

DEFICIENCY CHECK LIST OF CASE SHEET

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

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

ACTIVITY RECORD FOR BILLING

Name : _____
 UHID No. : _____
 Date of Admission: _____ Time : _____ Date of Discharge : _____ Time : _____
 Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

BAH-00662122 IP5-00176597
 Master RATHOD MANITEJ NAYAK
 06-01-2018 8 Y 6 M 13 D (M)
 Dr. FAISAL B NAHDI



Consultant: _____ Dept : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
19/7/25	7:50 AM	CA	204	Ramadevi

Cross Consultation Visit

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

[illegible]

dle

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

[illegible]

ANY OTHER INFORMATION

~~USA~~
X-ray - ①
USA - ①

Date : 22/7/26 Time : 9 AM Prepared By : *gina*

Date : 22/7/26

Time : 9 Am

Prepared By : *psina*

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
ngina	HD unit		

Shift / Ward

Billing Assistant

Billing Supervisor

psind

HP unit

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176597 Admit Date : 19-Jul-2026 Admit Time : 06:47 AM UHID : BAH-00662122

Patient Details :

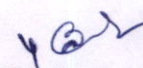
Patient Name	: Master RATHOD MANITEJ NAYAK	Age	: 8 Y 6 M 13 D
Guardian	: Mr RATHOD VISHWANATH	DOB	: 06-01-2018
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: #5-56,andhu guda, gundamamada jainoor mandal komaram bheem Ootnur Adilabad Telangana INDIA 504311	Phone No	: 9492431522/ 6303210675
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type : SEMI PRIVATE Bed No : SPVT 204 Ward Name : 2F-SECOND FLOOR
 Room No : SPVT 204 Admission Type : First Visit

Contact Details :

Name	: Mr RATHOD VISHWANATH	Relationship	: Father
Contact Address	: #5-56,andhu guda, gundamamada jainoor mandal komaram bheem Ootnur Adilabad Telangana INDIA 504311	Phone No	: 9492431522 / 6303210675


 Signature

Doctor Details :

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

Payment Details :

Payment Mode	: Cash	Deposit Amount	: 0.00
		Payor Name	: CARE HEALTH INSURANCE LIMITED



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00662122 IP5-00176597
Master RATHOD MANITEJ NAYAK
06-01-2018 8 Y 6 M 13 D (M)
Dr. FAISAL B NAHDI



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

BAH-00662122
Master RATHOD MANITEJ NAYAK
06-01-2018 8 Y 6 M 13 D (M)
Dr. FAISAL B NAHDI

Geriatric Multiorgan History & Physical Examination

Name : Manitej Age/Sex 9y / m
Information given by: Mother Relationship

Chief Presenting Complaints & Duration (Chronologically)

c/o fever ... 1 wk

History of present illness :

c/o fever ... 1 wk
cb

high grade, intermittent,
not a/c chills, rigors

no c/o cough, cold, loose stools,
vomiting, abdominal pain,
urinary incontinence

w/o joint pain of b/l knee for
2 days of fever



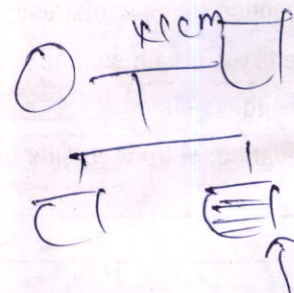
Pediatric Multiorgan History & Physical Examination

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

mif

Birth & Neonatal History:

normal Th. A. G. A. no perinatal issues



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

as per age

Immunization History :

upto date

Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____
Weight (kgs)) 29.7 (Centile _____)

On Examination :

Temperature : 100.6 F Pulse Rate : 96 / min B.P. 110 / 70 mmHg SPO2 97 %
Resp. rate and type of breathing : 22 / min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : R/L NVB

Any addles sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S1S2 (+)

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : soft, nontender

Auscultation : _____

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Plantars _____

Superficials:

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Acute febrile illness

High fever

Acute gastritis

Abdominal pain & Nausea



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

CBP

CRP

Blood c/s

CVE

Extra plate - 4 samples

NIB

Sugar

10/7/26

7:40 AM

Planned Management

IVF DNU

NIB

Sugar

10/7/26

7:40 AM

Signature of the Doctor: _____

Name of the Doctor: _____

Date & Time: _____

Signature of the Consultant: _____

Name of the Consultant: _____

Date & Time: _____

DR. FAISAL B NAHDI
Registration No: 66228



①

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7 8:30am	C/S/B Resident Δ: AFI (D8) C acute gastritis & dehydration fever x last Sunday. joint pain x 13-15 ^{HR} . no other localising fx. last fever - 100°F at night. O/E: alert vitals stable no rash over body P ⁺ I ⁺ C ⁺ C ⁺ L ⁺ E ⁺ Throat clear. chest: B/L NVBS ⁺ abdomen: soft / NT. MSK - no tenderness or joint limitation	Adv: 1) Send CUE 2) R/V: Widal. Dengue IgM. 5 viral panel. Xray abdomen. Mycoplasma IgM. Xray chest / abdomen 3) W/f fever spikes. 4) Monitor vitals 5) Ceftriaxone D1
19/7 10:30am	fever x sdy. C joint pain any 7d of fever.	USG abd t/m femur ✓ KIDAL ✓ CPK ✓ Mycoplasma IgM ✓ Weil felix ✓ Brucella IgM ✓ Achille now

