

## ACTIVITY RECORD FOR BILLING

Name : \_\_\_\_\_  
UHID No. : \_\_\_\_\_ IP No. : \_\_\_\_\_ Dept : \_\_\_\_\_

BAH-00662140 IP5-00176618  
Baby Of UDUTHA SARIKA  
21-04-2026 0 Y 2 M 28 D (F)  
Dr. UJJWALA DESAI



Date of Admission: \_\_\_\_\_ Time : \_\_\_\_\_ Date of Discharge : \_\_\_\_\_ Time: \_\_\_\_\_

Room / Bed No : \_\_\_\_\_ Ward : \_\_\_\_\_ Suggested Billable bed type : \_\_\_\_\_

## WARD TRANSFERS

| Date    | Time     | From | To | Signature of Nurse |
|---------|----------|------|----|--------------------|
| 20/9/26 | 12:20 AM | ER   | U9 | [Signature]        |
|         |          |      |    |                    |
|         |          |      |    |                    |
|         |          |      |    |                    |
|         |          |      |    |                    |

## Cross Consultation Visit

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

# PROCEDURE

| Date    | Procedure    | Quantity | Order No. | Signature |
|---------|--------------|----------|-----------|-----------|
| 20/7/26 | IV placement | 1        | 11339     | Kusat     |
|         |              |          |           |           |
|         |              |          |           |           |
|         |              |          |           |           |
|         |              |          |           |           |
|         |              |          |           |           |
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|         |              |          |           |           |
|         |              |          |           |           |

## ANY OTHER INFORMATION

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Date : 21/7 Time : 10am Prepared By : [Signature]

| Staff Nurse | Shift / Ward | Billing Assistant | Billing Supervisor |
|-------------|--------------|-------------------|--------------------|
| [Signature] | 119          |                   |                    |

## ADMISSION SHEET

### Registration Details :



Admission No : IP5-00176618      Admit Date : 19-Jul-2026      Admit Time : 11:32 PM      UHID : BAH-00662140

### Patient Details :

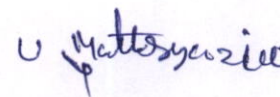
|              |                                                             |                |                          |
|--------------|-------------------------------------------------------------|----------------|--------------------------|
| Patient Name | : Baby Of UDUTHA SARIKA                                     | Age            | : 0 Y 2 M 28 D           |
| Guardian     | : Mr UDUTHA MATHSYAGIRI                                     | DOB            | : 21-04-2026 01:00 AM    |
| Gender       | : Female                                                    | Religion       | :                        |
| Occupation   | :                                                           | Martial Status | : Single                 |
| Address (H)  | : #4-88 BASWAPUR Bhongir Nalgonda<br>Telangana INDIA 508116 | Phone No       | : 9177579622/ 9398993346 |
|              |                                                             | E-mail         | : nomailid@gmail.com     |

### Admission Details :

Bed Type : GENERAL WARD      Bed No : GW 119      Ward Name : 1F-GENERAL WARD I  
Room No : GW 119      Admission Type : First Visit

### Contact Details :

Name : Mr UDUTHA MATHSYAGIRI      Relationship : Father  
Contact Address : #4-88 BASWAPUR Bhongir Nalgonda      Phone No :  
Telangana INDIA 508116



Signature

### Doctor Details :

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

### Payment Details :

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



110 Patient Saver

13110062140.

119

## DEFICIENCY CHECK LIST OF CASE SHEET

| Sl.No.             | List of Records                            | No. of Pages | Legibility | Completeness | Remarks |
|--------------------|--------------------------------------------|--------------|------------|--------------|---------|
| 1                  | Admission sheet                            | 1            |            |              |         |
| 2                  | Discharge Summary                          | 1            |            |              |         |
| 3                  | Nursing Initial assessment                 | 1            |            |              |         |
| 4                  | Patient Transfer form                      | 1            |            |              |         |
| 5                  | In-patient Medical record                  | 1            |            |              |         |
| 6                  | Doctors progress sheets                    | 3            |            |              |         |
| 7                  | Nursing plan of care and handover sheets   | 2            |            |              |         |
| 8                  | Consultation sheet                         |              |            |              |         |
| 9                  | General consent for treatment              |              |            |              |         |
| 10                 | Consent for Surgery                        |              |            |              |         |
| 11                 | Consent for blood transfusion              |              |            |              |         |
| 12                 | Consent for chemotherapy                   |              |            |              |         |
| 13                 | Consent for high risk                      |              |            |              |         |
| 14                 | Consent for Restraint                      |              |            |              |         |
| 15                 | LAMA consent                               |              |            |              |         |
| 16                 | Consent for special procedure / Sedation   |              |            |              |         |
| 17                 | Consent for Formula feed                   |              |            |              |         |
| 18                 | Consent for MTP                            |              |            |              |         |
| 19                 | Consent for Radiological Investigations    |              |            |              |         |
| 20                 | Consent for HIV test                       |              |            |              |         |
| 21                 | Anaesthesia notes (Pre Anaesthesia & post) |              |            |              |         |
| 22                 | Neonatal Admission/Delivery/Physical Exam  |              |            |              |         |
| 23                 | Medication Reconciliation                  | 1            |            |              |         |
| 24                 | Emergency Triage record                    | 1            |            |              |         |
| 25                 | Pre operative check list                   |              |            |              |         |
| 26                 | Surgical safety checklist                  |              |            |              |         |
| 27                 | Operation Theatre notes                    |              |            |              |         |
| 28                 | Nurses clinical Presentation               |              |            |              |         |
| 29                 | TPR & BP chart                             | 2            |            |              |         |
| 30                 | Intake and Out take chart (fluid chart)    | 1            |            |              |         |
| 31                 | Drug chart (Regular Prescription)          | 1            |            |              |         |
| 32                 | Investigation Values (result sheet)        | 1            |            |              |         |
| 33                 | Nebulization chart                         |              |            |              |         |
| 34                 | Nutritional review chart                   | 1            |            |              |         |
| 35                 | Intensive care unit (ICU Charts)           |              |            |              |         |
| 36                 | Consent for Admission in PICU / NICU       |              |            |              |         |
| 37                 | The Humpty dumpty scale                    | 1            |            |              |         |
| 38                 | Braden Q Scale                             | 1            |            |              |         |
| 39                 | Bed side check list                        |              |            |              |         |
| 40                 | PICU bed formula Dilution feeds            |              |            |              |         |
| 41                 | Gastro monitoring chart                    |              |            |              |         |
| 42                 | Rch ED doctors note                        |              |            |              |         |
| 43                 | BP Monitoring chart                        |              |            |              |         |
| 44                 | RBS monitoring chart                       |              |            |              |         |
| 45                 | Extra                                      | 4            |            |              |         |
| Total No. of Pages |                                            | 33           |            |              |         |



## ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



It takes a lot to treat the little.

## PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

8/0 Sange.

UHID ID:

BAH-00662140 IP5-00176618  
Baby Of UDUTHA SARIKA  
21-04-2026 0 Y 2 M 28 D (F)  
Dr. UJJWALA DESAI

Department:



Consultant:





## Pediatric Multiorgan History & Physical Examination

Name : \_\_\_\_\_ Age/Sex \_\_\_\_\_

Information given by: \_\_\_\_\_ Relationship \_\_\_\_\_

### Chief Presenting Complaints & Duration (Chronologically)

Cough, cold: 7 days

hurried breathing: 2 days

### History of present illness :

Cough - dry cough, ~~not~~ no diurnal variation / Peristaltic variation

H/o sneezing @.

No H/o Fever

No H/o decreased oral intake

No H/o vomiting, loose stools

No H/o travelling. No H/o similar illness in the family.

on OPD basis used mucipal drops for 5 days  
2 weeks

%/o increased work of breathing

→ referred to WISHU centre.

chest x ray - done - Bronchopneumonia

%/o - work of breathing @.

ER - Nasal suction

fever x 2 ) other ) RR - 49/min.



## Pediatric Multiorgan History & Physical Examination

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

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**Birth & Neonatal History:**

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Normal neonatal transition

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**Birth & Socio Economic History:**

About Father : 

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About Mother : 

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Any additional Information : 

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**Developmental History :**

Normal for age.

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**Immunization History :**

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(P.T.O.)

(P.T.O.)





### Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Cupellation

Desired goals of the treatment :

Hemodynamic stability

Planned Labs:

CBP, CRP

5 viral panel

1 Extrapleural

Noted by  
Rithu  
21/4/2026

CX-R - Outside done - 19/4/26

Planned Management

IV fluids

Plan of antibiotic after culture

Nasoclear nasal drops

Nebulizer

Nebulizer

Signature of the Doctor: N. Pr...

