

ADMISSION SHEET


Registration Details :

Admission No : IP5-00175923 Admit Date : 03-Jul-2026 Admit Time : 01:12 PM UHID : BAH-00524868

Patient Details :

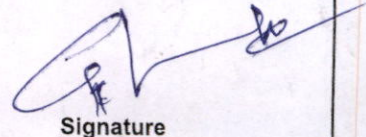
Patient Name	: Baby GADDE VIHKA BHARATHI	Age	: 3 Y 8 M 19 D
Guardian	: Mr HEMANSH GADDE	DOB	: 14-10-2022
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: PLOT NO 313, ROAD NO 10C Hyderabad Jubilee HO Hyderabad Telangana INDIA 500033	Phone No	: 9808609999/ 9494449999
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : DELUXE ROOM Bed No : DLX 314 Ward Name : 3F-ZONE A
 Room No : DLX 314 Admission Type : First Visit

Contact Details :

Name : Mr HEMANSH GADDE Relationship : Father
 Contact Address : PLOT NO 313, ROAD NO 10C Hyderabad
 Jubilee HO Hyderabad Telangana INDIA 500033 Phone No : 9808609999



Signature

Doctor Details :

Doctor Name : Dr. VIJAYANAND JAMALPURI Specialisation : GENERAL PEDIATRICS
 Referral Doctor : Self Phone No :
 Co-Consultant :

Payment Details :

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

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ **BAH-00524868** **IP5-00175923**
Baby GADDE VIHKA BHARATHI
14-10-2022 3 Y 8 M 19 D (F) Consultant: _____ Dept : _____
Dr. VIJAYANAND JAMALPURI

Date of Admission: _____ e of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/2/26	2:15pm	ER	ward	puor

Cross Consultation Visit

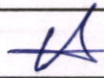
	Doctors Name	Date	Order No.	Signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
3/2/20	IV placement	①	5610	
3/2	nilg transfusion	①	9686131	

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Vihika

UHID ID:

BAH-00524868 IP5-00175923

Baby GADDE VIHKA BHARATHI

14-10-2022 3 Y 8 M 19 D (F)

Dr. VIJAYANAND JAMALPURI



Department:

Consultant:



Pediatric Multiorgan History & Physical Examination

Name : Vihika Age/Sex 3/F
Information given by: mother Relationship good

Chief Presenting Complaints & Duration (Chronologically)

cp fever x 10 days.

History of present illness :

- premorbidly well.

- cp fever x 10 days.

initially every 8h.

now 12hly. - 103°F.

not responding to IV antibiotics

Eye
ENT / exam (N)



Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

② perinatal transition

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : ②

Developmental History :

appropriate for age.

Immunization History :

immunised till date

Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): 105 cm (Centile _____)

Weight (kgs) : 14.35 kg (Centile _____)

On Examination :

Temperature : 98°F Pulse Rate : 112/min B.P. 102/68 SP02 100%

Resp. rate and type of breathing : 20/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BAE (+)

Any addles sounds : clear

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : (+)

Any murmur : none

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

Per Abdomen :

Inspection _____

Palpation : soft / NT / no HSM

Ausculation : _____

Spine : _____ External Genitalia : _____

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

BAH-00524868
Baby GADDE VIHIKA BHARATHI
14-10-2022 3 Y 8 M 18 D
Dr. VIJAYANAND JAMALPURI (F)

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score :

alert

Cranial Nerves :

Motor System:

Nutriton :

Tone:

Power

Co-ordinator :

Posture :

Involuntary Movements :

NFND

Reflexes :

DTR

Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

PWD

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: HCT

Desired goals of the treatment: resolution

Planned Labs:

CBP, ESR.
CRP.
LDH, LFT, Triglycerides
Widal / Leptospira IgM.
Brucella serology.
EBV quantitative PCR.
ANA t titres.
Septicemia panel.
TB quantiferon gold.

Planned Management

- 1) Fever management
- 2) Oral doxycycline
- 3) Tab Lanzol

all prob's
3/7/26
2:15 PM

Signature of the Doctor: Akhile

Name of the Doctor: Dr. Akhile

Date & Time: 3/7/26

Signature of the Consultant: Vijay S.

