

**ADMISSION SHEET**



**Registration Details :**

Admission No : IP5-00176642      Admit Date : 20-Jul-2026      Admit Time : 12:34 PM      UHID : VIH-00203199

**Patient Details :**

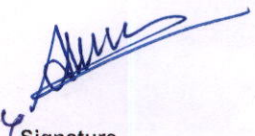
|              |                                                                                                                 |                |                             |
|--------------|-----------------------------------------------------------------------------------------------------------------|----------------|-----------------------------|
| Patient Name | : Master AEVIN NASH EARL                                                                                        | Age            | : 12 Y 3 M 23 D             |
| Guardian     | : Mrs FEONA ADRIANA EARL                                                                                        | DOB            | : 27-03-2014                |
| Gender       | : Male                                                                                                          | Religion       | :                           |
| Occupation   | :                                                                                                               | Marital Status | : Single                    |
| Address (H)  | : FLAT NO 202, PANCHAVATHI APARTMENTS,<br>PANCHAVATHI COLONY New Bowenpally<br>Hyderabad Telangana INDIA 500011 | Phone No       | : 9703790469/ 9959552020    |
|              |                                                                                                                 | E-mail         | : FEONAADRINAEARL@GMAIL.COM |

**Admission Details :**

Bed Type : FOUR SHARING      Bed No : FSW 127      Ward Name : 1F-HEMATO-ONCOLOGY  
Room No : FSW 127      Admission Type : First Visit

**Contact Details :**

Name : Mrs FEONA ADRIANA EARL      Relationship : MOTHER  
Contact Address : FLAT NO 202, PANCHAVATHI APARTMENTS, Phone No : 9703790469  
PANCHAVATHI COLONY New Bowenpally  
Hyderabad Telangana INDIA 500011

  
Signature

**Doctor Details :**

Doctor Name : Dr. SANDHYA VADDADI      Specialisation : HEMATO ONCOLOGY  
Referral Doctor : SELF      Phone No :  
Co-Consultant : Dr. SIRISHA RANI

**Payment Details :**

Deposit Amount : 4219.84  
Payment Mode : Cash      Payor Name : CARE HEALTH INSURANCE LIMITED



VIH-00203199 IP5-00176642  
Master AEVIN NASH EARL  
27-03-2014 12 Y 3 M 23 D (M)  
Dr. SANDHYA VADDADI

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

  
**BirthRight<sup>™</sup>**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

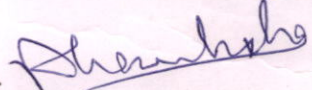
## ADMISSION CRITERIA – ONCOLOGY

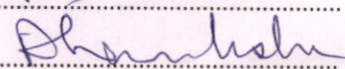
### Admission / Transfer from:

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

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

- ☒ For Chemotherapy-Day Care or IP Admission as per the Type of Chemotherapy
- ☐ Febrile Neutropenias (ANC <500 cells / mm<sup>3</sup>)
- ☐ Netropenic Enterocolitis
- ☐ Mucositis Induced Significant Diarrohea or Pain
- ☐ Neurological Complications (like Seizures, Bleeding, Thrombosis) that can arise while on Chemotherapy Treatment or at the Time of Presentation and also for other Systemic Problems like Pancreatitis during Chemotherapy
- ☐ Management of Oncological Emergencies
- ☐ Bleeding Problems (where it is indicated)
- ☐ Evaluation and Management of Severe Anemias
- ☐ Day Care Admissions for PRBC Transfusions
- ☐ Evaluation and Management of Sick Children who come with Hematological Problems like Severe Anemia like Autoimmune Hemolytic Anemia/ Bleeding/ Others
- ☐ Primary Immunodeficiency Disorders with Infections that Warrants Hospitalisation
- ☐ Management and Evaluation of Hemophagocytic LymphoHisticytosis
- ☐ Any Systemic Disorders with Significant Hematological issues like JRA / SLE with Secondary HLH

Signature of the Doctor: 

Name of the Doctor: 

Date & Time: 20/7/26 @ 1:40pm



VIH-00203199  
Master AEVIN NASH EARL  
27-03-2014 12 Y 3 M 23 D (M)  
Dr. SANDHYA VADDADI

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

BirthRight™  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## DISCHARGE CRITERIA – ONCOLOGY

### Discharge to:

☐ HDU / Step down ICU

☒ Ward

☐ Outside Facility

☐ Others: .....

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

- ☒ Completion of chemotherapy, with no debilitating side effects.
- ☐ Resolution of febrile episode, with no fever > 24hrs and Absolute Neutrophil count (ANC) > 500cells/mm<sup>3</sup>.
- ☐ Admitted patients - Once the admitting problem gets resolved or made a plan to manage further on out-patient basis.

Signature of the Doctor: .....

Name of the Doctor : .....

Date & Time: 20/12/26 @ 6pm .....



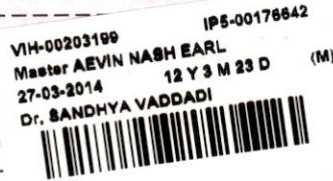
## ACTIVITY RECORD FOR BILLING

Name : \_\_\_\_\_

UHID No. : \_\_\_\_\_

Date of Admission : \_\_\_\_\_

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



ultant: \_\_\_\_\_ Dept : \_\_\_\_\_

of Discharge : \_\_\_\_\_ Time: \_\_\_\_\_

## WARD TRANSFERS

| Date    | Time    | From | To   | Signature of Nurse |
|---------|---------|------|------|--------------------|
| 20/3/26 | 1:10 pm | ER   | ONCO |                    |
|         |         |      |      |                    |
|         |         |      |      |                    |
|         |         |      |      |                    |
|         |         |      |      |                    |

## Cross Consultation Visit

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



[illegible][illegible]



[illegible]



# PROCEDURE

| Date | Procedure                                                     | Quantity | Order No. | Signature   |
|------|---------------------------------------------------------------|----------|-----------|-------------|
| 20/7 | lumbar puncture <sup>without sedation</sup><br>& chemotherapy | ①        | 9718805   | [Signature] |
|      |                                                               |          |           |             |
|      |                                                               |          |           |             |
|      |                                                               |          |           |             |
|      |                                                               |          |           |             |
|      |                                                               |          |           |             |
|      |                                                               |          |           |             |
|      |                                                               |          |           |             |
|      |                                                               |          |           |             |
|      |                                                               |          |           |             |
|      |                                                               |          |           |             |
|      |                                                               |          |           |             |
|      |                                                               |          |           |             |
|      |                                                               |          |           |             |

## ANY OTHER INFORMATION

Don't charge for N/A — N/A

.....

.....

.....

.....

.....

Date : 23/7/26

Time : 10am

Prepared By : [Signature]

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





# Rainbow<sup>®</sup> Children's Hospital

It takes a lot to treat the little.

## PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Aevin Nash Earl

UHID ID:

VIH-00203199 IP5-00176642  
Master AEVIN NASH EARL  
27-03-2014 12 Y 3 M 23 D (M)  
Dr. SANDHYA VADDADI

Department:

Pe



Consultant:

Dr. Sandhya



VIH-00203199

IP5-00176642

Master AEVIN NASH EARL

27-03-2014 12 Y 3 M 23 D (M)

Dr. SANDHYA VADDADI



## Pediatric Multiorgan History & Physical Examination

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

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

### Chief Presenting Complaints & Duration (Chronologically)

Kidney B cell ALL

### History of present illness :

Kidney B cell ALL

↓

one for chemotherapy

no other cycles

no Hb for, cycles

1





## Pediatric Multiorgan History & Physical Examination

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

---

---

---

---

---

---

---

---

---

---

### **Birth & Neonatal History:**

---

---

---

---

### **Birth & Socio Economic History:**

About Father : \_\_\_\_\_

About Mother : \_\_\_\_\_

Any additional Information : \_\_\_\_\_

*cupper middle class*

### **Developmental History :**

*Attained at per age in all 4 domains*

### **Immunization History :**

*upto 11 m*



VIH-00203199 IP5-00176642

Master Aevin Nash Earl

27-03-2014 12 Y 3 M 23 D (M)

Dr. SANDHYA VADDADI



## Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Secondary fever

Desired goals of the treatment:

Chemotherapy

### Planned Labs:

CBP

S. Electrolytes

Creatinine

done ✓

on 17/11/26

~~Serum~~ - Now

LFT Now

UBP

### Planned Management

~~Serum~~

Zij. Ondansetron

Cefixime, paracetamol, Intrathecal drugs

Tab. Domperidone

Zij. Dexamethasone

Exp. Sucral

NAC Injection

NIB

Sagar

20/11/26

at 12:30 pm

Signature of the Doctor:

Name of the Doctor:

Dr. Sagar

Date &amp; Time:

20/11/26, 12:20 pm

Signature of the Consultant:

Dr. SANDHYA VADDADI  
Reg. No: 71664

Name of the Consultant:

Dr. Sandhya

Date &amp; Time:

20/11/26 @ 9 am



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



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

## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time     | Progress Notes                                                                                                                                 | Doctor's Order                                                                                                                                                                                                                               |
|-----------------|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 20/7.<br>6:10pm | <p><u>Evening rounds</u></p> <p>Call Auf now for chemotherapy.</p> <p>No fresh issues<br/>Vitals (N)<br/>sl &amp; sws<br/>mg / (N)<br/>N.B</p> | <p><u>Ad</u></p> <ol style="list-style-type: none"> <li>1) eve thm</li> <li>2) went seat</li> <li>3) take WFT<br/>CDP.</li> <li>4) monitor vitals</li> <li>5) Inform SOS</li> </ol> <p>N.B<br/>Sonam<br/>015347<br/>@xpm</p> <p>Ahambhar</p> |



Sheet No: .....

REGULAR PRESCRIPTIONS

Weight .....

Ward .....

DRUG :

Dose

Route

Frequency

Start Dt.

Date

Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose

Route

Frequency

Start Dt.

Date

Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose

Route

Frequency

Start Dt.

Date

Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose

Route

Frequency

Start Dt.

Date

Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign



## DRUG CHART

Date of Admission: 20/9/20 Drug Allergies: Not known any 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>            |       |              |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|                          |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------|-------|--------------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b>            |       |              |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|                          |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------|-------|--------------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b>            |       |              |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

VERIFIED BY : Name



Weight. 75.7 kg. Ward. ....

VERIFIED

VERIFIED

VERIFIED

| 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. |            |

[illegible]



## I.V. FLUIDS CHART

Weight. 75 - 76 Ward. ....

