

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176023

Admit Date : 06-Jul-2026

Admit Time : 12:06 PM **UHID** : PHW-00107451

Patient Details :
Patient Name : Master HARSHITH PAPANI

Age : 2 Y 0 M 19 D

Guardian : Mr PAPANI SRINIVAS

DOB : 17-06-2024

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : H NO 7-86, Atmakur Warangal Telangana
INDIA 506342

Phone No : 8801147844/ 9908720581

E-mail : harshith@gmail.com

Admission Details :
Bed Type : FOUR SHARING

Bed No : FSW 126

Ward Name : 1F-HEMATO-ONCOLOGY

Room No : FSW 126

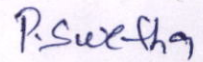
Admission Type : First Visit

Contact Details :
Name : Mr PAPANI SRINIVAS

Relationship : Father

Contact Address : H NO 7-86, Atmakur Warangal Telangana
INDIA 506342

Phone No : 9908720581 / 8801147844


Signature
Doctor Details :
Doctor Name : Dr. SANDHYA VADDADI

Specialisation : HEMATO ONCOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant : Dr. SIRISHA RANI

Payment Details :
Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

ACTIVITY RECORD FOR BILLING

Name : HA PHW-00107451 IP5-00176023
Master HARSHITH PAPANI
17-06-2024 2 Y 0 M 19 D (M)
UHID No. : Dr. SANDHYA VADDADI Consultant: _____ Dept : _____
Date of Admission: _____ Date of Discharge : _____ Time: _____
Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/2/26	12:45pm	EE	ONLO	POOTS

Cross Consultation Visit

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

[illegible]

Signature

१३

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
6/7	chemotherapy	①	9690554	<i>[Signature]</i>

ANY OTHER INFORMATION

Don't charge for NHA. - *[Signature]*

Date : 7/7/2020

Time : *[Signature]*

Prepared By : *[Signature]*

Staff Nurse <i>[Signature]</i>	Shift / Ward dayshift oncology	Billing Assistant	Billing Supervisor
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PHW-00107451 IP5-00176023
Master HARSHITH PAPANI
17-06-2024 2 Y 0 M 19 D (M)
Dr. SANDHYA VADDADI


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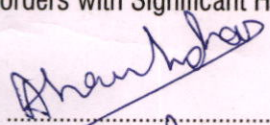
ADMISSION CRITERIA – ONCOLOGY

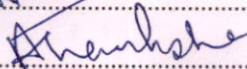
Admission / Transfer from:

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

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

- ☒ For Chemotherapy-Day Care or IP Admission as per the Type of Chemotherapy
- ☐ Febrile Neutropenias (ANC <500 cells / mm³)
- ☐ Netropenic Enterocolitis
- ☐ Mucositis Induced Significant Diarrhea or Pain
- ☐ Neurological Complications (like Seizures, Bleeding, Thrombosis) that can arise while on Chemotherapy Treatment or at the Time of Presentation and also for other Systemic Problems like Pancreatitis during Chemotherapy
- ☐ Management of Oncological Emergencies
- ☐ Bleeding Problems (where it is indicated)
- ☐ Evaluation and Management of Severe Anemias
- ☐ Day Care Admissions for PRBC Transfusions
- ☐ Evaluation and Management of Sick Children who come with Hematological Problems like Severe Anemia like Autoimmune Hemolytic Anemia/ Bleeding/ Others
- ☐ Primary Immunodeficiency Disorders with Infections that Warrants Hospitalisation
- ☐ Management and Evaluation of Hemophagocytic LymphoHisticytosis
- ☐ Any Systemic Disorders with Significant Hematological issues like JRA / SLE with Secondary HLH

Signature of the Doctor: 

Name of the Doctor: 

Date & Time: 6/7/26 @ 4pm

PHW-00107451 IP5-00176023
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DISCHARGE CRITERIA – ONCOLOGY

Discharge to:

☒ HDU / Step down ICU

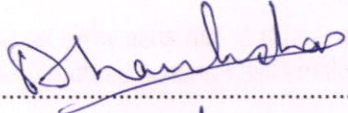
☐ Ward

☐ Outside Facility

☒ Others: home

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

- ☐ Completion of chemotherapy, with no debilitating side effects.
- ☐ Resolution of febrile episode, with no fever > 24hrs and Absolute Neutrophil count (ANC) > 500cells/mm³.
- ☐ Admitted patients - Once the admitting problem gets resolved or made a plan to manage further on out-patient basis.

Signature of the Doctor: 

Name of the Doctor: Sandhya Vaddadi

Date & Time: 7/7/2026 @ 12pm



PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Harshit Papani

UHID ID:

PHW-00107451 IP5-00176023

Master HARSHITH PAPANI

17-06-2024 2 Y 0 M 19 D (M)

Dr. SANDHYA VADDADI



Department:

Consultant:



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Paraspinal with Intraspinal Extension
of Ewing's sarcoma - on adjuvant chemo

History of present illness :

RT Right hemi craniotomy & tumor excision
D8 D8 Laminoplasty & total excision of
extradural SOL done on 6/11/25 / post radiation
admitted for chemotherapy
no H/O fever, cough, cold.



Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

_____ *normal for age* _____

Immunization History :

_____ *—* _____



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile _____)
Weight (kgs)) 9.512 (Centile _____)

On Examination :

Temperature : 98.3°f Pulse Rate : 126/min B.P. _____ SPO2 100.1% RA
Resp. rate and type of breathing : 26/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any addles sounds : _____

Relevant data from outside (Chest X-Ray, ABG, etc.,) B/clean

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : _____

Any murmur : _____

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : S2B

Per Abdomen :

Inspection _____

Palpation : _____

Ausculation : _____

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Aleer.

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

basal ganglia, cerebellum, brainstem, spinal cord, peripheral nerves, muscles, skin, joints, bones, and internal organs.

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

injection

Desired goals of the treatment: _____

Resolution of symptoms

Planned Labs:

cbp, urine

Planned Management

chemotherapy

*n/b proof
6/7/24 @ 12:30 pm*

Signature of the Doctor: *N. P. S.*

Name of the Doctor: *N. P. S.*

Date & Time: *06/7/24*

12:10 pm.

Signature of the Consultant: _____

Name of the Consultant: *Dr. Sandhya*

Date & Time: *7/7/24 @ 9:40 am*

*Dr. SANDHYA VADDADI
Reg. No: 71664*

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 5 PM	Evening rounds Palmar-plantar Erythema for chemotherapy. No fresh issues Vitals (N) Afebrile, Alert SLE 3 wgs NG/0 PR/0	Ado 1) start chemo 2) start supp care 3) monitor vitals Noted by Sumita 06/07/26 @ 5:30 PM
7/7/26 8:45 AM	Morning rounds Palmar-plantar Erythema for chemotherapy. Afebrile, Alert No fresh issues Vitals (N) SLE 3 wgs NG/0 PR/0	Ado 1) start chemotherapy 2) start supportive 3) monitor vitals 4) Inform SAs 5) Plan DLE R/O on 13/7 TCBP Ananthkumar

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②



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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RESULT SHEET

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

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Sheet No:

REGULAR PRESCRIPTIONS

Weight 9.5 kg. Ward

DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
5ml	PO	24H	6/7	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
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				

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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 :				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																				

PHW-00107451 IP5-00176023
Master HARSHITH PAPANI
17-06-2024 2 Y 0 M 19 D (M)
Dr. SANDHYA VADDADI



DRUG CHART

Date of Admission: 6/7/26 Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name Signature



REGULAR PRESCRIPTIONS

Weight. 9.5kg Ward.

DRUG : <u>14j. ON DANSETRON</u>				Date Time	<u>6/7</u>	<u>11</u>														
Dose	Route	Frequency	Start Date																	
<u>2mg</u>	<u>IV</u>	<u>12H</u>	<u>6/7</u>	<u>6am to 10pm</u>																
Name & Signature of the Doctor Starting the Drugs: <u>N. Prathishu</u>				<u>Suma</u> <u>Prathishu</u>																
Additional Instructions:				<u>6pm to 10pm</u> <u>Prathishu</u>																
Daily Doctor's Endorsement by a Sign				<u>12/0</u>																
DRUG : <u>SYP. SEPRAN</u>				Date Time	<u>6/7</u>	<u>11</u>														
Dose	Route	Frequency	Start Date																	
<u>2ml</u>	<u>PO</u>	<u>12H</u>	<u>6/7</u>	<u>8am to 10pm</u>																
Name & Signature of the Doctor Starting the Drugs: <u>N. Prathishu</u>				<u>X</u>																
Additional Instructions: <u>Monday - Wednesday, Friday</u>				<u>8am to 10pm</u>																
Daily Doctor's Endorsement by a Sign				<u>12</u>																
DRUG : <u>T. VORICONAZOLE</u>				Date Time	<u>6/7</u>															
Dose	Route	Frequency	Start Date																	
<u>4mg</u>	<u>PO</u>	<u>24H</u>	<u>6/7</u>	<u>8pm to 10pm</u>																
Name & Signature of the Doctor Starting the Drugs: <u>N. Prathishu</u>				<u>8pm to 10pm</u>																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				<u>12</u>																
DRUG : <u>SYP- ZINCUT</u>				Date Time	<u>6/7</u>															
Dose	Route	Frequency	Start Date																	
<u>5ml</u>	<u>PO</u>	<u>24H</u>	<u>6/7</u>	<u>8pm to 10pm</u>																
Name & Signature of the Doctor Starting the Drugs: <u>N. Prathishu</u>				<u>8pm to 10pm</u>																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				<u>12</u>																



Weight. Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Weight. 9.5/9 Ward.

