓	✓
Adequate Lighting		Yes	✓	✓	✓	✓
Wheel Chair Support		No	✓	✓	✓	✓
Other Intervention(s) Specify		No	✓	✓	✓	✓
Nurse's Name :		Raj	prey	g	g	g
Signature :		Raj	g	g	g	g
Date :		01/8	1/2	2/2	03/7	04/7
Time :		5:00 AM	7:00 AM	6:00 AM	6:00 AM	6:00 AM

BAH-00680340 IP5-00175793
Master MOHAMMED ZAYAN UDDIN
24-08-2022 3 Y 10 M 11 D (M)
Dr. KAPIL BHAGWATRAO SACHANE

PAIN ASSESSMENT FORM

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
5/7	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	NA
6/7	2am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	NA
5/7	3pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	NA
6/7	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	NA
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

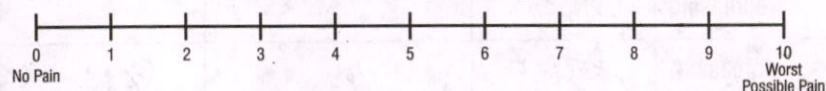
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

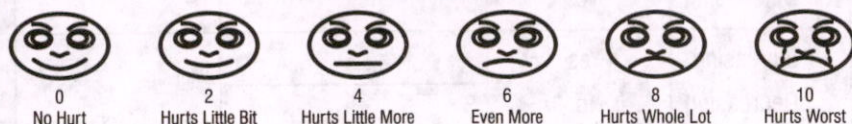
Numerical Pain Scale (Obstetric and Gynecology)



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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/7/26	10AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shuf.
3/7/26	4pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shuf.
03/07	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	R
04/07	12AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shuf.
04/07	6AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shuf.
4/7	10AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shuf.
4/7	4pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shuf.
5/7/26	12am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shuf.
5/7/26	8am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Appu
5/7/26	3pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Ry

Re-assessment Frequency:

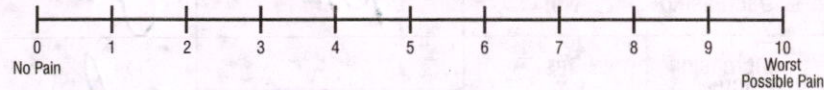
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

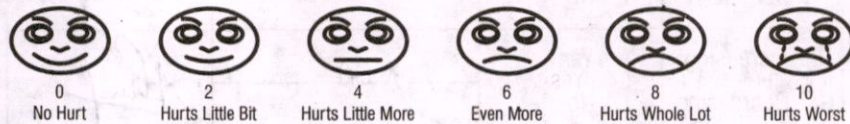
Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
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Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
01/07	3am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Pro
1/7/26	10am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	AM
1/7/26	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	AM
1/7/26	6pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
2/7/26	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
2/7/26	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
2/7	10am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	AM
2/7	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	AM
03/7	2AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	AM
03/07	6AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	AM

Re-assessment Frequency:

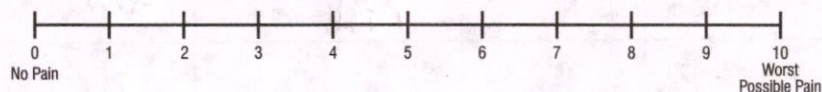
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 drawn 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

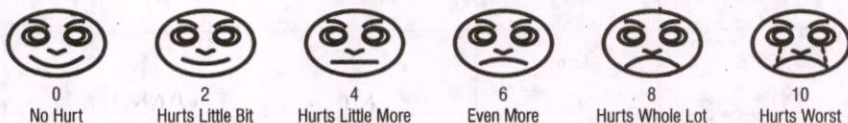
Numerical Pain Scale (Obstetric and Gynecology)



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 :	24/8/22	21/2	
					Time :	6am	8am	6pm
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.	4	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	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	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	
					TOTAL SCORE	28	28	28
					Evaluator's Name	[Signature]	[Signature]	[Signature]

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

AH-00660340

IP5-00175793

Waster MOHAMMED ZAYAN UDDIN
24-08-2022 3 Y 10 M 7 D (M)
Dr. KAPIL BHAGWATRAO SACHANE



BRADEN 'Q' SCALE

					Date :	01/8	02/8	03/8	04/8
					Time :	5:20	6:50	6:40	6:40
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 extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	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	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	4	
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FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	
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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	4	
TOTAL SCORE					28	28	28	28	
Evaluator's Name					Dr. K. Sachane	Dr. K. Sachane	Dr. K. Sachane	Dr. K. Sachane	

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

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)
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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							
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 cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	—	—	—							
Signature of the Nurse				Supriya	Deesaja								

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 : Pradeesh Name : Pradeesh

Signature of Ward In Charge :

Signature : Deesaja Name : Deesaja



CHECKLIST FOR THROMBOPHLEBITIS

4/7/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			5/7 DAY-2			5/7 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	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	-	1	-	-	-	-	-	-	Cannula Removed.	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-	-	-	-	-	↓ 5/7/26 Cannula @ 11:30 AM Change	
4	All of the following Signs are evident: Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-	-	-	-	-	-		
5	All of the following Signs are evident and Extensive: Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-	-	-	-	-	-		
6	All of the following Signs are evident and Extensive: Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-	-	-	-		
Signature of the Nurse				[Signature]			[Signature]			[Signature]			

