

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ Consultant: _____ Dept : _____

Date of Admissi _____ Date of Discharge : _____ Time: _____

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

BAH-00660976 IP5-00176087
Master PUPPALA SHASHI KRANTH
20-06-2022 4 Y 0 M 17 D (M)
Dr. UJJWALA DESAI



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
2/2/26	1:14pm	ER	139	Lachel.

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. mnu pourhyasai	9/2/26	182324	
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

[illegible]

[illegible]

Org Abdomen - 1
veg Check - 1

Date: 22/7/26 Time: @ 9.45 Am Prepared By: Merlin

Billing Supervisor

Merlin

6011

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176087 Admit Date : 07-Jul-2026 Admit Time : 11:51 PM UHID : BAH-00660976

Patient Details :

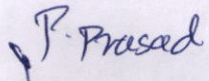
Patient Name	: Master PUPPALA SHASHI KRANTH	Age	: 4 Y 0 M 17 D
Guardian	: Mr PUPPALA PRASAD	DOB	: 20-06-2022
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: #H.NO:4-43 Quilashapur Warangal Telangana INDIA 506244	Phone No	: 9550510170/ 9959151917
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type : GENERAL WARD Bed No : GW 139 Ward Name : 1F-GENERAL WARD II
Room No : GW 139 Admission Type : First Visit

Contact Details :

Name : Mr PUPPALA PRASAD Relationship : Father
Contact Address : #H.NO:4-43 Quilashapur Warangal Telangana INDIA 506244 Phone No : 9550510170 / 9959151917


Signature

Doctor Details :

Doctor Name : Dr. UJJWALA DESAI Specialisation : GENERAL PEDIATRICS
Referral Doctor : Self Phone No :
Co-Consultant : Dr. FAISAL B NAHDI

Payment Details :

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



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00660976 IP5-00176087
Master PUPPALA SHASHI KRANTH
20-06-2022 4 Y 0 M 17 D (M)
Dr. UJJWALA DESAI



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

c/o fever
yellowish discoloration
vomiting of skin & eyes } ∴ 3d.

History of present illness :

∴ 3d
c/o fever - undocumented, multiple spikes/day. subsiding c medication
no cough/cold

c/o yellowish discoloration of skin & eyes - slowly progressing in severity
c/o vomiting 3d ago, better now.

passing high coloured urine
clay coloured stools
no pain abdomen
no blood in vomitings
no H/O travel

outside R - monocef. Amikacin → went to AIMS, admitted for id.

Lft - Bilirubin - direct - 4.98 - Vitamin K
SGOT - 1440 USG abd - GB edema &
SGPT - 1390 (R) pleural effusion
Total protein - 6.1
S-Albumin - 3 CBP - 8.5 } 5.8 k } 3.9 L
S-Globulin - 3 49/40
alt.
CRP - 14.5
Wt - 4-6 pus cells



Pediatric Multiorgan History & Physical Examination

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



Birth & Neonatal History:

① perinatal transition

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Developed as per age

Immunization History :

immunised as per age

(P.T.O.)

Plantars _____

Sensory System :

Tactile

Bladder / Bowel :

Regular

Clinical Summary & Diagnostic:

Fever & Jaundice

2 Acute Viral hepatitis



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 14kg (Centile _____)

On Examination :

Temperature : 98.8°F Pulse Rate : 120/min B.P. 71/50 ^{→ 108/62 mmHg} SP02 99% RA

Resp. rate and type of breathing : 26/min

victuous (+)

Rash _____

Lymphadenopathy 0

Oedema : _____



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

liver failure

Desired goals of the treatment : _____

hemodynamic stability

Planned Labs:

CBP, Blood C/S ✓
CRP, RBC ✓
S. Electrolytes ✓
LFT ✓
Hep. A, E, IgM ✓
PT/INR ✓
~~extra plain~~
urea, creat ✓
+ 1 extra plain ✓
EDTA ✓
+ HBSAg ✓

Planned Management

1. 2ij CEFTRIAXONE
2. 2ij ESOMEPRAZOLE
3. 8yp UDILIV
4. 2ij ONDANSETRON
4. fever management

Noted by
Dr. Ujjwala Desai

Signature of the Doctor: _____

Name of the Doctor: Sanithi

Date & Time: 8/7/26 12:10 Am

Signature of the Consultant: _____

Name of the Consultant: Dr. Ujjwala Desai

Date & Time: 8/7/26

DR. UJJWALA DESAI
Registration No: 90550

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26 2 AM	Seen by Resident - Ass - fever & jaundice. ? acute viral hepatitis.	Plan
	O/E child asleep; afebrile perfusion good, PPWF vitals stable CRT < 3 sec.	1. Trace - CRP, SE, RBS, LFT, Hepatitis serology, PT/INR
	BP-94/62 (70) PR-112/min Chest clear abd soft. hydration fair	2. monitor BP, HR & urine output. 3. continue IV fluids @ 100% maint
8/7/26 8 AM	Seen by Resident - Ass - fever & jaundice. ? Acute Viral hepatitis	Plan
	child asleep. If fever - GTM 10/1F oral intake poor. Peripheries warm, pulses well felt. BP-100/58 mttg. Chest clear, abdomen soft.	1. continue medications as charted 2. Trace Hep A, E, IgM, HbsAg. 3. monitor vitals & inform SOS.
	Acute viral hepatitis. febrile phase	Use abdomen & chest tada
	Icteric phase Fever on high.	Well felix ✓ Moxipenem Azithromycin Lepto spira IgM

DR. UJJWALA DESAI
Registration No: 90550

Date & Time	Progress Notes	Doctor's Order
8/12/26 4pm	SIB <u>Resident</u> 4: Acute viral hepatitis fever + 3 spikes no vomiting occ RUQ pain o/e - WBC alert vitals stable CVS RL PIR } normal	Plan. 1) continue mexipenem azithromycin 2) watch for fever 3) w/f full activity 4) monitor vitals 5) Inform GPs 6) trace leptospira - (NR) well felix blood CS medhuti
		Doc Dr. Ujjwala gen. spm DR. UJJWALA DESAI Registration No: 90550