DR. FAISAL B NAHDI
Registration No. 68228



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26 8 AM	SIB Resident 1. AFI & Acute galblitis plan. under Evaluation ongoing fever ⊕ 3 fever ⊕ → 3 PM moderate 9 PM Grade 4 AM no joint pain	①. Widal Leucoplasma Tgm ✓ Weil Felix ✓ Brucella Tgm Blood CS ②. cont. ceftriaxone Doxycycline ③. USG Abdomen ④. monitor vitals
	Verbal Widal negative mycoplasma Tgm Brucella Tgm Weil Felix negative	⑤. Child alert vitals stable M Wc PLA normal
		Madhu
20/7 9 AM	Culdi AFI @y y ten	Plan Continue same medical Send 5 viral panels USG Abdomen Chest X-ray NO PDS

Date & Time	Progress Notes	Doctor's Order
20/7 4pm	C/S/B Resident Δ: AF I (Dg) c acute gastritis c some dehydration → fever - 1 spike at 12pm - 100.9°F O/E: alert vitals stable S/E: NAD	Adv. 1) Trace adenovirus 8 48 h blood c/s t/m 6am 2) Monitor vitals 3) Cont Ceftriaxone & Doxycycline.
20/7		Akhile
Cul	Culd CARI	Plan:
Cul (10:30pm)	C Ate gaster. C some dehyd.	① Contn same Meds ② Rpt CMP / CRP (tom) NB poss.

DR. FAISAL B NAHDI
Registration No: 66228



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/1/2	Chel (13) Resident	
3:30pm	Dr. AFI E Atypical infection.	
	Temp 1:45 pm (101.2°F) 2:45 pm (100.8°F)	Pain
	Passing urine, stool	- ct by mefloquine (D ₁)
	No vomiting, pain abdomen, loose stools	oxytocin (D ₂)
	Rg - BAK (E), clear	ord Azithromycin (D ₁)
	PIA - soft, (N)	Aspirate
		- Temp checking
		- monitor vitals
		- no
		Pain
2/1/2	Chel (12) Dr. UD man	
		Pain
		add Lunexax 40 1/2 tab BD
		Naked Bx Nike
		Pain
2/1/2	Chel (13) PN in	
		Continue same
		Pain



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/12/2018 8 AM	SIB Resident 1. AFI c Atypical sepsis no fever last fever spike at 2.45 pm - 100.8°F no other issues OTE. CHSD alert vitals stable Rx - B/L AC ④ Cvs - S1S2 (w) PIA - soft	plan: ① cont. meropenem D2 Azee D2 doxycycline D4 ② monitor vitals ③ wif fever ④ Inform SOC
22/12/2018 Child (w/fev)	Child c AFI c Atypical sepsis Child c Atypical sepsis Child c Atypical sepsis	Disch 'at Equ. IV Meropenem BD x 4d. 1000mg 1gm x BD.
		① Tab Lumerax 40. 1 1/2 tabs. BD.
		Tab langul 30g (DT) ① MBF — self
		Syp Aru x x 4d
		① A/o next week Tuesday

BAH-00662122 IP5-00176597
Master RATHOD MANITEJ NAYAK
06-01-2018 8 Y 6 M 13 D (M)
Dr. FAISAL B NAHDI



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	13/7	15/7	19/7	20/7	
Time					
Hb	11.7	11.2	10.1	10.9	
PCV			30%	34.0	
RBC			3.77	4.07	
WBC	8100	10900	14700	1113	
N/L	77/16	79/13	83/12	67.7/24.6	
Platelets	2.7L	3.0L	5.84L	684	
CRP	3.45	3.0 2.15	65	35 ↓	
ESR	(<3)	110.			
PCT		ASO 113			
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	Widal neg	Dengue	Leishman-137		
N/L	MP card	Card	CPR-26		



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: GP

Shifted to: 204

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : DR. Harsha

Date & Time : 19/7/26

Nurse Name & Signature : Kamadevi

Date & Time : 19/7/26 at 7:20 AM

Date of Admission: 9/1/12 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 : T. PARACETAMOL				Date Time
Dose 160	Route PO	Frequency SOS	Start Date 19/7	Time 7:20 AM
Doctor's Signature				Pharm.
Additional Instructions: 160 = 500ml				

DRUG : Symp MEFTALP				Date Time
Dose 22ml PO	Route PO	Frequency SOS	Start Date 21/7	Time 6:30 PM
Doctor's Signature <i>[Signature]</i>				Pharm. Nasim Raza
Additional Instructions: (5/100) $T > 102^{\circ}F$				

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



REGULAR PRESCRIPTIONS

Weight. 29.2 kg Ward. 2nd/108

VERIFIED

VERIFIED

VERIFIED

VERIFIED

VERIFIED

DRUG: Dr. CEFTRIAXONE P. D.