Signature of the Consultant: Dr. Ujjwala

Name of the Doctor: N. Prathibha

Name of the Consultant: Dr. Ujjwala

Date & Time: 19/04/2026, 11:50 PM

Date & Time: 20/4/26

DR. UJJWALA DESAI  
Registration No: 90550



| Date & Time | Progress Notes                                                                                                                                                                                           | Doctor's Order                                                                                                                                                                                                                                                 |
|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 2017/28     | Bronchitis,<br>5 virus panel<br>awaited.<br>Saturator Normal<br>in room air.                                                                                                                             | Continue Nebulizer<br>Nasoclear drops<br>Nasonix mini drops<br>twice daily                                                                                                                                                                                     |
| 2017        | Clt/B Resident<br><br>As Bronchiolitis<br>No fever spikes<br>cough (+)<br>noisy breathing<br>O/R<br>Rf - RPE (+), wheeze (+)<br>Bleph hls (+)<br><br>Rf<br>Influa A, B } neg<br>COVID<br>Adeno - awaited | DR. UJJWALA DESAI<br>Registration No: 90550<br><br>Plan<br>- Add Rx Amoxicillin-clavulanate and<br>- Ct test of leishman 6 <sup>th</sup> hrs<br>Breakfast RD<br>- Add Nasoclear nasal drops<br>- Nasonix mini drops RD<br>- monitor w/f<br>- w/f Resp distress |









## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time        | Progress Notes                                                                                                                                                                                                                                  | Doctor's Order                                                                                                                                                                                                                                                                            |
|--------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 21/3/24<br>8:15 AM | Seen by Resident<br>Asis - Bronchiolitis.<br>No fever<br>cough better<br>nose block better.<br>O/E<br>baby on room air<br>alert, afebrile,<br>AF at level<br>perfusion good<br>RR-30/min, mild SRO.<br>BAE.<br>P/A - soft.<br>Adeno - Negative. | Plan<br>1. Continue medications<br>as charted<br>2. monitor vitals &<br>w/t resp distress.<br>f<br>Samir                                                                                                                                                                                  |
|                    | Discharge                                                                                                                                                                                                                                       | Domestol suspension<br>x 2 weeks<br>Augmentin<br>procg drops x 5 days.<br>Levolin - 0.3mg 3 times<br>Budecort - 1/2 resp. 2 times<br>Nasivion mini x 3 days max 1 wk<br>Nasoclear.<br>Review after - 1 wk<br>Vitamin D drops<br>Wednesday.<br>DR. UJJWALA DESAI<br>Registration No: 90550 |



UJJWALA DESAI



**BirthRight™**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

### PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



BAH-00682140 IPS-00176618  
 Baby Of UDUTHA SARIKA  
 21-04-2026 0 Y 2 M 28 D (F)  
 Dr. UJJWALA DESAI



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

**BirthRight**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

## RESULT SHEET

|                     |                           |  |  |  |  |
|---------------------|---------------------------|--|--|--|--|
| Date                | 20/7/26                   |  |  |  |  |
| Time                |                           |  |  |  |  |
| Hb                  | 11.3                      |  |  |  |  |
| PCV                 | 34.1                      |  |  |  |  |
| RBC                 | 4.11                      |  |  |  |  |
| WBC                 | 11080                     |  |  |  |  |
| N/L                 | <del>7.8</del> 7.8 / 86.9 |  |  |  |  |
| Platelets           | 5.84                      |  |  |  |  |
| CRP                 | 5                         |  |  |  |  |
| ESR                 |                           |  |  |  |  |
| PCT                 |                           |  |  |  |  |
| RBS                 |                           |  |  |  |  |
| Na                  |                           |  |  |  |  |
| K                   |                           |  |  |  |  |
| Cl                  |                           |  |  |  |  |
| Ca/Mg               |                           |  |  |  |  |
| Phosphate           |                           |  |  |  |  |
| Urea                |                           |  |  |  |  |
| Creatinine          |                           |  |  |  |  |
| ALP                 |                           |  |  |  |  |
| SGPT                |                           |  |  |  |  |
| SGOT                |                           |  |  |  |  |
| T.Bill/Conj         |                           |  |  |  |  |
| T.Protein           |                           |  |  |  |  |
| S.Albumin           |                           |  |  |  |  |
| S.Globulin          |                           |  |  |  |  |
| A/G Ratio           |                           |  |  |  |  |
| Uric Acid           |                           |  |  |  |  |
| S.Amylase           |                           |  |  |  |  |
| Sr.Lipase           |                           |  |  |  |  |
| Blood Lactate       |                           |  |  |  |  |
| S.Cholesterol       |                           |  |  |  |  |
| PT/INR              |                           |  |  |  |  |
| APTT                |                           |  |  |  |  |
| CSF Protein / Sugar |                           |  |  |  |  |
| Cells               |                           |  |  |  |  |
| N/L                 |                           |  |  |  |  |









## MEDICATION RECONCILIATION FORM

Drug Allergies: .....

☒ Not known any Drug Allergies

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

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

Shifting From: ..... ICU .....

Shifted to: ..... ward .....

| S.No | MEDICATION NAME<br>(GENERIC NAME CAPITAL LETTERS) | DOSE<br>(mg, mcg) | ROUTE<br>(PO, NG, SC, IV) | FREQUENCY  | LAST DOSE<br>Date / Time | ON<br>ADMISSION<br>/ SHIFTING                                     |
|------|---------------------------------------------------|-------------------|---------------------------|------------|--------------------------|-------------------------------------------------------------------|
| 1    | <u>omacortil drops</u>                            | <u>0.2ml</u>      | <u>PO</u>                 | <u>12H</u> | <u>18/7</u>              | <input type="checkbox"/> C <input checked="" type="checkbox"/> DC |
| 2    | <u>nasoclear drops</u>                            | <u>2 drops</u>    | <u>Nasal</u>              | <u>4H</u>  | <u>18/7</u>              | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 3    | <u>maxipid or drops</u>                           | <u>0.2ml</u>      | <u>PO</u>                 | <u>12H</u> | <u>18/7</u>              | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 4    |                                                   |                   |                           |            |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 5    |                                                   |                   |                           |            |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 6    |                                                   |                   |                           |            |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 7    |                                                   |                   |                           |            |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 8    |                                                   |                   |                           |            |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 9    |                                                   |                   |                           |            |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 10   |                                                   |                   |                           |            |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |

\* C- Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Parthiv N. Patel

Date & Time : 19/7/26, 11:50 AM

Nurse Name & Signature: Kethave DJ

Date & Time : 20/7 @ 12:30 PM





## DRUG CHART

Date of Admission: 19/7/26 Drug Allergies: ☒ Not known any Drug Allergies

### FOR THE SAFETY OF THE PATIENT

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

### SOS / PRN (As Required Medication)

|                                                                              |           |              |             |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|------------------------------------------------------------------------------|-----------|--------------|-------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b> <u>SYP. CROUN/DS</u>                                           |           |              |             | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                         | Route     | Frequency    | Start Date  |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                                                                              | <u>PO</u> | <u>805</u>   | <u>19/7</u> |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature                                                           |           | Valid Period | Pharm.      |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                                                                              |           | <u>48H</u>   |             |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:<br><u>(5ml/24gms)</u>                               |           |              |             |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b> <u>DROPS. CROUN</u>                                            |           |              |             | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                         | Route     | Frequency    | Start Date  |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <u>0.7ml</u>                                                                 | <u>PO</u> | <u>805</u>   | <u>19/7</u> |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature                                                           |           | Valid Period | Pharm.      |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                                                                              |           |              |             |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:<br><u>1+ Temp 299.9°F</u><br><u>max 4-6 hourly.</u> |           |              |             |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b>                                                                |           |              |             | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                         | Route     | Frequency    | Start Date  |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature                                                           |           | Valid Period | Pharm.      |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                                                                              |           |              |             |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                     |           |              |             |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

VERIFIED BY : Name Signature





REGULAR PRESCRIPTIONS

Weight. 5.76 kg Ward. ....

|                                                                      |       |           |            |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
|----------------------------------------------------------------------|-------|-----------|------------|--------------|------|------|------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| DRUG : CERVIN                                                        |       |           |            | Date<br>Time | 19/7 | 20/7 | 21/7 |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                 | Route | Frequency | Start Date |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 0.31                                                                 | NEB   | 6H        | 19/7       | 12PM         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br>N. Peatwale |       |           |            | 6AM          |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:<br>+ 2ml 3% NS.                             |       |           |            | 12PM         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                 |       |           |            | 6PM          |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DRUG : NEB T BUDEORT                                                 |       |           |            | Date<br>Time | 19/7 | 20/7 |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                 | Route | Frequency | Start Date |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 0.5                                                                  | NEB   | 8H        | 19/7       | 10AM         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br>N. Peatwale |       |           |            |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                             |       |           |            | 10PM         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                 |       |           |            |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DRUG : NASOCLEAR NASAL                                               |       |           |            | Date<br>Time | 19/7 |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                 | Route | Frequency | Start Date |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2 drops                                                              | Nasal | 4H        | 19/7       | 12AM         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br>N. Peatwale |       |           |            | 4AM          |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                             |       |           |            | 8AM          |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                 |       |           |            | 12PM         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DRUG : NEB WITH 3% NS                                                |       |           |            | Date<br>Time |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                 | Route | Frequency | Start Date |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                                                                      | NEB   |           |            |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:                |       |           |            |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                             |       |           |            |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                 |       |           |            |              |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |



| VARIABLE DOSE                  |            | Date<br>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. |            |

| VARIABLE DOSE                  |            | Date<br>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.  |

VERIF. BY: Name

[illegible]



[illegible]





**Rainbow<sup>®</sup>  
Children's  
Hospital**  
It takes a lot to treat the little.

Sheet No: .....