Date & Time	Progress Notes	Doctor's Order
9/7 8 am.	cl / 13 Resident pt: Acute viral hepatitis. - Temp - 103°F @ 1 pm No vomiting N (Did not pass stool) o/e Well active alert I/A - soft, non-tender. Teng - 98.5°F. Blood clt - NG for 24 hrs Leptospirosis - neg. Weil felix - neg.	Plan - Continue metoprolol (D ₂) Amoxicillin. (D ₂) - Monitor vitals - Ct. St fluid. - w/ fever spikes, constipation. Urine and stool color. - Rlv to add lactulose, Bexon
	Acute viral hepatitis.	LFT PT APTT Fem tri. Lactate Lemon juice Charto with food add Dypkalen 6am by evening if no stool
		DR. UJJWALA DESAI Registration No. 1900 drym car

Date & Time	Progress Notes	Doctor's Order
9/7/26 3:45pm	SIB Resident dx: viral hepatitis fever spike at 12:30pm - 100.4 F no vomiting No Abd. pain activity - good Gc - could asleep vitals stable RS / NAD Lvs B/A - soft, mended.	Plan 1. cont. memperem Acee 2. monitor vitals 3. w/f fever 4. LFT PT/INR ferritin lactate → tomorrow 6am 5. Send urinal c/y S. Triglycerides 71m 6am (1 Extra Plain EDTA) madhavi

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/5/26 8 AM	SIB Resident dx: Acute viral hepatitis 2 moderate grade fever in last 24 hrs Tpm - 100.5°F no vomiting Pained stools Oils - good O/E: Child alert M - Bilateral clear Cvs - A2 (2) PIA - soft, hyperactive	plan ① continue same meropenem Azee ② wif fever ③ monitor vitals ④ trace widal ⑤ inform cos.
	Acute viral hepatitis C Hepatitis A IgM +ve Secondary sepsis. Blood culture sterile Widal awaiting	meropenem Azithromycin Stop NF On Drgw ga
	Fever continues Resolving.	

DR. UJJWALA DESAI
 Registration No: 90550



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/3/26 8:30 AM	Seen by Resident Dis - Acute Viral hepatitis. child afebrile > 30 hrs No vomitings	Plan 1. MEROPENEM-D4 AZITHROMYCIN-D4 2. Trace widal. 3. Plan NC today.
	O/E child active, alert hemodynamically stable. passing (D) coloured stool cy urine Chest clear abdomen soft. Hydration fair Blood c/s - NG @ 48 hrs.	<u>Sahithi.</u>
	Discharge	Meropenem BD dose till tomorrow F/b cefixim x 3 da Lorazepam Bowen Dysphagia Udilitin x 2 week Repeat - LFT after GGT 2 week Review after 2 week Dr Dr. Ujjwala Desai Registration No: 80553



It takes a lot to treat the little.



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



CROSS CONSULTATION FORM

Doctor Name : Dr. MNV Perchya Sai Date : 9/7/26 Time :

Diagnosis : Acute viral hepatitis

Hospital : RCH Rangara

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

Acute viral hepatitis

Signature: Madhul

Findings and Recommendations :

1. Acute viral hepatitis

fever since 5 days
icterus since 3 days

↓
↑ Bilirubin
transaminitis ⊕
PT/INR - WNL

No outside food
consumption ⊕

HAV +ve

Plan :

- ① send widal -
- ② ferritin, TG/L to send
- ③ continue medication

USG Abd → C/o hepatitis
mild ascites
= Bk mild pleural effusion

HbsAg → negative

HAV IgM → positive

HEV IgM → negative

Consultant :

Name : Signature : reper Date & Time :

Dr. Mary Leachman, MD

27/12/2014

11-10-1911

all types have a thick

Stages 12 - 14

3/1/2011 11:11 AM

c. $\frac{1}{2}$ of the total

121

BAH-00680976 IP5-00176087
Master PUPPALA SHASHI KRANTH (M)
20-06-2022 4 Y 0 M 17 D
Dr. UJJWALA DESAI



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

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

RESULT SHEET

Date	8/7	10/7/26			
Time	12 AM	6 AM			
Hb	8.2				
PCV	27.5				
RBC	4.39				
WBC	7.85				
N/L	31/61				
Platelets	4.17 L				
CRP	6				
ESR					
PCT					
RBS	113	90			
Na	134				
K	4.1				
Cl	107				
Ca/Mg					
Phosphate					
Urea	9				
Creatinine	0.3				
ALP	332	298			
SGPT	134.5	620			
SGOT	1413	251			
T.Bill/Conj	uncon-0.9	6.4/5.6	4.8	0.8	
T.Protein	5.7	6.3			
S.Albumin	2.7	2.8			
S.Globulin	3	3.5			
A/G Ratio	0.9	0.8			
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR	15/1.1	14/1			
APTT	43	43			
CSF Protein / Sugar					
Cells					
N/L					

Ferritin-47.9
Lactate-1.6
Triglycerides-284



Sheet No:

REGULAR PRESCRIPTIONS

Weight ...14 kg Ward

DRUG : <u>Suj MEROPENEM</u>				Date Time	8/7	9/7	10/7	11/7	12/7	1/8	2/8	3/8	4/8	5/8	6/8	7/8	8/8	9/8	10/8	11/8	12/8	1/9	2/9	3/9	4/9	5/9	6/9	7/9	8/9	9/9	10/9	11/9	12/9	1/10	2/10	3/10	4/10	5/10	6/10	7/10	8/10	9/10	10/10	11/10	12/10	1/11	2/11	3/11	4/11	5/11	6/11	7/11	8/11	9/11	10/11	11/11	12/11	1/12	2/12	3/12	4/12	5/12	6/12	7/12	8/12	9/12	10/12	11/12	12/12
Dose	Route	Frequency	Start Dt.																																																																		
500mg	IV	TID	8/7																																																																		
Name & Signature of the Doctor Starting the Drugs:																																																																					
Additional Instructions:																																																																					
Daily Doctor's Endorsement by a Sign																																																																					
DRUG : <u>Syp AZITHROMYCIN</u>				Date Time	8/7	9/7	10/7																																																														
Dose	Route	Frequency	Start Dt.																																																																		
3 ml	PO	OD	8/7																																																																		
Name & Signature of the Doctor Starting the Drugs:																																																																					
Additional Instructions:																																																																					
Daily Doctor's Endorsement by a Sign																																																																					
DRUG : <u>Syrup DIPHENHIDRAMINE</u>				Date Time	9/7																																																																
Dose	Route	Frequency	Start Dt.																																																																		
7ml	PO	OD	9/7/26																																																																		
Name & Signature of the Doctor Starting the Drugs:																																																																					
Additional Instructions:																																																																					
Daily Doctor's Endorsement by a Sign																																																																					
DRUG : <u>Syrup DIPHENHIDRAMINE</u>				Date Time	10/7																																																																
Dose	Route	Frequency	Start Dt.																																																																		
7ml	PO	OD	10/7/26																																																																		
Name & Signature of the Doctor Starting the Drugs:																																																																					
Additional Instructions:																																																																					
Daily Doctor's Endorsement by a Sign																																																																					



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																				



DRUG CHART

Date of Admission: 8/2/26 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 : <u>Syr CROUN-DS</u>				Date Time
Dose <u>4ml</u>	Route <u>PO</u>	Frequency <u>SOS</u>	Start Date <u>8/2</u>	<u>6:10 PM</u>
Doctor's Signature <u>N. Prasad</u>		Valid Period <u>48H</u>	Pharm. <u>24/06/26</u>	
Additional Instructions: <u>(5ml/240mg) 16 Temp 39.9°F max 6ml hourly</u>				

DRUG : <u>Syr METAL</u>				Date Time
Dose <u>3ml</u>	Route <u>PO</u>	Frequency <u>SOS</u>	Start Date <u>8/2</u>	
Doctor's Signature <u>Asf</u>		Valid Period	Pharm.	
Additional Instructions: <u>24 Temp 39.0°F</u>				

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



REGULAR PRESCRIPTIONS

Weight. 14 kg Ward.

VERIFIED

VERIFIED

DRUG : <u>Wj. CEFTRIAXONE</u>				Date Time	8/7/21
Dose <u>750mg</u>	Route <u>IV</u>	Frequency <u>12H</u>	Start Date <u>8/7</u>		
Name & Signature of the Doctor Starting the Drugs: <u>N. Prathibha</u>				10am ✓ 10pm 1.50 AM STOP Salutari 8/7/21	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>Wj. ESOMEPRAZOLE</u>				Date Time	8/7 9/7 10/7 11/7
Dose <u>15mg</u>	Route <u>IV</u>	Frequency <u>24H</u>	Start Date <u>08/7</u>		
Name & Signature of the Doctor Starting the Drugs: <u>N. Prathibha</u>				6am 2am 500mg 500mg After 11h AD 5	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>Syp. URSODIOLIC ACID</u>				Date Time	8/7 9/7 10/7 11/7
Dose <u>5ml</u>	Route <u>PO</u>	Frequency <u>8H</u>	Start Date <u>08/7</u>		
Name & Signature of the Doctor Starting the Drugs: <u>N. Prathibha</u>				6am 500mg After 11h AD 5 2pm 500mg After 11h AD 5 10pm 500mg After 11h AD 5	
Additional Instructions: <u>(5ml/12.5mg)</u>					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>Wj. ONDANSERON</u>				Date Time	
Dose <u>2mg</u>	Route <u>IV</u>	Frequency <u>12H</u>	Start Date <u>08/7</u>		
Name & Signature of the Doctor Starting the Drugs: <u>N. Prath</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					



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

STAT / ONCE ONLY DRUGS[illegible]

[illegible]

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/6/22	Time: 2 am	6 am
Doctor / Nurse / Family Concern?		
Temperature (F)	98.0	97.0
Heart Rate (bpm)	106	109
Blood Pressure (mmHg) *	98/60	93/63
Resp. Rate (bpm) (Over 1 Minute) *	26	26
Receiving O ₂ (l/min) O ₂ Saturations (%)	100%	100%
Conscious Level	15/15	15/15
GCS *	1	1
TOTAL SCORE	0	1
Number of shaded boxes	0	1
Pain Score	0	0
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.



ERVATION 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 : 10/5/26... Time: 6pm	
Doctor / Nurse / Family Concern? 6am 10am 12pm 6pm 10pm	
Temperature (F)	
Heart Rate (bpm) and Blood Pressure (mmHg) *	Note: BP does not score in early warning scoring
Heart Rate (Number)	103b/m 110h 108h 106bm 119bpm
Resp. Rate (bpm) (Over 1 Minute) *	
Resp Rate (Number)	26b/m 28h 28h 27m 26b/m
Resp Distress	Mod/ Severe None / Mild
Receiving O ₂ (l/min)	
O ₂ Saturations (%)	99% 99% 99% 98% 100%
Conscious Level	Normal Altered
GCS *	15/15 15/15 15/15 15/15 15/15
TOTAL SCORE	
Number of shaded boxes	0 1 1 1 1
Pain Score	0 0 0 0 0
Observer's Initials	Uy C C C ; .

ACTIONS

NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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

- 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)

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.

