

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

KUH-00213239 IP5-00176056
Master ORAGANTI MAHASHWIN (M)
04-08-2021 4 Y 11 M 2 D
Dr. ANUPAMA Y

Consultant: _____ Dept: _____

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



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/1/2021	11:35 pm	ER	114	[Signature]

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

[illegible]

ANY OTHER INFORMATION

① USA - 1
② x Ray

Date : 10/11/25 Time : 2pm Prepared By : metcher

10/11/22

Don

petter

Staff Nurse

Neelam

Shift / Ward

SPV

114

Billing Assistant

Billing Supervisor

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176056

Admit Date : 06-Jul-2026

Admit Time : 11:40 PM UHID : KUH-00213239

Patient Details :

Patient Name : Master ORAGANTI MAHASHWIN

Age : 4 Y 11 M 2 D

Guardian : Mr SRAVAN KUMAR

DOB : 04-08-2021

Gender : Male

Religion :

Occupation :

Marital Status :

Address (H) : HNO-133/49 SAI GANESH COLONY
BEERAMGUDA Beeramguda Hyderabad
Telangana INDIA 502032

Phone No : 9849792553

E-mail : NO@GMAIL.COM

Admission Details :

Bed Type : SEMI PRIVATE

Bed No : SPVT 114

Ward Name : 1F-VIBGYOR

Room No : SPVT 114

Admission Type : First Visit

Contact Details :

Name : Mr SRAVAN KUMAR

Relationship : Father

Contact Address : HNO-133/49 SAI GANESH COLONY
BEERAMGUDA Beeramguda Hyderabad
Telangana INDIA 502032

Phone No : 9849792553



Signature

Doctor Details :

Doctor Name : Dr. ANUPAMA Y

Specialisation : GENERAL PEDIATRICS

Referral Doctor : SELF

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : CARE HEALTH INSURANCE LIMITED



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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: Mahashwin O

UHID ID: 912 7 2021 202-20 922 0

Department: Dr. ANUPAMA Y

Consultant:

KUH-00213239 IP5-00176056
Master ORAGANTI MAHASHWIN
04-08-2021 4 Y 11 M 2 D (M)





Pediatric Multiorgan History & Physical Examination

Name : Mahashwin O Age/Sex 5ys/male

Information given by: Father Relationship

Chief Presenting Complaints & Duration (Chronologically)

Fever x 3 days.
↓ oral intake

History of present illness :

child was apparently in light 3 days
back

he has developed fever x 3d
initially low grade (100F) for 2 days
flb high grade (102F) ∴ today
(06/07/20)

also oral ulceration over
angles of mouth, lips & cheek
mucosa sparing tongue.

↓ oral intake ∴ 1 day due to ulceration

no cold, coughs vomit, loose stools, rash.

Medication using

- ① Syrup cefoprox 100mg BID
- ② Tab Ecospir 75mg
- ③ Syrup Stungenic Plus.
- ④ Syrup Sucralfate



Pediatric Multiorgan History & Physical Examination

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

H10 High grade fever 2 weeks back (max 104°F)

↓

admitted in RCH Hyderabad (23rd to 29th)

Took IVig 30g. (2g/kg)

+ IV antibiotics & Escospirin 75mg (5mg/kg)

↓

Following which she was

afebrile ≥ 72 hrs

↓

now came with fever > 102°F

Birth & Neonatal History:

Normal perinatal & antenatal transition

Birth & Socio Economic History:

About Father : _____

About Mother : _____

middle

Any additional Information : _____

Developmental History :

Normally attained for age

Immunization History :

Immunized @ local hospital



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): 103 cm (Centile _____)

Weight (kgs) : 15.05 kg (Centile _____)

On Examination :

Temperature : 102 F Pulse Rate : 150 bpm B.P. 95/48 SP02 97%

Resp. rate and type of breathing : 26 bpm

Rash _____

Lymphadenopathy _____

Oral ulcers → whitish

Oedema : _____

over lips &

Allergies (if any): _____

cheeks.

Respiratory System :

no lymphadenopathy,

Inspection (any s/o distress) : Normal

Air entry & breath sounds : BAE (+), Airways clear

Any added sounds : Nil

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

Cardiovascular System :

Inspection of precordium : Normal

Heart Sounds : S1S2 (+)

Any murmur : Nil

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

Per Abdomen :

Inspection : Normal

Palpation : Soft

Auscultation : Bowel Sounds (+)

Spine : Normal External Genitalia : Normal

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : Intact

Motor System:

Nutrition : adequate

Tone : B/L Squash, good Power 4/5

Co-ordinator : well coordinated

Posture :

Involuntary Movements : Nil

Reflexes :

DTR +++

Superficials: +++

Plantars B/L Flexion

Sensory System :

Intact

Bladder / Bowel : adequate

Clinical Summary & Diagnostic:

PVD / ? Kawasaki disease
(Resistant)



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Sepsis, dehydration

Desired goals of the treatment : Resolution

Planned Labs:

CBP
CRP
RP-2
Blood c/s
U/E
Urine c/s
2D Echo T/m

Planned Management

① 2ij Piptaz TID
② 2ij Paracetamol sos
③ 2ij ESMOPRAZOLE OD
④ TAB ECOSPIRIN 75mg OD
NB Reassess

Signature of the Doctor: Soheli Signature of the Consultant: [Signature]
Name of the Doctor: Dr. Soheli Name of the Consultant: Dr. Anupama
Date & Time: 06/07/26 11:50pm Date & Time: 6/7/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Seen by Dr. Vikes (PICU fellow)	
6/7/26 11:30pm	Δ's : PUD ? Kawasaki disease (Atypical) (Resistant) Plan: - send - CBP - CRP - RP2 - Blood Gs. - CUE / Urine culture - Inj Piptaz 2D Echo (Tm) - Inj Esomeprazole - Inj PCM - PP (SOS)	
		Dr. Remy



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
07/10/2026 10:00 AM	clerk p/w fellow Klebs Δ Atypical Kawasaki on Aspirin Now came with fever & mucosal oral ulcers v2D O/E fever spike ⊕ Poor oral intake ⊕ Oral mucosal ulcers at corner of mouth No diaper rash exam : ivy-pinta2 & Aspirin (empty) 2/3rd IVF-DNC	Plan: 1) Fever Control 2) Fever charting 3) Needs 2D Echo to look for Coronaries after rounds 4) Add Zylor-L Gel 5) Abx 2 day 6) Counsel to add
7/10/26 10 AM	SLB Dr. Anupama fever & out from Previously managed & Incomplete KD. mucosal ulcers. on table	Plan 2d Echo (at rounds). Do Poo BM - Urine qd ✓ Ven abd ✓ 5 Viral panel