Dose	Route	Frequency	Start Date	Date Time
1.5g	IV	BD	19/7	10AM

Name & Signature of the Doctor Starting the Drugs: Akhil

Additional Instructions: 100 mg/kg/day

Daily Doctor's Endorsement by a Sign: A

Handwritten notes: 19/7 20/7 21/7, 10pm, 11/10, DIPA, change to Meropenam, Akhila 21/7

DRUG: Dr. ESMOPRAZOLE

Dose	Route	Frequency	Start Date	Date Time
30mg	IV	OD	19/7	6AM

Name & Signature of the Doctor Starting the Drugs: Akhil

Additional Instructions:

Daily Doctor's Endorsement by a Sign: A

Handwritten notes: 19/7 20/7 21/7, 6AM, 8AM, Nasim, 21/7, DIPA, Swathi

DRUG: Cap DOXYCYCLINE

Dose	Route	Frequency	Start Date	Date Time
4ml	PO	BID	19/7	10AM

Name & Signature of the Doctor Starting the Drugs: Akhil

Additional Instructions: 2.2ml/kg
1 cap = 100mg in 6ml
& give 4ml

Daily Doctor's Endorsement by a Sign: A

Handwritten notes: 19/7 20/7 21/7, 10AM 12:30 PM, 10pm, 11/10, DIPA, Swathi

DRUG: Inj MEROPENAM P. D.

Dose	Route	Frequency	Start Date	Date Time
1.2g	IV	TID	19/7	6am

Name & Signature of the Doctor Starting the Drugs: Akhil

Additional Instructions: 40mg/kg TID

Daily Doctor's Endorsement by a Sign: A

Handwritten notes: 19/7 20/7 21/7, 6am, 11/10, DIPA, Swathi

BAH-00662122 IP5-00176597
Master RATHOD MANITEJ NAYAK
06-01-2018 BY 6 M 15 D (M)
Dr. FAISAL B NAHDI



Sheet No. **REGULAR PRESCRIPTIONS** Dept. Ward.

DRUG : Syb AZITHROMYCIN Date: 21/7
Time: 11 AM

Dose	Route	Frequency	Start Dt.
7.5ml PO		OD	21/7

Name & Signature of the Doctor
Starting the Drugs:

Shubh 10 pm
2 pm
10 am

Additional Instructions:

(5ml/200mg)
10/14/day

Daily Doctor's Endorsement by a Sign

DRUG : Tab LARINATE Date: 21/7
Time: 2 PM

Dose	Route	Frequency	Start Dt.
1/2 tab PO		OD	21/7

Name & Signature of the Doctor
Starting the Drugs:

Shubh 2 pm
Change

Additional Instructions:

4ml/kg antecubitate
1 tab = 200mg

Daily Doctor's Endorsement by a Sign

DRUG : Tab LUMERAX 40 Date: 21/7
Time: 2 PM

Dose	Route	Frequency	Start Dt.
1 1/2 tab	PO	BD	21/7

Name & Signature of the Doctor
Starting the Drugs:

Cuf 10 pm
Dipe
Spathe

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor
Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

VERIFIED

Signature

VERIFIED BY: NAME

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Dept. 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																			

VERIFIED BY : Name Signature

Weight. 29.21kg Ward. 2nd floor

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.	

[illegible]

Weight. 29.25 Ward.

[illegible]



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Par

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
19/7	2:20 AM	2	Treatment and care plan	19	1	0	2	2	-	<i>[Signature]</i>
19/7	8am	9	Normal diet	M	1	0	1	1	-	<i>Nikhil</i>

Part - III: CODES

Who was taught:	PT: Patient	F: Father	M: Mother	S: Spouse	Sn: Son	D: Daughter	C: Caregiver	O: Other (Specify)															
Learning Barriers:	<table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice	2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)	3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	
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:	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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:	<table border="0"> <tr> <td>1. Verbalizes Understanding</td> <td>2. Demonstrates Understanding</td> <td>3. Needs Review</td> </tr> </table>								1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review												
1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review																					