Name of the Consultant: Dr. VIJAYANAND JAMALPURI

Date & Time: Reg. No: 40526

DEFICIENCY CHECK LIST OF CASE SHEET

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

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

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

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/9/26 5pm	Seen by Dr. Vijayanand.	
		Plan AC today
		flu - on Tuesday
		continue Doxycycline 50
		Lanzol
		X

BAH-00524868 IP5-00175923
 Baby GADDE VIHKA BHARATHI
 14-10-2022 3 Y 8 M 19 D (F)
 Dr. VIJAYANAND JAMALPURI



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

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

RESULT SHEET

LDH - 296

Date	3/7/26					
Time	8 PM					
Hb	11.5					
PCV	34.5					
RBC	4.56					
WBC	9,840					
N/L	40.7/53.6					
Platelets	3.77					
CRP	7.0					
ESR	64					
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP	184					
SGPT	58					
SGOT	41					
T.Bill/Conj	0.2/0.1					
T.Protein	7.3					
S.Albumin	04.1					
S.Globulin	3.2					
A/G Ratio	3.2					
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol	19 274					
PT/INR						
APTT						
CSF Protein / Sugar						
Cells	LDH - 296					
N/L	Triglyceride - 274					

BAH-00524868 IP5-00175923
Baby GADDE VIHKA BHARATHI
14-10-2022 3 Y 8 M 19 D (F)
Dr. VIJAYANAND JAMALPURI



MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From: ER

Shifted to: Ward

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Akhile Dr. Akhile

Date & Time : 3/7/26 @ 2pm

Nurse Name & Signature : poorja

Date & Time : 3/7/26 @ 2pm



DRUG CHART

Date of Admission: 3/7 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: <u>Inj PARACETAMOL</u>				Date/Time
Dose	Route	Frequency	Start Date	
<u>200mg</u>	<u>IV</u>	<u>SOS</u>	<u>3/7</u>	
Doctor's Signature		Valid Period	Pharm.	
<u>Akhile</u>				
Additional Instructions: <u>T > 100°F</u>				

DRUG: <u>SYP CROCIN DS</u>				Date/Time
Dose	Route	Frequency	Start Date	
<u>5ml</u>	<u>PO</u>	<u>SOS</u>	<u>3/7</u>	
Doctor's Signature		Valid Period	Pharm.	
<u>Akhile</u>				
Additional Instructions: <u>T > 100°F</u>				

DRUG: <u>SYP MEFTAL P</u>				Date/Time
Dose	Route	Frequency	Start Date	
<u>7ml</u>	<u>PO</u>	<u>SOS</u>	<u>3/7</u>	
Doctor's Signature		Valid Period	Pharm.	
<u>Akhile</u>				
Additional Instructions: <u>T > 102°F</u>				

Weight. 14.6 kg Ward.

@ 2.2 mg/kg/dose

Page: 2/4

Weight: 14.6 Kg Ward:

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
3/7	4 PM	Ierp AVIL	0.5ml	IV	[Signature]	[Signature]
3/7		Ierp HYDROCO	10g (100ml)	IV	[Signature]	[Signature]
	4:18 PM	IVIG	0.5ml/h	x 15 min		[Signature]
			1 ml/h x	15 min		[Signature]
			5 ml/h x	15 min		[Signature]
			10 ml/h	to continue		[Signature]

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time: 10 AM	2 PM	6 PM	8 PM	11 PM	12 AM	4 AM
Doctor / Nurse / Family Concern?							
Temperature (F)	104						
	103						
	102						
	101						
	100						
	99						
	98						
	97						
	96						
	95						
94							
Heart Rate (bpm)	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
and Blood Pressure (mmHg) *	90						
	80						
	70						
	60						
	50						
	40						
	30						
	20						
	10						
Note: BP does not score in early warning scoring							
Heart Rate (Number)							
Resp. Rate (bpm) (Over 1 Minute) *	70						
	60						
	50						
	40						
	30						
	20						
	10						
Resp Rate (Number)							
Resp	Mod/ Severe						
Distress	None / Mild						
Receiving O ₂ (l/min)							
O ₂ Saturations (%)							
Conscious	Normal						
Level	Altered						
GCS *							
TOTAL SCORE							
Number of shaded boxes							
Pain Score							
Observer's Initials							
ACTIONS	Score 1	: Continue normal observation by staff nurse					
	Score 2	: Shift in charge nurse to be informed and continue hourly observations					
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5/7/26

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	5:30 AM	8 AM	10 AM	2 PM	5 PM	
Doctor / Nurse / Family Concern?							
Temperature (°F)	104						
	103						
	102						
	101						
	100						
	99						
	98						
	97						
	96						
	94						
Heart Rate (bpm)	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
and Blood Pressure (mmHg) *	90						
	80						
	70						
	60						
	50						
	40						
	30						
	20						
	10						
	0						
Note: BP does not score in early warning scoring							
Heart Rate (Number)							
Resp. Rate (bpm) (Over 1 Minute) *	70						
	60						
	50						
	40						
	30						
	20						
	10						
	0						
	Resp Rate (Number)						
	Resp Distress Mod/ Severe None / Mild						
Receiving O ₂ (l/min) O ₂ Saturations (%)							
Conscious Level Normal Altered							
GCS *							
TOTAL SCORE							
Number of shaded boxes							
Pain Score							
Observer's Initials							