[illegible]

VIH-00203199 IP5-00176642  
Master AEVIN NASH EARL  
27-03-2014 12 Y 3 M 23 D (M)  
Dr. SANDHYA VADDADI



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

BirthRight™  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## 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    | Tab. Septan                                       | 1 tab             | PO                        | OD        | last<br>finds            | <input type="checkbox"/> C <input checked="" type="checkbox"/> DC |
| 2    | Tab. POTRATE MB6                                  | 2 tab             | PO                        | TID       |                          | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 3    | Tab. MAGVION                                      | 1 tab             | PO                        | TID       |                          | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 4    | Tab. UDILIV<br>3mg                                | 2 tab             | PO                        | BD        | 2 tab                    | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 5    | Tab AMLODIPINE 5mg                                | 5mg               | PO                        | BD        |                          | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 6    | Tab. NEUROBION FORTÉ                              | 1 tab             | PO                        | OD        |                          | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 7    | Tab. ZINCovit                                     | 1 tab             | PO                        | OD        |                          | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 8    | Tab SHELICAL                                      | 500mg             | PO                        | OD        |                          | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 9    | Tab DUMSTAL                                       | 10mg              | PO                        | BD        |                          | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 10   | Tab. ONDANSETRON                                  | 4mg               | PO                        | TID       |                          | <input type="checkbox"/> C <input checked="" type="checkbox"/> DC |

11 Tab. ALDACTONE 1 tab PO OD \* C- Continue, DC - Discontinue  
DC

### MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: [Signature]

Date & Time: 20/7/2016, 12:20 pm

Nurse Name & Signature: [Signature]

Date & Time: 20/7/2016 @ 12:30 pm





# CHEMOTHERAPY PRESCRIPTION

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

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

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

| Sheet No. : 1 |         | Weight (kg) : 74.76                                                                  | Body Surface Area: 1.8 | Diagnosis: B-ALL |                      | Protocol:       |                      |                     |                 |                      |
|---------------|---------|--------------------------------------------------------------------------------------|------------------------|------------------|----------------------|-----------------|----------------------|---------------------|-----------------|----------------------|
| DATE          | TIME    | Composition of Chemotherapy<br>(if infusion, mention ml / hr = Mcg / kg / min. etc.) | DOSE                   | ROUTE            | Flow Rate<br>(ml/hr) | Doctor<br>Sign. | Nurse<br>Sign.       | Date of<br>Stopping | Doctor<br>Sign. | Nurse<br>Sign.       |
| 20/7/26       | 4:30 PM | IV METOTREXATE<br>INT CYTARABINE<br>INT HYDROCORTISONE                               | 12mg<br>30mg<br>15mg   | INTER<br>THECAL  | stat                 | [Signature]     | Sonam<br>Am          | 20/7                | A               | Sonam<br>Am          |
| 20/7/26       | 6:30 PM | INT NaHCO <sub>3</sub><br>with 100 ml NS                                             | 10ml                   | IV               | @<br>100ml/hr        | [Signature]     | Sonam<br>Am          | 20/7                | d               | Sonam<br>Am          |
| 20/7          | 7:30 PM | INT METOTREXATE<br>with 100ml NS                                                     | 300mg                  | IV               | @<br>100ml/hr        | [Signature]     | Sonam<br>Am          | 20/7                | d               | Nasheep<br>Subantkar |
| 20/7          | 10 PM   | INT METOTREXATE<br>with 500ml DNS                                                    | 2.7gm                  | IV               | @<br>25ml/hr         | [Signature]     | Nasheep<br>Subantkar | 21/7                | A               | Karima<br>Nasheep    |
| 20/7          | 10 PM   | INT NaHCO <sub>3</sub><br>with 500 ml 1/2 DNS                                        | 20ml                   | IV               | @<br>100ml/hr        | [Signature]     | Nasheep<br>Subantkar | 21/7/26             | d               | Karima<br>Nasheena   |
| 21/7/26       | 2:30 AM | INT NaHCO <sub>3</sub><br>with 500 ml 1/2 DNS                                        | 20ml                   | IV               | @<br>100ml/hr        | [Signature]     | Karima<br>Nasheena   | 21/7/26             | A               | Karima<br>Nasheena   |





# CHEMOTHERAPY PRESCRIPTION

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

| Sheet No. : | Weight (kg) : | Body Surface Area:                                                                   | Diagnosis: | Protocol: |                      |                 |                     |                     |                 |                     |
|-------------|---------------|--------------------------------------------------------------------------------------|------------|-----------|----------------------|-----------------|---------------------|---------------------|-----------------|---------------------|
| 2           |               |                                                                                      |            |           |                      |                 |                     |                     |                 |                     |
| DATE        | TIME          | Composition of Chemotherapy<br>(if infusion, mention ml / hr = Mcg / kg / min. etc.) | DOSE       | ROUTE     | Flow Rate<br>(ml/hr) | Doctor<br>Sign. | Nurse<br>Sign.      | Date of<br>Stopping | Doctor<br>Sign. | Nurse<br>Sign.      |
| 21/7/26     | 8am           | INT NaHCO <sub>3</sub><br>with 500ml 1/2 DNS                                         | 20ml       | IV        | @<br>100ml/hr        |                 | Karima<br>Masheem   | 21/7/26             |                 | Naveen<br>Dina      |
| 21/7/26     | 12pm          | INT NaHCO <sub>3</sub><br>with 500ml 1/2 DNS                                         | 20ml       | IV        | @<br>100ml/hr        |                 | Naveen<br>Dina      | 21/7                |                 | pooja<br>sonam      |
| 21/7/26     | 4pm           | INT NaHCO <sub>3</sub><br>with 500ml 1/2 DNS                                         | 15ml       | IV        | @<br>100ml/hr        |                 | pooja<br>sonam      | 21/7                |                 | Subhanur<br>subhita |
| 22/7/26     | 12:30 AM      | INT NaHCO <sub>3</sub><br>with 500ml 1/2 DNS                                         | 15ml       | IV        | @<br>100ml/hr        |                 | Subhita<br>DAS      | 22/7                |                 | subhita<br>subhanur |
| 22/7        | 6AM           | INT NaHCO <sub>3</sub><br>with 500ml 1/2 DNS                                         | 15ml       | IV        | @<br>100ml/hr        |                 | Subhanur<br>RASAMAN | 22/7                |                 | Naveen<br>Dina      |
| 22/7        | 11am          | INT NaHCO <sub>3</sub><br>with 500ml 1/2 DNS                                         | 15ml       | IV        | @<br>100ml/hr        |                 | Naveen<br>Dina      | 22/7                |                 | N<br>Subh           |



VIH-00203199  
Master AEVIN NASH EARL  
27-03-2014 12 Y 3 M 24 D (M)  
Dr. SANDHYA VADDADI



## PAIN ASSESSMENT FORM

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

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

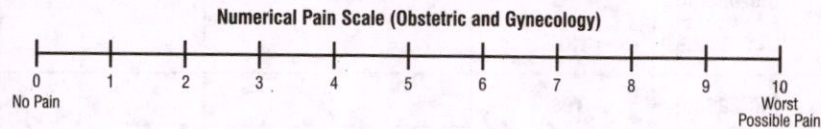
| Date | Time | (0/10) | Location | Duration                                                                     | Acuity                                                             | Character                                                                                                                        | Modifying Factors                                                          | Patient / Family Educated                                   | Intervention | Sign |
|------|------|--------|----------|------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------|--------------|------|
| 23/7 | 6AM  | 0      | N/A      | <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<br>NA     | Reji |
| 23/7 | 10am | 0      | ns       | <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 | ns           | B    |
|      |      |        |          | <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 |              |      |
|      |      |        |          | <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 pain-relieving intervention.
  - Within 30 – 60 minutes after pain relief intervention.



# PAIN ASSESSMENT TOOLS

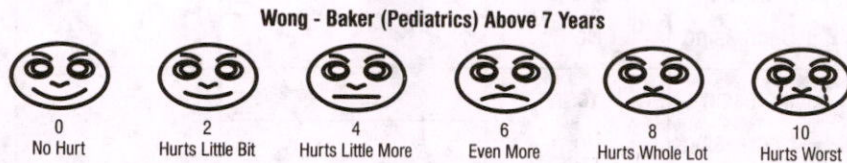


**FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)**

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

**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 |







## PAIN ASSESSMENT FORM

| Date    | Time     | Pain Score (0/10) | Location | Duration                                                                     | Acuity                                                             | Character                                                                                                                        | Modifying Factors                                                          | Patient / Family Educated                                   | Intervention | Sign |
|---------|----------|-------------------|----------|------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------|--------------|------|
| 20/7/26 | 12:30 pm | 0/10              | NA       | <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 | Nil          |      |
| 20/7    | 6pm      | 0                 | NA       | <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           | Somn |
| 21/7    | 2PM      | 0                 | NA       | <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           |      |
| 21/7    | 10AM     | 0                 | NA       | <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           | None |
| 21/7    | 6pm      | 0                 | NA       | <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           |      |
| 21/7    | 2pm      | 0                 | NA       | <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           |      |
| 22/7    | 10pm     | 0                 | NA       | <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 | Nil          | Somn |
| 22/07   | 6Am      | 0                 | NA       | <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 | Nil          | Somn |
| 22/7    | 2pm      | 0                 | NA       | <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           | None |
| 22/7    | 10pm     | 0                 | NA       | <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<br>NA     |      |

**Re-assessment Frequency:**

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

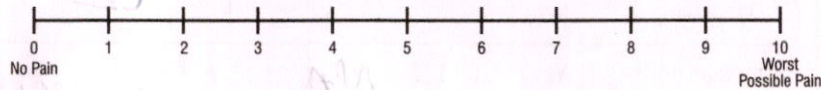


# PAIN ASSESSMENT TOOLS

## FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

## Numerical Pain Scale (Obstetric and Gynecology)



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

| Assessment Criteria                           | Sedation                                                |                                                             | Normal                                        | Pain / Agitation                                                                          |                                                                                                                                                         |
|-----------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                               | -2                                                      | -1                                                          | 0                                             | 1                                                                                         | 2                                                                                                                                                       |
| <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 - slow 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