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

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B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT : I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
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-00660976
Master PUPPALA SHASHI KRANTH
20-06-2022 4 Y 0 M 18 D (M)
Dr. UJJWALA DESAI

oc. No. : RCH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)

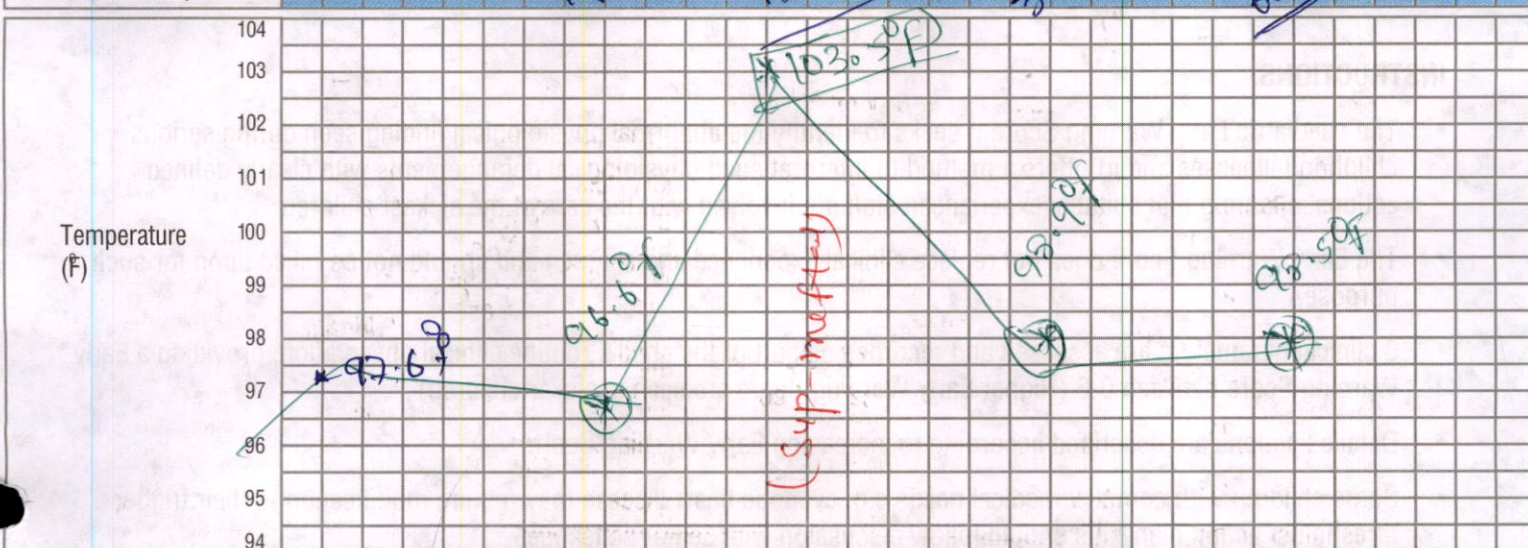
Children's Observation & Early Warning Scoring Chart

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 20/06/2022 Time: 7pm
Doctor / Nurse / Family Concern?



Heart Rate (bpm)	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50
and															
Blood Pressure (mmHg) *	96	96	96	96	96	96	96	96	96	96	96	96	96	96	96
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	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.
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- Detailed actions are described according to increasing Early Warning Score.
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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)

BAH-00660876
Master PUPPALA SHASHI KRANTH (M)
20-08-2022 4 Y 0 M 18 D
Dr. UJJWALA DESAI

Doc. No. : RCH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)

Children's Observation &
Early Warning Scoring Chart

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date	Time	Doctor / Nurse / Family Concern?
8/2	2:30 AM	
	6:10 AM	
	9 AM	
	10 AM	
	1 AM	
	9:30 PM	
	2:30 PM	

Temperature (°F)	Heart Rate (bpm)	Blood Pressure (mmHg) *	Heart Rate (Number)	Resp. Rate (bpm) (Over 1 Minute) *	Resp Rate (Number)	Resp Mod/ Severe Distress 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
98.1°F	126	94/62	1126/m	28	28		100%	15/15	15	1	1	0	0
101.0°F	108	101/58	1086/m	28	28		100%	15/15	15	1	1	0	0
97.9°F	110	110/65	1106/m	26	26		100%	15/15	15	1	1	0	0
96.5°F	109	109/75	1096/m	26	26		100%	15/15	15	1	1	0	0
98.9°F	110	110/60	1106/m	26	26		100%	15/15	15	1	1	0	0

ACTIONS	Score 1	Score 2	Score 3	Score 4	Score 5 & 6
NB: Scores 3 should be recorded overleaf	Continue normal observation by staff nurse	Shift in charge nurse to be informed and continue hourly observations	Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.	Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see	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 CLINICAL OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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- 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

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

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



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombophlebitis Score	Sign. Nurse		
			Mouth	I.V	N.G									
8/7	08:00 am	DMS	✓	40ml	/					100ml	0	[Signature]		
	09:00 am			40ml									0	
	10:00 am			-									100ml	0
	11:00 am			-									0	
	12:00 pm			40ml									0	
	01:00 pm			40ml									0	
Total Intake :						Total Output :								
	02:00 pm	DMS		40ml	/					100ml	0	[Signature]		
	03:00 pm	DMS		25ml									0	
	04:00 pm			-									0	
	05:00 pm	DMS		25ml									0	
	06:00 pm			-									0	
	07:00 pm			-									80ml	0
Total Intake :						Total Output :								
8/7	08:00 pm		250	25ml	/						0	[Signature]		
	09:00 pm			25ml									0	
	10:00 pm	DMS		25ml									0	
	11:00 pm			25ml									0	
	12:00 am			25ml									0	
	01:00 am			25ml									100ml	0
Total Intake :						Total Output :								
9/7	02:00 am			25ml	/						0	[Signature]		
	03:00 am			25ml									0	
	04:00 am	DMS		25ml									0	
	05:00 am			25ml									0	
	06:00 am			25ml									0	
	07:00 am			-									80ml	0
Total Intake :						Total Output : 560 ml								

Total 24 hrs. Intake	
----------------------	--

Total 24 hrs. Output	
----------------------	--

FLUID CHART

Sheet No. :

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

		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							
9/7	08:00 am			25ml							0	Jang
	09:00 am			25ml						55ml	0	
	10:00 am	DLS		25ml							0	
	11:00 am			25ml						65ml	0	
	12:00 pm			25ml						50ml	0	
	01:00 pm			25ml						60ml	0	

Total Intake :

Total Output :