ACTIONS

NB: Scores 3 should be recorded overleaf

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date :		Time:												
Doctor / Nurse / Family Concern?														
Temperature (°F)	104													
	103													
	102													
	101													
	100													
	99													
	98													
	97													
	96													
	95													
Heart Rate (bpm)	190													
	180													
	170													
	160													
	150													
	140													
	130													
	120													
	110													
	100													
and Blood Pressure (mmHg) *	90													
	80													
	70													
	60													
	50													
	Note: BP does not score in early warning scoring													
	Heart Rate (Number)													
	Resp. Rate (bpm) (Over 1 Minute) *	70												
		60												
		50												
40														
30														
20														
10														
Resp Rate (Number)														
Resp Distress		Mod/ Severe												
		None / Mild												
Receiving O ₂ (l/min)														
O ₂ Saturations (%)														
Conscious Level	Normal													
	Altered													
GCS *														
TOTAL SCORE														
Number of shaded boxes														
Pain Score														
Observer's Initials														
ACTIONS NB: Scores 3 should be recorded overleaf		Score 1 : Continue normal observation by staff nurse												
		Score 2 : Shift in charge nurse to be informed and continue hourly observations												
		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)

BAH-00524868 IP5-00175923
 Baby GADDE VIHKA BHARATHI
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FLUID CHART

Sheet No. : 1

3/7/26

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										0	mouth
	07:00 pm										0	mouth
Total Intake :						Total Output : 0 - m						
	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										0	Pooja
	03:00 am										0	Pooja
	04:00 am										0	Pooja
	05:00 am										0	Pooja
	06:00 am										0	Pooja
	07:00 am										0	Pooja
Total Intake :						Total Output : 0 - m						
Total 24 hrs. Intake												
Total 24 hrs. Output			0 - m									



FLUID CHART

Sheet No. : ②

4/7/20

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

		Intake			Output						IV Site	Sign.
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	Nurse
			Mouth	I.V	N.G							
	08:00 am										0	Always
	09:00 am	Any								✓	0	Always
	10:00 am										0	Always
	11:00 am	Any									0	Always
	12:00 pm									✓	0	Always
	01:00 pm	Any									0	Always
Total Intake :						Total Output : M - 0 U - 2						
	02:00 pm										0	Always
	03:00 pm	Any									0	Always
	04:00 pm										0	Always
	05:00 pm	Any									0	Always
	06:00 pm										0	Always
	07:00 pm	Any								✓	0	Always
Total Intake :						Total Output : M - 0 U - 2						
	08:00 pm										0	Always
	09:00 pm	H2O								✓	0	Always
	10:00 pm										0	Always
	11:00 pm										0	Always
	12:00 am	H2O								✓	0	Always
	01:00 am										0	Always
Total Intake :						Total Output : U - 2 M - 1						
	02:00 am										0	Always
	03:00 am	H2O								✓	0	Always
	04:00 am										0	Always
	05:00 am										0	Always
	06:00 am	H2O									0	Always
	07:00 am										0	Always
Total Intake :						Total Output : U - 1 M - 0						
Total 24 hrs. Intake												
Total 24 hrs. Output		U - 7 M - 2										



FLUID CHART

Sheet No. : (3)

5/7/26

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							
	08:00 am	↓	H ₂ O							0	Ward	
	09:00 am	↓	H ₂ O							0	Ward	
	10:00 am	POB	H ₂ O							0	Ward	
	11:00 am	POB	H ₂ O							0	Ward	
	12:00 pm	↑	H ₂ O							0	Ward	
	01:00 pm	↑	H ₂ O							0	Ward	
Total Intake :					Total Output : U: m:							
	02:00 pm	↓	H ₂ O							0	Ward	
	03:00 pm	↓	H ₂ O							0	Ward	
	04:00 pm	POB	H ₂ O							0	Ward	
	05:00 pm	POB	H ₂ O							0	Ward	
	06:00 pm	↑	H ₂ O							0	Ward	
	07:00 pm	↑	H ₂ O							0	Ward	
Total Intake :					Total Output : U: m:							
	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							

Patient Sticker

FLUID CHART

Sheet No. :

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

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

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 Baby GADDE VIHKA BHARATHI
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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/20

Assessment: Patient is Active

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
1:30AM	Assess the patient condition	1:35AM	Assessed the patient condition	
2:AM	Plan for monitor vitals	2:30AM	monitor vitals	new tg
5AM	Plan for maintain ilo chart	5:30AM	maintained ilo chart & recorded.	pt is stable
7AM	Plan for provide comfortable position	6:30AM	Provided comfortable position	
8AM	Ensure Safety	7:50AM	Ensured Safety	