## REGULAR PRESCRIPTIONS

Weight 8.76 kg Ward .....

| DRUG : <i>By Ceftriaxone</i>                       |       |           |           | Date<br>Time |
|----------------------------------------------------|-------|-----------|-----------|--------------|
| Dose                                               | Route | Frequency | Start Dt. |              |
| Name & Signature of the Doctor Starting the Drugs: |       |           |           |              |
| Additional Instructions:                           |       |           |           |              |
| Daily Doctor's Endorsement by a Sign               |       |           |           |              |

| DRUG : <i>By Ceftriaxone</i>                       |           |           |             | Date<br>Time |
|----------------------------------------------------|-----------|-----------|-------------|--------------|
| Dose                                               | Route     | Frequency | Start Dt.   |              |
| <i>20mg</i>                                        | <i>iv</i> | <i>BD</i> | <i>2017</i> |              |
| Name & Signature of the Doctor Starting the Drugs: |           |           |             |              |
| Additional Instructions:                           |           |           |             |              |
| Daily Doctor's Endorsement by a Sign               |           |           |             |              |

| DRUG : <i>Budocort Neb</i>                         |            |           |             | Date<br>Time         |
|----------------------------------------------------|------------|-----------|-------------|----------------------|
| Dose                                               | Route      | Frequency | Start Dt.   |                      |
| <i>Insp</i>                                        | <i>Neb</i> | <i>BD</i> | <i>2017</i> | <i>10 AM - 10 PM</i> |
| Name & Signature of the Doctor Starting the Drugs: |            |           |             |                      |
| Additional Instructions:                           |            |           |             |                      |
| Daily Doctor's Endorsement by a Sign               |            |           |             |                      |

| DRUG : <i>Amoxicillin Clavulanate</i>              |           |            |             | Date<br>Time         |
|----------------------------------------------------|-----------|------------|-------------|----------------------|
| Dose                                               | Route     | Frequency  | Start Dt.   |                      |
| <i>180mg</i>                                       | <i>iv</i> | <i>TID</i> | <i>2017</i> | <i>6AM x 3 times</i> |
| Name & Signature of the Doctor Starting the Drugs: |           |            |             |                      |
| Additional Instructions:                           |           |            |             |                      |
| Daily Doctor's Endorsement by a Sign               |           |            |             |                      |



Weight ..... Ward .....

| DRUG :                                                |                 |                    |           | Date  |
|-------------------------------------------------------|-----------------|--------------------|-----------|-------|
| Dose                                                  | Route           | Frequency          | Start Dt. | Time  |
| 2°                                                    | each<br>not mil | 6 <sup>th</sup> ly | 2017      | 12 AM |
| Name & Signature of the Doctor<br>Starting the Drugs: |                 |                    |           | 12 PM |
| Additional Instructions:                              |                 |                    |           | 6 PM  |
| Daily Doctor's Endorsement by a Sign                  |                 |                    |           |       |

| DRUG :                                                |                 |           |           | Date  |
|-------------------------------------------------------|-----------------|-----------|-----------|-------|
| Dose                                                  | Route           | Frequency | Start Dt. | Time  |
| 2°                                                    | each<br>not mil | BD        | 2017      | 10 AM |
| Name & Signature of the Doctor<br>Starting the Drugs: |                 |           |           | 10 PM |
| Additional Instructions:                              |                 |           |           |       |
| Daily Doctor's Endorsement by a Sign                  |                 |           |           |       |

| DRUG :                                                |       |           |           | Date |
|-------------------------------------------------------|-------|-----------|-----------|------|
| Dose                                                  | Route | Frequency | Start Dt. | Time |
| Name & Signature of the Doctor<br>Starting the Drugs: |       |           |           |      |
| Additional Instructions:                              |       |           |           |      |
| Daily Doctor's Endorsement by a Sign                  |       |           |           |      |

| DRUG :                                                |       |           |           | Date |
|-------------------------------------------------------|-------|-----------|-----------|------|
| Dose                                                  | Route | Frequency | Start Dt. | Time |
| Name & Signature of the Doctor<br>Starting the Drugs: |       |           |           |      |
| Additional Instructions:                              |       |           |           |      |
| Daily Doctor's Endorsement by a Sign                  |       |           |           |      |

Signature \_\_\_\_\_

VERIFIED BY: Name





Doc. No. : RCH / FRM / CLINICAL / 124

# INFANT (<1 year) 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: 22/3/26                    | Time: 6PM | 21/3/26 | 2PM     | 6PM     |
| Doctor/Nurse/Family Concern?     |           |         |         |         |
| Temperature (F)                  | 96.6 F    | 98.9 F  | 98.9 F  | 98.1 F  |
| Heart Rate (bpm)                 | 136 bpm   | 136 bpm | 136 bpm | 139 bpm |
| Blood Pressure (mmHg) *          | 100/56    | 105/60  | 105/60  | 105/60  |
| Resp. Rate (bpm)                 | 28 bpm    | 28 bpm  | 28 bpm  | 28 bpm  |
| Receiving O <sub>2</sub> (l/min) | 0.1       | 0.1     | 0.1     | 0.1     |
| O <sub>2</sub> Saturations (%)   | 99%       | 99%     | 99%     | 99%     |
| Conscious Level                  | 15/15     | 14/15   | 14/15   | 14/15   |
| GCS *                            | 15/15     | 14/15   | 14/15   | 14/15   |
| TOTAL SCORE                      | 1         | 1       | 1       | 1       |
| Number of shaded boxes           | 0         | 0       | 0       | 0       |
| Pain Score                       | 0         | 0       | 0       | 0       |
| Observer's Initials              | U         | S       | S       | S       |

### ACTIONS

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

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



# CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

## INSTRUCTIONS:

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

| Record Details when <b>EARLY WARNING SCORE &gt; 3</b> |      |                     | Record Time of Review and Plan |      |      |
|-------------------------------------------------------|------|---------------------|--------------------------------|------|------|
| Date                                                  | Time | Early Warning Score | Date                           | Time | Name |
|                                                       |      |                     |                                |      |      |
|                                                       |      |                     |                                |      |      |
|                                                       |      |                     |                                |      |      |
|                                                       |      |                     |                                |      |      |

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

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

|          |                                                                                                                                                                                                                                                                                                                                      |
|----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>I</b> | <b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)                                                                                                                                                                                                                                                      |
| <b>S</b> | <b>SITUATION :</b> 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>B</b> | <b>BACK GROUND :</b> 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) |
| <b>A</b> | <b>ASSESSMENT :</b> 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.                                                                                         |
| <b>R</b> | <b>RECOMMENDATION :</b> 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)                                                                                                                                                |