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 : [Signature] Name : Sreedh

Signature of Ward In Charge :

Signature : [Signature] Name : [Signature]

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	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	-	-	-	-	-	-	1	-	-	Cannula Removed.
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				Raj	Anu	Raj	Anu	Anu	Anu	Anu	Anu	Anu	

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 : [Signature] Name : [Name]

Signature of Ward In Charge :

Signature : [Signature] Name : [Name]



BED SIDE CHECK LIST FOR NURSES

Date:	11/7	2/8	03/8	04/8					
Doctor's Orders	Followed	Followed	Followed	Followed					
Carried out or not	Carried	Carried	Carried	Carried					
Bed Side									
Structured Handover done	taken	done	done	done					
IV Site	yes	yes	yes	yes					
Central Lines	no	no	no	no					
Arterial Lines	no	no	yes	yes					
Feeding Catheter	no	no	no	no					
Urinary Catheter	no	no	no	no					
Skin Care	given	given	given	given					
Eye Care	given	given	given	given					
Mouth Care	given	given	given	given					
Sterillum Bottle, Stethoscope	bedside	bedside	bedside	bedside					
Suction Bottle (Should be clean & empty)	clean	clean	clean	clean					
Intubation Tray	ready	ready	ready	ready					
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	loaded	loaded	loaded	loaded					
Ventilator Tubing, (Any Water, Blood)	no	no	no	no					
Humidification	no	no	no	yes					
Check all Infusion (Labelling, Correct Preparation)	labeled	labeled	labeled	labeled					
Chest Physio & Neb	no	no	no	no					
Handed Over By Name :	Raj	prerna							

Checked & Handover given by

Name of the Nurse : Raj

Signature : Raj

Date & Time : 11/7/26

Checked & Handover taken by

Name of the Nurse : Ann

Signature : Ann

Date & Time : 11/7/26



moderate Sedation Flow-Sheet

Immediate Pre-Sedation Assessment

B.P	P.R	R.R	Temp	SPO ₂	Pain Score	Weight
92/54	103	23/min	99°F	100%	0	13 kgs.

Diagnosis: MRI Brain

Procedure: Anti seizure Encephalopathy.

Comorbidities: No. H/o seizure & marks.

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

ASA Physical Status

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

☐ E: Emergency procedure

GCS: E M V

☒ IV Site: Right Gauge: 22G

Sedation Plan: MAC - Monitored Anesthesia

Allergies: Not known

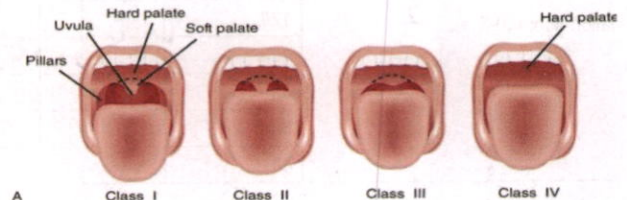
AIRWAY EVALUATION

Mouth:

- ☐ Normal
- ☒ Loose Teeth *→ carries upper Incisors.*
- ☐ Small Mouth
- ☐ Protruding Incisors
- ☐ Receding Lower Jaw
- ☐ Dentures

Neck:

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



Mallampati Class: ☒ I ☐ II ☐ III ☐ IV

Monitoring of Patient Intra – Procedure

Procedure Monitoring

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

Level of Consciousness (LOC):

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

TIME	BP	PR	RR	O ₂ Sat%	O ₂ Supplementation	Comments / Initials
Baseline	90/60mm	95	28	100%	-	-
2:40pm	"	100	26	100%	6L O ₂	-
2:50pm		101	24	100%	6L O ₂	-
3:10pm		103	24	99%	4L O ₂	-

Stamp

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

SAH-00660340 IP5-00175793
Name: Master MOHAMMED ZAYAN UDDIN
24-08-2022 3 Y 10 M 7 D (M)
Dr. KAPIL BHAGWATRAO SACHANE

Age: 1 Sex: Proposed Operation: MRI Brain

Date: 24-08-2022
Diagnosis: Acute febrile Encephalopathy

B.P / CRT: H.R: Weight: 13kg ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 10.3 Glucose: Protein: HIV: X-Ray:
PCV: Urea: Alb: HBS Ag: ECG:
WBC: 8460 Creat: 0.57 Total Bill: HCV: 2D Echo:
Plate: 1.56 Na: Dir. Bill: Blood group: Stress/Angio:
PT: 22 K: LDH: T3 Other:
PTT: Ca++: Alk phos: T4
INR: 1.7 Mg++: Amylase: TSH
Cl-: SGOT/SGPT:

Allergies: MLD

Medical History: CVS: 40 fever since 2 days. Problem / 3.5g / 12cs /
RESP: 40 seizure episodes Diabetes: 100 new
CNS: X 5-6 40 admission
Renal: 40 vomit 2 episode X 2-3 days
Hepatic / GE: 40 loose stools since 10 days Physical Activity: dull.