No. RCHBH/FRM / CLINICAL / 127

## TEENAGE (12 + years)

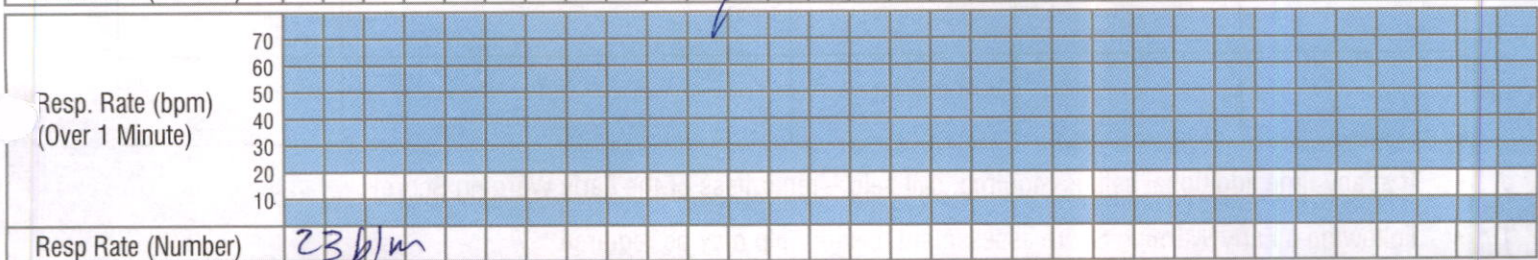
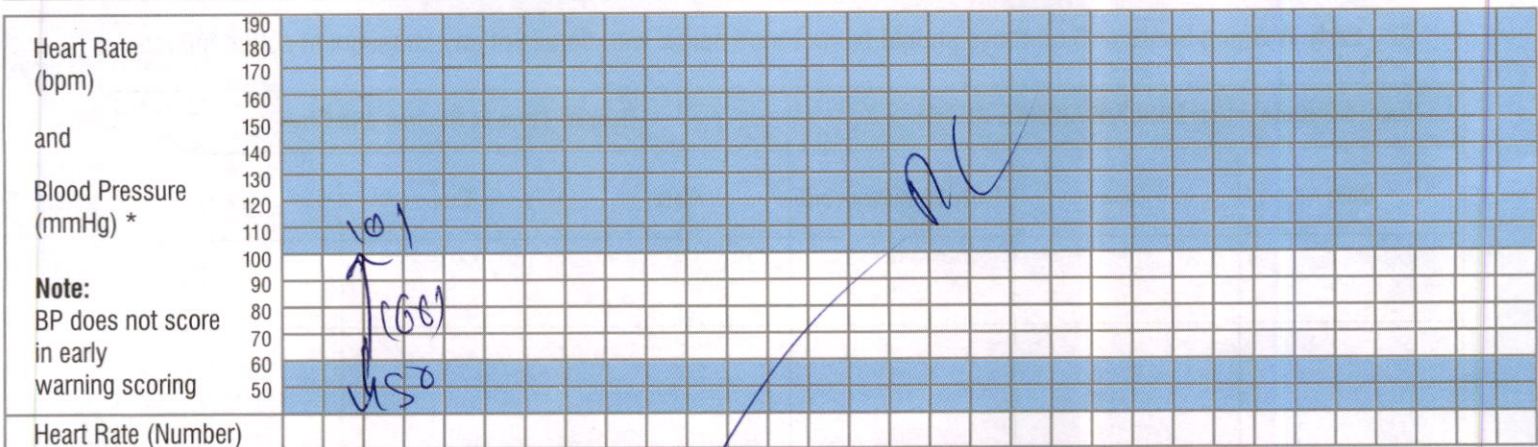
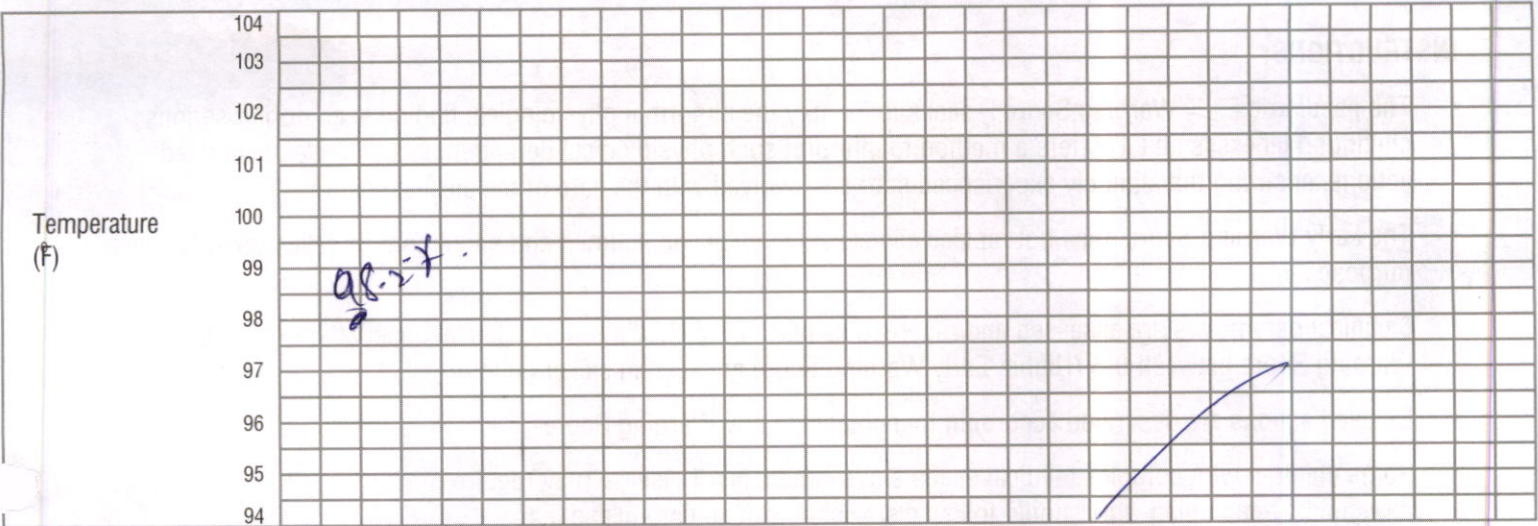
### Children's Observation & Early Warning Scoring Chart

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

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

## EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 22/8 Time: 9pm  
Doctor / Nurse / Family Concern?



Resp Mod/ Severe Distress None / Mild

Receiving O<sub>2</sub> (l/min) O<sub>2</sub> Saturations (%) 100%

Conscious Level Normal Altered

GCS \* (11)

**TOTAL SCORE**

Number of shaded boxes

Pain Score

Observer's Initials

**ACTIONS**

NB: Scores 3 should be recorded overleaf

Score 1 : Continue normal observation by staff nurse

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

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

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

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

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



# CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

## INSTRUCTIONS:

- 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)                                                                                                                                                |

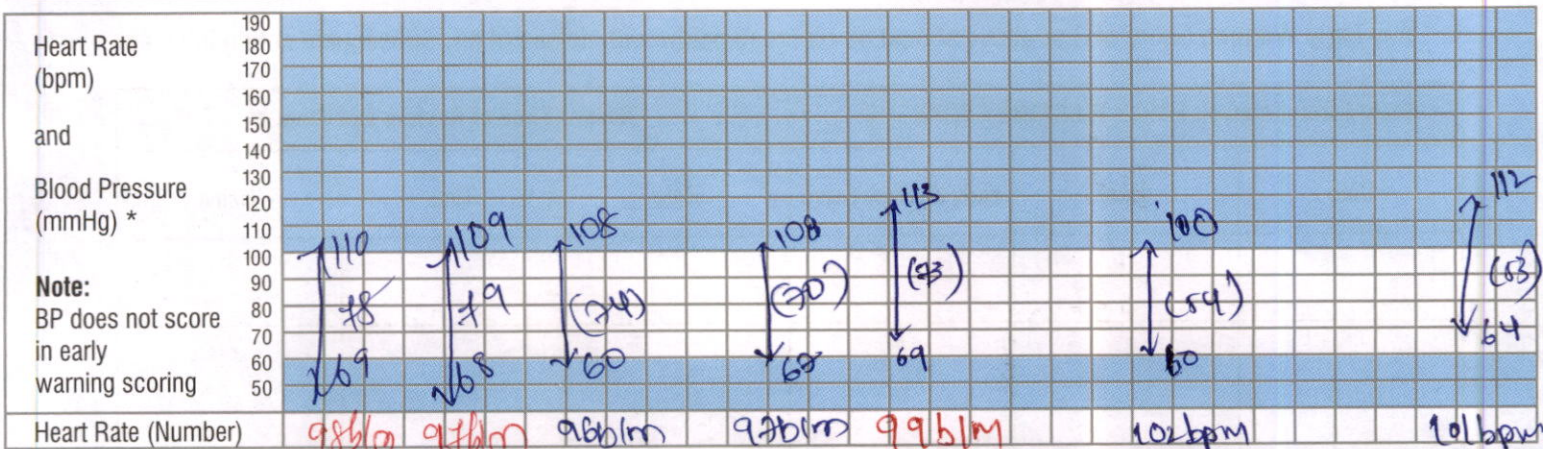
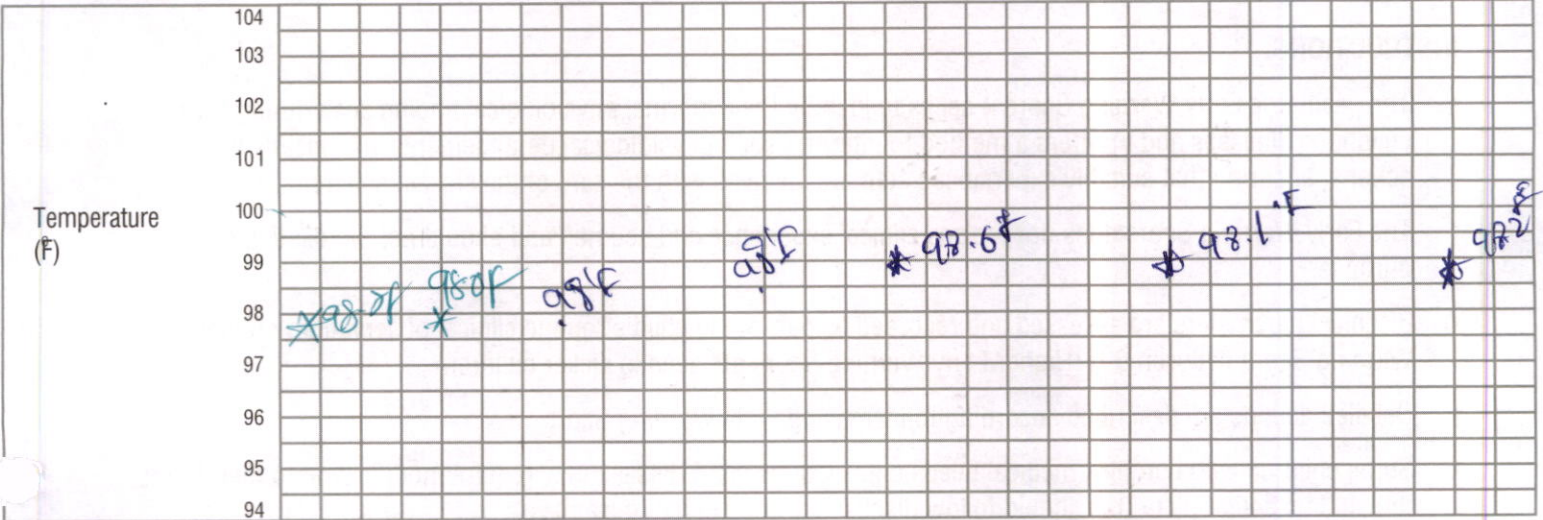


# TEENAGE (12 + years)

## Children's Observation & Early Warning Scoring Chart

### EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 22/07 Time: 9pm 1pm 4pm 7pm 10pm 3AM 6AM  
Doctor / Nurse / Family Concern?



|                                  |                                |             |
|----------------------------------|--------------------------------|-------------|
| Resp Distress                    | Mod/ Severe                    | None / Mild |
| Receiving O <sub>2</sub> (l/min) | O <sub>2</sub> Saturations (%) |             |
| Conscious Level                  | Normal                         | Altered     |
| GCS *                            |                                |             |

|                        |  |
|------------------------|--|
| TOTAL SCORE            |  |
| Number of shaded boxes |  |
| Pain Score             |  |
| Observer's Initials    |  |

|                                          |  |
|------------------------------------------|--|
| ACTIONS                                  |  |
| NB: Scores 3 should be recorded overleaf |  |

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

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



# CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

## INSTRUCTIONS:

- 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)                                                                                                                                                |





# TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

## EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 20/7 Time: 2pm 7pm 10pm 3am 6am

Doctor / Nurse / Family Concern?