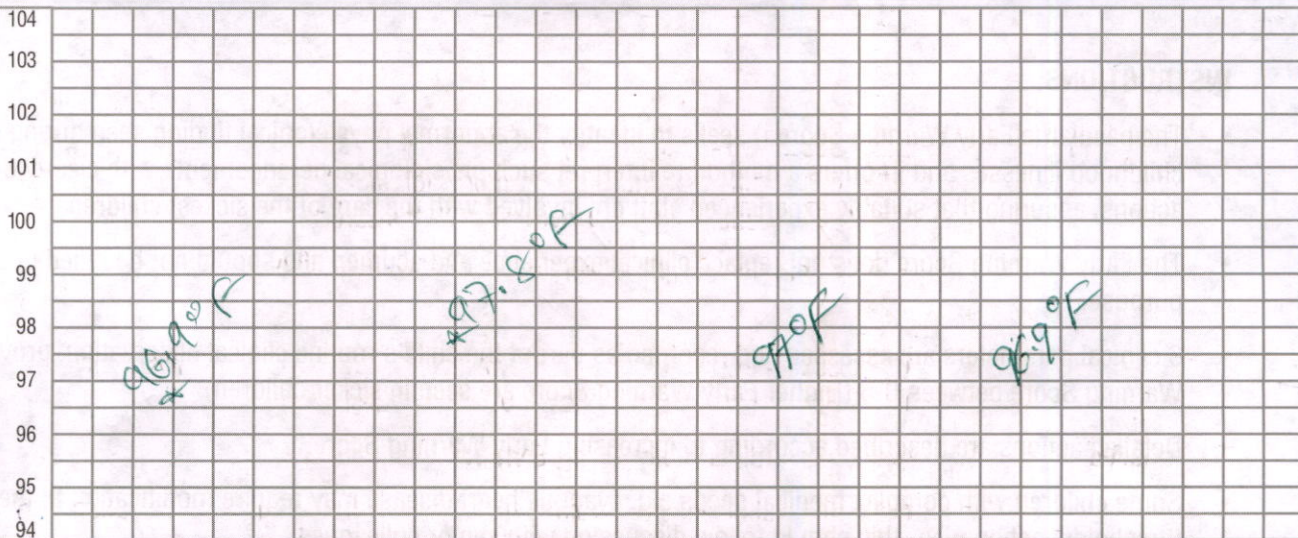


# INFANT (<1 year) Children's Observation & Early Warning Scoring Chart

## EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 20/4 Time: 2am 6am 10pm 1pm  
 Doctor/Nurse/Family Concern?

Temperature  
 (F)

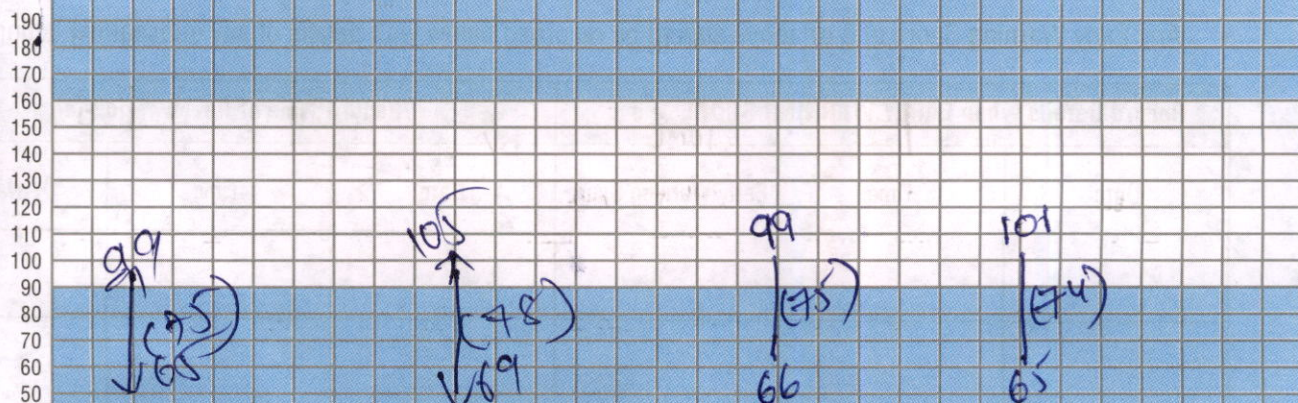


Heart Rate  
 (bpm)

and

Blood Pressure  
 (mmHg) \*

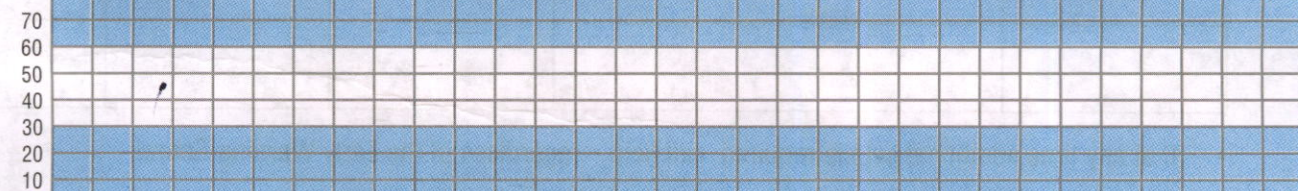
Note:  
 BP does not score  
 in early  
 warning scoring



Heart Rate (Number)

114b/m 107b/m 108b/m 106b/m

Resp. Rate (bpm)  
 over 1 Minute \*



Resp Rate (Number)

23b/m 28b/m 28b/m 28b/m

Resp Distress  
 Mod/ Severe  
 None / Mild

Receiving O<sub>2</sub> (l/min)  
 O<sub>2</sub> Saturations (%)

00% 100% 98% 98%

Conscious Level  
 Normal  
 Altered

GCS \*

15/15 15/15 15/15 15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

1 1 1 1  
 0 0 0 0  
 0 0 0 0

ACTIONS

NB: Scores 3 should be  
 recorded overleaf

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

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



# CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

## INSTRUCTIONS:

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

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

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

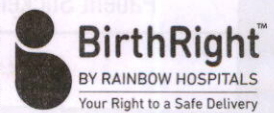
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

|          |                                                                                                                                                                                                                                                                                                                                      |
|----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>I</b> | <b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)                                                                                                                                                                                                                                                      |
| <b>S</b> | <b>SITUATION :</b> 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>B</b> | <b>BACK GROUND :</b> 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) |
| <b>A</b> | <b>ASSESSMENT :</b> 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.                                                                                          |
| <b>R</b> | <b>RECOMMENDATION :</b> I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)                                                                                                                                                |



BAH-00662140 IP5-00175618  
 Baby Of UDUTHA SARIKA  
 21-04-2026 0 Y 2 M 28 D (F)  
 Dr. UJJWALA DESAI

Patient



# 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 | Sign. Nurse |
|-----------------------------|----------|-----------------|-------|------|-----|-----------------------------|-----------|-------|----------|-------|-------------------------|---------|-------------|
| Date                        | Time     | Nature of Fluid | Route |      |     | NG                          | Diarrhoea | Vomit | Drainage | Urine | Thrombo-phlebitis Score |         |             |
|                             |          |                 | Mouth | I.V  | N.G |                             |           |       |          |       |                         |         |             |
|                             | 08:00 am |                 |       |      |     |                             |           |       |          |       |                         |         |             |
|                             | 09:00 am |                 |       |      |     |                             |           |       |          |       |                         |         |             |
|                             | 10:00 am |                 |       |      |     |                             |           |       |          |       |                         |         |             |
|                             | 11:00 am |                 |       |      |     |                             |           |       |          |       |                         |         |             |
|                             | 12:00 pm |                 |       |      |     |                             |           |       |          |       |                         |         |             |
|                             | 01:00 pm |                 |       |      |     |                             |           |       |          |       |                         |         |             |
| <b>Total Intake :</b>       |          |                 |       |      |     | <b>Total Output :</b>       |           |       |          |       |                         |         |             |
|                             | 02:00 pm |                 |       |      |     |                             |           |       |          |       |                         |         |             |
|                             | 03:00 pm |                 |       |      |     |                             |           |       |          |       |                         |         |             |
|                             | 04:00 pm |                 |       |      |     |                             |           |       |          |       |                         |         |             |
|                             | 05:00 pm |                 |       |      |     |                             |           |       |          |       |                         |         |             |
|                             | 06:00 pm |                 |       |      |     |                             |           |       |          |       |                         |         |             |
|                             | 07:00 pm |                 |       |      |     |                             |           |       |          |       |                         |         |             |
| <b>Total Intake :</b>       |          |                 |       |      |     | <b>Total Output :</b>       |           |       |          |       |                         |         |             |
|                             | 08:00 pm |                 |       |      |     |                             |           |       |          |       |                         |         |             |
|                             | 09:00 pm |                 |       |      |     |                             |           |       |          |       |                         |         |             |
|                             | 10:00 pm |                 |       |      |     |                             |           |       |          |       |                         |         |             |
| 19/4                        | 11:00 pm |                 |       |      |     |                             |           |       |          |       |                         |         |             |
|                             | 12:00 am | DNS             |       | 10ml |     |                             |           |       |          |       |                         |         |             |
|                             | 01:00 am |                 |       | 10ml |     |                             |           |       |          |       |                         |         |             |
| <b>Total Intake :</b>       |          |                 |       |      |     | <b>Total Output :</b>       |           |       |          |       |                         |         |             |
|                             | 02:00 am |                 |       | 10ml |     |                             |           |       |          |       |                         |         |             |
|                             | 03:00 am |                 |       | 10ml |     |                             |           |       |          |       |                         |         |             |
|                             | 04:00 am | DNS             |       | 10ml |     |                             |           |       |          |       |                         |         |             |
|                             | 05:00 am |                 |       | 10ml |     |                             |           |       |          |       |                         |         |             |
|                             | 06:00 am |                 |       | 10ml |     |                             |           |       |          |       |                         |         |             |
|                             | 07:00 am |                 |       | 10ml |     |                             |           |       |          |       |                         |         |             |
| <b>Total Intake :</b>       |          |                 |       |      |     | <b>Total Output :</b>       |           |       |          |       |                         |         |             |
| <b>Total 24 hrs. Intake</b> |          |                 |       |      |     | <b>Total 24 hrs. Output</b> |           |       |          |       |                         |         |             |