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: APF

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
19/7/26 7:20 AM	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fever x 2 weeks	H. Stability	vitals monitoring		☐ Nursing ☐ Others:
19/7/26 7:20 AM	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fever x 1 week.	H. stability	→ IV fluids → IV Antibiotics		☐ Medical ☐ Others:
19/7/26 8 am	☐ Medical ☐ Nursing ☒ Others: dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	APF	Normal diet	<u>RDA</u> e - 1500 kcal/d p - 27g/d		☐ 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-00862122
Master RATHOD MANITEJ NAYAK
06-01-2018
Dr. FAISAL B NAHDI
IP5-00178597
8 Y 6 M 13 D (M)

EMERGENCY ROOM TRIAGE FORM

Patient's Name: Rathod Manitej
Date: 06-01-2018
Allergies: ☒ No ☐ Yes
Source of Information: ☒ Parent ☐ For Others (Specify):
Mode of Arrival: ☒ Ambulance ☐ Stretcher ☐ Wheelchair

Age: 8 yrs

Gender: ☒ Male ☐ Female
Triage Completion Time: 6:23 AM
☐ Not known any drug Allergies

INITIAL PHYSIOLOGICAL STATUS

Appearance
☒ Normal ☐ Sick Looking
Circulation / Colour
☐ Abnormal ☐ Bleeding

Work of Breathing
☒ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS
☒ Stable
☐ Unstable:
☐ Not - Life - Threatening
☐ Life - Threatening

PR: 96 bpm BP: 111/73 RR: 26 bpm SpO₂: 97%

60.6 F
Fever
x 1 week

CTAS

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

Signature of Parent / Guardian

EMERGENT: Life or limb threatening
URGENT: Significant illness / injury with potential to become life threatening
LESS URGENT: Significant illness but not life threatening
NON - URGENT: May receive care when convenient
Level 5: NON - URGENT: All immunocompromised children and preterm babies to be considered
All Children less than 2 years age with high fever to be considered Level 3.
* CTAS - Canadian Triage and Acuity Scale

Communicable Disease 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?
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 unexplained, severe febrile respiratory or rash disease

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 answers "YES" to any of the questions on epidemiologic risk factors "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: Kanthan
12107

Signature of Triage Nurse: [Signature]

& Time: 6:23 AM
RCMBH / RM / CLINIC / 005

Condition of patient at time of shift:
 HR: 106 bpm, BP: 100/60 mmHg, SpO₂: 94%
 Temp: 37.4°C
 Details of Shift - out
 Shift - out from ER to: 7:25pm
 Time of Shift - out: 7:25pm

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign

Time	Nursing Notes (Including Labs / Medications / Other Care):
7:20 pm	Seen the child mom and covered dent fntly and best Dr. Heika and covered dent fntly and best → No placement are to be → Samples are collected and best → 5th shifted to 100% → Repeat 9.
7:25 pm	Samples collected by: / Mr. Faradey Samples sent by: / Mr. Venkat

Time: 7:20pm
 Time: 7:25pm
 Doctor Sign: [Signature]



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 7:55 AM Mode of Arrival: white chair Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: nil Body Weight: 29.7 kg Kg

Height: — cm

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

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

Family History: —

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

If yes please list, —

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

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

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

Observations: Weight: 29.7 kg Length: — Head Circumference (< 2 years): —

Temp.: 99.8°F HR: 103B/m RR: 26B/m BP: 106/64 mmHg

Pain Score: 0/10 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 28) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☐ Yes ☒ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker

Character of Pain — Location — Frequency — Duration —

FUNCTIONAL SCREENING: ☒ No Abnormalities Detected

☐ Mobility Problem

☐ Walking Problem

☐ Developmental Delay

☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormalities Detected

☐ Underweight

☐ Overweight

☐ Special Feeding Method

☐ Feeding Problem

☐ Special diet

☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

If Yes Consultant Notified: (Date/Time):