Re-Assessment: Re-assessment done

Special Notes: NA

Nurse Signature: Pooja

Nurse Name: pooja (013504)

Date & Time: 4/7/20 @ 8AM

BAH-00524868 IPS-00175923
 Baby GADDE VIHKA BHARATHI
 14-10-2022 3 Y 8 M 20 D (F)
 Dr. VIJAYANAND JAMALPURI

NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 24/11/20

Assessment: patient 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
8am	=> Assess The patient's General Condition.	9am	=> Assessed the patient General condition	patient now stable
10am	=> plan for monitor patient vitals.	12pm	=> TO monitoring patient vitals	
2pm	=> plan for monitor patient I/O chart	4pm	=> monitoring patient I/O chart.	
5pm	=> plan for personal hygiene	6pm	=> hand hygiene done	
7pm	=> plan for baby safety.	7:30pm	=> Nurse said vail.	

Re-Assessment: reassessed next day

Special Notes:

Nurse Signature: Alexys

Nurse Name: Alexys / 606820

Date & Time: 24/11/20 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Assessment:

Patient is having Discomfort

Date: 5/7/26

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 patient.	8:30pm	Assessed the general condition of the patient.	Now is the patient stable
10pm	Administer the medication as per Drug Chart.	10:30pm	Administered the medication as per Drug Chart.	
12Am	Maintain the I/O chart.	12:30Am	Maintaining the I/O chart.	
5Am	Maintain comfortable position.	5Am	Comfortable position given.	
7Am	Ensure the safety.	7:30Am	Provided side rails up.	

Re-Assessment:

Re-Assessment Done 4th only

Special Notes:

Temp Monitoring
Rime

Nurse Signature:

Nurse Name: Rime

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

Patient Sticker

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 5/7/26

Assessment: pt 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
8 pm	⇒ Assess the pt condition	8:30 pm	⇒ Assessed the pt condition	
10:30 pm	⇒ plan for vitals	10:30 pm	⇒ vitals checked & record	
12: pm	⇒ Administer medication as per doctor orders	12:30 pm	⇒ Administered medication as per doctor orders	⇒ now pt
⇒ 3 pm	⇒ maintain b/o chart	3:30 pm	⇒ maintained b/o chart	
6: pm	⇒ plan for vitals	6:30 pm	⇒ vitals checked & record	
8: pm	⇒ Ensure pt safety	8:10 pm	⇒ provided side rails	

Re-Assessment: re-assess due

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Licens

Date & Time: 5/7/26

Patient Sticker

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:

Patient Sticker

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:

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. V. J Department: ward Date of Admission: 3/7/26

SITUATION						
Diagnosis:		<u>puo</u>				
Any Infection: ☐ Yes ☐ No ☒ Not Known						
If Yes Specify:						
BACKGROUND	Area	CR 2:15 pm	3rd floor 7:30am-8a	3rd floor 8am-10:30am	3rd floor 8pm-8am	3rd floor 8pm-10am
	Shift Time					
Medical Condition (Any special condition to be noted):		<u>NO</u>	<u>puo</u>	<u>NA</u>	<u>NA</u>	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:					
	Temp:	<u>96.8°F</u>	<u>98.2°F</u>	<u>98.5°F</u>	<u>97.1°F</u>	<u>97.1°F</u>
	Res:	<u>28bpm</u>	<u>26bpm</u>	<u>28bpm</u>	<u>26bpm</u>	<u>28bpm</u>
	SpO ₂ :	<u>100%</u>	<u>99%</u>	<u>99%</u>	<u>98%</u>	<u>99%</u>
	Pulse:	<u>109bpm</u>	<u>102bpm</u>	<u>99bpm</u>	<u>112bpm</u>	<u>110bpm</u>
	BP:	<u>99/63</u>	<u>102/61</u>	<u>—</u>	<u>—</u>	<u>—</u>
Fall Risk Score:	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	
Recommendations	Safety Needs:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Handed Over By Name :		<u>Pooja</u>	<u>Pooja</u>	<u>Alekhya</u>	<u>Rinu</u>	<u>Lecitha</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>3/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>5/7/26</u>	<u>5/7/26</u>
Time:		<u>2:25pm</u>	<u>8am</u>	<u>8am</u>	<u>8am</u>	<u>8pm</u>
Taken Over By Name :		<u>mounika</u>	<u>Alekhya</u>	<u>Rinu</u>	<u>Lecitha</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>3/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>5/7/26</u>	
Time:		<u>2:30pm</u>	<u>8am</u>	<u>8am</u>	<u>8am</u>	

Patient Sticker

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area							
	Shift Time							
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
		Fall Risk Score:						
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