[illegible]

Signature

PHW-00107451 IP5-00176023
Master HARSHITH PAPANI
17-06-2024 2 Y 0 M 19 D (M)
Dr. SANDHYA VADDADI



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MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From: ICU

Shifted to: OT

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	Syr. Nurocont	5ml	PO	24H	5/7/24	☐ C ☐ DC
2	Syr. Calceinaplu	5ml	PO	24H	5/7/24	☐ C ☐ DC
3	T. Miconazole	10 tabs	PO	24H	5/7/24	☐ C ☐ DC
4	Syr. Septran	2ml	PO	12H morning and evening	6/7/24	☐ 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: N. Prakash N. Reddy

Date & Time: 06/7/24, 12:30pm

Nurse Name & Signature: padma

Date & Time: 6/7/24 e 12:30pm

PHW-00107451
Master HARSHITH PAPANI
17-06-2024 2 Y 0 M 19 D
Dr. SANDHYA VADDADI (M)

CHEMOTHERAPY PRESCRIPTION

All the chemotherapy medications are high risk / high alert drugs.
While administering chemotherapy drugs watch for nausea, vomiting, rashes,
urine output and any local extravasation of the drug.

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Sheet No. : ①	Weight (kg) :	Body Surface Area:	Diagnosis:	Protocol:
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DATE	TIME	Composition of Chemotherapy (if infusion, mention ml / hr = Mcg / kg / min. etc.)	DOSE	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
6/7/26	2:30pm	ly VINCRISTINE in 10ml NS	0.4mg	IV	over 10min	d	Pooja Dirya.	06/07		Pooja Dirya
6/7/26	2:40pm	ly DOXORUBICIN in 300ml 1/2 NS	7mg	IV	25ml/h	d	Pooja. Dirya	6/7		Anam Anuradha
6/7/26	10:10pm	ly CYCLOPHOSPHAMIDE in 100ml NS	300mg	IV	100ml/h	d	Sonam Anu	6/7		Sonam Anu
6/7	9:10pm	ly MECNA in 100ml NS	200mg	IV	100ml/h	d	Anam Anuradha	6/7		Sonam Anuradha
		ly MESNA in 100ml NS	200mg	IV	50ml/h	d				
2/7	10AM	ly DOXORUBICIN in 300ml 1/2 NS	7mg	IV	25ml/h	d	Veera Dirya	7/7/26		Sandhya Dirya

PHW-00107451 IP5-00176023
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17-06-2024 2 Y 0 M 20 D (M)
Dr. SANDHYA VADDADI



CHEMOTHERAPY PRESCRIPTION

All the chemotherapy medications are high risk / high alert drugs.
While administering chemotherapy drugs watch for nausea, vomiting, rashes,
urine output and any local extravasation of the drug.



Sheet No. :		Weight (kg) :	Body Surface Area:	Diagnosis:		Protocol:				
DATE	TIME	Composition of Chemotherapy (if infusion, mention ml / hr = Mcg / kg / min. etc.)	DOSE	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
6/7	11:30 am	1mg MESNA. 1/2 DNS 30ml	400mg	iv	40	Ag	Sonam Anuradha	7/7/26	Ⓟ	Sonam Anuradha



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/8/26	12:15 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	POOPS
6/7	8PM	0	MA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
7/7	4PM	0	ND	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
				☐ 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:

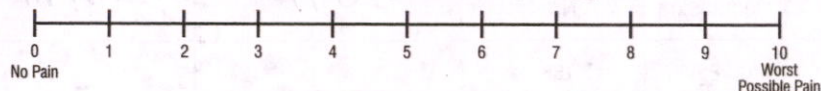
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

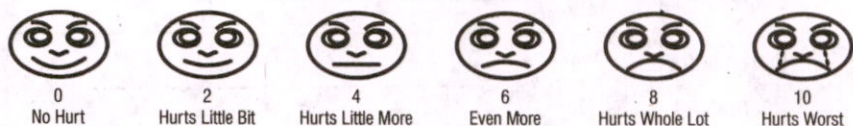
Numerical Pain Scale (Obstetric and Gynecology)



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



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 : 6/7

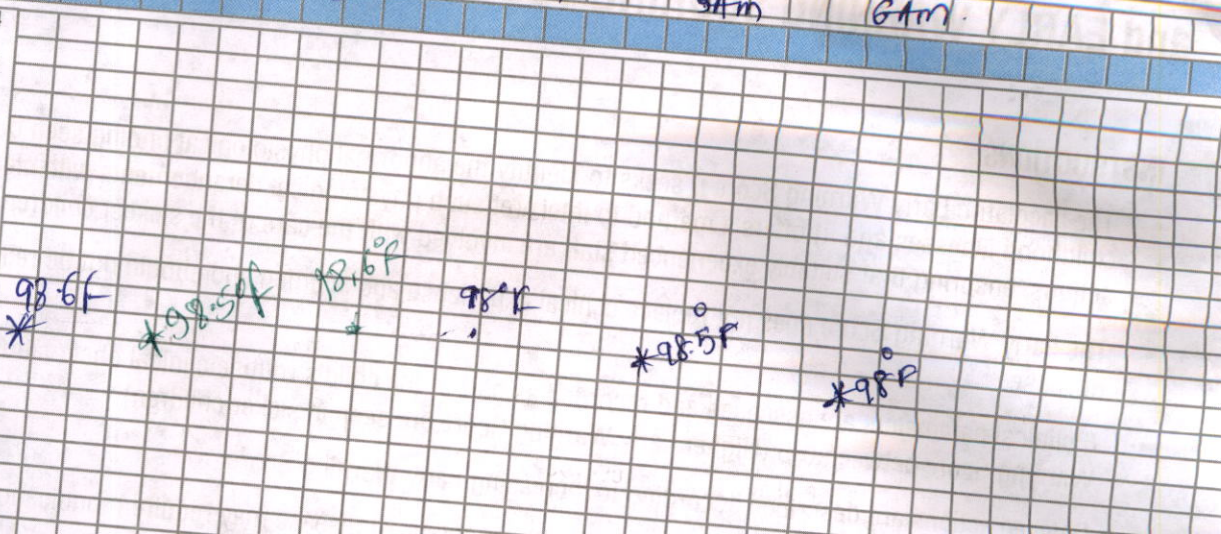
Time:

9pm 4pm 1pm 10PM 3Am 6Am

Doctor / Nurse / Family Concern?

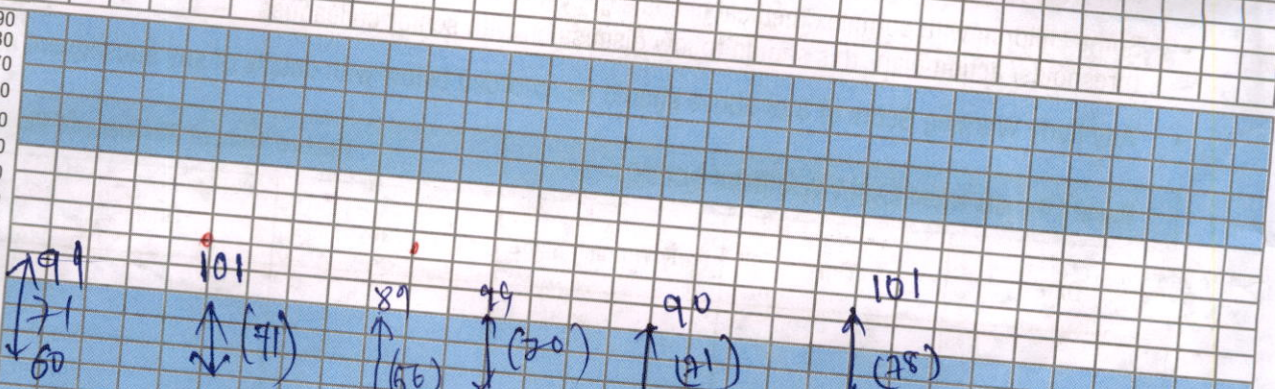
Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94



Heart Rate
(bpm)

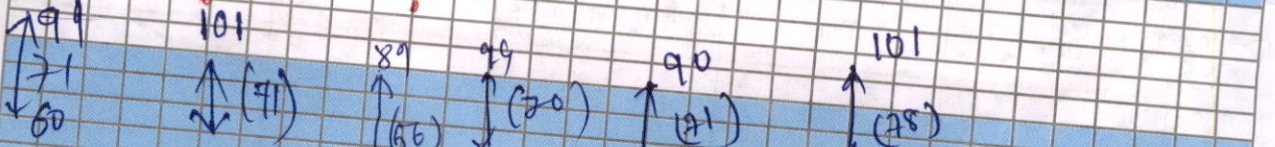
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50



Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

100
90
80
70
60
50



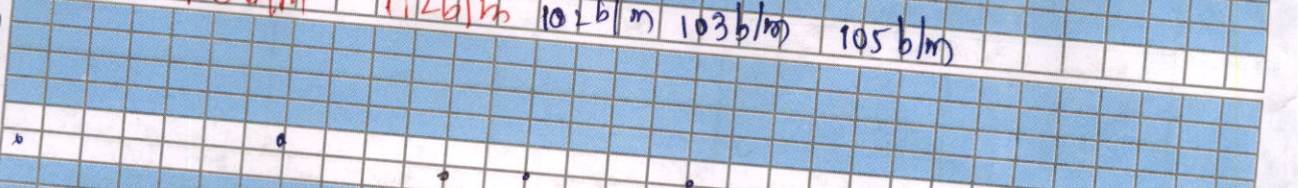
Heart Rate (Number)

106b/m



Resp. Rate (bpm)
(Over 1 Minute) *

70
60
50
40
30
20
10



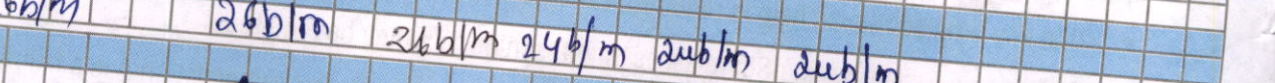
Resp Rate (Number)