104  
103

### TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

## EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/7 Time: 9am 12pm 4pm 10pm 3AM 6AM

Doctor / Nurse / Family Concern?

Temperature  
(°F)

Heart Rate  
(bpm)

and

Blood Pressure  
(mmHg) \*

Note:

BP does not score  
in early  
warning scoring

Heart Rate (Number)

Resp. Rate (bpm)  
(Over 1 Minute)

Resp Rate (Number)

Resp Mod/ Severe  
Distress None / Mild

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

Conscious Normal  
Level Altered

GCS \*

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be  
recorded overleaf

- Score 1 : Continue normal observation by staff nurse  
Score 2 : Shift in charge nurse to be informed and continue hourly observations  
Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.  
Score 4 : Shift in charge AND treating consultant (11am & 5 PM) or On call night duty consultant to see  
Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

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



# CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

## INSTRUCTIONS:

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

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

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

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

|          |                                                                                                                                                                                                                                                                                                                                      |
|----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <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)                                                                                                                                                |



VIH-00203199  
Master AEVIN NASH EARL  
27-03-2014 12 Y 3 M 25 D (M)  
Dr. SANDHYA VADDADI



# FLUID CHART

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

BirthRight™  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

Sheet No. : (4)

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<br>Thrombo-<br>phlebitis<br>Score | Sign.<br>Nurse |             |  |
|----------------------|----------|--------------------|----------------------|-----|--------|----------------|-----------|-------|----------|-------------------------------------------|----------------|-------------|--|
| Date                 | Time     | Nature<br>of Fluid | Route                |     |        | NG             | Diarrhoea | Vomit | Drainage |                                           |                | Urine       |  |
|                      |          |                    | Mouth                | I.V | N.G    |                |           |       |          |                                           |                |             |  |
| 23/7                 | 08:00 am |                    |                      |     |        |                |           |       |          |                                           | 40             | [Signature] |  |
|                      | 09:00 am | Orally             |                      |     |        |                |           |       |          | 400ml                                     | 0              |             |  |
|                      | 10:00 am | 120 100ml          |                      |     |        |                |           |       |          | 0                                         |                |             |  |
|                      | 11:00 am |                    |                      |     |        |                |           |       |          | 0                                         |                |             |  |
|                      | 12:00 pm |                    |                      |     |        |                |           |       |          | 0                                         |                |             |  |
|                      | 01:00 pm |                    |                      |     |        |                |           |       |          |                                           | 0              |             |  |
| Total Intake :       |          |                    |                      |     |        | Total Output : |           |       |          |                                           |                |             |  |
|                      | 02:00 pm |                    |                      |     |        |                |           |       |          |                                           |                |             |  |
|                      | 03:00 pm |                    |                      |     |        |                |           |       |          |                                           |                |             |  |
|                      | 04:00 pm |                    |                      |     |        |                |           |       |          |                                           |                |             |  |
|                      | 05:00 pm |                    |                      |     |        |                |           |       |          |                                           |                |             |  |
|                      | 06:00 pm |                    |                      |     |        |                |           |       |          |                                           |                |             |  |
|                      | 07:00 pm |                    |                      |     |        |                |           |       |          |                                           |                |             |  |
| Total Intake :       |          |                    |                      |     |        | Total Output : |           |       |          |                                           |                |             |  |
|                      | 08:00 pm |                    |                      |     |        |                |           |       |          |                                           |                |             |  |
|                      | 09:00 pm |                    |                      |     |        |                |           |       |          |                                           |                |             |  |
|                      | 10:00 pm |                    |                      |     |        |                |           |       |          |                                           |                |             |  |
|                      | 11:00 pm |                    |                      |     |        |                |           |       |          |                                           |                |             |  |
|                      | 12:00 am |                    |                      |     |        |                |           |       |          |                                           |                |             |  |
|                      | 01:00 am |                    |                      |     |        |                |           |       |          |                                           |                |             |  |
| Total Intake :       |          |                    |                      |     |        | Total Output : |           |       |          |                                           |                |             |  |
|                      | 02:00 am |                    |                      |     |        |                |           |       |          |                                           |                |             |  |
|                      | 03:00 am |                    |                      |     |        |                |           |       |          |                                           |                |             |  |
|                      | 04:00 am |                    |                      |     |        |                |           |       |          |                                           |                |             |  |
|                      | 05:00 am |                    |                      |     |        |                |           |       |          |                                           |                |             |  |
|                      | 06:00 am |                    |                      |     |        |                |           |       |          |                                           |                |             |  |
|                      | 07:00 am |                    |                      |     |        |                |           |       |          |                                           |                |             |  |
| Total Intake :       |          |                    |                      |     |        | Total Output : |           |       |          |                                           |                |             |  |
| Total 24 hrs. Intake |          |                    | Total 24 hrs. Output |     |        |                |           |       |          |                                           |                |             |  |





# FLUID CHART

Sheet No. : 3

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

|                |          | Intake             |       |       |     | Output         |           |       |          |       | IV Site<br>Thrombo-<br>phlebitis<br>Score | Sign.<br>Nurse |   |
|----------------|----------|--------------------|-------|-------|-----|----------------|-----------|-------|----------|-------|-------------------------------------------|----------------|---|
| Date           | Time     | Nature<br>of Fluid | Route |       |     | NG             | Diarrhoea | Vomit | Drainage | Urine |                                           |                |   |
|                |          |                    | Mouth | I.V   | N.G |                |           |       |          |       |                                           |                |   |
| 22/7           | 08:00 am |                    |       | 100ml |     |                |           |       |          |       | 200ml                                     | }              | } |
|                | 09:00 am | Also vada          |       | 100ml |     |                |           |       |          |       |                                           |                |   |
|                | 10:00 am |                    |       | 100ml |     |                |           |       |          |       |                                           |                |   |
|                | 11:00 am |                    |       | 100ml |     |                |           |       |          |       |                                           |                |   |
|                | 12:00 pm |                    |       | 100ml |     |                |           |       |          |       | 350ml                                     |                |   |
|                | 01:00 pm |                    |       | 100ml |     |                |           |       |          |       | 100ml                                     |                |   |
| Total Intake : |          |                    | 400ml |       |     | Total Output : |           |       | 650ml    |       |                                           |                |   |
|                | 02:00 pm |                    |       | 50ml  |     |                |           |       |          |       |                                           | }              | } |
|                | 03:00 pm |                    |       | 50ml  |     |                |           |       |          |       | 200ml                                     |                |   |
|                | 04:00 pm |                    |       | 50ml  |     |                |           |       |          |       |                                           |                |   |
|                | 05:00 pm | Also 200ml         |       | 50ml  |     |                |           |       |          |       | 150ml                                     |                |   |
|                | 06:00 pm | caconut            |       | 50ml  |     |                |           |       |          |       |                                           |                |   |
|                | 07:00 pm | Also               |       | 50ml  |     |                |           |       |          |       | 200ml                                     |                |   |
| Total Intake : |          |                    | 500ml |       |     | Total Output : |           |       | 550ml    |       |                                           |                |   |
|                | 08:00 pm | porrig             |       | 25ml  |     |                |           |       |          |       | 200ml                                     | }              | } |
|                | 09:00 pm | Aluany             |       | 25ml  |     |                |           |       |          |       |                                           |                |   |
|                | 10:00 pm | Also 100ml         |       | 25ml  |     |                |           |       |          |       |                                           |                |   |
|                | 11:00 pm |                    |       |       |     |                |           |       |          |       |                                           |                |   |
|                | 12:00 am |                    |       |       |     |                |           |       |          |       |                                           |                |   |
|                | 01:00 am |                    |       |       |     |                |           |       |          |       | 250ml                                     |                |   |
| Total Intake : |          |                    | 175ml |       |     | Total Output : |           |       | 450ml    |       |                                           |                |   |
|                | 02:00 am |                    |       |       |     |                |           |       |          |       |                                           | }              | } |
|                | 03:00 am |                    |       |       |     |                |           |       |          |       |                                           |                |   |
|                | 04:00 am |                    |       |       |     |                |           |       |          |       |                                           |                |   |
|                | 05:00 am |                    |       |       |     |                |           |       |          |       | 300ml                                     |                |   |
|                | 06:00 am |                    |       |       |     |                |           |       |          |       |                                           |                |   |
|                | 07:00 am |                    |       |       |     |                |           |       |          |       | 350ml                                     |                |   |
| Total Intake : |          |                    |       |       |     | Total Output : |           |       | 650ml    |       |                                           |                |   |

Total 24 hrs. Intake

1375% 18% 16c/kg

Total 24 hrs. Output

2900% 1% 2c/kg





## FLUID CHART

Sheet No. : 2

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<br>Thrombo-<br>phlebitis<br>Score | Sign.<br>Nurse |
|----------------|----------|---------------------------|-------|----------|--------|----|-----------|-------|----------|-------------------------------------------|----------------|
| Date           | Time     | Nature<br>of Fluid        | Route |          |        | NG | Diarrhoea | Vomit | Drainage | Urine                                     |                |
|                |          |                           | Mouth | I.V      | N.G    |    |           |       |          |                                           |                |
| 8/12           | 08:00 am |                           |       | 100+25ml |        |    | ✓         |       |          | 200ml                                     | M-1            |
|                | 09:00 am | 100ml<br>H <sub>2</sub> O |       | 100+25   |        |    |           |       |          |                                           |                |
|                | 10:00 am |                           |       | 100+25   |        |    |           |       |          |                                           |                |
|                | 11:00 am |                           |       | 100+25ml |        |    |           |       |          | 300ml                                     |                |
|                | 12:00 pm |                           |       | 100+25ml |        |    |           |       |          |                                           |                |
|                | 01:00 pm |                           |       | 100+25ml |        |    |           |       |          | 250ml                                     |                |
| Total Intake : |          |                           |       | 750ml    |        |    |           |       |          | Total Output : 750ml                      |                |
|                | 02:00 pm |                           |       | 100+25   |        |    |           |       |          |                                           | M-1            |
|                | 03:00 pm |                           |       | 100+25   |        |    |           |       |          | 200ml                                     |                |
|                | 04:00 pm | H <sub>2</sub> O 100ml    |       | 100+25   |        |    |           |       |          |                                           |                |
|                | 05:00 pm |                           |       | 100+25   |        |    |           |       |          | 350ml                                     |                |
|                | 06:00 pm |                           |       | 100+25   |        |    |           |       |          | 300ml                                     |                |
|                | 07:00 pm |                           |       | 25+2     |        |    |           |       |          |                                           |                |
| Total Intake : |          |                           |       | 52ml     |        |    |           |       |          | Total Output : 800ml                      |                |
|                | 08:00 pm | D/G                       |       | 100+2    |        |    |           |       |          |                                           | D/G            |
|                | 09:00 pm |                           |       | 100+2    |        |    |           |       |          | 350ml                                     |                |
|                | 10:00 pm | H <sub>2</sub> O 100ml    |       | 100+2    |        |    |           |       |          | 200ml                                     |                |
|                | 11:00 pm |                           |       | 100+2    |        |    |           |       |          |                                           |                |
|                | 12:00 am | H <sub>2</sub> O 100ml    |       | 100+2    |        |    |           |       |          | 300ml                                     |                |
|                | 01:00 am |                           |       | 100+2    |        |    |           |       |          | 300ml                                     |                |
| Total Intake : |          |                           |       | 812ml    |        |    |           |       |          | Total Output : 800ml                      |                |
|                | 02:00 am |                           |       | 100+2    |        |    |           |       |          |                                           | D/G            |
|                | 03:00 am |                           |       | 100+2    |        |    |           |       |          |                                           |                |
|                | 04:00 am |                           |       | 100+2    |        |    |           |       |          | 250ml                                     |                |
|                | 05:00 am |                           |       | 100+2    |        |    |           |       |          |                                           |                |
|                | 06:00 am |                           |       | 100+2    |        |    |           |       |          |                                           |                |
|                | 07:00 am |                           |       | 100+2    |        |    |           |       |          | 360ml                                     |                |
| Total Intake : |          |                           |       | 612ml    |        |    |           |       |          | Total Output : 610ml                      |                |