3/2 4/2 5/7

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					
	Female	1	1	1	1		
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.)	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1		
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1		
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2		
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1		
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1		
TOTAL			10	10	10		

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes	yes		
Call device within reach	yes	yes	yes		
Wheels Locked	yes	yes	yes		
Room free of clutter	yes	yes	yes		
Adequate Lighting	yes	yes	yes		
Wheel Chair Support	no	NA	NA		
Other Intervention(s) Specify	no	NA	NA		
Nurse's Name :	poor	poor	Rim		
Signature :	R	R	Rim		
Date :	3/2	4/2	5/7		
Time :	2pm	6am	6am		

BRADEN 'Q' SCALE

					Date :	3/10/26	4/2	5/10/26
					Time :	2 pm	6 am	8 am
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity 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	
FRICION-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 of 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 mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23								
Docu. No. : RCHBH /FRM / CLINICAL / 119								
TOTAL SCORE					28	29	28	
Evaluator's Name					Prof. Pooja Pooja			

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

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/2/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	poor's
3/2/26	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	S
4/2/26	2Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Boop
4/2/26	10Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Always
4/2/26	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Always
5/7/26	12Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Rino
5/7/26	6Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Rino
5/7/26	1pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Cicuta
5/7/26	5pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Cicuta
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

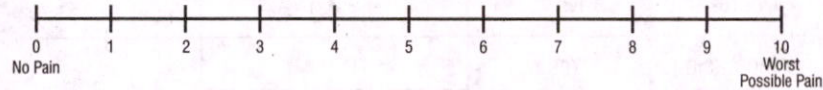
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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
				☐ 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		
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				☐ 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:

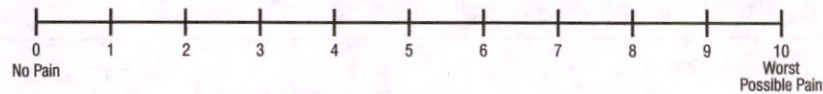
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Wong - Baker (Pediatrics) Above 7 Years





CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0	0	0	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													

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 : Lijasha

Signature of Ward In Charge :

Signature : ANITHA Name : ANITHA



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: Bangla Th 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		
3/10/26	2pm	7	infection control measures	F	4	0	1	1	na	paresh
4/7/26	9:50 am	9	soft diet	F, M	1	0	1	1	-	Saima

Part - III: CODES

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

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: pno

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
3/2/26 2pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	pno	hemodynamic stabilizing	202u	Dr Ach	☒ Nursing ☐ Others:
3/2/26 2pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	fever	lt- stability	IV2u	poofa	☒ Medical ☐ Others:
4/7/26 9:50 am	☐ Medical ☐ Nursing ☒ Others: dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	pvo	soft diet	RDA E : 1300kcal/D P : 22gm/D	saima	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

BAH-00524868 IP5-00175923
Baby GADDE VIHKA BHARATHI
14-10-2022 3 Y 8 M 19 D (F)
Dr. VIJAYANAND JAMALPURI

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

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

DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: As per doctors order

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

☐ Medication	☒ Yes	☐ No
☐ Bathing	☐ Yes	☒ No
☐ Eating	☐ Yes	☒ No
☐ Walking	☐ Yes	☒ No
☐ Dressing	☐ Yes	☒ No
☐ Toileting	☐ Yes	☒ No

no need Assistance

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: About patient Condition

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: Pooja

Nurse Name: Pooja

Date and Time: 4/21/26 @ 2AM



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 2:30pm Mode of Arrival: wheel chair Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Body Weight: 14.6 Kg
..... NA Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>NA</u>	<u>NA</u>	<u>NA</u>

Family History: D-O

Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☒ No

If yes please list,

Was the child's birth normal? ☒ Yes ☐ No If No, please describe problems:

Are the child's immunization up to date? ☒ Yes ☐ No

Current Medication: ☐ None ☐ Yes, If Yes, fill reconciliation form

Observations: Weight: 14.6 kg Length: Head Circumference (< 2 years):

Temp.: 97.8 HR: 102b/m RR: 25b/m BP: 102/61(72)

Pain Score: 0/10 Specify Site: (Follow Pain Assessment Sheet & Document)

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

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

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

Character of Pain Location Frequency Duration

FUNCTIONAL SCREENING: ☒ No Abnormalities Detected

- ☐ Mobility Problem ☐ Walking Problem
- ☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

If Yes Consultant Notified: (Date/Time):