Past Anaesthetic History: Nil syncope

Physical Exam: afebrile, drowsy

Airway: MP 1 2 3 4 Mouth Opening: 73f Mentohyoid Distance: Neck: N Teeth: 20/20

Lungs: BACE

Heart: 92b

CNS: NAM

Pregnant: ☐ Yes ☐ No ☒ NA

Venous Access Site: P

Spine Exam for regional: e

Anaesthetic Plan: ☒ MAC ☐ REGIONAL ☐ GA-ETT ☐ LMA

RA Antine

Peri-Operative Plan Explained to the Patient: ☐ Yes ☐ No

CURRENT MEDICATIONS	DOSAGE
B. LEVOPILL	260mg IV.
IV. VALPROATE	260mg IV
Di. ALUCLOVA	200mg orally

Pre-Operative Instructions:

- DVT Prophylaxis: > 6hr
- NIL ORAL: Water / ORS 2 Hours
Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☐ Discussed with Patient
- Other Instructions:

Signature: Dr. Amreen Name: Dr. Amreen

BAH-00660340 IP5-00175793
Master MOHAMMED ZAYAN UDDIN
24-08-2022 3 Y 10 M 10 D (M)
Dr. KAPIL BHAGWATRAO SACHANE



ANAESTHESIA CHART

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Change in Patient Condition:

☐ Yes ☐ No

Fasting Status:

Physical Status:

☐ Patient Identified

☐ Consent Present

☐ Chart Reviewed

H.R:

B.P / CRT:

SpO₂:

R.R:

Last Feed:

Pre-OP Diagnosis:

Operation:

Date :

Surgeon:

Anaesthesiologist:

Technician:

TIME
N₂O /AIR /O₂ LPM
HALO /SO /SEVO
Drugs:

Antibiotic

Suppository

Blood Loss

FIO₂ / SaO₂
ETCO₂
ECG
Temperature
Urine Output

NOTES

Fluids
Blood

B.P
V Systolic
A Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

LAB Values

ABG

GRBS

Others

- ☐ Equipment Checked and Functional
- ☐ BP
- ☐ Cuff Site:
- ☐ Art Site:
- ☐ EKG Lead
- ☐ Temp Site
- ☐ FIO₂ Monitor
- ☐ Agent Monitor
- ☐ Pulse Oximeter
- ☐ Capnograph
- ☐ Ventilator
- ☐ Nerve Stimulator

Position:

- ☐ Pressure Points Checked

Eye Care:

- ☐ Oint
- ☐ Tape
- ☐ Padding
- ☐ Awake

Temp:

- ☐ HME
- ☐ Cling Film
- ☐ Hugger's
- ☐ Other
- ☐ Fluid Warmer
- ☐ OH Warmer
- ☐ Cotton Wool

Times:

Anaes Start:

OP Start:

OP End:

Leave OR:

Anaesthesia:

- ☐ GA
- ☐ Monitored Anaesthesia Care
- ☐ Regional

Line (Size & Location)

- ☐ CVP:
- ☐ ART:
- ☐ IV:
- ☐ IV:
- ☐ IV:

Induction

- ☐ IV
- ☐ Pre O₂
- ☐ Others
- ☐ Inhal
- ☐ RSI

- ☐ Mask
- ☐ Airway
- ☐ Oral
- ☐ Tracheostomy
- ☐ Drug:
- ☐ SGA
- ☐ Nasal
- ☐ Cuff
- ☐ Topical

- ☐ Awake
 - ☐ Video Laryngoscopy
 - ☐ Fiberoptic
 - ☐ Direct Vision
 - ☐ Stylette / Bougie
- Blade# Attempts:
Difficulty Why?

- ☐ Bilat = BS
- ☐ Semi-Closed Circle
- ☐ Closed Circle
- ☐ Other

Regional:

- Extremity
- Spinal
- Others:
- Specify:
- Epidural
- Caudal

Position:

Site:

Needle Size: Depth:

Parasthesia ☐ Yes ☐ No

Catheter at skin cm

Drug Name & Conc:

Bolus:

Infusion:

Block Level:

Comments:

Transportation to

☐ PACU ☐ ICU ☐ Other

Relaxant Reversed ☐ Yes ☐ No ☐ NA

Name of the Doctor :

Signature of the Doctor :