26b/m



Resp Mod/ Severe
Distress None / Mild

1



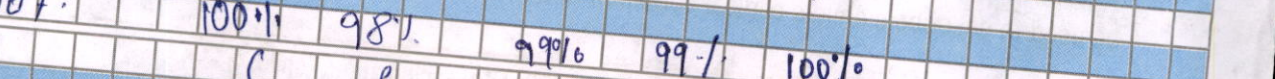
Receiving O₂ (l/min)
O₂ Saturations (%)

100%



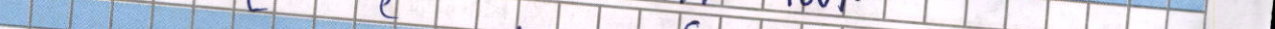
Conscious Level
Normal Altered

C



GCS *

15/15



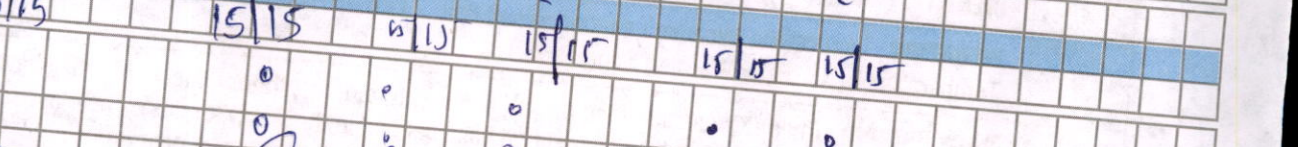
TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0
0
0
0
0
0



ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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Date	Time	Early Warning Score	Date	Time	Name

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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)



FLUID CHART

Sheet No. : ①

- All measurements in ml.
- 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	curd rice		25ml							
	03:00 pm			25ml						180ml	
	04:00 pm	juice 50ml		25ml							
	05:00 pm			25ml							
	06:00 pm	water 60ml		25ml							
	07:00 pm			25ml						120ml	
Total Intake : 260 ml						Total Output : 300 ml M-①					
	08:00 pm			25 ml							
	09:00 pm	Rice		100ml						150ml	
	10:00 pm	H ₂ O 100ml		100ml							
	11:00 pm			100ml							
	12:00 am			50ml						200ml	
	01:00 am			50ml							
Total Intake : 525 ml.						Total Output : 350 ml.					
	02:00 am			50ml							
	03:00 am			50ml						200ml	
	04:00 am			50ml							
	05:00 am			50ml							
	06:00 am			50ml						100ml	
	07:00 am			50ml							
Total Intake : 300 ml						Total Output : 300 ml.					

Total 24 hrs. Intake

1086 ÷ 114.3 cc/kg/day

Total 24 hrs. Output

950 ÷ 5.5 cc/kg/hr.



FLUID CHART

Sheet No. : 9

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
17/12	08:00 am	idly		50ml							200ml	[Signature]	
	09:00 am	H2O	100ml	50ml									
	10:00 am			50ml									
	11:00 am			50ml									
	12:00 pm			50ml									
	01:00 pm												
Total Intake : 350ml						Total Output : 200ml							
	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 General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 12:50 pm Mode of Arrival: By mother Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction

Body Weight: Kg

no allergy reaction

Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
NA	NA	NA

Family History:

Healthy family

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

If yes please list,

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

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

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

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

Temp: 98.6 F HR: 106 bpm RR: 24 bpm BP: 96/56 (H) mmHg

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

Fall Risk Assessment: ☒ Yes ☐ No Score: 10 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 29) (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

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 7/7/26

Assessment: patient having weakness, nausea

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 pt general condition	8:30 AM	→ Assessed the pt general condition	pt feels better
9AM	→ monitor the vital signs	9:30 AM	→ TO check & recorded the vital signs	
10AM	→ Ensure the pt general condition	10:30 AM	→ Maintained the D/O chart	
11AM	→ Maintain the D/O chart	11:30 AM	→ TO provided the side rails	
12pm	→ Ensure the safety needs	1pm	→ TO given the oral medication	
	→ provide the supportive care			
	→ Administer the medication		→ Administered the medication	

Re-Assessment: pt feels better

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

7/7/26 @ 12pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6/7/26

Assessment: patient is having weakness

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	8:30am	*Assessed the general condition	patient is comfortable
10am	*Monitor and note vitals	10:30am	*Monitored and noted vitals	
12am	*Provide comfortable position	12:30am	*Provided comfortable position	
2am	*Provide supportive care	2:30am	*Provided supportive care	
4am	*Ensure Safety.	4:30am	*Provided side rails & pillows	
6am	*Administer medications	6:30am	*Administered medications as per order.	
7am	*Monitor output.	7:30am	*Monitoring output.	