Social History: Lives With

Siblings in household ☐ Yes ☒ No (if yes How Many?) *2*

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

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☒ Yes ☐ No

Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump : ☒ Yes ☐ No

Hand hygiene Explained: ☒ Yes ☐ No

☐ Others

Patient Rights & Responsibilities: ☒ Yes ☐ No

Information given to *Mother*

Nurse's Name: *Rosnora*

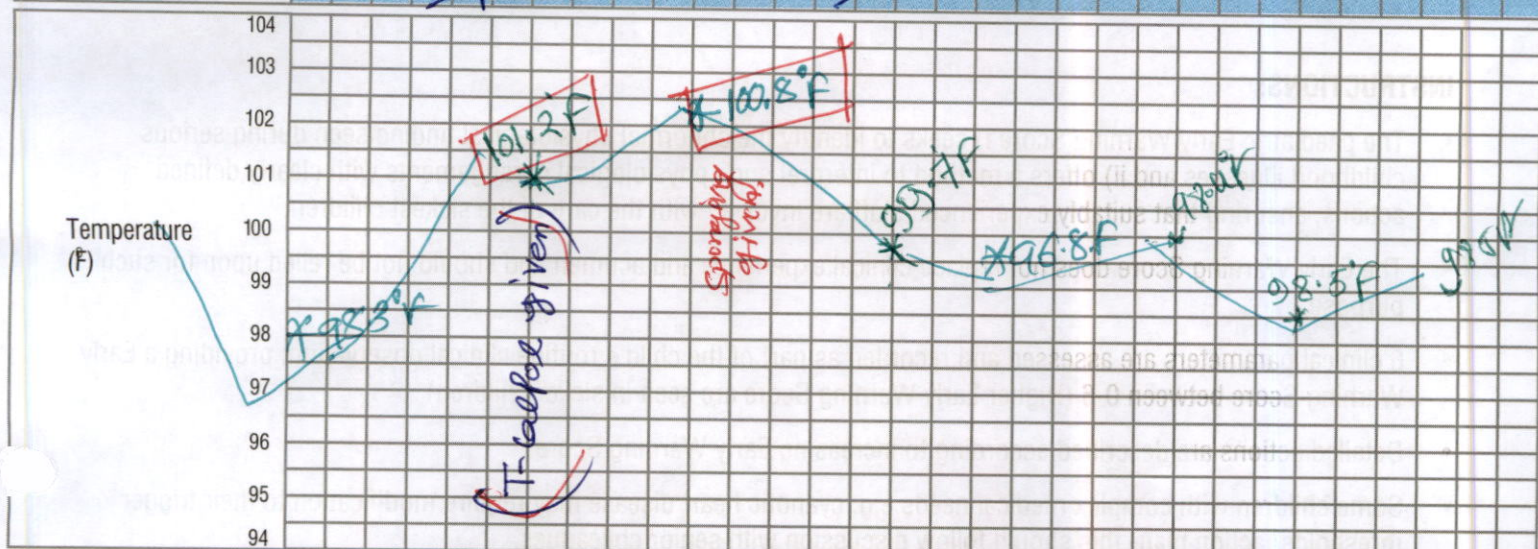
Date: *19/7/26*

Time: *at 7:55am*

Signature *Rosnora*

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 10AM 1:45 PM 2PM 2:45 PM 4PM 6PM 10PM 2AM 6AM
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) *															
Note: BP does not score in early warning scoring															
Heart Rate (Number)	96B/m	99B/m	96B/m	99B/m	98B/m	99B/m									

Resp. Rate (bpm) (Over 1 Minute) *	70	60	50	40	30	20	10
Resp Rate (Number)	24B/m	29B/m	26B/m	27B/m	26B/m	26B/m	26B/m

Resp Distress	Mod/ Severe None / Mild																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																</
---------------	----------------------------	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	----

TOTAL SCORE	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	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.

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)



20/12/26.

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time: <u>2am</u>	<u>3am</u>	<u>4am</u>	<u>5am</u>	<u>6am</u>	<u>7am</u>	<u>8am</u>	<u>9am</u>	<u>10am</u>	<u>11am</u>	<u>12pm</u>	<u>1pm</u>	<u>2pm</u>	<u>3pm</u>	<u>4pm</u>	<u>5pm</u>	<u>6pm</u>	<u>7pm</u>	<u>8pm</u>	<u>9pm</u>	<u>10pm</u>	<u>11pm</u>	<u>12am</u>
Doctor / Nurse / Family Concern?																							
Temperature (°F)																							
Heart Rate (bpm)																							
and																							
Blood Pressure (mmHg) *																							
Note: BP does not score in early warning scoring																							
Heart Rate (Number)		<u>112b/m</u> <u>112b/m</u>																					
Resp. Rate (bpm) (Over 1 Minute) *																							
Resp Rate (Number)		<u>24b/m</u> <u>25b/m</u>																					
Resp Distress		Mod/ Severe None / Mild																					
Receiving O ₂ (l/min)		<u>RA</u> <u>RA</u>																					
O ₂ Saturations (%)		<u>99%</u> <u>98%</u>																					
Conscious Level		Normal Altered																					
GCS *		<u>15/15</u> <u>15/15</u>																					
TOTAL SCORE																							
Number of shaded boxes		<u>0</u> <u>0</u>																					
Pain Score		<u>0</u> <u>0</u>																					
Observer's Initials		<u>HT</u> <u>HT</u>																					
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: Scores 3 should be recorded overleaf																							