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26 6pm	ds/B PICU resident	Plan
	ds: ds pyrexia of unknown origin	1) Trace + pro-BNP + 5 viral panel. + Blood ds + urine ds
	fever spikes (+) mucosal ulcers poor oral intake on room air hemodynamically stable. systemic exam - (N)	2) Give paracetamol 808 for fever spike. 3) Send CBP, CRP, Ferritin +/m Gam keep extra sample.
		Dr. Prabhu
08/07/26	S/B PICU resident	
	Δ: PVO	Advice
	FS (+) oral mucosal ulcer (+) led oral intake Hemodynamically stable. Systemic Exam: WNL	1) 5 viral panel 2) Paracetamol 808, w/r fever.
	NT ProBNP = 125 2d Echo = WNL	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26. 9:24am	S/B Dr. Anupama	
	fever & out focus. fever spikes near cep ↑. monitors	Plan Trace 5 vital pulse. 1. -ve
		cancel family for Tx if
		- Riboflavin "2 tab po
8/8/26 5:00pm	c/s/bw yellow fever & out focus	plan
	(2) fever spikes: morning 100.0f and 100.4f 5:30pm few dysrhythmic spots Tachy only well poor oral intake Multiple Apnoe plus free tongue/brake and hand pink.	(1) continue Antibiotics (2) W/F fever spikes (3) continue fluids



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/2/2020 8:00pm	c/s/B Pw yellow fever out joy No fever & no morn only intake - bottle Also fresh constant Hemodynamically stable	pl 1) Dil/K fever spi's 2) encourage only <u>AA</u> <u>Pro</u>
10/4/2026 8:10AM	c/s/B Pw yellow Δ Fever without focus - suspected IKD No fever spells in last 24hrs Blood No growth till now urine On Aug. mps 2mg/kg/day Piperacillin Tazobactam D6 Aug. poxy D4 - acceptly orally - ulcer ↓	Plan: 1) plan to stop IV fluids after rounds 2) inform sos 1 ketter

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/07/2026 10:30 AM	clerk Mr. Anupama - Fever with out focus Treated like in complete KD outside O/E Hemodynamically stable Oral intake - Improved than previous. Incomplete KD ↓ ↑CRP - ① ↑WBC - ② ↑PC - ③ Anemia	Plan: 1) Hematology Review (Informed) 2) Uncaud, CBP, CRP to send, LFT 3) With hold steroids 4) X ray Review 5) Keep Extra Samples
10/07/2026 12:30 PM	Hematology updates Informed to Mr. Anupama	Plan: 1) Add ELR & to do Rebival test from morning sample 2) Discharge plan after above reports -

KUH-00213239
Master DRAGANTI MAHASHWIN
04-08-2021 4 Y 11 M 6 D (M)
Dr. ANUPAMA Y



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

CROSS CONSULTATION FORM

Doctor Name: Dr. Simha Date: 10/7/16 Time: 12:00pm

Diagnosis: PVO ? Atypical Kawasaki

Hospital: _____

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:

Signature: _____

Findings and Recommendations :

dx fever on 7/17/6/16.

No other symptoms (WBC, inflammatory markers)

Resolved with IVIG 2g/kg
afebrile after 24 hrs of IVIG for
4 days.

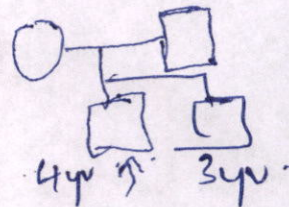
Reappearance of fever with oral ulcers
+ chelitis on 4/17

with WBC, platelet, CRP.

206 LNO (N).

? Atypical resistant Kawasaki.

Resolved with 1x Methylprednisolone
afebrile - 1 1/2 days.



Teen / LSCS / 2.9 kg /
No H/O NNS /
delayed and full.

No family H/O /
met H/O

vaccinated till date
(N18).

No Antenatal / with
H/O

Consultant :

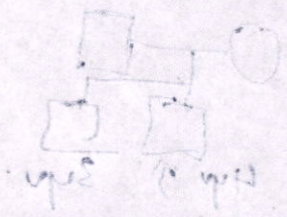
Name : _____ Signature: _____ Date & Time : _____

Ado

- 1) stop steroids after 3 days ~~stop~~
- 2) if fever recurs.

↓
after ~~late~~
Main PG UT/AMA later.

- 3) Mandox 500 later
- 4) Anti HIV Abs later level
- 5) Add ESR,
- 6) Review Tuesday OPD



1/2/2012
Fever 102.5
No N/A
No fever
No lymph

No family Hx
No fever
No lymph
No lymph

No lymph
No lymph

1/2/2012
Fever 102.5
No fever
No lymph
No lymph

1/2/2012
Fever 102.5
No fever
No lymph
No lymph

1/2/2012
Fever 102.5
No fever
No lymph
No lymph

CARDIOLOGY REQUISITION FORM

Name: Prayanti Maheshwari

Age: 4411m

Sex: Male

Date: 7/2/26

UHID No: KUH - 00213229

Weight: 15 kg

DIAGNOSIS: P.U.O ; 'Kawasaki'

SILENT CLINICAL FINDINGS:

-> Fever x 3 days.

IMPORTANT LAB PARAMETERS:

8.2 } 20,800 } 6.6 L
76/15

INDICATION FOR ECHO & REQUIRED INFORMATION:

-> Kindly look for coronary dilation

CONSULTANT NAME:

Dr. Anupama

RESIDENT SIGNATURE:



CROSS CONSULTATION FORM

Doctor Name : Dr. Chweta Date : 7/12/26 Time : 6 pm.

Diagnosis : pyrexia of unknown origin

Hospital : pet, Ranjara Hills.

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

Type of Referral :

- ☐ Emergency
☐ Urgent
☐ Non Urgent

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

to rule out kawasaki disease

Signature: Dr. Chweta

Findings and Recommendations :

2D Echo:- Normal size cardiac chambers

LMCA ~~LAD~~ - 2.7 mm (+1.59)

LAD - 1.7 mm (+0.23)

RCA - 1.9 mm (+0.15)

ABV

left arch no COA

Dr Chweta m

Consultant :

Name : _____ Signature : _____ Date & Time : _____

no new coronary arterial
dilation seen.
however high grade fever
↑CRP (+)

CRP - 132

plt - 5.42 lacs.

Alb - 2.9.

Adv :

- to do other causes
for high grade fever.
- will Dr. Arunpama.

→ if no improvement
will treat as resistant
KD.

Start

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04-08-2021 4 Y 11 M 4 D (M)
Dr. ANUPAMA Y



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RESULT SHEET

Date	6/7/26	08/07/26	10/07			
Time	11:30pm	6:00a	12:00pm			
Hb	8.2	8.8	8.9			
PCV	26.1	27.5	28.4			
RBC	2.72	3.96	4.0			
WBC	20860	16,970 ↓	11,490 ↓			
N/L	76/15	65/24	56/30			
Platelets	6.66 Lakh	5,62,000	5,95,000 ↑			
CRP	155	172	45.7 ↓			
ESR						
PCT						
RBS						
Na	132					
K	4.8					
Cl	100					
Ca/Mg						
Phosphate						
Urea	21					
Creatinine	0.3					
ALP			139.			
SGPT			13			
SGOT			19			
T.Bill/Conj			0.3/0.2			
T.Protein			6.8			
S.Albumin			3.2			
S.Globulin			3.6			
A/G Ratio						
Uric Acid			1.3			
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L	Hw. 21					