Social History: Lives With

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

All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☒ Yes ☐ No

Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump : ☒ Yes ☐ No

Hand hygiene Explained: ☒ Yes ☐ No

☐ Others

Patient Rights & Responsibilities: ☒ Yes ☐ No

Information given to mother

Nurse's Name: Pooja Date: 4/2/20 Time: 2Am

Pooja
Signature



EMERGENCY ROOM TRIAGE FORM

Patient's Name: Bvrihika Bharathi Age: 3yrs Gender: ☐ Male ☒ Female
Date: 03/07/2022 Time of Arrival: 1:30pm Triage Completion Time: 1:32pm
Allergies: ☐ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): NA ☐ Not known any drug Allergies
Source of Information: ☒ Parents ☐ Others (Specify): NA
Mode of Arrival: ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance ☒ Normal ☐ Sick Looking	Work of Breathing ☒ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea	☒ Stable ☐ Unstable : ☐ Not - Life - Threatening ☐ Life -Threatening
Circulation / Colour ☒ Normal ☐ Abnormal ☐ Bleeding		

Initial Vital Signs: Temp: 96.3°F PR: 145b/m BP: RR: 24b/m SpO₂: 99%

Chief Complaints: clo fever x 10 days

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☒ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☐ 60 min
☐ Level 5 : NON - URGENT : May receive care when convenient	☐ 120 min

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Renuka

Signature of Triage Nurse : [Signature]

Date & Time : 03/07/2022 & 1:32pm

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 3/7/26 Time of arrival : 1:33 pm

Chief Complaints : clo fever x 10 days RBS : NA

Height : NA Weight : 14.6 kg BMI : NA Head Circumference (<2 years) : NA

Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: NA

If yes, identify : NA

Pain Screening: ☒ Yes ☐ No If Yes, Pain Score : 9/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker

☐ Character : NA ☐ Location : NA ☐ Frequency : NA ☐ Duration : NA

RISK FOR FALL:

☒ If patient is < 6 years
tick below fall risk intervention directly

☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☐ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☐ No
- Uses furniture for support ☐ Yes ☐ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☐ No
- Weak ☐ Yes ☐ No
- Impaired ☐ Yes ☐ No

Mental Status: Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- ☒ Escort while ambulating
- ☒ Assist Patient
- ☒ Educate patient and family on fall precautions/prevention

Functional Screening: ☒ No Abnormalities Detected

- ☐ Mobility Problem
- ☐ Walking Problem
- ☐ Developmental Delay
- ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

- ☐ Underweight
- ☐ Overweight
- ☐ Feeding Problem
- ☐ Special diet
- ☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

If Yes Consultant Notified: NA (Date/Time): NA

Social History: Lives With : parents

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

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

Time of Initial assessment completed by ER Nurse : 12:35 pm

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

Time	Nursing Notes
1:33pm	Assess the child condition's
	- monitored vitals & recorded
	- seen Dr. Akhila
	- shifted to ward

Samples collected by: /nr. venkat

Samples sent by :

Time: / 1:45pm

Time:

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 109 bpm BP: 99/63 CFT: 12 sec	Shift - out from ER to: ward
RR: 28 bpm SPO ₂ : 100%	Time of Shift - out: 2:15 pm
GCS: 4/5/6 Temperature: 96.2° F	Handover given to: (Nurse's Name)
Pain Score: 0	
Repeat RBS (if applicable): NA	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

OR placement done

Name of the Nurse : pooja

Signature of the Nurse :

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

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00524868 IP5-00175923 Baby GADDE VIHKA BHARATHI 14-10-2022 3 Y 8 M 19 D (F) Dr. VIJAYANAND JAMALPURI 		Date & Time of Admission 3/2/2022 1:12 pm	Date & Time of Transfer Order 3/2/2022 2:15 pm
		Transfer Ordered by Dr. Akshita	Reason for Transfer Admission
From Unit ICU	To Unit Ward	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Number of Imaging Films NA	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what? op files	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring NR - Pooja		Name of Person Ordered Transfer Dr. Akshita	
Patient & Clinical Records Received by : no unit			
Date & Time of Patient Received : 3/2/2022 @ 2:30 PM			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

CONSENT FOR BLOOD TRANSFUSION



Name: Vih BAH-00524868 IP5-00175923
 Baby GADDE VIHKA BHARATHI
 14-10-2022 3 Y 8 M 19 D (F)
 Dr. VIJAYANAND JAMALPURI
 UHID.No : 
 Age: 3 years Gender: Male ☐ Female ☒
 Date: Bah-00524868

Type of Blood Product: ☐ Fresh Frozen Plasma ☐ Packed Red Blood Cells ☐ Random Donor Platelets
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood
☐ Albumin ☐ Red Blood Cell ☐ Others IVIG

..... hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immuno-deficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that nil

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Signature: [Signature]

Name: Gadde Hemansh

Date & Time: 7/3/2026

Doctor (Who is talking the consent)

Signature: [Signature]

Name: Jayashri

Date & Time: 3/2/26 @ 3pm

Witness

Signature: [Signature]