BAH-00660340 IP5-00175793
Master MOHAMMED ZAYAN UDDIN
24-08-2022 3 Y 10 M 8 D (M)
Dr. KAPIL BHAGWATRAO SACHANE

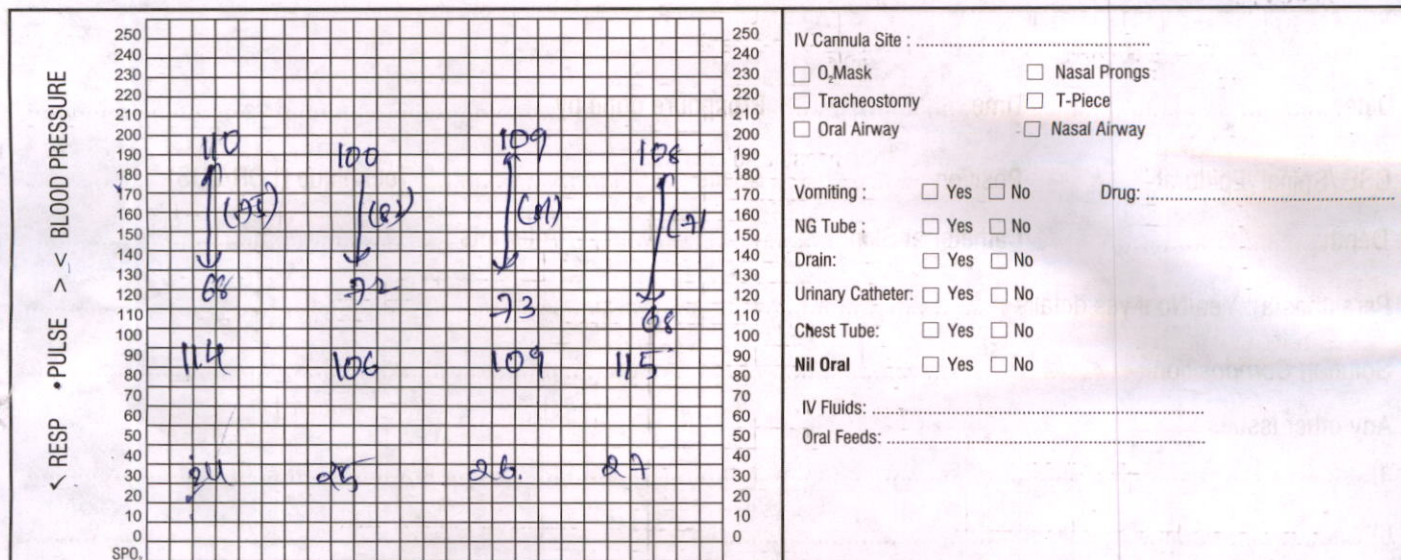


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PAIN UNIT RECORD

Received in PACU by : Time Received : Time Discharged :



IV Cannula Site :

- ☐ O₂ Mask ☐ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway

Vomiting : ☐ Yes ☐ No

Drug :

NG Tube : ☐ Yes ☐ No

Drain : ☐ Yes ☐ No

Urinary Catheter : ☐ Yes ☐ No

Chest Tube : ☐ Yes ☐ No

Nil Oral ☐ Yes ☐ No

IV Fluids :

Oral Feeds :

POST ANAESTHESIA SCORE (Modified Aldrete Score)		MINUTES			OUT	SCORING INTERPRETATION
		IN	30	60	90	
Able to move 4 extremities voluntary or on command	= 2					A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to move 2 extremities voluntary or on command	= 1					
Able to move 0 extremities voluntary or on command	= 0					
Able to deep breathe & cough freely	= 2					
Dyspnea or limited breathing	= 1					
Apneic	= 0					
BP $\pm$ 20 of Pre Anaesthetic level	= 2					
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1					
BP $\pm$ 50 of Pre Anaesthetic level	= 0					
Fully awake	= 2					
Arousable on calling	= 1					
Not responding	= 0					
Pink	= 2					
Pale, dusky, blotchy, jaundiced, other	= 1					
Cyanotic	= 0					
TOTAL						

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

Pain Tool Used: ☐ N PASS ☐ FLACC ☐ Wong Baker ☐ NPS

Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Anaesthesiologist Name :

Anaesthesiologist Signature:

Date & Time:

PACU Nurse Name :

PACU Nurse Signature:

Date & Time:

Transferred to Unit by (PACU):

Date & Time:

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Master MOHAMMED ZAYAN UDDIN
24-08-2022 3 Y 10 M 10 D (M)
Dr. KAPIL BHAGWATRAO SACHANE

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

CSE /Spinal /Epidural Position : Space : Technique (LOR/LOS)

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left Right		Maternal		FHR	Comments
					BP	Pulse		

Delivery Details : Time : APGAR: SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

Patient Name : Age : Gender : Male ☐ Female ☐
UHID NO:
Anaesthesiologist :
Operative procedure planned : MR2 Brain



PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk (s) : The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- | | | | |
|---|---------------------------------------|---|--|
| ☐ Heart disease | ☐ Hypertension | ☐ Diabetes mellitus | ☐ Renal failure |
| ☐ Hepatic disorders | ☐ Shock | ☐ Multiple organ failure | ☐ Polytrauma / Renal Tubular Acidosis |
| ☐ Incapacitating Chronic Obstructive Pulmonary Disease | | | |

☒ Others : Laryngospasm, Bradycardia, Desaturation.
Comments :

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient
..... the above mentioned operation / Diagnostic / Therapeutic procedures
MR2 Brain

I authorize and give consent for anaesthesia (☐ Regional / ☐ General Anesthesia / ☒ Monitored Anesthesia Care as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthetic team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant: ☐ Yes ☒ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / Monitored Anesthesia Care to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

Patient / Patient Attendant :

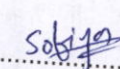
Signature : 

Name : MOHAMMED MOIZUDDIN

Relationship with Patient : Father

Date & Time : 11/7/26 2pm

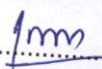
Witness :

Signature : 

Name : Sabiya Anam Khan

Date & Time : 11/7/26 2pm

Doctor (who is taking the consent) :

Signature : 

Name : Dr. Amreen

Date & Time : 11/7/26 2pm

CONSENT FOR ADMISSION IN PEDIATRIC INTENSIVE CARE UNIT

BAH-00660340 IP5-00175793
Master MOHAMMED ZAYAN UDDIN
24-08-2022 3 Y 10 M 8 D (M)
Dr. KAPIL BHAGWATRAO SACHANE



Name:

UHID.No : ...