KUH-00213239 IP5-00176056
Master ORAGANTI MAHASHWIN
04-08-2021 4 Y 11 M 2 D (M)
Dr. ANUPAMA Y

OUTSIDE

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RESULT SHEET

Date	23/6/26	24/6/26	26/6/26	27/6/26		
Time						
Hb	9.4		9.8			
PCV	29.8		31.5			
RBC	4.43		4.69			
WBC	20.38		23.010			
N/L	78/18		78/18			
Platelets	472		542			
CRP	156		132 ↓			
ESR	95		48			
PCT		2.91				
RBS	98			99		
Na	135					
K	4.1					
Cl	102					
Ca/Mg						
Phosphate						
Urea	6.5					
Creatinine	0.3					
ALP		165				
SGPT		10				
SGOT		19				
T.Bill/Conj		0.3 < 0.2 0.1				
T.Protein		5.5				
S.Albumin		2.9				
S.Globulin		2.6				
A/G Ratio		1.1				
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date		24/6/26				
Time						
CUE - Alb		Nil				
CUE - Sugar		Nil				
CUE - Ketones		Neg				
CUE - PUS Cells		3-5 cells				
CUE - RBC Cells		Absent				
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

23/6 Widel — Negative (Tube agglutination)
 Culture and Sensitivities :
 Meleni smear — Negative

24/6: Leptospirose IgM — Negative

Brucella IgM, IgG → Negative

Widal test — Negative

Radiology : USG : 27/6/26 : ANA c Hirus — Negative

X-Ray : RA factor — Negative

ECHO : 2D Echo → (N) study : (24/6/26 & 26/6/26)

CT : Xray → (N)

MRI

Others (ECG, Contrast Studies etc.) :



MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From: ER

Shifted to: ward

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Ramya

Date & Time: 6/7/26 11:30pm

Nurse Name & Signature: Nurshida

Date & Time: 06/07/26 @ 11pm



Sheet No:

REGULAR PRESCRIPTIONS

Weight 15 kg

Ward

DRUG : <u>QUADRAJEL</u>				Date Time	<u>2/7/2021</u>
Dose	Route	Frequency	Start Dt.		
	<u>Topically</u>	<u>Q6H</u>	<u>07/07</u>	<u>12pm</u>	<u>X</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Kelele</u>				<u>6pm</u>	<u>X</u>
Additional Instructions: <u>apply over mouth ulcer</u>				<u>10pm</u>	<u>X</u>
				<u>6pm</u>	<u>X</u>
Daily Doctor's Endorsement by a Sign					

DRUG : <u>EYP AD2</u>				Date Time	<u>2/7/2021</u>
Dose	Route	Frequency	Start Dt.		
<u>5ml</u>	<u>PO</u>	<u>OD</u>	<u>07/07</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Kelele</u>				<u>10pm</u>	<u>X</u>
Additional Instructions:				<u>12pm</u>	<u>X</u>
				<u>6pm</u>	<u>X</u>
Daily Doctor's Endorsement by a Sign					

DRUG : <u>INJ-DOXYCYCLINE</u>				Date Time	<u>2/7/2021</u>
Dose	Route	Frequency	Start Dt.		
<u>35mg</u>	<u>IV</u>	<u>BD</u>	<u>07/07</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Kelele</u>				<u>6AM</u>	<u>X</u>
Additional Instructions:				<u>6pm</u>	<u>X</u>
Daily Doctor's Endorsement by a Sign					

DRUG : <u>TAB RIBOFLAVIN</u>				Date Time	<u>2/6/2021</u>
Dose	Route	Frequency	Start Dt.		
<u>1/2 tab</u>	<u>PO</u>	<u>OD</u>	<u>02/06</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Vamshi</u>				<u>12pm</u>	<u>X</u>
Additional Instructions: <u>(1 tab - 10mg)</u>				<u>6pm</u>	<u>X</u>
Daily Doctor's Endorsement by a Sign					



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : Inj METHYL PREDNISOLONE				Date Time	10/8/2021															
Dose 15mg	Route IV	Frequency BD	Start Dt. 08/07	10																
Name & Signature of the Doctor Starting the Drugs: Dr. Jayashree				Signature 10/8/2021 Dr. Jayashree																
Additional Instructions:				10/8/2021 Dr. Jayashree																
Daily Doctor's Endorsement by a Sign				Signature 10/8/2021 Dr. Jayashree																
DRUG : CANDID MOUTA				Date Time	10/8/2021															
Dose	Route	Frequency twice	Start Dt. 08/07	10																
Name & Signature of the Doctor Starting the Drugs: Dr. Vamsi				Signature 10/8/2021 Dr. Vamsi																
Additional Instructions: Application on ulcer				10/8/2021 Dr. Vamsi																
Daily Doctor's Endorsement by a Sign				Signature 10/8/2021 Dr. Vamsi																
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																				

Signature

VERIFIED BY : Name



DRUG CHART

Date of Admission: 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 : <i>Inj PARACE TOMOL</i>				Date Time	<i>17</i>														
Dose <i>150mg</i>	Route <i>IV</i>	Frequency <i>SOS</i>	Start Date <i>6/7/26</i>																
Doctor's Signature <i>Dr. Ranjan</i>		Valid Period	Pharm.																
Additional Instructions:																			

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

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

VERIFIED BY : Name Signature



REGULAR PRESCRIPTIONS

Weight. 15 kg Ward.

DRUG : <u>1g PIPERACILLIN + TAZOBACTAM</u>				Date Time	<u>6/7/26</u>	<u>8/7/26</u>	<u>8/7/26</u>	<u>9/7/26</u>	<u>10/7/26</u>
Dose <u>1.5gm</u>	Route <u>IV</u>	Frequency <u>TID</u>	Start Date <u>6/7/26</u>						
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Remya</u>									
Additional Instructions:									
Daily Doctor's Endorsement by a Sign									
DRUG : <u>1g ESOMEPRAZOLE</u>				Date Time	<u>6/7/26</u>	<u>8/7/26</u>	<u>9/7/26</u>	<u>10/7/26</u>	
Dose <u>15mg</u>	Route <u>IV</u>	Frequency <u>OD</u>	Start Date <u>6/7/26</u>						
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Remya</u>									
Additional Instructions:									
Daily Doctor's Endorsement by a Sign									
DRUG : <u>1cb ASPIRIN</u>				Date Time	<u>6/7/26</u>	<u>8/7/26</u>	<u>9/7/26</u>		
Dose <u>1cb</u>	Route <u>PO</u>	Frequency <u>OD</u>	Start Date <u>6/7/26</u>						
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Remya</u>									
Additional Instructions: <u>1cb = 75mg</u>									
Daily Doctor's Endorsement by a Sign									
DRUG : <u>ZYTEE-L Gel</u>				Date Time	<u>07/07</u>				
Dose <u>100mg</u>	Route <u>Orally</u>	Frequency <u>Q4H</u>	Start Date <u>07/07</u>						
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Remya</u>									
Additional Instructions: <u>apply over mouth ulcers</u>									
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.	

[illegible]



I.V. FLUIDS CHART

Weight. 15 kg Ward.

[illegible]

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/7 Time:

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)

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

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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

Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

Score 1 : Continue normal observation by staff nurse

Score 2 : Shift in charge nurse to be informed and continue hourly observations

Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see

Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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- 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

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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)

KUH-00213239 IP5-00176056
Master ORAGANTI MAHASHWIN
04-08-2021 4 Y 11 M 4 D (M)
Dr. ANUPAMA Y



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 : 04/08/2021	Time: 6AM	10am	1pm	6pm	10pm
Doctor / Nurse / Family Concern?					
Temperature (F)	98.0°F	98.5°F	97.5°F	96.9°F	96.8°F
Heart Rate (bpm)	108	95	100	112	105
Blood Pressure (mmHg) *	70/82	58/69	60/65	65/85	55/66
Heart Rate (Number)	92b/m	104b/m	106b/m	111b/m	112b/m
Resp. Rate (bpm) (Over 1 Minute) *	26b/m	23b/m	25b/m	28b/m	26b/m
Resp Mod/ Severe Distress					
Receiving O ₂ (l/min)					
O ₂ Saturations (%)	99%	99%	98%	97%	98%
Conscious Level	15/15	15/15	15/15	15/15	15/15
GCS *	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE	1	1	1	0	1
Number of shaded boxes	1	1	1	0	1
Pain Score	0	2	2	0	0
Observer's Initials	a	a	a	a	a

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
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- 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.