# 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. Nurse |
|----------------|----------|-----------------|-------|------|----------------|-----------|-------|----------|-------|-------------------------|-------------|
| Date           | Time     | Nature of Fluid | Route |      | NG             | Diarrhoea | Vomit | Drainage | Urine | Thrombo-phlebitis Score |             |
|                |          |                 | Mouth | I.V  | N.G            |           |       |          |       |                         |             |
| 20/7           | 08:00 am | DNS             |       | 10ml | NA             | ✓         | NA    | ✓        |       | 0                       | Aruna       |
|                | 09:00 am |                 | 10ml  |      |                |           |       |          | 0     |                         |             |
|                | 10:00 am |                 | 10ml  |      |                |           |       |          | 0     |                         |             |
|                | 11:00 am |                 | -     |      |                |           |       |          | 0     |                         |             |
|                | 12:00 pm |                 | 10ml  |      |                |           |       |          | 0     |                         |             |
|                | 01:00 pm |                 | 10ml  |      |                |           |       |          | 0     |                         |             |
| Total Intake : |          |                 |       |      | Total Output : |           |       |          |       |                         |             |
| 20/7           | 02:00 pm | DNS             |       | 10ml | NA             | ✓         | NA    | ✓        |       | 0                       | Aruna       |
|                | 03:00 pm |                 | 10ml  |      |                |           |       |          | 0     |                         |             |
|                | 04:00 pm |                 | 10ml  |      |                |           |       |          | 0     |                         |             |
|                | 05:00 pm |                 | 10ml  |      |                |           |       |          | 0     |                         |             |
|                | 06:00 pm |                 | 10ml  |      |                |           |       |          | 0     |                         |             |
|                | 07:00 pm |                 | 10ml  |      |                |           |       |          | 0     |                         |             |
| Total Intake : |          |                 |       |      | Total Output : |           |       |          |       |                         |             |
| 20/7           | 08:00 pm | DNS             |       | 10ml | NA             | ✓         | NA    | ✓        |       | 0                       | Susha       |
|                | 09:00 pm |                 | 10ml  |      |                |           |       |          | 0     |                         |             |
|                | 10:00 pm |                 | 10ml  |      |                |           |       |          | 0     |                         |             |
|                | 11:00 pm |                 | -     |      |                |           |       |          | 0     |                         |             |
|                | 12:00 am |                 | 10ml  |      |                |           |       |          | 0     |                         |             |
|                | 01:00 am |                 | 10ml  |      |                |           |       |          | 0     |                         |             |
| Total Intake : |          |                 |       |      | Total Output : |           |       |          |       |                         |             |
| 21/7           | 02:00 am | DNS             |       | 10ml | NA             | ✓         | NA    | ✓        |       | 0                       | Susha       |
|                | 03:00 am |                 | 10ml  |      |                |           |       |          | 0     |                         |             |
|                | 04:00 am |                 | 10ml  |      |                |           |       |          | 0     |                         |             |
|                | 05:00 am |                 | 10ml  |      |                |           |       |          | 0     |                         |             |
|                | 06:00 am |                 | 10ml  |      |                |           |       |          | 0     |                         |             |
|                | 07:00 am |                 | 10ml  |      |                |           |       |          | 0     |                         |             |
| Total Intake : |          |                 |       |      | Total Output : |           |       |          |       |                         |             |

**Total 24 hrs. Intake**

**Total 24 hrs. Output**



BAH-00662140 IP5-00176618  
 Baby Of UDUTHA SARIKA  
 21-04-2026 0 Y 2 M 29 D (F)  
 Dr. UJJWALA DESAI

## NURSING CARE RECORD

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

BirthRight™  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 19/7

Assessment: Baby having cold / cough

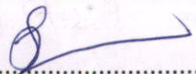
Goals

- ☒ 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               |
|------|-----------------------------------------------|--------|-------------------------------------------------|--------------------------|
| 1am  | → Assess the baby general condition           | 1:10am | → Assessed the baby general condition           | baby Condition is stable |
| 2am  | → monitor the vital's                         | 2:10am | → monitored the vital's                         |                          |
| 3am  | → maintain IV fluid's                         | 3:10am | → maintained IV fluid's                         |                          |
| 4am  | → give nebulization.                          | 4:10am | → given nebulization                            |                          |
| 6am  | → Administer medication as per doctor order's | 6:10am | → Administered medication as per doctor order's |                          |

Re-Assessment: .....

Special Notes: given nebulization

Nurse Signature: 

Nurse Name: Serial

Date & Time: 20/7 @ 8am



BAH-00662140  
Baby Of UDUTHA SARIKA  
21-04-2026  
Dr. UJJWALA DESAI  
IP5-00176618  
0 Y 2 M 29 D (F)

## NURSING CARE RECORD

Rainbow  
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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 20/7/26

Assessment: Baby having discomfort

### Goals

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

| Time   | Plan of Care                                                           | Time   | Implementation                                                     | Evaluation                                   |
|--------|------------------------------------------------------------------------|--------|--------------------------------------------------------------------|----------------------------------------------|
| 8am    | Assess the general condition of the baby                               | 8am    | Assessed the general condition of the baby                         | by done all these to improv- baby condition. |
| 9:30am | Dr. vijwala mam adv's antibiotic. add. levolin 6th hourly Budocort BD. | 9:30am | Dr. vijwala mam advised antibiotic added. levolin 6th. Budocort BD |                                              |
| 2pm    | monitor vital sings & record<br>Provid comfortable position            | 2pm    | monitored vital sings & record<br>provided comfortable position    |                                              |
| 6pm    | Administrt medication as per doctor order.                             | 6pm    | Administred medication as per doctor orders.                       |                                              |

Re-Assessment:

Special Notes:

Nurse Signature: Aruna

Nurse Name: Aruna

Date & Time: 20/7/26 8PM



BAH-00652140 IP5-00176618  
 Baby Of UDUTHA SARIKA  
 21-04-2026 0 Y 2 M 29 D (F)  
 Dr. UJJWALA DESAI

## NURSING CARE RECORD

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 Children's  
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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/7/26

Assessment: Baby having cough

Goals

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

| Time | Plan of Care                       | Time   | Implementation                  | Evaluation                              |
|------|------------------------------------|--------|---------------------------------|-----------------------------------------|
| 8pm  | Assess the pt general Condition    | 9pm    | Assess the pt general Condition | By dawn all implementation as per order |
| 9pm  | monitor vital sign                 | 10pm   | monitor vital sign              |                                         |
| 10pm | maintain I/O chart                 | 11pm   | maintained I/O chart            |                                         |
| 11pm | provide comfortable position       | 12Am   | provided comfortable position   |                                         |
| 6am  | Administer medication as per order | 6:30Am | Administered medication         |                                         |

Re-Assessment:

Special Notes: wif fever

Nurse Signature: Sum

Nurse Name: Sushma

Date & Time: 21/7/26 @ 8Am



BAH-00682140  
 Baby Of UDUTHA SARIKA  
 21-04-2028 0 Y 2 M 29 D (F)  
 Dr. UJJWALA DESAI



# NURSING CARE RECORD



Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: .....

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
- ☐ Maintain Skin Integrity
- ☐ Patient & Family Education

| Time | Plan of Care | Time | Implementation | Evaluation |
|------|--------------|------|----------------|------------|
|      |              |      |                |            |

Re-Assessment: .....

Special Notes: .....

Nurse Signature: ..... Nurse Name: ..... Date & Time: .....