Re-Assessment: patient is comfortable

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Anu m

Date & Time: 7/7/26 8am



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 6/7/26

Assessment: Patient Having chemotherapy

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	to Assess the baby condition	2:30pm	Assessed the baby condition	Patient feel better
3pm	to monitor vitals and Record	3:30pm	monitored vitals and Recorded	
4pm	to maintain fluid balance	4:30pm	maintained fluid balance	
5pm	to Ensure safety	5:30pm	provided supportive care	
6pm	Administer medication as per doctor's order	6:30pm	medication given as per doctor's order	
7pm	to maintain Hand Hygiene	7:30pm	maintained Hand Hygiene	

Re-Assessment: Re-assessment done

Special Notes:

Nurse Signature:

Nurse Name: Moumita

Date & Time: 6/7/26 8pm



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 6/7/26

Assessment: patient having weakness & dull

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
1pm	→ Assess the pt general condition	1:30 pm	→ Assessed the pt general condition	pt feels better
2pm	→ Monitor the vital signs	2:30 pm	→ monitored the vital signs	
3pm	→ Ensure the safety needs	3:30 pm	→ provided the side rails	
4pm	→ provide the supportive care	4:30 pm	→ given the supportive care	
5pm	→ maintain the I/O chart	5:30 pm	→ took & recorded the I/O chart	
6pm	→ Administer the medication	8pm	→ administered the medication	

Re-Assessment: pt feels better

Special Notes:

Nurse Signature: Vijay

Nurse Name: Vijay

Date & Time: 6/7/26 10:45 am



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sandhya Department: ward Date of Admission: 6/7/26

SITUATION	Diagnosis: <u>chemotherapy</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
	Area	Shift Time	<u>12:45 pm</u>	<u>01:00</u>	<u>01:00 8PM</u>	<u>01:00 8PM-8PM</u>	<u>01:00</u>
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</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>98.2°F</u>	<u>98.6°F</u>	<u>98.4°F</u>	<u>98°F</u>	<u>98.6°F</u>
		Res:	<u>28 bpm</u>	<u>26 bpm</u>	<u>25 bpm</u>	<u>24 bpm</u>	<u>26 bpm</u>
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>
		Pulse:	<u>112 bpm</u>	<u>106 bpm</u>	<u>105 bpm</u>	<u>105 bpm</u>	<u>107 bpm</u>
		BP:	<u>—</u>	<u>96/56 mmHg</u>	<u>100/60</u>	<u>100/60 mmHg</u>	<u>96/56 mmHg</u>
	Fall Risk Score:		<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>
Pain Score:		<u>0/10</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	
Recommendations	Safety Needs:		<u>yes</u>	<u>side rails</u>	<u>yes</u>	<u>side rails</u>	<u>side rails</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>poos</u>	<u>Veena</u>	<u>moomita</u>	<u>Am m</u>	<u>Veena</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>6/7/26</u>	<u>6/7/26</u>	<u>6/7</u>	<u>7/7</u>	<u>7/7/26</u>	
Time:		<u>12:50 pm</u>	<u>—</u>	<u>8 PM</u>	<u>8 PM</u>	<u>12 pm</u>	
Taken Over By Name :		<u>Veena</u>	<u>moomita</u>	<u>[Signature]</u>	<u>Veena</u>	<u>[Signature]</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>6/7/26</u>	<u>6/7</u>	<u>6/7</u>	<u>7/7/26</u>	<u>—</u>	
Time:		<u>12:50 pm</u>	<u>2 PM</u>	<u>8 PM</u>	<u>8:05 AM</u>	<u>—</u>	

PHW-00107451 IP5-00176023
Master HARSHITH PAPANI
17-06-2024 2 Y 0 M 19 D (M)
Dr. SANDHYA VADDADI



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
	Tubes/Drains/Catheter:		☐ 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
	Others Specify:						
	Special Diet:		☐ 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:							

CONSENT FOR CHEMOTHERAPY

Patient Name : Harehit Papani Age : Gender: Male ☐ Female ☐
UHID No : Department : PNO Date : 6/7/20

Type of Chemotherapy : intravenous chemotherapy

The type of reactions, nature of the major risks and complications arising from the treatment despite precautions has been explained to me. These can include Bone Marrow depression with subsequent infections, bleeding, nausea, vomiting, diarrhea, mouth ulcers, alopecia, fever, phlebitis, ulceration at the site of injection organ injuries etc.

The doctor have explained to me about the benefits and alternative for this procedure that None.

(Explained)

I understand that no promise of cure or freedom from risk can be given. During the course of treatment I will report any symptoms if they become bothersome.

I have read the above and have no further questions about the treatment to be given.

Patient Attendant :

Signature : P. Srinivas

Name : P. Srinivas Srinivas

Relationship with Patient: father

Date & Time : 06/07 @ 2:30 pm

Witness :

Signature : P. Srinivas P. Srinivas

Name : P. Srinivas

Date & Time : 06/07 @ 2:30 pm

Doctor (who is taking the consent):

Signature : Ashwini

Name : Ashwini

Date & Time : 6/7/20 at 2:30 pm

PHW-00107451
Master HARSHITH PAPANI
17-06-2024 2 Y 0 M 19 D
Dr. SANDHYA VADDADI (M)

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

6/7 7/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	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			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	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			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1			
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
TOTAL			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		no	no			
Other Intervention(s) Specify		no	no			
Nurse's Name :		poof	poof			
Signature :		poof	poof			
Date :		6/7	7/7			
Time :		12:15 pm	8 AM			