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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- 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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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: 8/7/21	Time: 2pm	5.30pm	8.30pm	10PM	8AM		
Doctor / Nurse / Family Concern? <i>1pm</i>							
Temperature (F)	104						
	103						
	102						
	101						
	100	<i>100.0°F</i>	<i>99.8°F</i>	<i>100.4°F</i>			
	99			<i>98.2°F</i>	<i>99.0°F</i>		
	98				<i>98.7°F</i>		
	97						
	96						
	95						
	94						
Heart Rate (bpm)	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
	90						
Blood Pressure (mmHg) *	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
	90						
	80						
Note: BP does not score in early warning scoring	70						
	60						
	50						
	40						
	30						
	20						
	10						
	Heart Rate (Number)			<i>125bpm</i>	<i>101b/m</i>	<i>109b/m</i>	
	Resp. Rate (bpm) (Over 1 Minute) *	70					
		60					
		50					
40							
30							
20							
10							
Resp Rate (Number)				<i>26bpm</i>	<i>28b/m</i>	<i>26b/m</i>	
Resp Distress		Mod/ Severe					
		None / Mild					
		Receiving O ₂ (l/min)					
	O ₂ Saturations (%)			<i>100%</i>	<i>100%</i>	<i>99%</i>	
	Conscious Level						
	Normal						
	Altered						
	GCS *			<i>15/15</i>	<i>15/15</i>	<i>15/15</i>	
	TOTAL SCORE	Number of shaded boxes			<i>1</i>	<i>1</i>	<i>1</i>
		Pain Score			<i>0</i>	<i>0</i>	<i>0</i>
		Observer's Initials			<i>O</i>	<i>O</i>	<i>O</i>

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.

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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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
20/					

- 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

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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)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 2/1/26 Time: 10:25 PM 8/9/26 10:50 AM 3 PM 6 AM 10 AM	
Doctor / Nurse / Family Concern?	
Temperature (F)	104 103 102 101 100 99 98 97 96 95 94 101.0f° 99.0f° 100.5f° 98.8f° 97.9f° 98.0f° (sponging) (syr. cocaine)
Heart Rate (bpm)	190 180 170 160 150 140 130 120 110 100 90 80 70 60 50
and	
Blood Pressure (mmHg) *	112 100 70 84 101 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200
Note:	
BP does not score in early warning scoring	
Heart Rate (Number)	102 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200
Resp. Rate (bpm) (Over 1 Minute) *	70 60 50 40 30 20 10
Resp Rate (Number)	28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
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	

* 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.

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KUH-00213239 IP5-00176056
Master ORAGANTI MAHASHWIN
04-08-2021 4 Y 11 M 2 D (M)
Dr. ANUPAMA Y



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

PRESCHOOL (1-5 years)

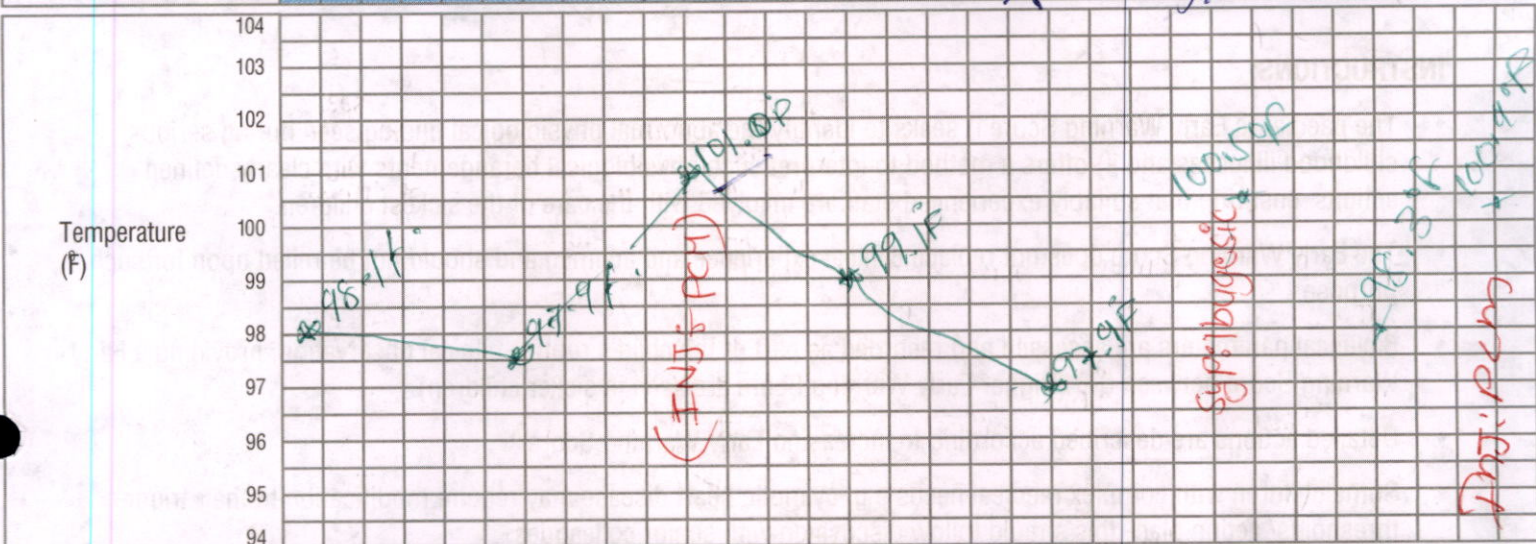
Children's Observation & Early Warning Scoring Chart

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 : 04/08/2021 Time: 2AM 6AM 10am 11pm 1pm 5PM 8PM 12:30PM
Doctor / Nurse / Family Concern?