9/7	02:00 pm			25ml							0	Suri
	03:00 pm			25ml							0	
	04:00 pm	DLS	chi	25ml						Emotion	0	
	05:00 pm			-						55ml	0	
	06:00 pm			-						50ml	0	
	07:00 pm			-							0	

Total Intake :

Total Output :

9/7	08:00 pm			-						50ml	0	Chand
	09:00 pm			25ml							0	Chand
	10:00 pm			25ml						50ml	0	
	11:00 pm	DLS		-						50ml	0	Chand
	12:00 am			25ml							0	
	01:00 am			25ml						100ml	0	

Total Intake :

Total Output :

10/7	02:00 am			25ml							0	Chand
	03:00 am			25ml							0	
	04:00 am			25ml							0	Chand
	05:00 am	DLS		25ml							0	
	06:00 am			25ml						100ml	0	Chand
	07:00 am			-							0	

Total Intake :

Total Output :

Total 24 hrs. Intake

Total 24 hrs. Output

4-695ml

FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
10/2	08:00 am					/					0	} pm
	09:00 am					/				100ml	0	
	10:00 am	No	adly			/				100ml	0	
	11:00 am	DUP				/				100ml	0	
	12:00 pm					/				100ml	0	
	01:00 pm					/					0	
Total Intake :						Total Output :						
10/2	02:00 pm			-		/					0	} AM
	03:00 pm			-		/				100	0	
	04:00 pm	No		-		/				6	0	
	05:00 pm	IVF		-		/				100	0	
	06:00 pm			-		/				100	0	
	07:00 pm			-		/				100	0	
Total Intake :						Total Output :						
11/2	08:00 pm	↑				/					0	} pm
	09:00 pm	↑	RPE			/				100ml	0	
	10:00 pm	NO	HF			/					0	
	11:00 pm	IVF				/					0	
	12:00 am	↓				/					0	
	01:00 am	↓				/					0	
Total Intake :						Total Output :						
11/2	02:00 am	↑				/					0	} pm
	03:00 am	↑				/					0	
	04:00 am	NO				/					0	
	05:00 am	IVF				/					0	
	06:00 am	↓				/					0	
	07:00 am	↓				/					0	
Total Intake :						Total Output : 800ml						
Total 24 hrs. Intake			Total 24 hrs. Output									

BAH-00660976 IP5-00176087
 Master PUPPALA SHASHI KRANTH
 20-06-2022 4 Y 0 M 18 D (M)
 Dr. UJJWALA DESAI

NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/7/26

Assessment: Pt having full activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
1:30AM	→ Assess the Pt General Condition	1:30AM	→ Assessed Pt General Condition.	Pt condition is normal
2:30AM	→ monitor vital signs	2:30AM	→ monitor vital signs	
6AM	→ maintain I/O chart	6AM	→ maintain I/O chart	
8AM	→ Administered the medications as per doctors order.	8AM	→ Administered the medications as per doctors order.	

Re-Assessment: 2:11

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Sravanthi

Date & Time: 8/7/26 8AM

BAH-00660976 IPS-00176087
Master PUPPALA SHASHI KRANTH
20-08-2022 4 Y 0 M 18 D (M)
Dr. UJJWALA DESAI



NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 8/7/26

Assessment: patient Complaint is fear

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
10 am	→ Assess the baby general condition & monitor vital sign	10:30 am	→ Assessed the baby general condition & monitored the vital sign.	Baby condition is improved
10:30 am	→ Maintain the I/O chart	11:30 am	→ Maintained the I/O chart	
11:00 am	→ Administered the medication as per doctor's order	12:00 pm	→ provide the comfortable position	
12:00 pm	→ provide the comfortable position	1 pm	→ Administered the medication as per doctor's order	
1 pm	→ Maintain the IV fluids	1:30 pm	→ maintain the IV fluids	

Re-Assessment: Monitor vital

Special Notes:

Nurse Signature: V. Ravine

Nurse Name: V. Ravine Chatterjee

Date & Time: 8/7/26 @ 2 pm

NURSING CARE RECORD

BAH-00860976 IP5-00176087
Master PUPPALA SHASHI KRANTH
20-06-2022 4 Y 0 M 18 D (M)
Dr. UJJWALA DESAI



Shift:

☐ Night

Date: 8/7/26

Assessment: Pt having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	=> Assess the pt general condition	2:30pm	=> Assessed the pt general condition	Pt condition Improving.
3pm	=> maintain I/O chart	3:30pm	=> maintained I/O chart	
4pm	=> monitor vital signs	4:30pm	=> monitored vitals	
5pm	=> provide comfortable position	5:30pm	=> provided comfortable position	
6pm	=> give all medications as per doctors order	6:30pm	=> given all medications as per doctors order	

Re-Assessment:

Special Notes: check the fence 6th hourly

Nurse Signature: Jamesa Nurse Name: Jamesa Date & Time: 8/7/26



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/7/24

Assessment: Baby Having Pyrexia (103.5°F)

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
10pm	→ Assess the Baby General Condition, monitor vital's Record	11pm	→ Assessed the Baby General Condition vital's Recorded	By Auntie's doc PA conditions improved
12am	→ provide Comfortable position	1am	→ provided Comfortable position	
2am	→ Continue IV fluid	3am	→ continued IV fluid	
4am	→ maintain I/O chart	5am	→ maintained I/O chart	
6am	→ Administer medication as per doctor order	8am	→ Administered medication as per doctor order	

Re-Assessment: sup- mftl given fever reduce

Special Notes:

Nurse Signature:

Nurse Name: Aparajitha, C21066

Date & Time: 9/7/24 2:02



IP5-00176087
Master PUPPALA SHASHI KRANTH
20-06-2022 4 Y 0 M 18 D
Dr. UJJWALA DESAI

NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 9/7/26

Assessment: Baby having pyrexia [100.4°F]

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	* Assess the general condition of the patient.	8am	* Assessed the general condition of the patient.	By done all the procedure the patient can be Stable
10am	* maintain personal hygiene.	10am	* maintained personal hygiene.	
12p	* monitor vitals.	12p	* monitored vitals.	
1p	* monitor for Temperature.	1p	* monitored Temperature.	