Name: Moukida . K

Date & Time: 3/2/26 @ 3pm

రక్త మార్పిడి కొరకు అంగీకార పత్రము

రోగి పేరు: వయస్సు: లింగము ☐ పురుషుడు ☐ స్త్రీ
UHID. సంఖ్య: తేదీ:

రక్త ఉత్పత్తి రకాలు:

- ☐ తాజా ఘనీభవించిన ప్లాస్మా ☐ ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు ☐ Random Donor Platelets
☐ క్రయోప్రెసిపిటేట్ ☐ ఒకే దాత స్టేటిలెట్స్ ☐ Whole Blood
☐ మొత్తం రక్తం ☐ ఎర్ర రక్త కణం ☐ ఇతరులు.....

నేను ఇందు మూలముగా రెయిన్ఫీ ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడి/రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హాప్ ఐ బి యాంటీ బడిస్, హైపటైటీస్ బి సర్వైస్ యాంటిజన్, హైపటైటీస్ యాంటిబడిస్, మలేరియా మరియు సిస్టిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని బివరించడమైనది. రక్త పరీక్ష నిర్ణీత కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్ల సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతివర్కలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలత్తవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు

పై సేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి చికిత్స చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. చికిత్స చేస్తున్న సమయంలో అన్ని రక్తముల రక్తమార్పిడులకు (మొత్తం రక్తం / లేదా రక్త ఉత్పత్తులు ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ప్రిష్ ప్రోజెక్ట్ ప్లాస్మా, క్రయోప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకం

పేరు

పేరు

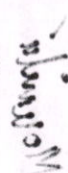
తేదీ మరియు సమయము

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు


N. N. N. N.
2023 06 23/23



BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 3/7/26 Time: 4 p.m.

Blood Group of the Patient: F- Blood Group on the Blood Bag: -

Blood Bank Issue No: - Date of Collection: - Date of Expiry: -

Date & Time of Starting Transfusion: 10 gm over 12 hrs 3/7/26 @ 4 p.m. Planned duration of Transfusion: 10 gm / 12 hrs.

Check for Correct Unit: ☐ Correct Patient: ☐

Blood products cross checked by: Nurse 1: Amulya Nurse 2: [Signature]

Before starting transfusion vitals: Temp: 98.4°F HR 100 RR: 28 BP: 98/76 SpO₂ 98%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
3/7/26	15 Min	100	94°F	98/76	99%	Nil	Nil	Nil	Nil
3/7/26	15 Min	101	96°F		98%	Nil	Nil	Nil	Nil
3/7/26	30 Min	98	97°F		100%	Nil	Nil	Nil	Nil
3/7/26	30 60 Min	81	98.4°F		99%	Nil	Nil	Nil	Nil
3/7/26	30 60 Min	84	97.5°F		100%	Nil	Nil	Nil	Nil
3/7/26	1 Hr	89	97.9°F		100%	Nil	Nil	Nil	Nil
3/7/26	1 Hr								

Comments:

Name of the Incharge-Nurse: sis Anitha

Name of the Nurse: Dnti: Amulya Mani

Signature of the Incharge-Nurse: [Signature]

Signature of the Nurse: [Signature]

Date & Time: 3/7/26 @ 8 p.m.

Date & Time: 3/7/26 @ 5 p.m.

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00524868 IP5-00175923 Baby GADDE VIHKA BHARATHI 14-10-2022 3 Y 8 M 19 D (F) Dr. VIJAYANAND JAMALPURI 		Date & Time of Admission	Date & Time of Transfer Order 3/7/26 @ 3PM
		Transfer Ordered by Dr. madhuri	Reason for Transfer IVIG
From Unit 3rd floor	To Unit 2nd floor (PICU)	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 31	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If Yes, what?		Patient shifted with ID band: Yes ☒ No ☐ If No:
Number of Imaging Films -			
Medications / Consumables / Surgical / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring sis monika		Name of Person Ordered Transfer Dr. madhuri	
Patient & Clinical Records Received by : Dr. Anil Kumar			
Date & Time of Patient Received : 3/7/26 @ 3:28pm			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready



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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 31/7/26 Time: 2:15pm

Weight: 14.35 kgs Centile: >25th

Height: 105 cm Centile: >75th

Inference: well child.

RDA: — Calories: 1300 kcal/d Protein: 22 gm/d

Diet Recommendations: soft diet

Re-Assessment: avoid spicy, chilled and outside foods.