Heart Rate (bpm)	190
and	180
Blood Pressure (mmHg) *	170
	160
	150
	140
	130
	120
	110
	100
	90
	80
	70
	60
	50
Note: BP does not score in early warning scoring	
Heart Rate (Number)	103b/m

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

Resp Distress	Mod/ Severe
	None / Mild
Receiving O ₂ (l/min)	
O ₂ Saturations (%)	100%
Conscious Level	Normal
	Altered
GCS *	15/15

TOTAL SCORE	
Number of shaded boxes	1
Pain Score	0
Observer's Initials	2

ACTIONS

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KUH-00213239 IP5-00176056
 Master ORAGANTI MAHASHWIN
 04-08-2021 4 Y 11 M 2 D (M)
 Dr. ANUPAMA Y



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			3								
	12:00 am	1		35ml			1		1	0		Smooth
	01:00 am	1		35ml						0		Smooth
Total Intake :					Total Output :							
	02:00 am	1		35ml						0		Smooth
	03:00 am	1		35ml					✓	2		Smooth
	04:00 am	DNS		35ml					✓	2		Smooth
	05:00 am			35ml					✓	2		Smooth
	06:00 am	1		-					✓	1		Smooth
	07:00 am			-					✓	1		Smooth
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			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
7/7	08:00 am	DMS		35ml	/	/	NP	/	/	✓	0	[Signature]	
	09:00 am		35ml	0									
	10:00 am		-	0									
	11:00 am		-	0									
	12:00 pm		35ml	0									
	01:00 pm		35ml	0									
Total Intake :						Total Output :							
7/7	02:00 pm	DMS		35ml	/	/	NP	/	/	✓	0	[Signature]	
	03:00 pm		35ml	0									
	04:00 pm		35ml	0									
	05:00 pm		-	0									
	06:00 pm		-	0									
	07:00 pm		35ml	0									
Total Intake :						Total Output :							
7/7	08:00 pm	DMS		35ml	/	/	NP	/	/	✓	0	[Signature]	
	09:00 pm		35ml	0									
	10:00 pm		-	0									
	11:00 pm		-	0									
	12:00 am		35ml	0									
	01:00 am		35ml	0									
Total Intake :						Total Output :							
8/7	02:00 am	DMS		35ml	/	/	NP	/	/	✓	0	[Signature]	
	03:00 am		35ml	0									
	04:00 am		35ml	0									
	05:00 am		35ml	0									
	06:00 am		-	0									
	07:00 am		-	0									
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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse		
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine				
8/7	08:00 am	↑			/	/	/	/	✓	0	[Signature]			
	09:00 am												0	
	10:00 am	DNS	35ml										0	
	11:00 am		35ml										0	
	12:00 pm	↓	-										0	
	01:00 pm		✓										0	
Total Intake :						Total Output :								
08/07	02:00 pm		Rice		/	/	/	/		0	[Signature]			
	03:00 pm		H ₂ O	35ml										0
	04:00 pm	DNS	35ml										0	
	05:00 pm		35ml										0	
	06:00 pm												0	
	07:00 pm												0	
Total Intake :						Total Output :								
8/7	08:00 pm			35ml	/	/	/	/		0	[Signature]			
	09:00 pm			35ml										0
	10:00 pm	DNS	-										0	
	11:00 pm		-										0	
	12:00 am		35ml										0	
	01:00 am		35ml										0	
Total Intake :						Total Output :								
9/7	02:00 am			35ml	/	/	/	/		0	[Signature]			
	03:00 am			35ml										0
	04:00 am	DNS	35ml										0	
	05:00 am		35ml										0	
	06:00 am		35ml										0	
	07:00 am		-										0	
Total Intake :						Total Output :								
Total 24 hrs. Intake			Total 24 hrs. Output											



FLUID CHART

Sheet No. :

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

		Intake			Output					IV Site	Sign.					
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	Nurse				
			Mouth	I.V	N.G											
9/7	08:00 am	Dns and rice		35ml	/	/	/	/	/	/	0	S. S. S. S. S. S.				
	09:00 am		35ml													
	10:00 am		-													
	11:00 am		-													
	12:00 pm		35ml													
	01:00 pm		-													
Total Intake :					Total Output :											
9/7	02:00 pm	Dns		35ml	/	/	/	/	/	/	0	M. S. S. S. S. S.				
	03:00 pm		35ml													
	04:00 pm		-													
	05:00 pm		20ml													
	06:00 pm		20ml													
	07:00 pm		-													
Total Intake :					Total Output :											
9/7	08:00 pm	Dns		25ml	/	/	/	/	/	/	0	A. S. S. S. S. S.				
	09:00 pm		25ml													
	10:00 pm		-													
	11:00 pm		-													
	12:00 am		25ml													
	01:00 am		25ml													
Total Intake :					Total Output :											
10/7	02:00 am	Dns		25ml	/	/	/	/	/	/	0	A. S. S. S. S. S.				
	03:00 am		25ml													
	04:00 am		25ml													
	05:00 am		25ml													
	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.

		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								
10/02/21	08:00 am		100								0	Shah	
	09:00 am										0		
	10:00 am										0		
	11:00 am										0		
	12:00 pm										0		
	01:00 pm										0		
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							

Patient Sticker

FLUID CHART

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BirthRight
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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																				
	08:00 am																								
	09:00 am																								
	10:00 am																								
	11:00 am																								
	12:00 pm																								
	01:00 pm																								
Total Intake :						Total Output :																			
	02:00 pm																								
	03:00 pm																								
	04:00 pm																								
	05:00 pm																								
	06:00 pm																								
	07:00 pm																								
Total Intake :						Total Output :																			
	08:00 pm																								
	09:00 pm																								
	10:00 pm																								
	11:00 pm																								
	12:00 am																								
	01:00 am																								
Total Intake :						Total Output :																			
	02:00 am																								
	03:00 am																								
	04:00 am																								
	05:00 am																								
	06:00 am																								
	07:00 am																								
Total Intake :						Total Output :																			
Total 24 hrs. Intake													Total 24 hrs. Output												

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 06/07/2026

Assessment: Baby having dull

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the baby general condition and monitor the vitals and record.	12:10 am	→ Assessed the baby general condition and monitored the vitals and recorded.	By doing all above procedure baby condition improving well.
1am	→ Doctor advised to continue medication as per chart.	1:10 am	→ Doctor advised to continued medication as per chart.	
2am	→ Advise to conduct 2D echo.	2:10 am	→ Advised to conduct 2D echo.	
3am	→ Collect CUE, Urine cl. Continue DMS @ 4ml/hr	3:10 am	→ Collected CUE, Urine cl.	
6am	→ Provide comfortable position.	6:10 am	→ Continued DMS @ 4ml/hr → Provided comfortable position	
8am	→ Ensure the safety needs.	8:10 am	→ Ensured the safety needs	

Re-Assessment: Re assessment done

Special Notes: 2D echo 9am

Nurse Signature: [Signature]

Nurse Name: G. Srujantha

Date & Time: 07/06/2026 @ 8am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 7/07/26

Assessment: Baby having fever / pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the pt general condition. & monitor the vital sign.	8:30 AM	→ Assessed the pt general condition. & monitored the vital sign.	By noon all the procedure Baby condition is improved.
10am	→ Maintain the I/O chart	10:30 am	→ Maintained the I/O chart	
12pm	→ Administer the medication as per doctor order.	11:30 AM	→ Administered the medication as per doctor order	
12pm	→ provide the comfortable position.	12:30 am	→ provided the comfortable position.	
1pm	→ Give Inj-PCM	1:00 PM	→ Given Inj-PCM.	