Total 24 hrs. Intake

2925 ÷ 38.9 cc/kg

Total 24 hrs. Output

2960ml ÷ 1.64 cc/kg



VIH-00203199 IP5-00176642  
Master AEVIN NASH EARL  
27-03-2014 12 Y 3 M 23 D (M)  
Dr. SANDHYA VADDADI



# FLUID CHART

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

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

Sheet No. : 1

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

| Date                        | Time     | Nature of Fluid | Intake   |        |     | Output                            |           |       |          |       | IV Site Thrombo-phlebitis Score | Sign. Nurse |  |
|-----------------------------|----------|-----------------|----------|--------|-----|-----------------------------------|-----------|-------|----------|-------|---------------------------------|-------------|--|
|                             |          |                 | Mouth    | I.V    | N.G | NG                                | Diarrhoea | Vomit | Drainage | Urine |                                 |             |  |
| 2/7                         | 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 |                 |          |        |     |                                   |           |       |          | 200ml |                                 |             |  |
|                             | 04:00 pm |                 |          |        |     |                                   |           |       |          |       |                                 |             |  |
|                             | 05:00 pm |                 |          | 100 ml |     |                                   |           |       |          |       |                                 |             |  |
|                             | 06:00 pm | 100-100ml       | 100ml    |        |     |                                   |           |       |          | 150ml |                                 |             |  |
|                             | 07:00 pm |                 | 100ml    |        |     |                                   |           |       |          |       |                                 |             |  |
| <b>Total Intake : 400ml</b> |          |                 |          |        |     | <b>Total Output : 350ml + 150</b> |           |       |          |       |                                 |             |  |
|                             | 08:00 pm |                 |          | 100ml  |     |                                   |           |       |          | 200ml |                                 |             |  |
|                             | 09:00 pm | Chapati         |          | 100ml  |     |                                   |           |       |          |       |                                 |             |  |
|                             | 10:00 pm | 1/2 200ml       | 25+100ml |        |     |                                   |           |       |          |       |                                 |             |  |
|                             | 11:00 pm |                 | 25+100ml |        |     |                                   |           |       |          |       |                                 |             |  |
|                             | 12:00 am |                 | 25+100ml |        |     |                                   |           |       |          |       |                                 |             |  |
|                             | 01:00 am |                 | 25+100ml |        |     |                                   |           |       |          | 250ml |                                 |             |  |
| <b>Total Intake : 900ml</b> |          |                 |          |        |     | <b>Total Output : 450ml</b>       |           |       |          |       |                                 |             |  |
|                             | 02:00 am |                 | 25+100ml |        |     |                                   |           |       |          | 300ml |                                 |             |  |
|                             | 03:00 am |                 | 25+100ml |        |     |                                   |           |       |          |       |                                 |             |  |
|                             | 04:00 am |                 | 25+100ml |        |     |                                   |           |       |          |       |                                 |             |  |
|                             | 05:00 am |                 | 25+100ml |        |     |                                   |           |       |          |       |                                 |             |  |
|                             | 06:00 am |                 | 25+100ml |        |     |                                   |           |       |          |       |                                 |             |  |
|                             | 07:00 am |                 | 25+100ml |        |     |                                   |           |       |          | 300ml |                                 |             |  |
| <b>Total Intake : 750ml</b> |          |                 |          |        |     | <b>Total Output : 600ml</b>       |           |       |          |       |                                 |             |  |

Total 24 hrs. Intake

2,050 - 27.30kg

Total 24 hrs. Output

1,400 - 1.037kg



## Nursing General Admission Assessment Form For Pediatrics

### Diagnosis:

Arrival Time: 1:40 pm Mode of Arrival: wheelchair Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: no Allergy reactions Body Weight: 24.80 Kg

Height: cm

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

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

Family History: Healthy Family

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

If Yes, please list: .....

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

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

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

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

Temp.: 98.4 F HR: 106 b/m RR: 20 b/m BP: 106 / 76 (8/1)

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

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

Risk of Pressure Sore (Braden Q Score) (Document in the Braden Q Assessment Sheet)

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

Character of Pain: Location: Frequency: Duration:



**FUNCTIONAL SCREENING:**☒ No Abnormalities Detected☐ Mobility Problem☐ Walking Problem☐ Developmental Delay☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

**NUTRITIONAL SCREENING:**☒ No Abnormalities Detected☐ Underweight☐ Overweight☐ Special Feeding Method☐ Feeding Problem☐ Special diet☐ No Abnormality Detected

Inform consultant for positive criteria

**Psychological Screening:**☒ No Significant FindingsUnusual concerns about patient's Psychological Status: ☐ Yes ☒ NoIf Yes Consultant Notified: ..... parents ..... (Date/Time): .....Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify ..... Inform consultant for positive criteria.Social History: Lives With ..... Family .....Siblings in household ☐ Yes ☒ No (if yes How Many?) .....All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach : ☒ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump : ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No ☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ NoInformation given to ..... mother .....Nurse Signature: ..... pooja .....Nurse Name: ..... pooja .....Date: ..... 20/7/26 .....Time: ..... @ 1:50 pm .....



VIH-00203199 IP5-00176642  
Master AEVIN NASH EARL  
27-03-2014 12 Y 3 M 25 D (M)  
Dr. SANDHYA VADDADI



## 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: .....

Assessment: .....

**Goals**

- |                                                           |                                                    |                                                 |                                                     |                                                           |                                                     |
|-----------------------------------------------------------|----------------------------------------------------|-------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Maintain Airway and Oxygenation  | <input type="checkbox"/> Relieve Pain & Discomfort | <input type="checkbox"/> Maintain Fluid Balance | <input type="checkbox"/> Improve Activity Tolerance | <input type="checkbox"/> Maintain Good Nutritional Status | <input type="checkbox"/> Maintain Skin Integrity    |
| <input type="checkbox"/> Maintain Personal Hygiene        | <input type="checkbox"/> Prevent Infection         | <input type="checkbox"/> Meet Elimination Needs | <input 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 |
|------|--------------|------|----------------|------------|
|      |              |      |                |            |

Re-Assessment: .....

Special Notes: .....

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





# NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 23/7/26

Assessment: patient having meanness

## 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           |
|-------|--------------------------------------|-------|----------------------------------------|----------------------|
| 8 AM  | Assess the patient general condition | 9 AM  | Assessed the patient general condition | patient feels better |
| 10 AM | check vital                          | 10:30 | checked vital                          |                      |
| 11 AM | provide sick snack                   | 11:30 | provided sick snack                    |                      |
| 12 PM | Maintain 2/10 chest                  | 12:30 | Maintained 2/10 chest                  |                      |
| 1 PM  | Administer medication                | 2 PM  | Administered medication                |                      |

Re-Assessment: not

Special Notes:

Nurse Signature: [Signature] Nurse Name: Gayathri Date & Time: 23/7/26 C 2 PM



VIH-00203199  
Master AEVIN NASH EARL  
27-03-2014  
Dr. SANDHYA VADDADI  
12 Y 3 M 25 D  
IP5-00176642  
(M)

Patient

## 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: 22/7

Assessment: patient has nausea related to chemotherapy

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               |
|---------|--------------------------------------|---------|----------------------------------------|--------------------------|
| 8pm     | Assess General condition of the baby | 8pm     | assessed General condition of the baby | Baby doesn't have Nausea |
| 8:10 pm | Monitor vital signs                  | 8:10 pm | monitored vital signs                  |                          |
| 10pm    | Administer medications as per chart  | 10pm    | administered medications as per chart  |                          |
| 12am    | Ensure safety                        | 12am    | provided side rails                    |                          |
| 2am     | Maintain fluid balance               | 2am     | Administered IV fluids                 |                          |
| 4am     | change position with hourly          | 4am     | changed position frequently            |                          |
| 6am     | maintain c/o chart                   | 6am     | maintained I/O chart                   |                          |

Re-Assessment: Baby feel better

Special Notes:

Nurse Signature: [Signature] Nurse Name: Dajamani Date & Time: 23/7/2020 8am





# **NURSING CARE RECORD**

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 22/7/16

Assessment: The Patient having Wreaks

**Goals**

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

| Time | Plan of Care                               | Time | Implementation                                | Evaluation     |
|------|--------------------------------------------|------|-----------------------------------------------|----------------|
| 2pm  | Monitor Vitals                             | 3pm  | Monitored Vitals                              |                |
| 3pm  | Administer medication as per doctor advice | 5pm  | Administered medication as per doctor advice. | Pt felt better |
| 4pm  | Provide Hydration                          | 6pm  | Provided Hydration                            |                |
| 5pm  | Provide Supportive Care.                   | 7pm  | Provided Supportive Care                      |                |

Re-Assessment: Pt felt better

Special Notes:

Nurse Signature: *[Signature]*

Nurse Name: Pojia

Date & Time: 22/7/16 8pm





# NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 22/7/20

Assessment: patient having weakness

Goals

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

| Time  | Plan of Care                         | Time  | Implementation                         | Evaluation           |
|-------|--------------------------------------|-------|----------------------------------------|----------------------|
| 8 Am  | Assess the patient general condition | 9 Am  | Assessed the patient general condition | patient feels better |
| 10 Am | check vital                          | 10:30 | checked vital                          |                      |
| 11 Am | provided oral care                   | 11:30 | provided oral care                     |                      |
| 12 pm | Maintain 810 chart                   | 12:30 | Maintained 810 chart                   |                      |
| 1 pm  | Administer medication                | 2 pm  | Administered medication                |                      |

Re-Assessment:

NA

Special Notes:

NA

Nurse Signature:

*[Signature]*

Nurse Name:

Gayathri

Date & Time:

22/7/20 @ 8 pm





Patient Sticker

# (5) NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 21/7/26

Assessment: patient having weakness.