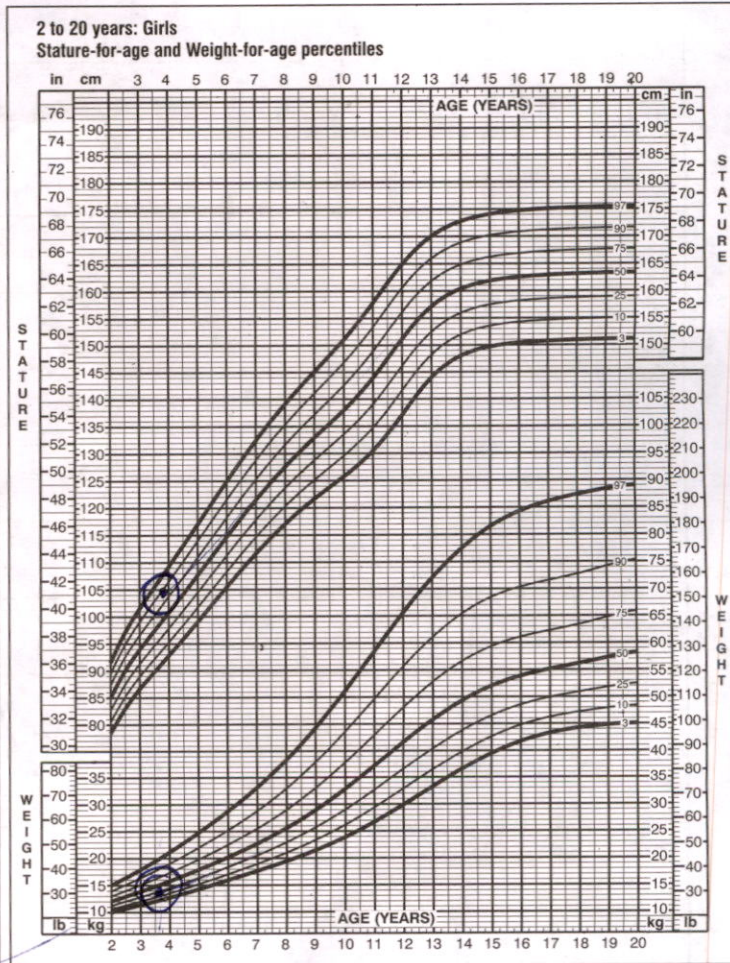
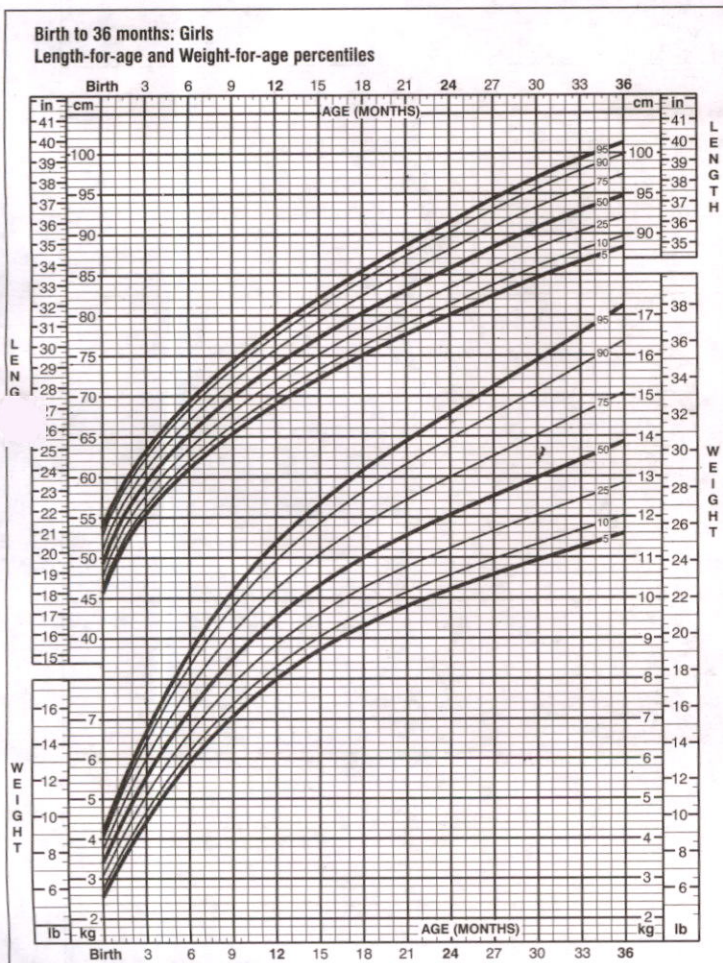
Food Allergies: No Veg/Non-veg

Diagnosis: PUO

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (GIRLS)



Dietician's Name SAIMA

Dietician's Signature Saima

Daily Notes:

4/3/26

child is stable, oral intake is given

10am

continue soft diet

Saving

5/7/26

child is stable, oral intake is optimal.

12pm

continue soft dict

Saine