Re-Assessment:

Special Notes:

20 Eco

Nurse Signature: V. Ravina

Nurse Name: V. Ravina (607729)

Date & Time: 7/07/26 @ 2pm

г. АНУПАМА Y

BirthRight
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Date: 7/7/26

☒ Patient & Family EducationDocu. No: RCHBH /FRM / CLINICAL / 148

KUH-00213239
Master ORAGANTI MAHASHWIN
04-08-2021 4 Y 11 M 4 D (M)
Dr. ANUPAMA Y
Barcode

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 7/8/26

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
8PM	→ Assess the pt general condition.	8PM	→ Assessed pt general condition.	pt condition is normal.
10PM	→ monitor vital signs	10PM	→ monitored vital signs	
2AM	→ maintain I/O chart	2AM	→ maintained I/O chart.	
6AM	→ Administer the medications as per doctors order.	6AM	→ Administered the medications as per doctors order.	
8AM	→ provide comfortable position	8AM	→ provided comfortable position	

Re-Assessment: null

Special Notes:

Nurse Signature: [Signature]

Nurse Name: swasthi

Date & Time: 8/8/26 8AM

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 8/7/26

Assessment: baby having Pyrexia

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the pt general condition	8:10a	Assessed pt general condition	by done above all the care pt condition is now
10am	provide comfortable position.	10:10a	provided comfortable position.	
12pm	monitor vitals & record.	12:10p	monitored vitals & recorded	
2pm	maintain i/o chart		maintained i/o chart	
	ensure safety.		ensured safety.	
4pm	Administer medications as per chart	4:10p	Administered medications as per chart	

Re-Assessment:

monitored vitals

Special Notes:

trace & vitals per chart

Nurse Signature:

[Signature]

Nurse Name:

[Signature]

Date & Time:

8/7/26 @ 2pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 08/07/2021

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the baby general condition and monitor the vitals and record.	2:20pm	→ Assessed the baby general condition and monitored the vitals and recorded.	By doing all above procedure baby condition improving well.
3pm	→ Doctor advice to continue medication as per chart	3:10pm	→ Doctor advised continued medication as per chart.	
5pm	→ watch for fever spikes.	5:10pm	→ Watched for fever spikes.	
6pm	→ Continue ORS @ 35ml/hr.	6:10pm	→ Continued ORS @ 35ml/hr.	
7pm	→ Provide comfortable position	7:10pm	→ Provide comfortable position.	
8pm	→ Ensure the safety needs.	8:10pm	→ Ensure the safety needs.	

Re-Assessment: Re assessment done

Special Notes: Monitor the vitals

Nurse Signature: [Signature] Nurse Name: K. Sumanthi Date & Time: 08/07/21 @ 8pm

KUH-00213239 IP5-00176056
Master ORAGANTI MAHASHWIN
04-08-2021 4 Y 11 M 4 D (M)
Dr. ANUPAMA Y



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/7/26

Assessment: pt having discomfort

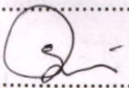
Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the pt general condition	8pm	→ Assessed pt general condition	pt condition is normal
10pm	→ monitor vital signs	10pm	→ monitored vital signs	
2am	→ maintain I/O chart	2am	→ maintain I/O chart	
8am	→ Administer the medications as per doctors order.	8am	→ Administered the medications as per doctors order	
	→ provide comfortable position			

Re-Assessment: N/A

Special Notes:

Nurse Signature: 

Nurse Name: Soudamini

Date & Time: 9/7/26 8am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 9/7

Assessment: Baby having pain.

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
9am	→ Assess the baby general condition	9:10am	→ Assessed the baby general condition	baby Condition is Normal
10am	→ monitor the vital's	10:10am	→ monitored the vital's	
11am	→ maintain IV fluid's	11:10am	→ maintained IV fluid's	
12pm	→ wlf mouth ulcer	12:10pm	→ wlf mouth ulcer	
1pm	→ Administer medication as per doctor orders	1:10pm	→ Administered medication as per doctor orders	

Re-Assessment:

Special Notes: wlf mouth ulcer

Nurse Signature: [Signature]

Nurse Name: Sirish

Date & Time: 9/7/20 @ 2pm

KUH-00213239 IP5-00176056
Master ORAGANTI MAHASHWIN
04-08-2021 4 Y 11 M 4 D (M)
Dr. ANUPAMA Y



NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/7/26

Assessment: Baby having mouth ulcer.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the general condition of the baby.	2.30pm	Assessed the general condition of the baby.	Implemented all the procedure.
3pm	Continue w fluids	3.30pm	Continued w fluids	
4pm	Watch for fever spikes.	4.30pm	Watched for fever spikes.	
5pm	Apply ulcer cream.	5.30pm	Applied ulcer cream	
6pm	Administer medication as per doctor order.	6.30pm	Administered medication as per doctor order.	
7pm	Monitor vital signs.	7.30pm	Monitored vital signs.	

Re-Assessment:

Special Notes:

Nurse Signature: Merlin

Nurse Name: Merlin

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

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 Dr. ANUPAMA Y

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/26

Assessment:

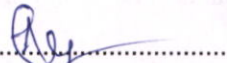
Goals

- ☒ 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
☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
10pm	→ Assess the Baby General condition, monitor vitals & Record	11pm	→ Assessed the Baby General condition, monitored vitals & Recorded	By Aunty's doc pt condition is improved
12am	→ Continue IV fluids	1am	→ Continued IV fluids	
2am	→ provide comfortable position	4am	→ provided comfortable position	
6am	→ Administer medication as per doctor order	8am	→ Administered medication as per doctor order	

Re-Assessment:

Special Notes:

Nurse Signature: 

Nurse Name: Anurag K. Corobb

Date & Time: 10/7/26 8AM



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 10/07/26

Assessment: pt having well active

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	*Assess the pt General condition	8:30 am	*Assessed the pt General condition	pt is stable
9am	*check the pt all vitals	9:30 am	*checked the pt all vitals	
10am	*maintain SpO2 chart	11am	*maintained SpO2 chart	
12pm	*provide comfortable position	12:30 pm	*provided comfortable position	
1pm	*administer all medication given as per doctor order	2pm	*administered all medication given as per doctor order	

Re-Assessment:

Special Notes:

sending samples

Nurse Signature:

[Signature]

Nurse Name:

Shanthi

Date & Time:

10/7/26 2pm

KUH-00213239 IP5-00176056
Master ORAGANTI MAHASHWIN
04-08-2021 4 Y 11 M 6 D (M)
Dr. ANUPAMA Y



NURSING CARE RECORD


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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



ROTATING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Anupama Department: Paed Date of Admission: 06/07/20

SITUATION		Diagnosis: <u>Kawasaki disease</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:			
BACKGROUND	Area	EP: 7:55 pm	1st 11:00 am	2nd 4:00 pm	3rd 11:00 am	4th 11:00 am	
	Shift Time	7:55 pm	11:00 am	4:00 pm	11:00 am	11:00 am	
ASSESSMENT	Medical Condition (Any special condition to be noted):	Nil	NA	NA	NA	NA	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
ASSESSMENT	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	99°F	98.6°F	98.1°F	97.5°F	98.1°F
		Res:	30b/m	28b/m	28b/m	25b/m	28b/m
		SpO ₂ :	98%	100%	100%	99%	100%
		Pulse:	140b/m	105b/m	102b/m	105b/m	101b/m
		BP:	92/44	98/59	102/62	109/70	93/54
	Fall Risk Score:	11	11	11	11	11	
	Pain Score:	0/10	0/10	0/10	0/10	0/10	
Recommendations	Safety Needs:	yes	yes	yes	yes	yes	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	nil	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:		nil	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		nil	NA	NA	NA	NA	
Handed Over By Name :		<u>Kavitha</u>	<u>Saravathi</u>	<u>Ravina</u>	<u>Saravathi</u>	<u>Arth</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>7/7/20</u>	<u>7/7/20</u>	<u>7/7</u>	<u>7/7</u>	<u>7/7</u>	
Time:		<u>12am</u>	<u>5am</u>	<u>2pm</u>	<u>8pm</u>	<u>2am</u>	
Taken Over By Name :		<u>Saravathi</u>	<u>Ravina</u>	<u>Shrinu</u>	<u>Saravathi</u>	<u>Aarth</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>7/7/20</u>	<u>7/7/20</u>	<u>7/7/20</u>	<u>7/7/20</u>	<u>8/7</u>	
Time:		<u>12pm</u>	<u>8am</u>	<u>2pm</u>	<u>8am</u>	<u>2pm</u>	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Anupama Y Department: Pediatrics Date of Admission: 6/07/20