Re-Assessment: By given medication the baby reduce temperature.

Special Notes:

Nurse Signature:

Nurse Name: Winga

Date & Time: 9/7/26 @ 2p

BAH-00660976 IP5-00176087
Master PUPPALA SHASHI KRANTH
20-06-2022 4 Y 0 M 18 D (M)
Dr. UJJWALA DESAI



NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/7/26

Assessment: Baby having poor oral Intake

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the child general condition.	2:10 pm	→ Assessed the child general condition.	By done all the procedure baby condition is Improved.
3pm	→ provide comfortable position	4pm	→ provided comfortable position.	
5pm	→ Maintain good nutritional food	5:30 pm	→ Maintained good nutritional food.	
6pm	→ Maintain Dr fluid	6:30 pm	→ ONS 25ml/hr.	
7:30 pm	→ Monitor the vitals signs	8pm	→ Monitored the vitals signs	

Re-Assessment:

Special Notes:

Monitor urine output

Nurse Signature:

Nurse Name: Swarnika

Date & Time: 9/7/26 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/7/22

Assessment: pt having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the pt General Condition	8:10pm	→ Assessed the pt General Condition	
10pm	→ Check the vital signs	10:10pm	→ Checked the vital signs	
12am	→ plan for Administration medication	12:10am	→ providing medication as per doctor Order	pt is stable
2am	→ plan for I/O Chart	2:10am	→ strictly I/O Chart	
8am	→ plan for Comfortable position	8:10am	→ providing Comfortable position	

Re-Assessment: Re-Assessment Every 4th hrly

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Chandan

Date & Time: 10/7/22 2pm



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 10/7/26

Assessment: Baby having poor intake.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	* Assess the general condition of the patient & monitor vitals.	8am	* Assessed the general condition of the patient & monitor vitals.	By above all the procedures the patient can be stable
10am	* maintain personal hygiene.	10am	* maintained personal hygiene.	
11am	* Encourage orally.	11am	* encouraged orally.	
12p	* monitor vitals.	12p	* monitored vitals.	
1p	* maintain good nutrition.	1p	* maintained good nutrition.	

Re-Assessment: Monitor vitals.

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Dinya [Signature]

Date & Time: 10/7/26 @ 2p



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 10/7/26

Assessment: Baby having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the general condition of the patient	2pm	Assessed the general condition of the patient	Baby condition is good
3pm	monitor vitals signs	3:30pm	monitored the vitals signs	
	maintain Ilo chart		maintained the Ilo chart	
4:30pm	Administer medication as per as chart	4:30pm	Administered medication as per as chart	
	maintain personal Hygiene		maintained personal Hygiene	
	Ensure the patient safety		Ensured the patient safety	

Re-Assessment: Re-assessment

Special Notes:

Nurse Signature:

Nurse Name: Nikita Gossai

Date & Time: 10/7/26 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/07/26

Assessment: Baby having no fever

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the baby General condition	8pm	→ Assessed the baby general condition	By doing the all procedures the baby condition is improved slowly.
10pm	→ provide comfort position	10pm	→ provided comfort position	
12am	→ monitor the vitals & Recorded it	12am	→ monitored the vitals & Recorded it	
2am		2am		
4am	→ administer the all drugs as per doctor orders	4am	→ administered the all drugs as per doctor orders	
6am		6am		
8am	→ Ensured the Safety.	8am	→ Ensured the Safety & Side rails	

Re-Assessment: Done by seeing her activity

Special Notes: Plan D/c T/m

Nurse Signature: Shailaja

Nurse Name: Shailaja (605564)

Date & Time: 11/07/26 (6am)



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Ujjwala Desai Department: General med. Date of Admission: 2/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify: _____					
	<u>fever of unknown</u>							
BACKGROUND	Area	CP	1st floor 2nd floor	1st floor 2nd floor	1st floor 2nd floor	1st floor 2nd floor	1st floor 2nd floor	1st floor 2nd floor
	Shift Time	NA	NA	NA	NA	NA	NA	NA
ASSESSMENT	Medical Condition (Any special condition to be noted):		NA	NA	NA	NA	NA	NA
	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:		Temp: 98.5°F	98.1°F	98.2°F	97.6°F	97.8°F	98.2°F
	Res:		26b/m	26b/m	26b/m	28b/m	27b/m	28b/m
	SpO ₂ :		97.1%	100%	100%	100%	99.1%	99.1%
	Pulse:		120b/m	112b/m	117b/m	110	112b/m	110b/m
	BP:		88/68	94/59	102/68	96/66	98/62	99/60
	Fall Risk Score:		13	13	13	13	13	12
	Pain Score:		0	0	0/10	0/10	0/10	0/10
RECOMMENDATIONS	Safety Needs:		side rails	yes	yes		yes	yes
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		NA	NA	NA	NA	NA	NA
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		NA	NA	NA	NA	NA	NA
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Lachel	Saravathi	Ramona	Saravathi	Apurva	Ding	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		8/7/26	8/7/26	8/7	8/7	9/7	9/7	
Time:		12:10pm	1:00pm	2:00pm	2:00pm	3:00pm	4:00pm	
Taken Over By Name :		Saravathi	Ramona	Saravathi	Apurva	Ding	Saravathi	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		8/7/26	8/7/26	8/7/26	8/7	8/7	8/7	
Time:		1:30pm	2:00pm	2:30pm	3:00pm	3:30pm	4:00pm	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. V.D. Department: pede Date of Admission: 7/7/24