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

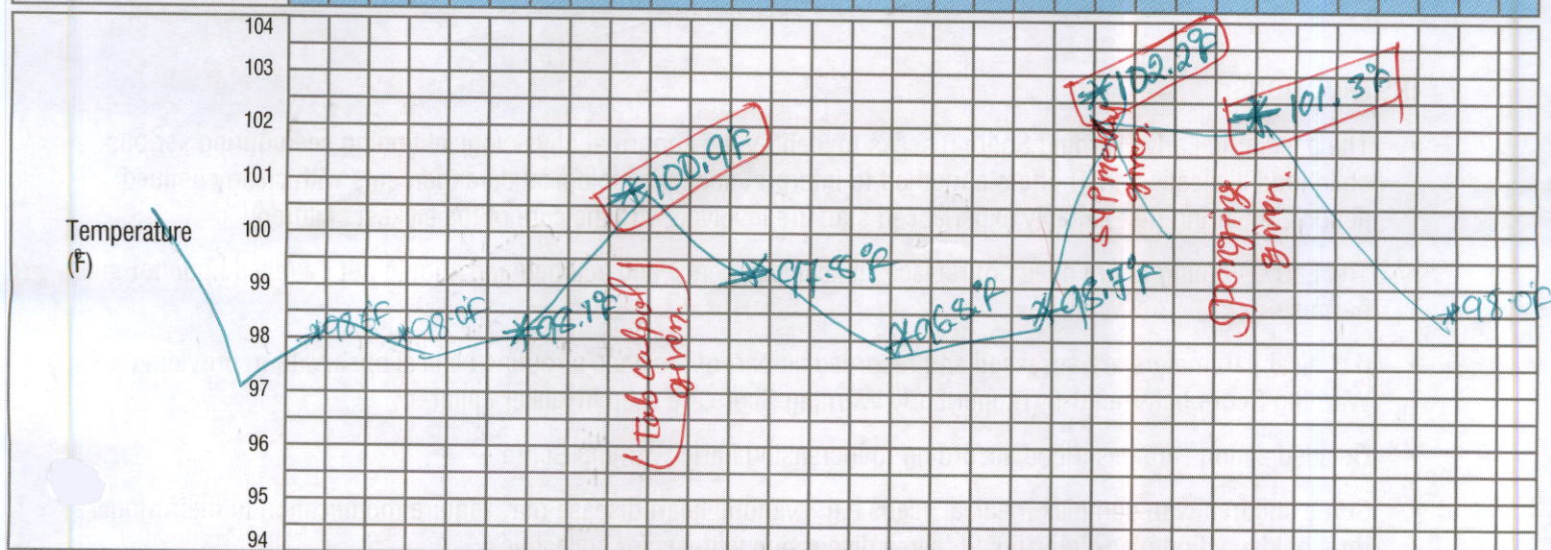
- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 4am 6am 10am 12pm 1:30pm 2pm 6pm 6:30pm 7:40pm 10pm
Doctor / Nurse / Family Concern?



Heart Rate (bpm)	190								
and	180								
Blood Pressure (mmHg) *	170								
Note:	160								
BP does not score	150								
in early	140								
warning scoring	130								
Heart Rate (Number)	120								
	110								
	100								
	90								
	80								
	70								
	60								
	50								
	100	104	106	103	109	93			
	(153)	(165)	(171)	(81)	(79)	(63)			
	68	57	59	64	65	59			
	104b/m	109b/m	106b/m	110b/m	100b/m				

Resp Rate (bpm)	70								
(Over 1 Minute) *	60								
Resp Rate (Number)	50								
	40								
	30								
	20								
	10								
	24b/m	28b/m	26b/m	29b/m	25b/m				

Resp Mod/ Severe									
Distress None / Mild									
Receiving O ₂ (l/min)									
O ₂ Saturations (%)									
Conscious Level									
Normal Altered									
GCS *									
	15/15	15/15	15/15	15/15	15/15				

TOTAL SCORE									
Number of shaded boxes		0	0	0	0			0	
Pain Score		0	0	0	0			0	
Observer's Initials		HH	PL	DD	DD			HH	

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time: <u>10 AM</u>	<u>2pm</u>	<u>2:45</u>	<u>3:45pm</u>	<u>6pm</u>	<u>8:50pm</u>	<u>10pm</u>	<u>12:20am</u>
Doctor / Nurse / Family Concern?								

Temperature (F)

94 95 96 97 98 99 100 101 102 103 104

97.7° 98.3°

100.8°

98.0° 98.7°

101.0°

99.0°

100.7°

(Tas - calpo / given)

(Tas - calpo / given)

	Heart Rate (bpm)	Blood Pressure (mmHg) *
and		
Blood Pressure (mmHg) *		
Note: BP does not score in early warning scoring		
Heart Rate (Number)	109 bpm	162 bpm

[illegible][illegible][illegible][illegible]