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.Patient's / Learner Language: Religion Patient / Learner Literacy: ☐ Read ☐ Write ☒ Speak Willingness to Learn: ☒ Yes ☐ No Healthcare Literacy: ☒ Yes ☐ No**Identified Education Needs:**

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
6/12/26	12:15 pm	7	Infection control measures	M	9	0	1	1	NA	Pooja
7/12/26	1:30 pm	9	soft High protein diet	M	1	0	1	1		monika

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: chemotherapy

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
6/7/26 12:30 pm	☒ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Feeding issue	Hemodynamic stability	Chemotherapy	V. Prasad	☐ Nursing ☐ Others:
6/7/26 12:30 pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	chemotherapy	stabilizing	chemotherapy	As	☒ Medical ☐ Others:
6/7/26 1:30 pm	☐ Medical ☐ Nursing ☒ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Transspinal to Feeding issue Chemotherapy	soft High Protein diet	<u>RDA</u> E: 1250kcal/d P: 2g/d	manu	☐ 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:



BRADEN 'Q' SCALE

					Date : 6/2 7/7		
					Time : 12/17pm 8PM		
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	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	
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	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	paaji	Arm

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



NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 6/7/26 Time: 1:30pm

Weight: 9.5 kgs Centile: < 5th

Height: 81 cm Centile: 5th

Inference: underweight child

RDA: — Calories: 1250 kcal/d Protein: 21g/d

Diet Recommendations: soft High protein diet

Re-Assessment: Avoid spicy, chilled and outside foods

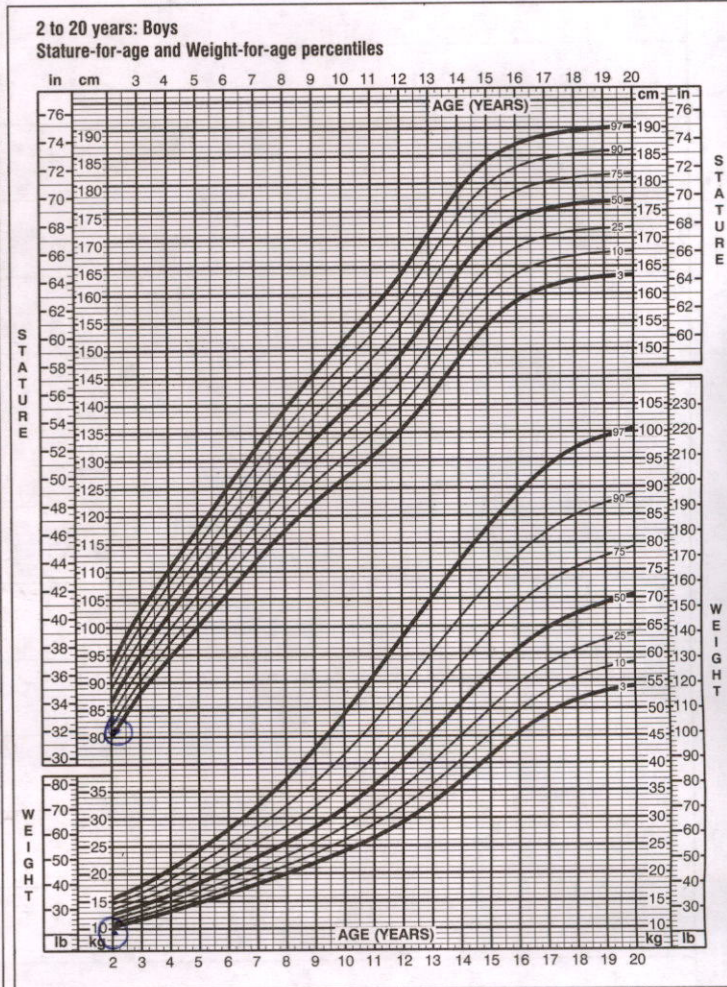
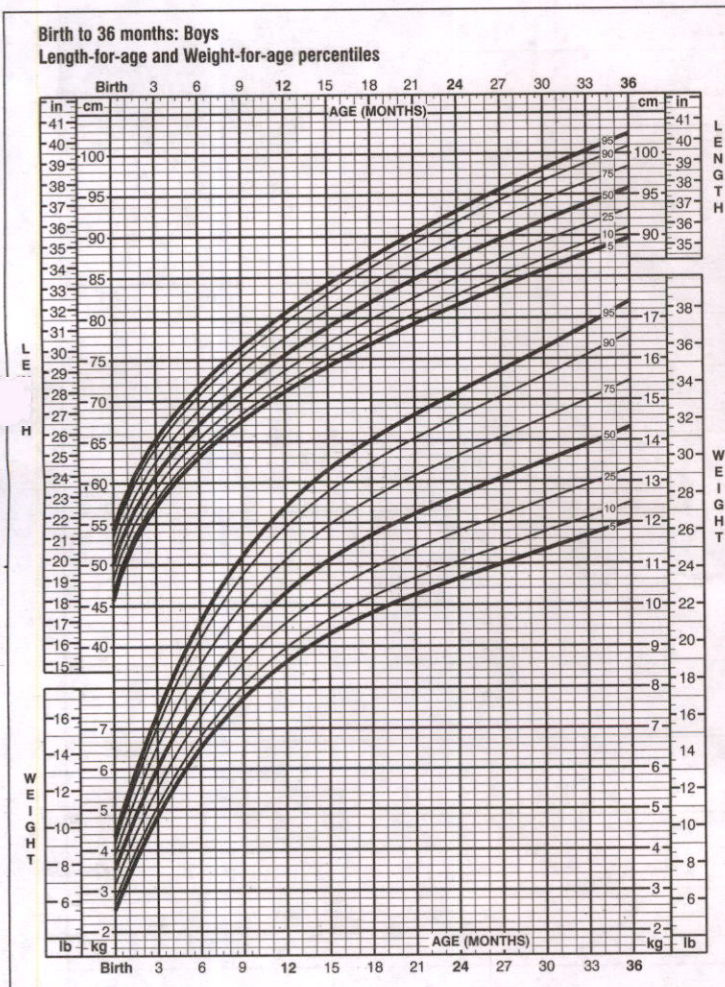
Food Allergies: NO Veg/Non-veg: nonveg