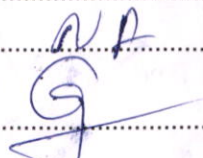
Goals

- |                                                           |                                                               |                                                            |                                                                |                                                                      |                                                     |
|-----------------------------------------------------------|---------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Maintain Airway and Oxygenation  | <input checked="" type="checkbox"/> Relieve Pain & Discomfort | <input checked="" type="checkbox"/> Maintain Fluid Balance | <input checked="" 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 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                                                                                           |
|------|--------------------------------------|--------------------|----------------------------------------|------------------------------------------------------------------------------------------------------|
| 9m   | Assess the patient general condition | 9m                 | Assessed the patient general condition | patient feel<br> |
| 4m   | check vitals                         | 4:30               | checked vitals                         |                                                                                                      |
| 5m   | provide sick rails                   | 5:30 <sup>AM</sup> | provided sick rails                    |                                                                                                      |
| 6m   | Maintain BLO chart                   | 6:30 <sup>AM</sup> | Maintained BLO chart                   |                                                                                                      |
| 7m   | Administer medication                | 8m <sup>AM</sup>   | Administered medication                |                 |

Re-Assessment: NA

Special Notes:

Nurse Signature: 

Nurse Name: GARGI

Date & Time: 22/7/26 8m





4

# NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 21/7/20

Assessment: patient having convulsions

## Goals

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

| Time | Plan of Care                         | Time | Implementation                         | Evaluation           |
|------|--------------------------------------|------|----------------------------------------|----------------------|
| 2pm  | Assess the patient general condition | 3pm  | Assessed the patient general condition | patient feels better |
| 4pm  | check vitals                         | 4:30 | checked vitals                         |                      |
| 5pm  | provide side rails                   | 5:30 | provided side rails                    |                      |
| 6pm  | Maintain 210 chart                   | 6:30 | Maintained 210 chart                   |                      |
| 7pm  | Administer medication                | 8pm  | Administered medication                |                      |

Re-Assessment: NA

Special Notes: NA

Nurse Signature: [Signature] Nurse Name: Gonyathu Date & Time: 21/7/20 @ 8pm



# NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 21/1/26

Assessment: patient having nausea

Goals

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

| Time     | Plan of Care                         | Time     | Implementation                                | Evaluation    |
|----------|--------------------------------------|----------|-----------------------------------------------|---------------|
| 10:15 AM | Assess the patient general condition | 10:20 AM | Assessed the patient general condition        | pt was stable |
| 11 AM    | monitor the vital and renal          | 11:00 AM | monitored the vital and renal vital ok stable |               |
| 11:45 AM | maintain fluid balance               | 12 PM    | provide hydration & oral + chemotherapy       |               |
| 12:15 PM | provide safer safety                 | 1 PM     | provided side rail                            |               |
| 12:20 PM | provide medications                  | 1:30 PM  | provided medication orders                    |               |
| 1:20 PM  | to send CV                           | 2:30 PM  | sent CV                                       |               |
| 2:00 PM  | provide Personal Hygiene             |          |                                               |               |

Re-Assessment: patient was stable

Special Notes: continue n/c, oral hydration

Nurse Signature: [Signature]

Nurse Name: Nandini

Date & Time: 21/1/26 4:00



②

## NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/7/26

Assessment: Patient Having nausea

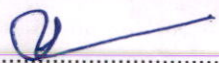
Goals

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

| Time   | Plan of Care                  | Time   | Implementation                  | Evaluation                        |
|--------|-------------------------------|--------|---------------------------------|-----------------------------------|
| 8pm    | Assess the patient condition. | 8:30pm | Assessed the patient condition. | Patient<br>Feel<br>better<br>now. |
| 8pm    | monitor vital.                | 8:30pm | monitored vital.                |                                   |
| 8:30pm | maintain IV fluids            | 10pm   | maintained IV fluids.           |                                   |
| 10pm   | Administer medication.        | 11pm   | Administered medication.        |                                   |
| 5Am    | provide personal hygiene.     | 6Am    | provided supportive care.       |                                   |
| 7Am    | provide supportive care.      | 7:30pm | provided supportive care.       |                                   |

Re-Assessment: Patient feel better now.

Special Notes: CUB Today.

Nurse Signature: 

Nurse Name: SUBHANKAR

Date & Time: 21/7/26 & 8am





# NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 20/7/2016

Assessment: patient hearing weakness

Goals

- |                                                               |                                                    |                                                            |                                                     |                                                                      |                                                     |
|---------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------------|
| <input 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 checked="" type="checkbox"/> Maintain Personal Hygiene | <input 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                 |
|------|--------------------------------------|--------|----------------------------------------|----------------------------|
| 2pm  | Assess the patient general condition | 2:45pm | Assessed the patient general condition | patient is now comfortable |
| 3pm  | monitor vitals                       | 3:20pm | monitored vitals                       |                            |
| 4pm  | maintain fluid balance               | 4:30pm | maintained fluid balance               |                            |
| 5pm  | maintain personal hygiene            | 5:20pm | To explained personal hygiene          |                            |
| 6pm  | Administer medications               | 6:15pm | Administered medications               |                            |
| 7pm  | maintain O/R chart                   | 8pm    | maintained O/R chart                   |                            |

Re-Assessment: patient feels better

Special Notes:

Nurse Signature: pooja

Nurse Name: pooja

Date & Time: 20/7/2016 @ 8pm



Pat



1

## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sandhya Vaddadi Department: ER Date of Admission: 20/7/26

| SITUATION                                | Diagnosis: <u>chemotherapy f LP</u>                       |                                                                     | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known<br>If Yes Specify: ..... |                                                                     |                                                                     |                                                                     |                                                                     |            |
|------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|------------|
| BACKGROUND                               | Area                                                      | Shift Time                                                          | ER<br>1:15 pm                                                                                                                                  | ONCO<br>8pm                                                         | ONCO<br>8pm                                                         | ONCO<br>8pm to 2pm                                                  | ONCO<br>2pm to 8pm                                                  |            |
|                                          | Medical Condition<br>(Any special condition to be noted): |                                                                     | Nil                                                                                                                                            | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  |            |
| ASSESSMENT                               | 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 |            |
|                                          | 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 |            |
|                                          | Vital Signs:                                              | Temp:                                                               | 98°F                                                                                                                                           | 98.4°F                                                              | 98.5°F                                                              | 98.3°F                                                              | 98.2°F                                                              | 98.2°F     |
|                                          |                                                           | Res:                                                                | 24b/m                                                                                                                                          | 24b/m                                                               | 24b/m                                                               | 23b/m                                                               | 23b/m                                                               | 22b/m      |
|                                          |                                                           | SpO <sub>2</sub> :                                                  | 100%                                                                                                                                           | 99%                                                                 | 100%                                                                | 99%                                                                 | 99%                                                                 | 98%        |
|                                          |                                                           | Pulse:                                                              | 82b/m                                                                                                                                          | 81b/m                                                               | 92b/m                                                               | 95b/m                                                               | 95b/m                                                               | 92b/m      |
|                                          |                                                           | BP:                                                                 | 100/52                                                                                                                                         | 102/62                                                              | 96/60                                                               | 96/60                                                               | 100/56                                                              | 116/71(81) |
|                                          | Fall Risk Score:                                          | 10                                                                  | 10                                                                                                                                             | 10                                                                  | 10                                                                  | 10                                                                  | 10                                                                  |            |
| Pain Score:                              | 0                                                         | 0                                                                   | 0                                                                                                                                              | 0                                                                   | 0                                                                   | 0                                                                   |                                                                     |            |
| Recommendations                          | Safety Needs:                                             | yes                                                                 | side rails                                                                                                                                     | side rails                                                          | side rails                                                          | side rails                                                          | side rails                                                          |            |
|                                          | 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:                                           | Nil                                                                 | NA                                                                                                                                             | NA                                                                  | NA                                                                  | 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:                       | Nil                                                                 | NA                                                                                                                                             | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  |            |
| Post Operative Procedure Special Orders: |                                                           | Nil                                                                 | NA                                                                                                                                             | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  |            |
| Handed Over By Name :                    |                                                           | Sagar                                                               | Sonam                                                                                                                                          | Subramaniam                                                         | Naveen                                                              | Gowtham                                                             | Susmita                                                             |            |
| Signature :                              |                                                           | [Signature]                                                         | [Signature]                                                                                                                                    | [Signature]                                                         | [Signature]                                                         | [Signature]                                                         | [Signature]                                                         |            |
| Date:                                    |                                                           | 20/7/26                                                             | 20/7                                                                                                                                           | 21/7                                                                | 21/7                                                                | 21/7                                                                | 22/7                                                                |            |
| Time:                                    |                                                           | 1:15 pm                                                             | 8pm                                                                                                                                            | 8pm                                                                 | 2pm                                                                 | 8pm                                                                 | 8 Am.                                                               |            |
| Taken Over By Name :                     |                                                           | Sonam                                                               | Harsh                                                                                                                                          | Naveen                                                              | Naveen                                                              | Susmita                                                             | Naveen                                                              |            |
| Signature :                              |                                                           | [Signature]                                                         | [Signature]                                                                                                                                    | [Signature]                                                         | [Signature]                                                         | [Signature]                                                         | [Signature]                                                         |            |
| Date:                                    |                                                           | 20/7                                                                | 20/7                                                                                                                                           | 21/7                                                                | 21/7                                                                | 21/7                                                                | 22/7                                                                |            |
| Time:                                    |                                                           | 5:20pm                                                              | 8pm                                                                                                                                            | 8pm                                                                 | 2pm                                                                 | 8pm                                                                 | 8pm                                                                 |            |