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

19/7/25

FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
19/7	08:00 am	↓	Toly	65ml							0	Rosny
	09:00 am	↓	Toly	65ml					✓		0	Rosny
	10:00 am	↓									0	Rosny
	11:00 am	↓		65ml							0	Rosny
	12:00 pm	↓		65ml					✓		0	Rosny
	01:00 pm	↓		65ml							0	Rosny
Total Intake :			325ml			Total Output :					M-0 U-2	
19/7	02:00 pm	↓	DRUG								0	Rosny
	03:00 pm	↓	DRUG						✓		0	Rosny
	04:00 pm	↓		65ml							0	Rosny
	05:00 pm	↓		65ml					✓		0	Rosny
	06:00 pm	↓		30ml							0	Rosny
	07:00 pm	↓		30ml					✓		0	Rosny
Total Intake :			220ml			Total Output :					M-0 U-3	
19/7	08:00 pm	↓	Rice	30ml							0	Hanily
	09:00 pm	↓	water	30ml							0	Hanily
	10:00 pm	↓							✓		0	Hanily
	11:00 pm	↓									0	Hanily
	12:00 am	↓									0	Hanily
	01:00 am	↓									0	Hanily
Total Intake :			60ml			Total Output :					M-0 U-1	
20/7	02:00 am	↓		30ml							0	Hanily
	03:00 am	↓		30ml							0	Hanily
	04:00 am	↓		30ml							0	Hanily
	05:00 am	↓		30ml							0	Hanily
	06:00 am	↓		30ml							0	Hanily
	07:00 am	↓							✓		0	Hanily
Total Intake :			150ml			Total Output :					M-0 U-1	
Total 24 hrs. Intake			755ml			Total 24 hrs. Output			M-0 U-6			



FLUID CHART

Sheet No. :

20/12/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
20/12	08:00 am	↑	water	30ml						✓	0	Rosny
	09:00 am			30ml							0	Rosny
	10:00 am	DNS		-			NP				0	Rosny
	11:00 am			-						✓	0	Rosny
	12:00 pm	↓		30ml							0	Rosny
	01:00 pm			30ml							0	Rosny
Total Intake :				120ml		Total Output :					0-2	
20/12	02:00 pm	↑	Rice cury	30ml							0	Rosny
	03:00 pm			30ml						✓	0	Rosny
	04:00 pm	DNS		30ml			NP				0	Rosny
	05:00 pm			30ml							0	Rosny
	06:00 pm	↓		-							0	Rosny
	07:00 pm			30ml							0	Rosny
Total Intake :				150ml		Total Output :					0-2	
20/12	08:00 pm	↓	Rice water	-							0	Hanily
	09:00 pm			-							0	Hanily
	10:00 pm	DNS		-			NP			✓	0	Hanily
	11:00 pm	↑		30ml							0	Hanily
	12:00 am			30ml							0	Hanily
	01:00 am			30ml							0	Hanily
Total Intake :				90ml		Total Output :				0-0	0-1	
21/12	02:00 am	↓		30ml							0	Hanily
	03:00 am			30ml						✓	0	Hanily
	04:00 am	DNS		30ml			NP				0	Hanily
	05:00 am	↑		30ml							0	Hanily
	06:00 am			-							0	Hanily
	07:00 am			-						✓	0	Hanily
Total Intake :				120ml		Total Output :				0-0	0-2	
Total 24 hrs. Intake			480ml			Total 24 hrs. Output			0-0 0-7			



21/2/26.

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
21/2/26	08:00 am	No Oral ↓ IV		-							0	Kaly	
	09:00 am			-						0	Kaly		
	10:00 am			-			✓			0	Kaly		
	11:00 am			-						0	Kaly		
	12:00 pm			-					✓	0	Kaly		
	01:00 pm			-						0	Kaly		
Total Intake :						Total Output : M-1 U-2							
21/2	02:00 pm	No Oral ↓ IV	rice	-							0	Kaly	
	03:00 pm		rice	-					✓	0	Kaly		
	04:00 pm			-						0	Kaly		
	05:00 pm			-			✓			0	Romy		
	06:00 pm			-					✓	0	Romy		
	07:00 pm			-						0	Romy		
Total Intake :						Total Output : M-1 U-2							
21/2	08:00 pm	No Oral ↓ IV		-							0	Diya	
	09:00 pm			-						0	Diya		
	10:00 pm			-					✓	0	Diya		
	11:00 pm			-			✓			0	Diya		
	12:00 am			-						0	Diya		
	01:00 am			-					✓	0	Diya		
Total Intake :						Total Output : M-1 U-2							
21/2	02:00 am	No Oral ↓ IV		-							0	Diya	
	03:00 am			-						0	Diya		
	04:00 am			-					✓	0	Diya		
	05:00 am			-			✓			0	Diya		
	06:00 am			-						0	Diya		
	07:00 am			-					✓	0	Diya		
Total Intake :						Total Output : M-1 U-2							
Total 24 hrs. Intake						Total 24 hrs. Output			M-1 U-2				

BAH-00662122 IP5-00176597
Master RATHOD MANITEJ NAYAK
06-01-2018 8 Y 6 M 16 D (M)
Dr. FAISAL B NAHDI

FLUID CHART

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No. :