Diagnosis: peripheral T Ewing - for chemotherapy

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Parent's Don't need diet plan. Don't change for NHA.

GROWTH CHART (BOYS)



Dietician's Name Manoja

Dietician's Signature Manoja

Daily Notes:

[illegible]

CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

Type of Line: ☒ PICC Line ☐ UAC ☐ UVC ☐ Other Date of Initial Line Insertion: Duration of Central Line:

- Always perform hand hygiene before accessing central line
- Use Sterile gloves for handling central line
- Clean the hub with antiseptic solution every time before & after it is accessed
- Consider – antibiotic via central line before removal of the line
- Inspect Central line in each shift for the following

Parameters	Date	Shift Time	6A	2pm	6P	8PM-8PM	6P	8PM-8PM				
Can we remove Central Line today (Discuss in the clinical round)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Evidence of any inflammation at insertion site (Redness / Swelling (If yes inform the doctor))			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Blood at insertion site (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any peeling of dressing? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is dressing clean and dry? (If no inform the doctor)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any leakage at insertion site? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there any obstruction to the infusion flow? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing intact and labelled properly			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Central line changed on												
Name of the Nurse			Ueena	Moumita	Aam							
Signature of the Nurse			Ueena	Moumita	Aam							



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master Harshith Papani Age : 2y Gender: ☒ Male ☐ Female
Date : 6/7/20 Time of Arrival : 11:25 AM Triage Completion Time : 11:27 AM
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

Appearance

- ☒ Normal
☐ Sick Looking

Work of Breathing

- ☒ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

Circulation / Colour

- ☒ Normal ☐ Abnormal ☐ Bleeding

INITIAL PHYSIOLOGICAL STATUS

☒ Stable

☐ Unstable :

- ☐ Not - Life - Threatening
☐ Life - Threatening

Initial Vital Signs: Temp: 98.3°F PR: 128b/m BP: 90/60 RR: 26b/m SpO₂: 100% RA

Chief Complaints: Came for chemotherapy

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

P. Soeltra
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 : NR Subbur

Signature of Triage Nurse : [Signature]

Date & Time : 26/07/20 at 11:27 AM



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 6/7/26 Time of arrival : 11:28 AM

Chief Complaints : came for chemotherapy RBS : NA

Height : NA Weight : 9.5 kgs 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 : 0/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker

☐ Character : Nil ☐ Location : Nil ☐ Frequency : Nil ☐ Duration : Nil

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 : 11:30 AM

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

Time	Nursing Notes
11:30 AM	Assess the child condition's - monitored vitals & recorded - seen Dr. prathiba - shifted to onco

Samples collected by:

Time:

Samples sent by :

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: 108 bpm BP: — CFT: 52 sec RR: 28 bpm SPO ₂ : 100% GCS: 15/16 Temperature: 98.2°F Pain Score: 0 Repeat RBS (if applicable): NA	Shift - out from ER to: oncology Time of Shift - out: 12:45 pm Handover given to: [Signature] (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

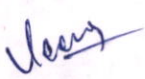
Procedures done with details (if any):

Name of the Nurse : P. P. [Signature]

Signature of the Nurse : [Signature]

Date & Time : 6/7/2020 12:30 pm

PATIENT TRANSFER FORM

Patient Name & UHID No. PHW-00107451 IP5-00176023 Master HARSHITH PAPANI 17-06-2024 2 Y 0 M 19 D (M) Dr. SANDHYA VADDADI 		Date & Time of Admission 6/7/26 @ 12:06 pm	Date & Time of Transfer Order 6/7/26 @ 12:45 pm
		Transfer Ordered by Dr. prathibha	Reason for Transfer Admission
From Unit ER	To Unit	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 19	Number of Imaging Films 2/0	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.	nil		
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring nr poys		Name of Person Ordered Transfer Dr. Ramya	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received : 6/7/26 @ 12:50 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