Age:

Gender: Male ☒ Female ☐

Date:

I md. moizuddin 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 01/07/2026

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

Seizures

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: MOHAMMED MOIZUDDIN

Relationship with Patient: Father

Date & Time: 01/07/26 ; 5:50 AM

Doctor (who is taking the consent) :

Signature: [Signature]

Name: Bharath Reddy

Date & Time: 01/07/2026 ; 5:50 AM

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

Witness :

Signature: [Signature]

Name: [Signature]

Date & Time: 01/07/26 5:50pm

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

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రోగి పేరు వయస్సు లింగం ☐ పు ☐ స్త్రీ
యు.హెచ్.డి.

నేను s/o. d/o. w/o.
..... అనే బాలుడు / బాలిక యొక్క చికిత్స మేరకు రెయిన్ఫో 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 చిల్డ్రన్స్ హాస్పిటల్ లోని పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో చేరింది జడ్డకు ఆరోగ్య సంబంధిత సమస్యలు ఉన్నాయని వైద్యులు నాకు అర్థమయ్యే భాషలో వివరించారు. రోగి పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో ఉన్న సమయంలో అతను వివిధ వైద్య మరియు శస్త్ర చికిత్సలకు లోనవుతారని వైద్యులు నాకు స్పష్టంగా వివరించారు. ఎయిర్ వే మేనేజ్ మెంట్, మెకానికల్ వెంటిలేషన్, బొడ్డు ధమని కాథెటర్, బొడ్డు సిర మరియు ధమనుల కాథెటర్ వంటి. పెరిఫెరల్ ఇన్ఫర్మ్ చేయబడిన సెంట్రల్ కాథెటర్ లైన్ మరియు ఆర్థో లైన్ ప్లేస్ మెంట్స్, ఛాతీ డ్రైయిన్ లేదా పెరిటోనియల్ డ్రైయిన్ ఇన్సర్షన్ 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 జడ్డ ప్రాణాన్ని కాపాడేందుకు ఇతర వైద్య ప్రక్రియలకకు నేను సమ్మతి ఇస్తున్నాను.

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

ఒక జడ్డ అనారోగ్యంతో పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో ఉన్నప్పుడు అతని/ఆమెపై నిర్వహించబడు అనేక వైద్య మరియు శస్త్రచికిత్సా విధానాలతో ఈ అధిక ప్రమాదకరమైన విధానాల వల్ల సంభవించు నష్టాలు 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

సంతకము

పేరు

తేదీ మరియు సమయము

CONSENT FOR SPECIAL PROCEDURES

Patient Name

3AH-00660340 IP5-00175793

UHID No :

Waster MOHAMMED ZAYAN UDDIN
24-08-2022 3 Y 10 M 7 D (M)
Dr. KAPIL BHAGWATRAO SACHANE

Department :

Gender: ☐ Male ☐ Female

Date :

S / D / W / O

Here by give consent for procedure of :

Arterial line

For my patient, Named :

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

Bleeding, swelling

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

none

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

Name of the Doctor performing the procedure:

Dr. Chik

Consent Attendant :

Signature :

[Signature]

Name :

MD moizuddin

Relationship with Patient:

father

Date & Time :

1/7 10am

Witness :

Signature :

[Signature]

Name :

Date & Time :

1/7 10am

Doctor (who is taking the consent) :

Signature :

[Signature]

Name :

Dr. vikash

Date & Time :

1/7 10am

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

.....

.....

.....