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known					
		<u>Asl. Kawasaki disease</u>		If Yes Specify:					
BACKGROUND	Area	Shift Time	1st floor 2pm-8pm	1st floor 8pm-5am	1st floor 5am-2pm	1st floor 2pm-8pm	1st floor 8pm-5am	1st floor 5am-2pm	
	Medical Condition (Any special condition to be noted):		NA	NA	NA	NA	NA	NA	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ 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	☐ Yes ☒ No	
	Vital Signs:	Temp:	98.1°F	98.5°F	98.9°F	98.9°F	98.2°F	98.2°F	98.2°F
		Res:	26b/m	26b/m	25b/m	25	26b/m	26b/m	28b/m
		SpO ₂ :	100%	100%	99.1%	99	98.3%	98.3%	99%
		Pulse:	125b/p	108b/m	111b/m	110	112b/m	112b/m	110b/m
		BP:	98/61	89/52	99/60	98/60	90/63	90/63	100/60
Fall Risk Score:	0	0	1	1	1	1	1		
Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10	0/10		
Recommendations	Safety Needs:	yes	yes	yes	yes	yes	yes	yes	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NA	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NA	NA	NA	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	NA	
Handed Over By Name :		<u>K. Saurabh</u>	<u>Saurabh</u>	<u>Saurabh</u>	<u>Mehli</u>	<u>Aparajita</u>	<u>Shub</u>	<u>Shub</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>6/07/20</u>	<u>9/7/20</u>	<u>9/7</u>	<u>9/7</u>	<u>10/7</u>	<u>10/7</u>	<u>10/7</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>2pm</u>	<u>8pm</u>	<u>8pm</u>	<u>2pm</u>	
Taken Over By Name :		<u>Saurabh</u>	<u>Saurabh</u>	<u>Mehli</u>	<u>Aparajita</u>	<u>Shankh</u>	<u>Mehli</u>	<u>Mehli</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>9/7/20</u>	<u>9/7</u>	<u>9/7</u>	<u>9/7</u>	<u>10/7</u>	<u>10/7</u>	<u>10/7</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>2pm</u>	<u>8pm</u>	<u>2pm</u>	

KUH-00213239 IP5-00176056
Master ORAGANTI MAHASHWIN
04-08-2021 4 Y 11 M 6 D (M)
Dr. ANUPAMA Y



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					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	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					
Cognitive Impairments	Not Aware of Limitations	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					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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					
TOTAL							

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position						
Call device within reach						
Wheels Locked						
Room free of clutter						
Adequate Lighting						
Wheel Chair Support						
Other Intervention(s) Specify						
Nurse's Name :						
Signature :						
Date :						
Time :						



THE HUMPTY DUMPTY SCALE

6/12 8/12 8/12 9/12 10/12

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	3	3	3
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1	1	1
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	1
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
TOTAL			11	11	11	11	11

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	Yes
Call device within reach	Yes	Yes	Yes	Yes	Yes
Wheels Locked	Yes	Yes	Yes	Yes	Yes
Room free of clutter	Yes	Yes	Yes	Yes	Yes
Adequate Lighting	Yes	Yes	Yes	Yes	Yes
Wheel Chair Support	Yes	No	No	No	No
Other Intervention(s) Specify	No	No	No	No	No
Nurse's Name :	manu	gaut	gaut	gaut	Appu
Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :	6/12	7/12	8/12	9/12	10/12
Time :	11:30	12:00	12:00	02:00	06:00

CHECKLIST FOR THROMBOPHLEBITIS

10/07/26

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								
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				shy matis									

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 : Anirban Name : Anirban

Signature of Ward In Charge :

Signature : Name :

KUH-00213239 IP5-00176056
Master DRAGANTI MAHASHWIN
04-08-2021 4 Y 11 M 4 D (M)
Dr. ANUPAMA Y



CHECKLIST FOR THROMBOPHLEBITIS

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	7/07 DAY-1			8/07 DAY-2			9/07 DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0	0	0	0		
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-	-	-	-	-	-		
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 : Name :

Signature of Ward In Charge :

Signature : Name :



BRADEN 'Q' SCALE

				Date : 10/4			
				Time : 6:00m			
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:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	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		
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		
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		
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4		
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		
				TOTAL SCORE	24		
				Evaluator's Name	Appy		

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

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



BRADEN 'Q' SCALE

				Date:	6/8	7/12	8/17	9/17
				Time:	11:30 AM	6 AM	6 AM	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	4	4	4
"Activity The degree of physical activity"	1. Bedfast: Confined to bed	2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
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	28	28	28
					Evaluator's Name	Mend.	Q	Q

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
2017	8am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	ABP
2017	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	slm
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

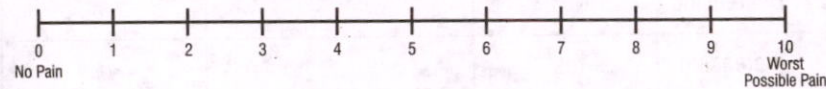
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	n Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/7/20	11:30 PM	0/10	WIC	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Self	Personnel
7/7	8am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Dr
7/7	4pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Spencer
8/7	12am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Spencer
8/7	8am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Spencer
8/7	4pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Dr
9/7	12Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Spencer
9/7	8am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Spencer
9/7	4pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Meeli's
10/2	12am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Appy

Re-assessment Frequency:

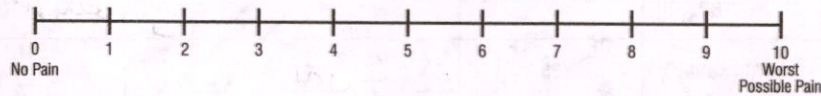
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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	0	1	2
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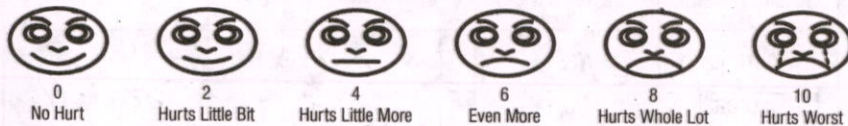
Numerical Pain Scale (Obstetric and Gynecology)



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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		
6/7	11:20 pm	5	medication.	M	1	0	1	1	ml	Dr. Anupama
6/8	9am	9	soft diet	F	1	0	1	1	-	Nikitha

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:

2 Kawasaki disease

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
<i>6/11/26 11M</i>	☒ Medical ☐ Nursing ☐ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	<i>2 Kawasaki disease</i>	<i>1/1 Stability</i>	<i>- W medenif - W Phell</i>	<i>[Signature]</i>	☐ Nursing ☐ Others:
<i>6/11/26 11:30</i>	☐ Medical ☐ Nursing ☒ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	<i>Fever.</i>	<i>1/1 Study</i>	<i>- IV Fluids - IV medn</i>	<i>[Signature]</i>	☒ Medical ☐ Others:
<i>7/1/26 9am</i>	☐ Medical ☐ Nursing ☒ Others: <i>dictation</i>	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<i>PUD E.? Kawasaki disease</i>	<i>Soft diet</i>	<i><u>RDS</u> E: -1350 kcal/d P: 23 g/d</i>	<i>Niritha</i>	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: Mode of Arrival: Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction

Body Weight: 15 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
NA	NA	NA

Family History: NA

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: 15 Length: Head Circumference (< 2 years):

Temp.: 97.9 F HR: 107 RR: 29 BP: 107/65

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

Fall Risk Assessment: ☐ Yes ☐ No Score: 4 (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: 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 Family

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

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

Orientation has been given regarding the following aspects:

Call Bell in Reach: ☒ Yes ☐ No

Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump: ☒ Yes ☐ No

Hand hygiene Explained: ☒ Yes ☐ No

☐ Others

Patient Rights & Responsibilities: ☐ Yes ☐ No

Information given to Mother

Nurse's Name: Date: 7/17 Time:

Signature

KUH-00213239 IP5-00176056
Master ORAGANTI MAHASHWIN
04-08-2021 4 Y 11 M 2 D (M)
Dr. ANUPAMA Y



DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: 9/7/26

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:

☐ Medication ☒ Yes ☐ No

☐ Bathing ☒ Yes ☐ No

☐ Eating ☒ Yes ☐ No

☐ Walking ☒ Yes ☐ No

☐ Dressing ☒ Yes ☐ No

☐ Toileting ☒ Yes ☐ No

Remarks

Explain to Mother

with Mother help

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: [Signature]

Nurse Name: Oravanti

Date and Time: 7/7/26 2 AM



NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 7/2/26 Time: 9am

Weight: 15.05 kgs Centile: 10th

Height: 103 cms Centile: >10th

Inference: underweight child

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

Diet Recommendations: soft diet

Re-Assessment: Avoid spicy, chilled & outside foods

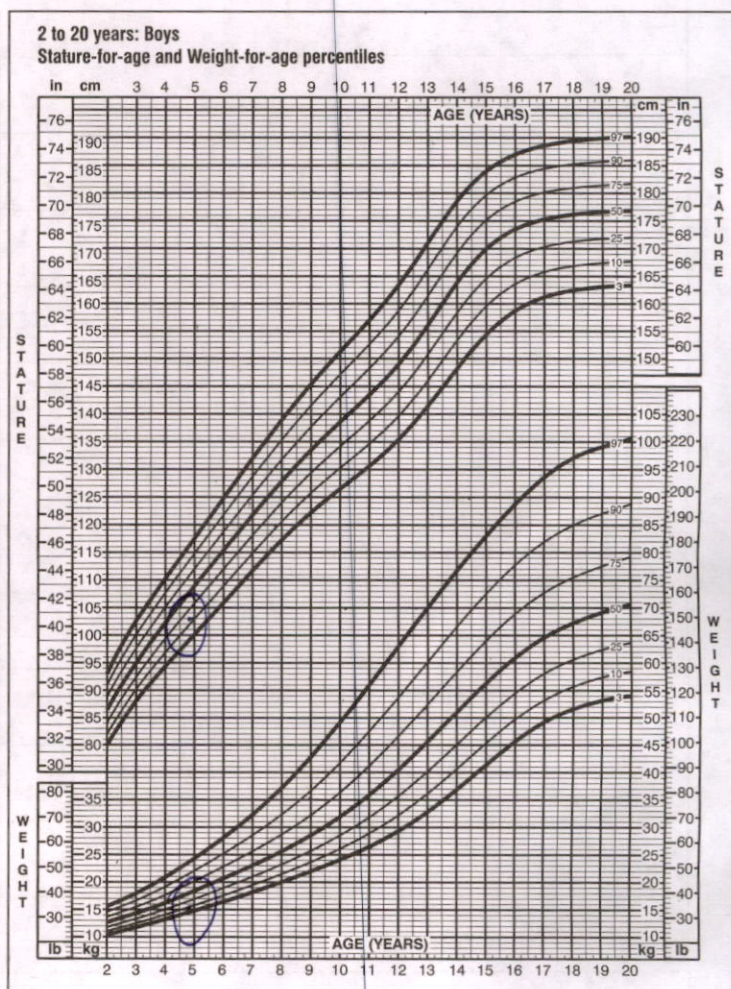
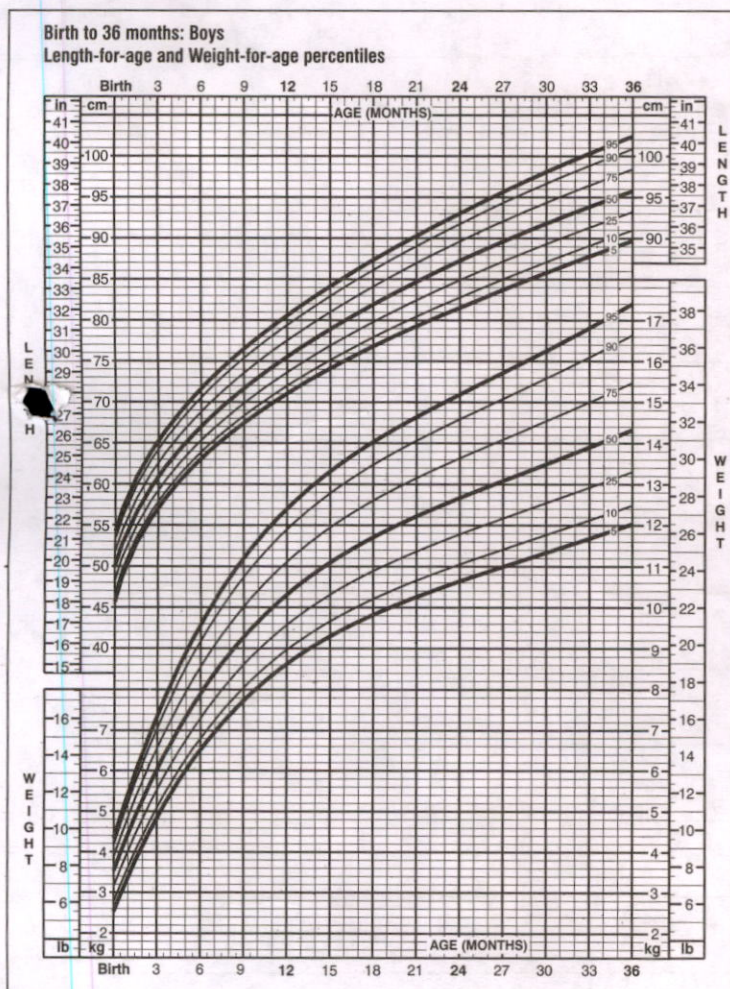
Food Allergies: NO Veg/Non-veg: Non-veg

Diagnosis: PUD ? kawasaki disease (Resistant)

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha

8/12/26	10am	chil q is stable. Graf intake is fair.	continue c soft diet	-mowing
9/8/26	8am	Child is stable. Intake is poor	continue c soft diet	10/10/26
10/10/26	9am	child is stable. Intake is fair	continue c soft diet	-mowing