BAH-00662140  
Baby Of UDUTHA SARIKA  
21-04-2026 0 Y 2 M 28 D (F)  
Dr. UJJWALA DESAI



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## THE HUMPTY DUMPTY SCALE

| PARAMETER                                 | CRITERIA                                                                                                    | SCORE | DATE | DATE | DATE | DATE | DATE |
|-------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------|------|------|------|------|------|
| Age                                       | Less than 3 years old                                                                                       | 4     | 4    | 4    | 4    |      |      |
|                                           | 3 to less than 7 years old                                                                                  | 3     |      |      |      |      |      |
|                                           | 7 to less than 13 years old                                                                                 | 2     |      |      |      |      |      |
|                                           | 13 years old and above                                                                                      | 1     |      |      |      |      |      |
| Gender                                    | Male                                                                                                        | 2     | 2    |      |      |      |      |
|                                           | Female                                                                                                      | 1     | 1    | 1    | 1    |      |      |
| Diagnosis                                 | Neurological Diagnosis                                                                                      | 4     |      |      |      |      |      |
|                                           | Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.) | 3     |      |      |      |      |      |
|                                           | Psych / Behavioral Disorders                                                                                | 2     |      |      |      |      |      |
|                                           | Other Diagnosis                                                                                             | 1     | 1    | 1    | 1    |      |      |
| Cognitive Impairments                     | Not Aware of Limitations                                                                                    | 3     |      |      |      |      |      |
|                                           | Forget Limitations                                                                                          | 2     | 2    | 2    | 2    |      |      |
|                                           | Oriented to own Ability                                                                                     | 1     |      |      |      |      |      |
|                                           | History of Falls or Infant - Toddler Placed in Bed                                                          | 4     |      |      |      |      |      |
| Environmental Factors                     | Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)             | 3     |      |      |      |      |      |
|                                           | Patient Placed in Bed                                                                                       | 2     | 2    | 2    | 2    |      |      |
|                                           | Outpatient Area                                                                                             | 1     |      |      |      |      |      |
| Response to Surgery / Sedation Anesthesia | Within 24 hours                                                                                             | 3     |      |      |      |      |      |
|                                           | Within 48 hours                                                                                             | 2     |      |      |      |      |      |
|                                           | More than 48 hours / None                                                                                   | 1     | 1    | 1    | 1    |      |      |
| Medication Usage                          | Sedatives (excluding ICU patients sedated and paralyzed)                                                    | 3     |      |      |      |      |      |
|                                           | Hypnotics                                                                                                   | 3     |      |      |      |      |      |
|                                           | Barbiturates                                                                                                | 3     |      |      |      |      |      |
|                                           | Phenothiazines                                                                                              | 3     |      |      |      |      |      |
|                                           | Antidepressants                                                                                             | 3     |      |      |      |      |      |
|                                           | Laxatives / Diuretics                                                                                       | 3     |      |      |      |      |      |
|                                           | Narcotics                                                                                                   | 3     |      |      |      |      |      |
|                                           | One of the Meds listed above                                                                                | 2     |      |      |      |      |      |
|                                           | Other Medications / None                                                                                    | 1     | 1    | 1    | 1    |      |      |
| TOTAL                                     |                                                                                                             |       | 12   | 12   | 12   |      |      |

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

|                               |                       |     |     |  |  |
|-------------------------------|-----------------------|-----|-----|--|--|
| Bed in low position           | yes                   | yes | yes |  |  |
| Call device within reach      | yes                   | yes | yes |  |  |
| Wheels Locked                 | yes                   | yes | yes |  |  |
| Room free of clutter          | yes                   | yes | yes |  |  |
| Adequate Lighting             | yes                   | yes | yes |  |  |
| Wheel Chair Support           | no                    | no  | no  |  |  |
| Other Intervention(s) Specify | no                    | no  | no  |  |  |
| Nurse's Name :                | Shruti S. B. S. S. S. |     |     |  |  |
| Signature :                   | [Signature]           |     |     |  |  |
| Date :                        | 19/7/2017, 21/7       |     |     |  |  |
| Time :                        | 10:40pm 6am 6A        |     |     |  |  |



Patient

Dr. UJJWALA DESAI



## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Ujjwala Department: CR Date of Admission: 19/2/26

| SITUATION                                                 |  | Diagnosis:                                                          |                                                                     | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known |                                                                     |                                                                     |                                                                     |
|-----------------------------------------------------------|--|---------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|
| BACKGROUND                                                |  | Shift Time                                                          |                                                                     | If Yes Specify: .....                                                                                                 |                                                                     |                                                                     |                                                                     |
| Area                                                      |  | CR                                                                  | 12:20                                                               | 1st Hour                                                                                                              | 5-8 PM                                                              | 1st Hour                                                            | 8 PM - 8 AM                                                         |
| Medical Condition<br>(Any special condition to be noted): |  | NA                                                                  | NA                                                                  | NA                                                                                                                    | NA                                                                  | NA                                                                  | NA                                                                  |
| Allergy:                                                  |  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Tubes/Drains/Catheter:                                    |  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Vital Signs:                                              |  | Temp:                                                               | 98.2°F                                                              | 98.3°F                                                                                                                | 97°F                                                                |                                                                     |                                                                     |
|                                                           |  | Res:                                                                | 306/m                                                               | 286/m                                                                                                                 | 286/m                                                               |                                                                     |                                                                     |
|                                                           |  | SpO <sub>2</sub> :                                                  | 99%                                                                 | 99%                                                                                                                   | 98%                                                                 |                                                                     |                                                                     |
|                                                           |  | Pulse:                                                              | 143 /m                                                              | 133/m                                                                                                                 | 113                                                                 |                                                                     |                                                                     |
|                                                           |  | BP:                                                                 | 94/74                                                               | 99/70                                                                                                                 | 99/65                                                               |                                                                     |                                                                     |
|                                                           |  | Fall Risk Score:                                                    | 12                                                                  | 12                                                                                                                    | 12                                                                  |                                                                     |                                                                     |
|                                                           |  | Pain Score:                                                         | 0/10                                                                | 0/10                                                                                                                  | 0/10                                                                |                                                                     |                                                                     |
| Safety Needs:                                             |  | Yes                                                                 | Yes                                                                 | Yes                                                                                                                   | Yes                                                                 |                                                                     |                                                                     |
| Physiotherapy                                             |  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Others Specify:                                           |  | Yes                                                                 | Yes                                                                 | NA                                                                                                                    | NA                                                                  |                                                                     |                                                                     |
| Special Diet:                                             |  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Other Special Orders / Medications:                       |  | NA                                                                  | NA                                                                  | NA                                                                                                                    | NA                                                                  |                                                                     |                                                                     |
| Post Operative Procedure Special Orders:                  |  | NA                                                                  | NA                                                                  | NA                                                                                                                    | NA                                                                  |                                                                     |                                                                     |
| Handed Over By Name :                                     |  | Shavani                                                             | Shavani                                                             | Arora                                                                                                                 | Shavani                                                             |                                                                     |                                                                     |
| Signature :                                               |  | [Signature]                                                         | [Signature]                                                         | Arora                                                                                                                 | [Signature]                                                         |                                                                     |                                                                     |
| Date:                                                     |  | 20/2/26                                                             | 20/2                                                                | 20/2                                                                                                                  | 21/2                                                                |                                                                     |                                                                     |
| Time:                                                     |  | 12:20 AM                                                            | 8 AM                                                                | 8 PM                                                                                                                  | 8 AM                                                                |                                                                     |                                                                     |
| Taken Over By Name :                                      |  | Shavani                                                             | Arora                                                               | Shavani                                                                                                               |                                                                     |                                                                     |                                                                     |
| Signature :                                               |  | [Signature]                                                         | Arora                                                               | [Signature]                                                                                                           |                                                                     |                                                                     |                                                                     |
| Date:                                                     |  | 20/2                                                                | 20/2                                                                | 20/2                                                                                                                  |                                                                     |                                                                     |                                                                     |
| Time:                                                     |  | 12:30 AM                                                            | 8 AM                                                                | 8 AM                                                                                                                  |                                                                     |                                                                     |                                                                     |



BAH-00662140  
Baby OI UDUTHA SARIKA  
21-04-2026 0 Y 2 M 29 D  
Dr. UJJWALA DESAI  
IP5-00176618  
(F)

## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

|                                          |                                                           |                    |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|------------------------------------------|-----------------------------------------------------------|--------------------|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| <b>SITUATION</b>                         | Diagnosis:                                                |                    | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |                                                          |                                                          |                                                          |                                                          |                                                          |
|                                          |                                                           |                    |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
| <b>BACKGROUND</b>                        | Area                                                      | Shift Time         |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                                          | Medical Condition<br>(Any special condition to be noted): |                    |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
| <b>ASSESSMENT</b>                        | Allergy:                                                  |                    | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                          | Tubes/Drains/Catheter:                                    |                    | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                          | Vital Signs:                                              | Temp:              |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                                          |                                                           | Res:               |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                                          |                                                           | SpO <sub>2</sub> : |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                                          |                                                           | Pulse:             |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                                          |                                                           | BP:                |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                                          |                                                           | Fall Risk Score:   |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
| Pain Score:                              |                                                           |                    |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
| <b>Recommendations</b>                   | Safety Needs:                                             |                    |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                                          | Physiotherapy                                             |                    | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                          |
|                                          | Others Specify:                                           |                    |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                                          | Special Diet:                                             |                    | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                          |
|                                          | Other Special Orders / Medications:                       |                    |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
| Post Operative Procedure Special Orders: |                                                           |                    |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
| Handed Over By Name :                    |                                                           |                    |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
| Signature :                              |                                                           |                    |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
| Date:                                    |                                                           |                    |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
| Time:                                    |                                                           |                    |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
| Taken Over By Name :                     |                                                           |                    |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
| Signature :                              |                                                           |                    |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
| Date:                                    |                                                           |                    |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
| Time:                                    |                                                           |                    |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |





## CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature : [Signature] Name : Sourav

Signature of Ward In Charge :

Signature : [Signature] Name : Neeraj



# CHECKLIST FOR THROMBOPHLEBITIS

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

Signature : ..... Name : .....