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము



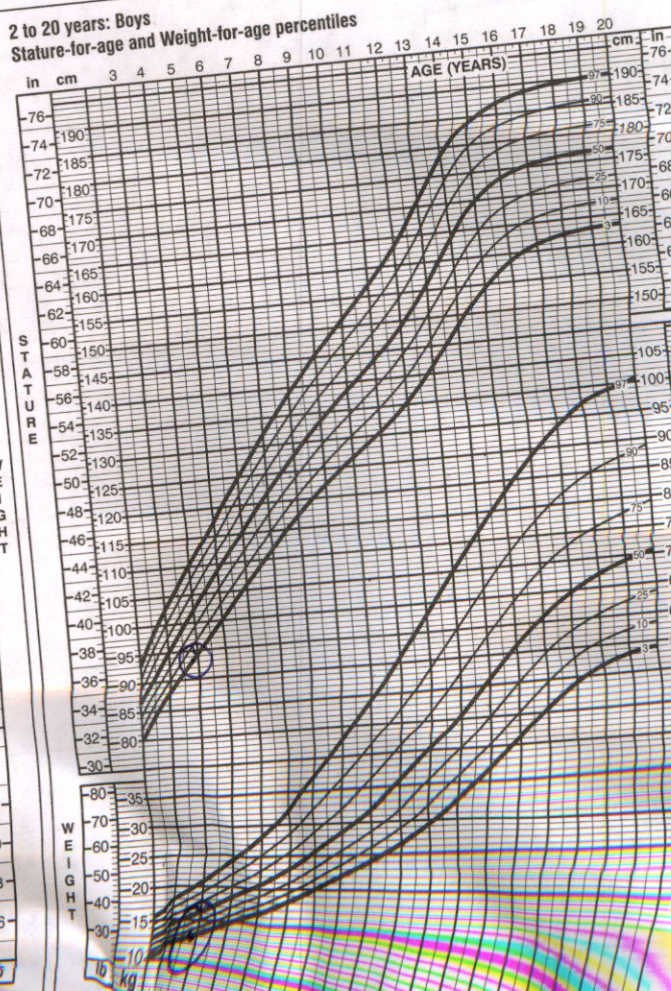
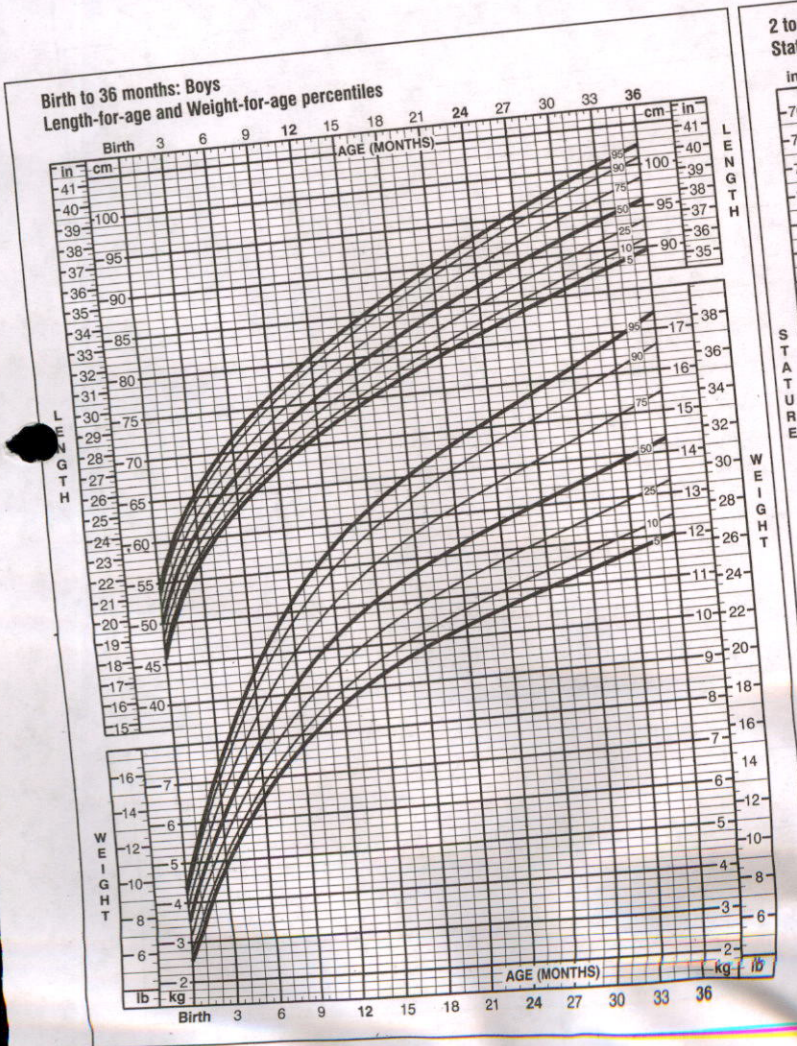
102

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 5/2/26 Time: 8 am

Weight: 13 kgs Centile: 5th
Height: 93 cms Centile: 5th
Inference: underweight child
RDA: - Calories: 1300 kcal/d Protein: 22 g/d
Diet Recommendations: Soft diet
Avoid spicy, chilled, outside foods
Re-Assessment: No Veg/Non-veg Non-veg
Food Allergies: No
Diagnosis: Influenza A illness & MODS
Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral
Patient's Signature: Sobiya

GROWTH CHART (BOYS)



Dietician's Name

Daily Notes:

6/2/76

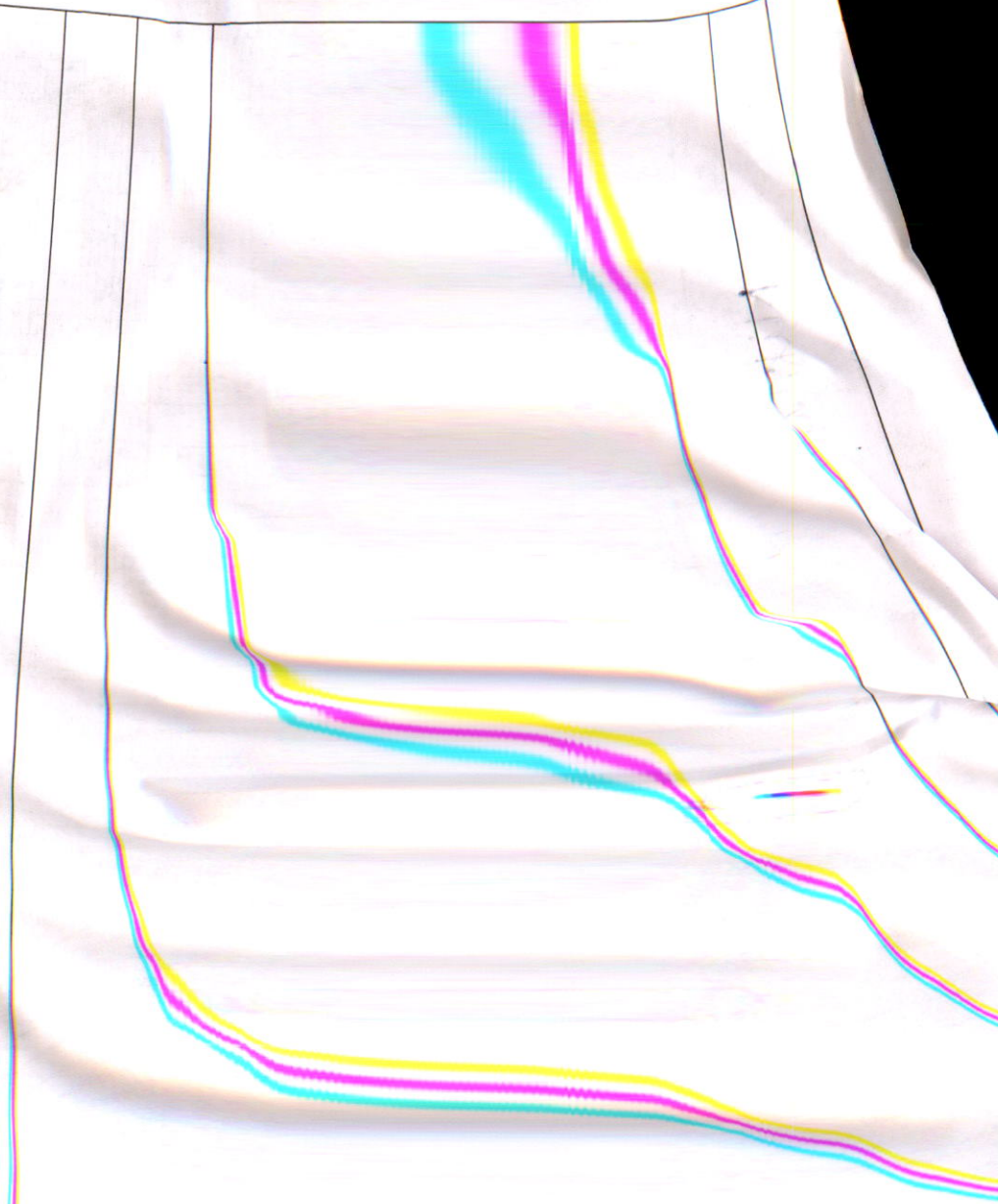
9:30am child is stable. oral intake is fair
continue $\bar{c}$ soft diet