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
	<u>fever & jaundice</u>						
BACKGROUND	Area	Shift Time	<u>1st floor 8pm-8p</u>	<u>1st floor 8pm-8am</u>	<u>1st floor 8am-4p</u>	<u>1st floor 4pm-8pm</u>	<u>1st floor 8pm-8am</u>
	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	☐ Yes ☒ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>96.3°</u>	<u>98.1°</u>	<u>98.0°</u>	<u>98.1°</u>	<u>98.6</u>
	Res:	<u>24</u>	<u>26b</u>	<u>28b</u>	<u>22b</u>	<u>26b</u>	
	SpO ₂ :	<u>100%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	
	Pulse:	<u>110</u>	<u>116b</u>	<u>118b</u>	<u>112b</u>	<u>115bpm</u>	
	BP:	<u>101/64</u>	<u>98/62</u>	<u>99/62</u>	<u>100/64</u>	<u>106/70</u>	
	Fall Risk Score:	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</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>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</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>Swarup</u>	<u>Chandana</u>	<u>Divy</u>	<u>Nikita</u>	<u>Shariya</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>9/7</u>	<u>10/7</u>	<u>10/7</u>	<u>10/7</u>	<u>11/7</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>2p</u>	<u>2pm</u>	<u>(8am)</u>	
Taken Over By Name :		<u>Chandana</u>	<u>Divy</u>	<u>Nikita</u>	<u>Shariya</u>	<u>Melina</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>9/7</u>	<u>10/7</u>	<u>10/7</u>	<u>10/7</u>	<u>11/7</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>2p</u>	<u>2pm</u>	<u>8am</u>	

THE HUMPTY DUMPTY SCALE

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

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	Yes	Yes	Yes	Yes
Call device within reach	Yes	Yes	Yes	Yes
Wheels Locked	Yes	Yes	Yes	Yes
Room free of clutter	Yes	Yes	Yes	Yes
Adequate Lighting	Yes	Yes	Yes	Yes
Wheel Chair Support	No	No	No	No
Other Intervention(s) Specify	No	No	No	No
Nurse's Name :	Lalitha	APPU	Shruti	Shruti
Signature :	[Signature]	[Signature]	[Signature]	[Signature]
Date :	8/12/2022	9/12	10/12	11/12
Time :	12 AM	6 AM	6 AM	6 AM

BAH-00660976
Master PUPPALA SHASHI KRANTH
20-06-2022
Dr. UJJWALA DESAI
IPS-00176087
4 Y 0 M 19 D
(M)

CHECKLIST FOR THROMBOPHLEBITIS

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S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-							
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-							
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-							
Signature of the Nurse				[Signature]									

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

Signature of Shift In Charge :

Signature : [Signature] Name : Anirban

Signature of Ward In Charge :

Signature : [Signature] Name : Neeraja

BAH-00860976
Master PUPPALA SHASHI KRANTH
20-08-2022 4 Y 0 M 18 D
Dr. UJJWALA DESAI (M)

CHECKLIST FOR THROMBOPHLEBITIS

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S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	7/7/26 DAY-1			8hr DAY-2			9/7 DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			-	-	-	-	-	-	✓	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			-	-	-	-	-	-	-	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			-	-	-	-	-	-	-	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			-	-	-	-	-	-	-	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-	-	-	-	-	-	
Signature of the Nurse													

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 : Pulakesh Name : Pulakesh

Signature of Ward In Charge : Neeraja

Signature : Neeraja Name : Neeraja



BRADEN 'Q' SCALE

				Date :	8/12/20	9/12	10/12	11/12
				Time :	12 AM	6 AM	6 PM	6 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	6	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	6	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
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	4
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	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	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			
					Evaluator's Name			
					28	28	28	28
					2	2	2	2

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
8/7/26	12 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Lachel
8/7/26	8 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sravanthi
8/7/26	2 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Dr
8/7/26	10 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Appo
9/7/26	6 am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Am
9/7/26	2 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	af
9/7	10 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chander
10/7	6 am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chander
10/7	10 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
10/7	6 am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shaiy

Re-assessment Frequency:

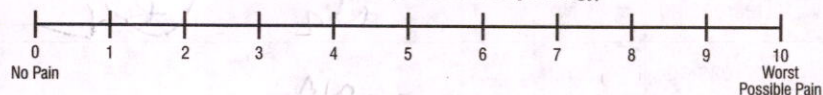
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

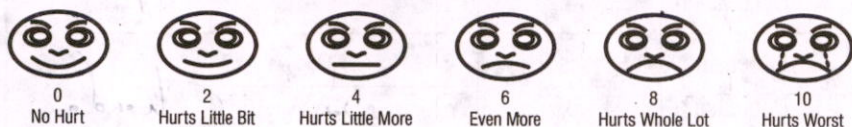
Numerical Pain Scale (Obstetric and Gynecology)



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





INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: Telugu Patient / Learner Literacy: ☐ Read ☒ Write ☒ Speak Willingness to Learn: ☒ Yes ☐ No Healthcare Literacy: ☒ Yes ☐ No

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
8/7/21	12 AM	2	Treatment and care plan	M	1	0	1	1	NA	Label
8/7/21	8 AM	9	Self care	M	1	0	1	1	-	Master

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:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
8/7/26 1 Am	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Acute viral hepatitis	Hemodynamical stability	IV fluids	\$ Salithi	☐ Nursing ☐ Others:
8/7/26	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	fever	H. stability	IV fluids	Lachel	☒ Medical ☐ Others:
8/7/26 2 Am	☐ Medical ☐ Nursing ☒ Others: Dietician	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Tenderness & ? Acute viral Hepatitis	Soft diet	RDA E = 1350 Kcal/d P = 23g/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:

BAH-00660976 IP5-00176087
Master PUPPALA SHASHI KRANTH
20-06-2022 4 Y 0 M 18 D (M)
Dr. UJJWALA DESAI



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

Explain to mother

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:

Personal hygiene

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

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: Si

Nurse Name: S. Sauranthi

Date and Time: 8/7/26

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00660976 IP5-00176087 Master PUPPALA SHASHI KRANTH 20-06-2022 4 Y 0 M 17 D (M) Dr. UJJWALA DESAI 		Date & Time of Admission 3/2/26 @ 11:51pm	Date & Time of Transfer Order 8/2/26 @ 1:14pm
		Transfer Ordered by Dr. Sahithi	Reason for Transfer Admission
From Unit ER	To Unit 139	Information to Attendant Yes ☐ No ☒	
Number of Sheets in Clinical File 20	Number of Imaging Films nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what? op file P. Prasad	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	DNS	①	
2.	Intrafix	①	
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Mr. Lachel		Name of Person Ordered Transfer Dr. Sahithi	
Patient & Clinical Records Received by : Savanthi			
Date & Time of Patient Received : 8/2/26 1:30 AM			