VIH-00203199  
Master AEVIN NASH EARL  
27-03-2014 12 Y 3 M 24 D (M)  
Dr. SANDHYA VADDADI



## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ER Date of Admission: 20/7/12

|                                          |                                                           |                                                                     |                                                                                                                                                |                                                                     |                                                                     |                                                                     |                                                                     |  |
|------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|--|
| SITUATION                                | Diagnosis:                                                |                                                                     | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known<br>If Yes Specify: ..... |                                                                     |                                                                     |                                                                     |                                                                     |  |
|                                          | <u>chemotherapy f</u><br><u>LP</u>                        |                                                                     |                                                                                                                                                |                                                                     |                                                                     |                                                                     |                                                                     |  |
| BACKGROUND                               | Area                                                      | <u>ER</u>                                                           | <u>Onco 2m-4p</u>                                                                                                                              | <u>Onco 4p-8pm</u>                                                  | <u>DR 8AM</u>                                                       | <u>Onco 8AM</u>                                                     |                                                                     |  |
|                                          | Shift Time                                                |                                                                     |                                                                                                                                                |                                                                     |                                                                     |                                                                     |                                                                     |  |
| BACKGROUND                               | Medical Condition<br>(Any special condition to be noted): | <u>Nil</u>                                                          | <u>NA</u>                                                                                                                                      | <u>NA</u>                                                           | <u>2A</u>                                                           | <u>NA</u>                                                           |                                                                     |  |
|                                          |                                                           |                                                                     |                                                                                                                                                |                                                                     |                                                                     |                                                                     |                                                                     |  |
| ASSESSMENT                               | 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:                                                               | <u>98°F</u>                                                                                                                                    | <u>98.6°F</u>                                                       | <u>98°F</u>                                                         | <u>98.3°F</u>                                                       | <u>98.2°F</u>                                                       |  |
|                                          |                                                           | Res:                                                                | <u>20b/m</u>                                                                                                                                   | <u>20b/m</u>                                                        | <u>20b/m</u>                                                        | <u>20b/m</u>                                                        | <u>20b/m</u>                                                        |  |
|                                          |                                                           | SpO <sub>2</sub> :                                                  | <u>100%</u>                                                                                                                                    | <u>100%</u>                                                         | <u>100%</u>                                                         | <u>100%</u>                                                         | <u>100%</u>                                                         |  |
|                                          |                                                           | Pulse:                                                              | <u>106b/m</u>                                                                                                                                  | <u>106b/m</u>                                                       | <u>100b/m</u>                                                       | <u>101b/m</u>                                                       | <u>101b/m</u>                                                       |  |
|                                          |                                                           | BP:                                                                 | <u>107/75</u>                                                                                                                                  | <u>107/75</u>                                                       | <u>107/60</u>                                                       | <u>100/61</u>                                                       | <u>100/61</u>                                                       |  |
|                                          |                                                           | Fall Risk Score:                                                    | <u>10</u>                                                                                                                                      | <u>10</u>                                                           | <u>10</u>                                                           | <u>10</u>                                                           | <u>10</u>                                                           |  |
|                                          | Pain Score:                                               | <u>0</u>                                                            | <u>0</u>                                                                                                                                       | <u>0</u>                                                            | <u>0</u>                                                            | <u>0</u>                                                            |                                                                     |  |
|                                          | Recommendations                                           | Safety Needs:                                                       | <u>Yes</u>                                                                                                                                     | <u>Yes</u>                                                          | <u>Yes</u>                                                          | <u>Yes</u>                                                          | <u>Yes</u>                                                          |  |
| 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:                          |                                                           | <u>Nil</u>                                                          | <u>Nil</u>                                                                                                                                     | <u>NA</u>                                                           | <u>NA</u>                                                           | <u>NA</u>                                                           |                                                                     |  |
| 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 |  |
| Recommendations                          | Other Special Orders / Medications:                       | <u>Nil</u>                                                          | <u>Nil</u>                                                                                                                                     | <u>NA</u>                                                           | <u>NA</u>                                                           | <u>NA</u>                                                           |                                                                     |  |
|                                          |                                                           |                                                                     |                                                                                                                                                |                                                                     |                                                                     |                                                                     |                                                                     |  |
| Post Operative Procedure Special Orders: |                                                           | <u>Nil</u>                                                          | <u>Nil</u>                                                                                                                                     | <u>NA</u>                                                           | <u>NA</u>                                                           | <u>NA</u>                                                           |                                                                     |  |
| Handed Over By Name :                    |                                                           | <u>Sagar</u>                                                        | <u>Nandini</u>                                                                                                                                 | <u>Pooja</u>                                                        | <u>Say</u>                                                          | <u>Gaurav</u>                                                       |                                                                     |  |
| Signature :                              |                                                           | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                                                                                             | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  |                                                                     |  |
| Date:                                    |                                                           | <u>20/7/12</u>                                                      | <u>24/7</u>                                                                                                                                    | <u>22/7</u>                                                         | <u>23/7</u>                                                         | <u>23/7</u>                                                         |                                                                     |  |
| Time:                                    |                                                           |                                                                     | <u>2pm</u>                                                                                                                                     | <u>8pm</u>                                                          | <u>8AM</u>                                                          | <u>2pm</u>                                                          |                                                                     |  |
| Taken Over By Name :                     |                                                           |                                                                     | <u>Pooja</u>                                                                                                                                   | <u>Subham</u>                                                       | <u>Gaurav</u>                                                       | <u>DIC</u>                                                          |                                                                     |  |
| Signature :                              |                                                           |                                                                     | <u>[Signature]</u>                                                                                                                             | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  |                                                                     |  |
| Date:                                    |                                                           |                                                                     | <u>24/7</u>                                                                                                                                    | <u>22/7</u>                                                         | <u>23/7</u>                                                         | <u>23/7</u>                                                         |                                                                     |  |
| Time:                                    |                                                           |                                                                     | <u>2pm</u>                                                                                                                                     | <u>8pm</u>                                                          | <u>8AM</u>                                                          | <u>2pm</u>                                                          |                                                                     |  |



VIH-03203199 IP5-00176642  
Master AEVIN NASH EARL  
27-03-2014 12 Y 3 M 24 D (M)  
Dr. SANDHYA VADDADI



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

BirthRight™  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## CONSENT FOR CHEMOTHERAPY

Patient Name : Aevin nash Earl Age : 12y Gender : Male ☐ Female ☒  
UHID No : 203199 Department : Oncology Date : 20/7/26  
Type of Chemotherapy : 14

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

The doctor have explained to me about the benefits and alternative for this procedure that .....

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

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

### Patient Attendant :

Signature : Feona  
Name : FEONA  
Relationship with Patient : mother  
Date & Time : 20/7/26 @ 4:30pm

### Witness :

Signature : Feona  
Name : FEONA  
Date & Time : 20/7/26 @ 4:30pm

### Doctor (who is taking the consent):

Signature : Dr. Savani  
Name : Dr. Savani  
Date & Time : 20/7/26 @ 4:30pm





## CONSENT FOR SPECIAL PROCEDURES

Patient Name : Aevin Nash Earl Gender: ☒ Male ☐ Female

UHID No : VIH-00203199 Department : Oncology Date : 20/2/26

I Feona S/P/W/O Aevin  
Parent of

Here by give consent for procedure of : Ip + CT Chemotherapy

For my patient, Named : Aevin

The doctors have clearly explained to me that the procedure has following possible complications:

Pain, Bleeding, Headache

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

None

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Mr. Srinivas

### Patient Attendant :

Signature : Feona

Name : Feona

Relationship with Patient: Mother

Date & Time : 20/2/26 @ 4 PM

### Witness :

Signature : Sonam

Name : Sonam

Date & Time : 20/2/26 @ 4 PM

### Doctor (who is taking the consent) :

Signature : Ushwaja

Name : Ushwaja

Date & Time : 20/2/26 @ 4 PM



## ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు ..... లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి ..... విభాగం ..... తేదీ .....

నేను ..... S/D/W/O .....

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా .....

నా రోగికి, పేరు : .....

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

.....

.....

.....

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు : .....

సహాయకుడు(అటెండెంట్)

సంతకము .....

పేరు .....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము .....

పేరు .....

సాక్షి

సంతకము .....

పేరు .....

తేదీ మరియు సమయము .....



## PROCEDURE SAFETY CHECK LIST (TIMEOUT OUTSIDE OT)

Procedure Name: LP+ IT chemotherapy Date: 20/3/24 In-Time: 4:00 Out-Time: 4:50 PM  
Doctor Performing Procedure: Dr. Sandhya Doctor Giving Sedation: Dr. Sandhya Assisting Nurse: Sonam

| SIGN IN                                                       | Time: <u>4:00</u>                                                                               |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| Patient is verified using two identifiers (Name & UHID)       | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> |
| All required documents, images, studies are available         | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> |
| NPO Status Checked from Patient / Patient Attendant           | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> |
| Consent is Signed                                             | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> |
| Any need for blood products                                   | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA <input type="checkbox"/> |
| If Yes Comment: .....                                         |                                                                                                 |
| Any Risk of Hemodynamic Compromise                            | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA <input type="checkbox"/> |
| If Yes Comment: .....                                         |                                                                                                 |
| Any drug or food allergy                                      | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA <input type="checkbox"/> |
| If Yes Comment: .....                                         |                                                                                                 |
| Correct Site of Procedure Marked                              | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> |
| All resources required are correct, available and functioning | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> |
| Signature of the Doctor: <u>Dr. Sandhya</u>                   |                                                                                                 |
| Name of the Doctor: <u>Dr. Sandhya</u>                        |                                                                                                 |

| TIME OUT                               | Time: <u>4:20 PM</u>                                                                            |
|----------------------------------------|-------------------------------------------------------------------------------------------------|
| Correct Patient                        | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> |
| Correct Site                           | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> |
| Correct Procedure                      | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> |
| All the team members introduced        | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> |
| Signature of the Nurse: <u>Anuradh</u> |                                                                                                 |
| Name of the Nurse: <u>Anuradh</u>      |                                                                                                 |

| SIGN OUT                                              | Time: <u>4:50</u>                                                                               |
|-------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| Name of the Surgical / Invasive Procedure is recorded | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> |
| Instrument, Sponge and Needle Count Completed         | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> |
| Specimens are labeled                                 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> |
| Any equipment problems are addressed                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA <input type="checkbox"/> |
| Signature of the Nurse: <u>Sonam</u>                  |                                                                                                 |
| Name of the Nurse: <u>Sonam</u>                       |                                                                                                 |

### Any Adverse / Unexpected Events



VIH-00203199  
Master AEVIN NASH EARL  
27-03-2014 12 Y 3 M 25 D (M)  
Dr. SANDHYA VADDADI

# INARARY PATIENT / FAMILY EDUCATION RECORD



Learner Language: ..... 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 |          |                         |
| 23/2 | 9am  | 7               | infection control measures | M                                   | 1                 | 0              | 1                                 | 1             | -        | G                       |
|      |      |                 |                            |                                     |                   |                |                                   |               |          |                         |
|      |      |                 |                            |                                     |                   |                |                                   |               |          |                         |
|      |      |                 |                            |                                     |                   |                |                                   |               |          |                         |

## 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 |                               |                                                   |           |                                 |           |                                |             |              |                          |



# INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Pa Patients / Learner Language: Hindi 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 |          |                         |
| 20/3/22 | 12:30 pm | 7               | Infection control measures | M                                   | 1                 | 0              | 1                                 | 1             | -        | [Signature]             |
| 21/3    | 11 AM    | 7               | infection control meas     | m                                   | 1                 | 0              | 1                                 | 1             | -        | aw                      |
| 21/3/22 | 12:50 pm | 9               | Normal high protein diet   | m                                   | 1                 | 0              | 1                                 | 1             | -        | Nickety                 |
| 22/7    | 1 pm     | 7               | infection control measures | M                                   | 1                 | 0              | 1                                 | 1             | -        | [Signature]             |

## Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify) .....