Signature : ..... Name : .....





## BRADEN 'Q' SCALE

|                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Date :   | 19/12/2027 | 21/12 |     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|------------|-------|-----|
|                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Time :   | 10pm       | 6am   | 5am |
| Mobility                                                                                                                                                      | <b>1. Completely immobile:</b><br>Does not make even slight changes in body or extremity position without assistance.                                                                                                                                                                                                                    | <b>2. Very limited:</b><br>Makes occasional slight changes in body or extremity position but unable to completely turn self independently.                                                                                                                                                                                                                   | <b>3. Slightly limited:</b><br>Makes frequent through slight changes in body or e.tremity position independently.                                                                                                                                                                               | <b>4. No limitations:</b><br>Makes major and frequent changes in position without assistance.                                                                                                                                                                                          | 4        | 4          | 4     |     |
| "Activity The degree of physical activity"                                                                                                                    | <b>1. Bedfast :</b><br>Confined to bed                                                                                                                                                                                                                                                                                                   | <b>2. Chairfast :</b><br>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."                                                                                                                                                                                                         | <b>3. Walks occasionally:</b><br>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.                                                                                                                        | <b>4. All patients too young to ambulate; OR walks frequently:</b><br>Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.                                                                                                    | 4        | 4          | 4     |     |
| Sensory Perception                                                                                                                                            | <b>1. Completely limited:</b><br>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.                                                                                                                  | <b>2. Very limited:</b><br>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.                                                                                                                               | <b>3. Slightly limited:</b><br>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.                                                           | <b>4. No impairment:</b><br>Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.                                                                                                                                    | 4        | 4          | 4     |     |
| Moisture Degree to which skin is exposed to moisture                                                                                                          | <b>1. Constantly moist:</b><br>Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.                                                                                                                                                                   | <b>2. Very moist:</b><br>Skin is often, but not always, moist. Linen must be changed at least every 8 hours.                                                                                                                                                                                                                                                 | <b>3. Occasionally moist:</b><br>Skin is occasionally moist, requiring linen change every 12 hours.                                                                                                                                                                                             | <b>4. Rarely moist:</b><br>Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.                                                                                                                                                                   | 4        | 4          | 4     |     |
| <b>FRICION-SHEAR</b><br>Friction Occurs when Skin moves against support surfaces<br>Shear Occurs when skin and adjacent bony surface slide across one another | <b>1. Significant problem:</b><br>Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.                                                                                                                                                                                                        | <b>2. Problem:</b><br>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.                                                                                                                    | <b>3. Potential problem:</b><br>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.            | <b>4. No apparent problem:</b><br>Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."                         | 4        | 4          | 4     |     |
| Nutritional Usual food intake pattern                                                                                                                         | <b>1. Very Poor:</b><br>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. | <b>2. Inadequate:</b><br>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. | <b>3. Adequate:</b><br>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. | <b>4. Excellent:</b><br>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     |     |
| Tissue Perfusion & Oxygenation                                                                                                                                | <b>1. Extremely compromised:</b><br>Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.                                                                                                                                                                                   | <b>2. Compromised:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.                                                                                                                                                                                                | <b>3. Adequate:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.                                                                                                                                        | <b>4. Excellent:</b><br>Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.                                                                                                                                                                               | 4        | 4          | 4     |     |
| <b>TOTAL SCORE</b>                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | 28       | 28         | 28    |     |
| <b>Evaluator's Name</b>                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Shavai S |            |       |     |

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<br>(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       | <ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul> | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                           |
| 13-14       | Moderate Risk | <ul style="list-style-type: none"> <li>• Use the Same Protocol as for “<b>At Risk</b>” Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>                                                                                                                                                        | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                           |
| 10-12       | High Risk     | <ul style="list-style-type: none"> <li>• Follow the same protocol as for “<b>Moderate Risk</b>” Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>                                                                                                             | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                           |
| Less than 9 | Severe Risk   | <ul style="list-style-type: none"> <li>• Use same protocol as for “<b>High Risk</b>” Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>                                                                                                                     | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                           |





# PAIN ASSESSMENT FORM

| Date    | Time | Pain Score (0/10) | Location | Duration                                                                     | Acuity                                                             | Character                                                                                                                        | Modifying Factors                                                          | Patient / Family Educated                                              | Intervention | Sign    |
|---------|------|-------------------|----------|------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------|--------------|---------|
| 19/7/26 | 10pm | 0/10              | —        | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input checked="" type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Bhavani |
| 20/7/26 | 6AM  | 0/0               | —        | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA           | Shrisha |
| 20/7/26 | 2PM  | 0/0               | —        | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA           | Anura   |
| 20/7    | 11AM | 0/10              | —        | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA           | Susha   |
| 21/7    | 6AM  | 0/10              | —        | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA           | Susha   |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            |              |         |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            |              |         |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            |              |         |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            |              |         |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> 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.

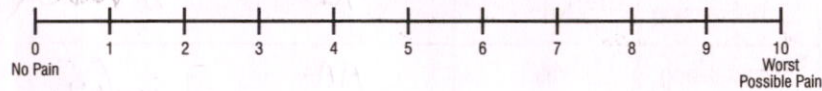


# PAIN ASSESSMENT TOOLS

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

## Numerical Pain Scale (Obstetric and Gynecology)



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

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

## Wong - Baker (Pediatrics) Above 7 Years







# INTERDISCIPLINARY P/ ENT / 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 |          |                         |
| 19/8 | 10pm | 10              | fall risk education | m                                   | 1                 | 0              | 1                                 | 1             | -        | Shivan                  |
|      |      |                 |                     |                                     |                   |                |                                   |               |          |                         |
|      |      |                 |                     |                                     |                   |                |                                   |               |          |                         |
|      |      |                 |                     |                                     |                   |                |                                   |               |          |                         |

## Part - III: CODES

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



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: \_\_\_\_\_

| Date Time        | Discipline                                                                                                          | Type                                                                                                                                                    | Patient Needs / Problem List               | Goal                  | Plan / Intervention | Signature | Team Verification                                                                                        |
|------------------|---------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-----------------------|---------------------|-----------|----------------------------------------------------------------------------------------------------------|
| 19/12/24<br>10:5 | <input checked="" type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others: | <input checked="" type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op | Cough / Fever<br>Asthma breathing<br>Fever | Hemodynamic stability | IV fluids<br>ventil | N. Pr     | <input checked="" type="checkbox"/> Nursing<br><input type="checkbox"/> Others:                          |
| 19/12/26<br>10pm | <input type="checkbox"/> Medical<br><input checked="" type="checkbox"/> Nursing<br><input type="checkbox"/> Others: | <input checked="" type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op | cold x 1 week.<br>cough x 1 week.          | Hemodynamic stability | In fluids           | Shovan    | <input type="checkbox"/> Medical<br><input checked="" type="checkbox"/> Others:                          |
|                  | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:            | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op            |                                            |                       |                     |           | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others: |
|                  | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:            | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op            |                                            |                       |                     |           | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others: |
|                  | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:            | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op            |                                            |                       |                     |           | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others: |



BAH-00662140  
Baby Of UDUTHA SARIKA  
21-04-2026  
Dr. UJJWALA DESAI

IP5-00176618

0 Y 2 M 29 D

(F)



## DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: Advise doctor today

2. Destination Post Discharge: ☐ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status:

☐ Self Care

☒ Family Home Care

☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication

☒ Yes

☐ No

☐ Bathing

☐ Yes

☒ No

☐ Eating

☐ Yes

☒ No

☐ Walking

☐ Yes

☒ No

☐ Dressing

☐ Yes

☒ No

☐ Toileting

☐ Yes

☒ No

} Explain to parents

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: [Signature]

Date and Time: 2017 Jan





## EMERGENCY ROOM TRIAGE FORM

Patient's Name : Blo: sarika Age : 3 months Gender: ☐ Male ☒ Female  
Date : 19/07/26 Time of Arrival : 10:30pm Triage Completion Time : 10:38pm  
Allergies: ☐ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): ☒ Not known any drug Allergies  
Source of Information : ☒ Parents ☐ Others (Specify):  
Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

| INITIAL PHYSIOLOGICAL CATEGORIZATION                                                                           |                                                                               | INITIAL PHYSIOLOGICAL STATUS                      |  |
|----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------|--|
| Appearance                                                                                                     | Work of Breathing                                                             | <input type="checkbox"/> Stable                   |  |
| <input checked="" type="checkbox"/> Normal                                                                     | <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Increased | <input checked="" type="checkbox"/> Unstable:     |  |
| <input type="checkbox"/> Sick Looking                                                                          | <input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea   | <input type="checkbox"/> Not - Life - Threatening |  |
| Circulation / Colour                                                                                           |                                                                               | <input type="checkbox"/> Life - Threatening       |  |
| <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding |                                                                               |                                                   |  |

Initial Vital Signs: Temp: 98.7 PR: 166bpm BP: 90/56 RR: 58bpm SpO<sub>2</sub>: 97% CRA  
Chief Complaints: Cold x 1 week, cough x 1 week, fast breathing x 3 days.