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 - BOYS

Date: 8/7/26 Time: 8Am

Weight: 14kg Centile: 10th

Height: 99cm Centile: 25th

Inference: underweight child

RDA: — Calories: 1350kcal/d Protein: 23g/d

Diet Recommendations: soft diet

Re-Assessment: Avoid spicy, chilled and outside foods

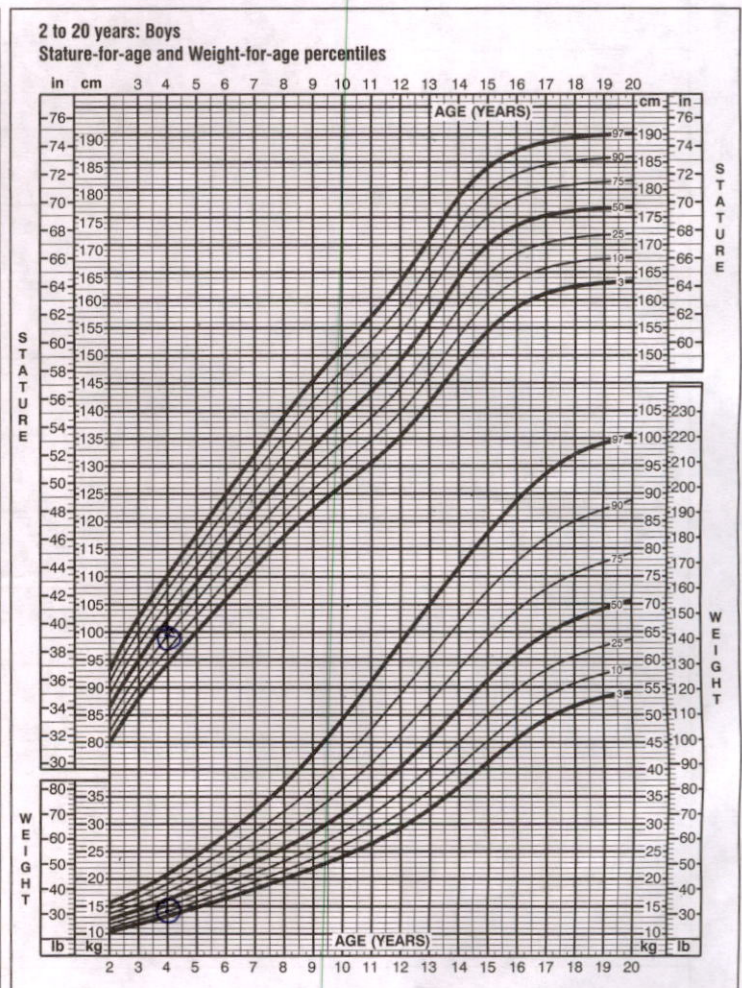
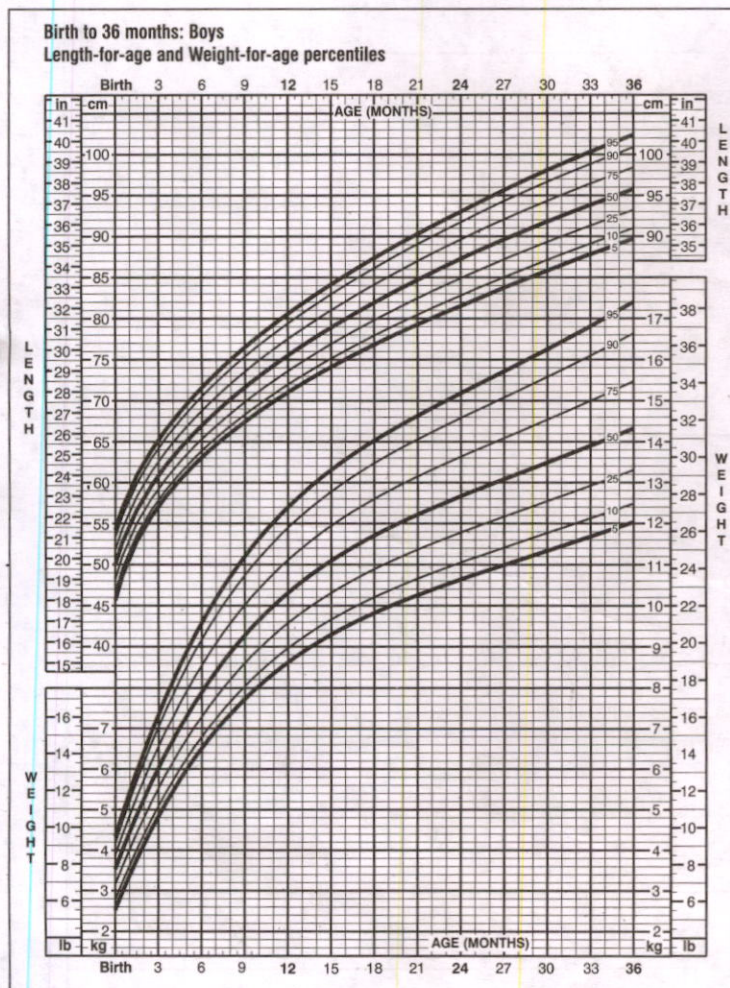
Food Allergies: ND Veg/Non-veg: non veg

Diagnosis: Fever & Jaundice & Acute viral hepatitis

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: P. Prasad

GROWTH CHART (BOYS)



Dietician's Name: Manjula

Dietician's Signature: Manjula

Daily Notes:

9/7/26
8am

child is stable. Intake is fair.

Continue on soft diet

Nil

10/7/26
8:30am

Child is Stable Oral Intake is good.

Continue on Soft diet.

None