22/7

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

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



204

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 19/7/20 Time: 8am

Weight: 29.7kg Centile: >50th

Height: 144cm Centile: >97th

Inference: well child

RDA: - Calories: 1550 kcal/d Protein: 27g/d

Diet Recommendations: Normal diet

Re-Assessment: Avoid spicy, chilled, outside foods

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

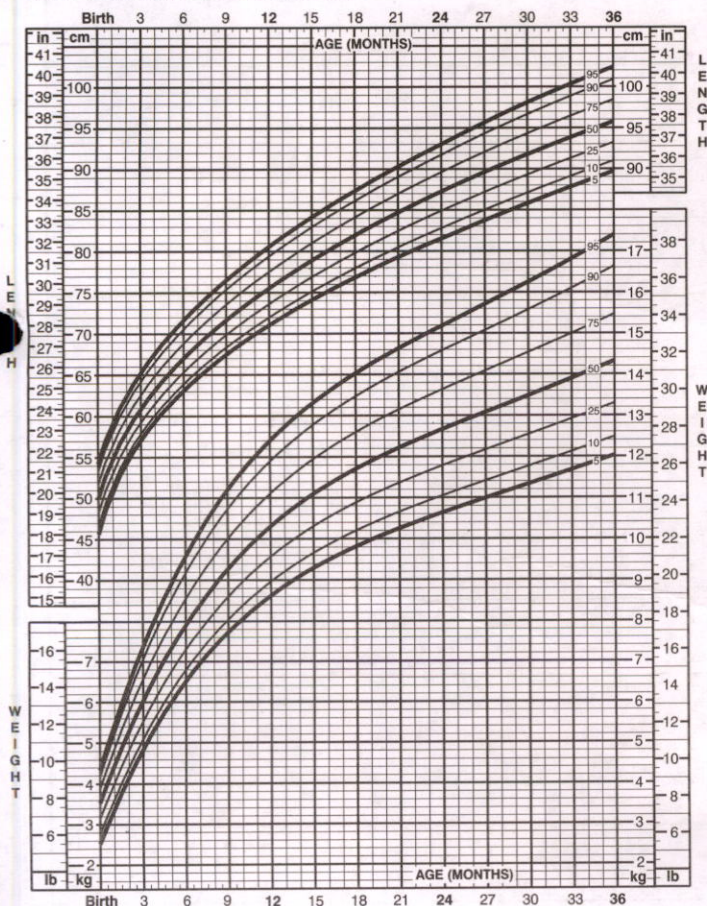
Diagnosis: API

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

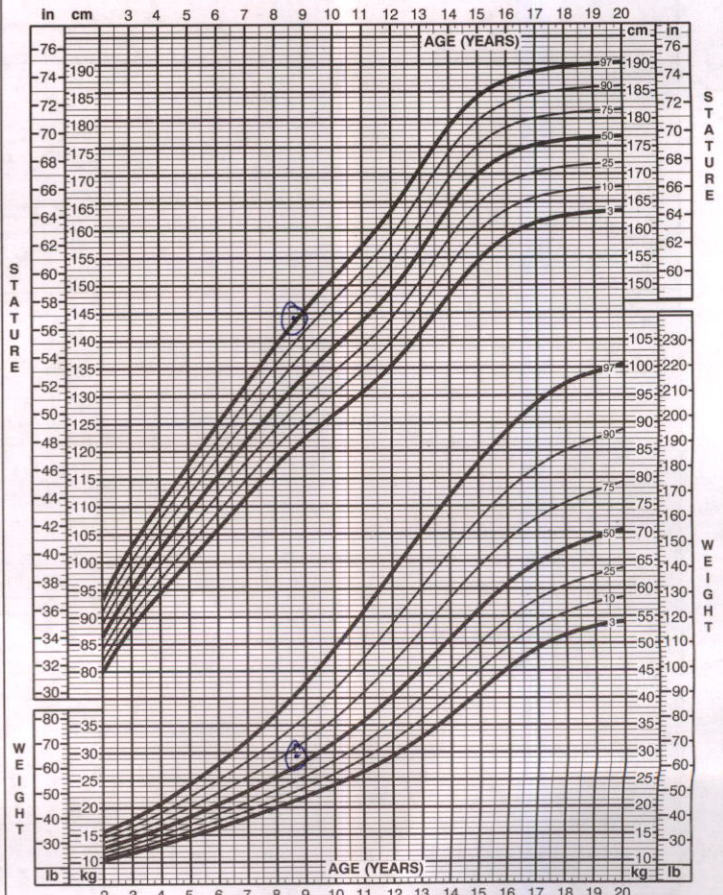
Patient's Signature: [Signature]

GROWTH CHART (BOYS)

Birth to 36 months: Boys
Length-for-age and Weight-for-age percentiles



2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles



Dietician's Name: Nikitha

Dietician's Signature: [Signature]

20/9/26
garn

child is stable. Intake is fair
continue on normal diet

~~Millett~~

21/9/26
garn

child is stable. Intake is better
continue on normal diet

~~Millett~~