— morning,

10:30am

10am child is stable. oral intake is optimal
continue $\bar{c}$ soft diet

— night





102

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 5/2/26 Time: 8 am

Weight: 13 kgs Centile: 5th

Height: 93 cms Centile: 5th

Inference: underweight child

RDA: - Calories: 1200 kcal/d Protein: 22 g/d

Diet Recommendations: soft diet

Re-Assessment: Avoid spicy, chilled, outside foods

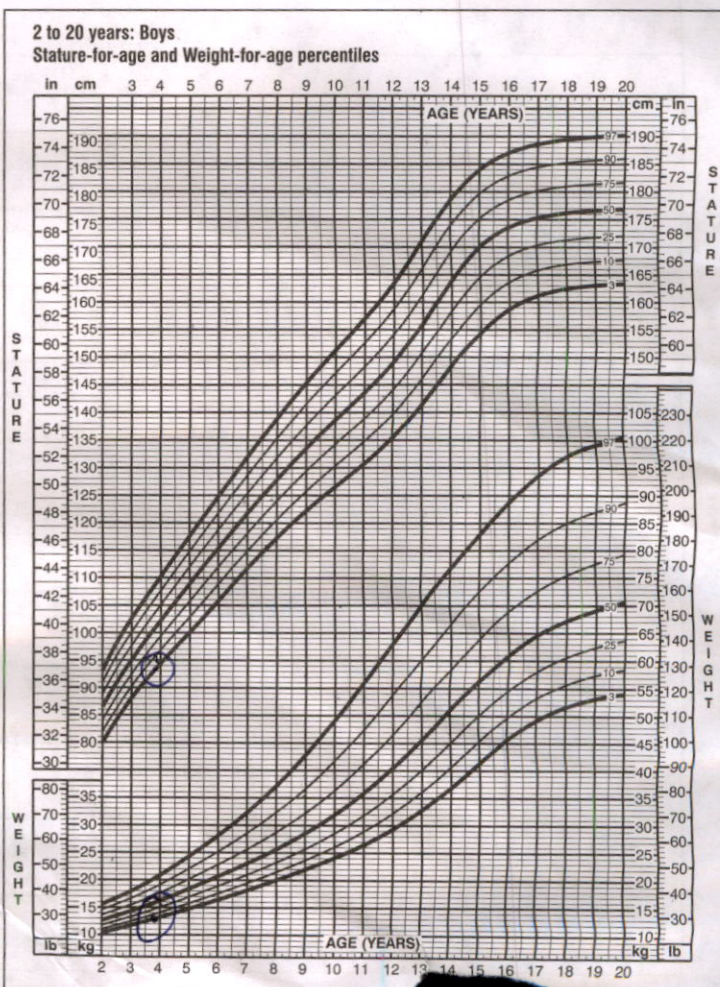
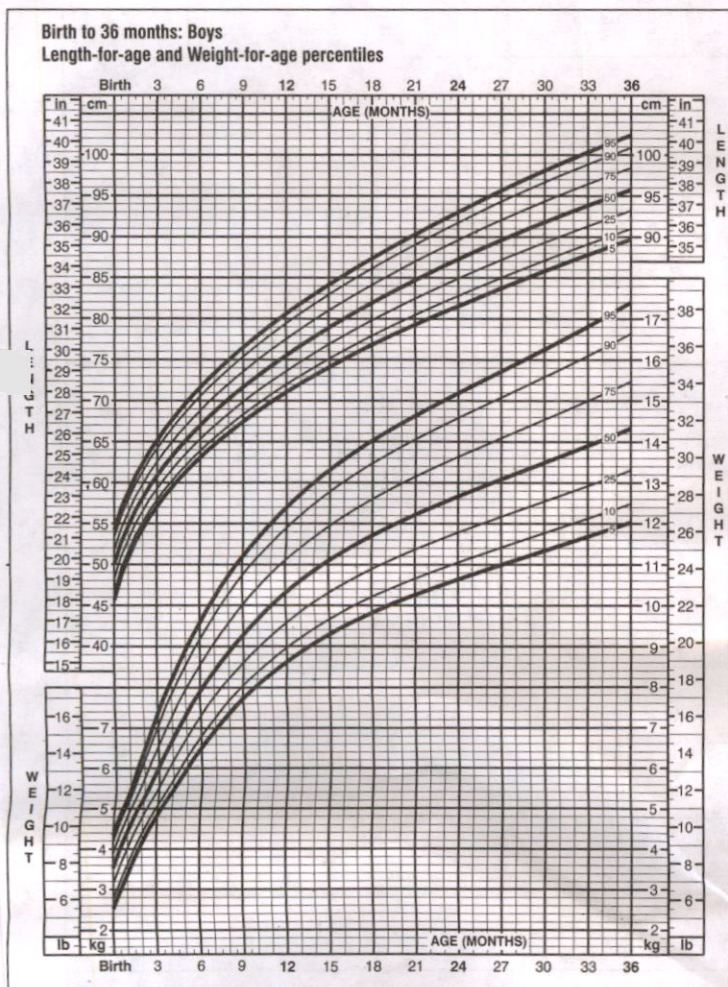
Food Allergies: No Veg/Non-veg: Non-veg

Diagnosis: Influenza A illness & MODS

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Sobiya

GROWTH CHART (BOYS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha (P.T.O.)

Daily Notes:

6/2/26
9:30am

child is stable. oral intake is fair

continue $\bar{c}$ soft diet

— mouning.

7/2/26
10am

child is stable. oral intake is optimal

continue $\bar{c}$ soft diet

— Nixithg



REQUEST FOR CREDIT FACILITY

To,
The Credit Billing,
Tenet Diagnostics,
Banjara Hills, Hyderabad.

Patient details:

BAH-00660340 IP5-00175793
Master MOHAMMED ZAYAN UDDIN
24-08-2022 3 Y 10 M 7 D (M)
Dr. KAPIL BHAGWATRAO SACHANE


Dear Sir/Madam,

We are sending the above mentioned patient for the diagnostic test MRI Brain Plan (505) cat scan
under sedation in your diagnostic center on credit basis. Request
you to kindly do the needful. The bill will be settled by Rainbow Hospital, billing department as per the agreement. For
any further queries, please contact the billing manager.

Order ID: 5-000968-523

Thanking you,
Department of Inpatient Billing

Billing Department
Rainbow Children's Hospitals Ltd
Banjara Hills, Hyd

Coordinator:

Signature: B. Srinivas

Name: B. Srinivas

Date & Time: 01/07/2026 @ 12 PM

Billing Executive:

Signature: [Signature]

Name: 1346 Sd.

Date & Time: 01/07/26

Mobile (Billing Manager): 9247505898

Manager on Duty (MOD):

Signature: [Signature]

Name: M. R. Desai

Date & Time: 01/07/2026 1 PM

Mobile: 9676838787

Docu. No: RCH/FRM/GENERAL/ 663



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