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

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

\* CTAS - Canadian Triage and Acuity Scale

G. Hattayazhai  
Signature of Parent / Guardian

### Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Javane

Date & Time : 19/07/26 @ 10:30pm

Docu. No. : RCHBH / FRM / CLINICAL / 085

Signature of Triage Nurse : Javane





## NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 19/07/26 Time of arrival : 10:34 pm  
 Chief Complaints: Cold & cough x 1 week RBS: NA  
 Height : NA Weight : 5.76 kg BMI : ..... Head Circumference (<2 years) .....  
 Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: .....  
 If yes, identify .....  
 Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker  
☐ Character NA ☐ Location NA ☐ Frequency NA ☐ Duration NA

### RISK FOR FALL:

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

- ☐ If Patient is > 6 years

Assess the below parameters

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

### Ambulatory Aids:

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

### Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☐ No

### IF YES FOR ANY CATEGORY = RISK FOR FALLING

### Fall Risk Intervention:

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

### Functional Screening: ☒ No Abnormalities Detected

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

### Inform consultant for positive criteria

### Nutritional Screening: ☒ No Abnormalities Detected

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

### Inform consultant for positive criteria

### Psychological Screening: ☒ No Significant Findings

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

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

Social History: Lives With family

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

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

Time of Initial assessment completed by ER Nurse : 10:36 pm



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

| Time | Nursing Notes           |
|------|-------------------------|
|      |                         |
|      | → Assessed by Dr prabha |
|      | + nasal suction done    |
|      | + Nebulization done     |
|      | → Iv placement done     |
|      | 12:20 PM sample sent    |
|      | + shifted to ward       |

Samples collected by: /  
 Samples sent by: /

Time: /  
 Time: /

Medication given in ER:

| Date / Time       | Medication    | Route | Dosage & Instructions | Doctor Sign | Nurse Sign 1 |
|-------------------|---------------|-------|-----------------------|-------------|--------------|
| 11:20 AM 19/12/24 | NEBE VENTOLIN | NEB   | 0.31 e back to back   | S.R.D       | gandey       |
|                   |               |       |                       |             |              |
|                   |               |       |                       |             |              |
|                   |               |       |                       |             |              |
|                   |               |       |                       |             |              |
|                   |               |       |                       |             |              |

| Condition of patient at time of shift - out :                                                                                                                       | Details of Shift - out                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| HR: 142/min BP: 92/52 mmHg CFT: 28 sec<br>RR: 38/min SPO <sub>2</sub> : 96%<br>GCS: 15/15 Temperature: 98.6 F<br>Pain Score: 0/10<br>Repeat RBS (if applicable): NA | Shift - out from ER to: 119<br>Time of Shift - out: 12:20 PM<br>Handover given to: shreshtha<br>(Nurse's Name) |

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

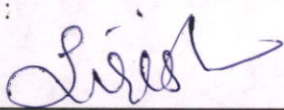
Iv placement

Name of the Nurse: Kethare Signature of the Nurse: /

Date & Time: 20/12/24 @ 12:20 AM



# PATIENT TRANSFER FORM

|                                                                                                                                                                                                                            |                                                                                                                                                                                                                          |                                                                                                      |                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| Patient Name & UHID No.<br><br>BAH-00682140 IP5-00176618<br>Baby Of UDUTHA SARIKA<br>21-04-2026 0 Y 2 M 28 D (F)<br>Dr. UJJWALA DESAI<br> |                                                                                                                                                                                                                          | Date & Time of Admission<br><br>19/7/26 @ 11:32p                                                     | Date & Time of Transfer Order<br><br>20/7/26 @ 12:20A |
|                                                                                                                                                                                                                            |                                                                                                                                                                                                                          | Transfer Ordered by<br><br>Dr. prathiba                                                              | Reason for Transfer<br><br>Admission                  |
| From Unit<br><br>E2                                                                                                                                                                                                        | To Unit<br><br>119                                                                                                                                                                                                       | Information to Attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>      |                                                       |
| Number of Sheets in Clinical File<br><br>21                                                                                                                                                                                | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/><br>If Yes, what? <del>outside files</del> outside files (array) | Patient shifted with ID band:<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |                                                       |
| Number of Imaging Films<br><br>No                                                                                                                                                                                          |                                                                                                                                                                                                                          |                                                                                                      |                                                       |
| Medications / Consumables / Surgicals / Hand over U. Sarika                                                                                                                                                                |                                                                                                                                                                                                                          |                                                                                                      |                                                       |
| Sl.No.                                                                                                                                                                                                                     | Item Name                                                                                                                                                                                                                | Quantity                                                                                             |                                                       |
| 1.                                                                                                                                                                                                                         | plavix                                                                                                                                                                                                                   | ①                                                                                                    |                                                       |
| 2.                                                                                                                                                                                                                         | N                                                                                                                                                                                                                        |                                                                                                      |                                                       |
| 3.                                                                                                                                                                                                                         |                                                                                                                                                                                                                          |                                                                                                      |                                                       |
| 4.                                                                                                                                                                                                                         |                                                                                                                                                                                                                          |                                                                                                      |                                                       |
| 5.                                                                                                                                                                                                                         |                                                                                                                                                                                                                          |                                                                                                      |                                                       |
| Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                                           |                                                                                                                                                                                                                          |                                                                                                      |                                                       |
| Name & Signature of Person who is Transferring<br><br>Dr. Bhavani                                                                                                                                                          |                                                                                                                                                                                                                          | Name of Person Ordered Transfer<br><br>Dr. prathiba                                                  |                                                       |
| Patient & Clinical Records Received by :<br><br>                                                                                        |                                                                                                                                                                                                                          |                                                                                                      |                                                       |
| Date & Time of Patient Received :<br><br>20/7 12:30 ~                                                                                                                                                                      |                                                                                                                                                                                                                          |                                                                                                      |                                                       |

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready



## ACTIVITY RECORD FOR BILLING

Name : \_\_\_\_\_  
UHID No. : \_\_\_\_\_ IP No. : \_\_\_\_\_ Dept : \_\_\_\_\_

BAH-00662140 IP5-00176618  
Baby Of UDUTHA SARIKA  
21-04-2026 0 Y 2 M 28 D (F)  
Dr. UJJWALA DESAI



Date of Admission: \_\_\_\_\_ Time : \_\_\_\_\_ Date of Discharge : \_\_\_\_\_ Time: \_\_\_\_\_

Room / Bed No : \_\_\_\_\_ Ward : \_\_\_\_\_ Suggested Billable bed type : \_\_\_\_\_

## WARD TRANSFERS

| Date    | Time     | From | To | Signature of Nurse |
|---------|----------|------|----|--------------------|
| 20/9/26 | 12:20 AM | ER   | U9 | [Signature]        |
|         |          |      |    |                    |
|         |          |      |    |                    |
|         |          |      |    |                    |
|         |          |      |    |                    |

## Cross Consultation Visit

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



[illegible]

2017/26

CBP, CRP,  
↓  
5 viral panel

|       |
|-------|
| 72516 |
|-------|

Paul

5.  $\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$



[illegible]



# PROCEDURE

| Date    | Procedure    | Quantity | Order No. | Signature |
|---------|--------------|----------|-----------|-----------|
| 20/7/26 | IN placement | 1        | 11839     | Kwast     |
|         |              |          |           |           |
|         |              |          |           |           |
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|         |              |          |           |           |
|         |              |          |           |           |
|         |              |          |           |           |

## ANY OTHER INFORMATION

Date :

21/7

Time :

10am

Prepared By :

*[Signature]*

Staff Nurse

*[Signature]*

Shift / Ward

119

Billing Assistant

Billing Supervisor