**Learning Barriers:**

|                         |                               |                                                   |                                 |                                |
|-------------------------|-------------------------------|---------------------------------------------------|---------------------------------|--------------------------------|
| 1. No Learning Barriers | 4. Language Barrier           | 7. Impaired Thought Process/Cognitive limitations | 10. Financial Difficulties      | 13. Cultural/Religion Practice |
| 2. Physical Impairment  | 5. Educational Level          | 8. Responsibilities at Home                       | 11. Beliefs and Values          | 14. Others (Specify) .....     |
| 3. Emotional Barriers   | 6. Desire / Motivate to Learn | 9. Cultural Differences                           | 12. Impaired Vision/ or Hearing |                                |

**Teaching Tools Used:** A: Audio D: Demonstration V: Video O: Oral P: Printed

**Mechanism/s to overcome barrier/s:**

|                      |                          |                                           |                         |
|----------------------|--------------------------|-------------------------------------------|-------------------------|
| 1. None              | 3. Reassurance & Support | 5. Respect values & beliefs               | 7. Other, Specify ..... |
| 2. Obtain translator | 4. Teach Family / Others | 6. Respect Cultural / Religion Preference |                         |

**Understanding:** 1: Verbalizes Understanding 2: Demonstrates Understanding 3: Needs Review





# MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: chemotherapy & L.P

| Date Time           | Discipline                                                                                                                      | Type                                                                                                                                                    | Patient Needs / Problem List | Goal                        | Plan / Intervention                   | Signature | Team Verification                                                                                                   |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|---------------------------------------|-----------|---------------------------------------------------------------------------------------------------------------------|
| 20/3/26<br>12:30 pm | <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 | kic B ALL                    | H-stability                 | chemotherapy                          |           | <input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:                                                |
| 20/3/26<br>12:30 pm | <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 | chemotherapy<br>& L.P        | H-stability                 | monitoring<br>vitals                  |           | <input type="checkbox"/> Medical<br><input type="checkbox"/> Others:                                                |
| 21/3/26<br>12:50 pm | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input checked="" type="checkbox"/> Others:<br>di-drian | <input checked="" type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op | kic B Acc                    | Normal high<br>protein diet | ROA:-<br>E1- 1750 kcal/d<br>P1- 3191g | Nicitha   | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<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:            |



VH-00203199  
Master AEVIN NASH EARL  
27-03-2014 12 Y 3 M 23 D (M)  
Dr. SANDHYA VADDADI



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

BirthRight™  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## THE HUMPTY DUMPTY SCALE

2017 2/17 22/2

| PARAMETER                                 | CRITERIA                                                                                                   | SCORE | DATE | DATE | DATE | DATE | DATE |
|-------------------------------------------|------------------------------------------------------------------------------------------------------------|-------|------|------|------|------|------|
| Age                                       | Less than 3 years old                                                                                      | 4     |      |      | 20/7 |      |      |
|                                           | 3 to less than 7 years old                                                                                 | 3     |      |      |      |      |      |
|                                           | 7 to less than 13 years old                                                                                | 2     | 2    | 2    | 2    | 2    |      |
|                                           | 13 years old and above                                                                                     | 1     |      |      |      |      |      |
| Gender                                    | Male                                                                                                       | 2     | 2    | 2    | 2    | 2    |      |
|                                           | Female                                                                                                     | 1     |      |      |      |      |      |
| Diagnosis                                 | Neurological Diagnosis                                                                                     | 4     |      |      |      |      |      |
|                                           | Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc. | 3     |      |      |      |      |      |
|                                           | Psych / Behavioral Disorders                                                                               | 2     |      |      |      |      |      |
|                                           | Other Diagnosis                                                                                            | 1     | 1    | 1    | 1    | 1    |      |
| Cognitive Impairments                     | Not Aware of Limitations                                                                                   | 3     |      |      |      |      |      |
|                                           | Forget Limitations                                                                                         | 2     |      |      |      |      |      |
|                                           | Oriented to own Ability                                                                                    | 1     | 1    | 1    | 1    | 1    |      |
|                                           | History of Falls or Infant - Toddler Placed in Bed                                                         | 4     |      |      |      |      |      |
| Environmental Factors                     | Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)            | 3     |      |      |      |      |      |
|                                           | Patient Placed in Bed                                                                                      | 2     | 2    | 2    | 2    | 2    |      |
|                                           | Outpatient Area                                                                                            | 1     |      |      |      |      |      |
| Response to Surgery / Sedation Anesthesia | Within 24 hours                                                                                            | 3     |      |      |      |      |      |
|                                           | Within 48 hours                                                                                            | 2     |      |      |      |      |      |
|                                           | More than 48 hours / None                                                                                  | 1     | 1    | 1    | 1    | 1    |      |
| Medication Usage                          | Sedatives (excluding ICU patients sedated and paralyzed)                                                   | 3     |      |      |      |      |      |
|                                           | Hypnotics                                                                                                  | 3     |      |      |      |      |      |
|                                           | Barbiturates                                                                                               | 3     |      |      |      |      |      |
|                                           | Phenothiazines                                                                                             | 3     |      |      |      |      |      |
|                                           | Antidepressants                                                                                            | 3     |      |      |      |      |      |
|                                           | Laxatives / Diuretics                                                                                      | 3     |      |      |      |      |      |
|                                           | Narcotics                                                                                                  | 3     |      |      |      |      |      |
|                                           | One of the Meds listed above                                                                               | 2     |      |      |      |      |      |
|                                           | Other Medications / None                                                                                   | 1     | 1    | 1    | 1    | 1    |      |
| TOTAL                                     |                                                                                                            |       | 10   | 10   | 10   | 10   |      |

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

|                               |             |             |             |             |
|-------------------------------|-------------|-------------|-------------|-------------|
| Bed in low position           | Yes         | Yes         | Yes         | Yes         |
| Call device within reach      | Yes         | Yes         | Yes         | Yes         |
| Wheels Locked                 | Yes         | Yes         | Yes         | Yes         |
| Room free of clutter          | Yes         | Yes         | Yes         | Yes         |
| Adequate Lighting             | Yes         | Yes         | Yes         | Yes         |
| Wheel Chair Support           | NO          | NO          | NA          | NA          |
| Other Intervention(s) Specify | NO          | NO          | NA          | NA          |
| Nurse's Name :                | Sagar       | Suj         | Sumit       | Devi        |
| Signature :                   | [Signature] | [Signature] | [Signature] | [Signature] |
| Date :                        | 20/7        | 20/7        | 22/7        | 23/7        |
| Time :                        | 12:20 pm    | 8 AM        | 8 AM        | 8 AM        |



VIH-00203199  
Master AEVIN NASH EARL  
27-03-2014 12 Y 3 M 26 D (M)  
Dr. SANDHYA VADDADI

2

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

BirthRight™  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

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

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

| Parameters                                                                                        | Date | Shift Time |                                                                     |                                                          |                                                          |                                                                     |                                                                     |                                                          |
|---------------------------------------------------------------------------------------------------|------|------------|---------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------|
| Can we remove Central Line today<br>(Discuss in the clinical round)                               | 23/4 | 8AM        | <input type="checkbox"/> Yes <input checked="" 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 |
| Evidence of any inflammation at insertion site<br>(Redness / Swelling (If yes inform the doctor)) |      |            | <input type="checkbox"/> Yes <input checked="" 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 |
| Blood at insertion site<br>(If yes inform the doctor)                                             |      |            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any peeling of dressing?<br>(If yes inform the doctor)                                            |      |            | <input type="checkbox"/> Yes <input checked="" 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 |
| Is dressing clean and dry?<br>(If no inform the doctor)                                           |      |            | <input checked="" 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 |
| Any leakage at insertion site?<br>(If yes inform the doctor)                                      |      |            | <input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is there any obstruction to the infusion flow?<br>(If yes inform the doctor)                      |      |            | <input type="checkbox"/> Yes <input checked="" 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 |
| Dressing intact and labelled properly                                                             |      |            | <input checked="" 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 |
| Central line changed on                                                                           |      |            |                                                                     |                                                          |                                                          |                                                                     |                                                                     |                                                          |
| Name of the Nurse                                                                                 |      |            |                                                                     |                                                          |                                                          |                                                                     |                                                                     |                                                          |
| Signature of the Nurse                                                                            |      |            |                                                                     |                                                          |                                                          |                                                                     |                                                                     |                                                          |



## CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

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

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

| Parameters                                                                                        | Date | Shift Time | 20/7                                                                | 20/7                                                                | 21/7                                                                | 22/7                                                                | 22/7                                                                | 23/7                                                                |
|---------------------------------------------------------------------------------------------------|------|------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|
|                                                                                                   |      |            | 8pm                                                                 | 8AM                                                                 | 8AM to 2pm                                                          | 8AM                                                                 | 2pm                                                                 | 8pm                                                                 |
| Can we remove Central Line today<br>(Discuss in the clinical round)                               |      |            | <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 |
| Evidence of any inflammation at insertion site<br>(Redness / Swelling (If yes inform the doctor)) |      |            | <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 |
| Blood at insertion site<br>(If yes inform the doctor)                                             |      |            | <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 |
| Any peeling of dressing?<br>(If yes inform the doctor)                                            |      |            | <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 |
| Is dressing clean and dry?<br>(If no inform the doctor)                                           |      |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Any leakage at insertion site?<br>(If yes inform the doctor)                                      |      |            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input 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 type="checkbox"/> No            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Is there any obstruction to the infusion flow?<br>(If yes inform the doctor)                      |      |            | <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 |
| Dressing intact and labelled properly                                                             |      |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Central line changed on                                                                           |      |            |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |
| Name of the Nurse                                                                                 |      |            | Pooja                                                               | Subhna                                                              | Deepa                                                               | Ommita                                                              | Gaya                                                                | Pooja                                                               |
| Signature of the Nurse                                                                            |      |            | [Signature]                                                         | [Signature]                                                         | [Signature]                                                         | [Signature]                                                         | [Signature]                                                         | [Signature]                                                         |



VIH-00203199  
Master AEVIN NASH EARL  
27-03-2014 12 Y 3 M 23 D (M)  
Dr. SANDHYA VADDADI

# BRADEN 'Q' SCALE

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

BirthRight  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

|                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 | Date :                                                                                                                                                                                                                                                                                 | 20/7                    | 21/7 | 22/7 | 23/7   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------|------|--------|
|                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 | Time :                                                                                                                                                                                                                                                                                 | 12:20pm                 | 8Am  | 8Am  |        |
| 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    | 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    | 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    | 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    | 4      |
| <b>FRICITION-SHEAR</b><br><b>Friction</b> Occurs when Skin moves against support surfaces<br><b>Shear</b> 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    | 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    | 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    | 4      |
| <b>Severe Risk : less than 9   High Risk : 10-12   Moderate Risk : 13-14   Mild Risk : 15-18   Not at Risk: 19-23</b>                                                         |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | <b>TOTAL SCORE</b>      | 28   | 28   | 28     |
| Docu. No. : RCHBH /FRM / CLINICAL / 119                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | <b>Evaluator's Name</b> | 9    | OR   | Sumrit |



| Risk Score  | Category      | Action                                                                                                                                                                                                                                                                                                                                       | <b>Support Surfaces</b><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                                                                  |





## NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 21/7/26 Time: 12:50pm

Weight: 74.80 kg Centile: >99<sup>th</sup>

Height: 168 cms Centile: >99<sup>th</sup>

Inference: obese child

RDA: — Calories: 1750 kcal/d Protein: 3.1 g/d

Diet Recommendations: normal high protein diet

Re-Assessment: Avoid spicy, chilled & outside foods

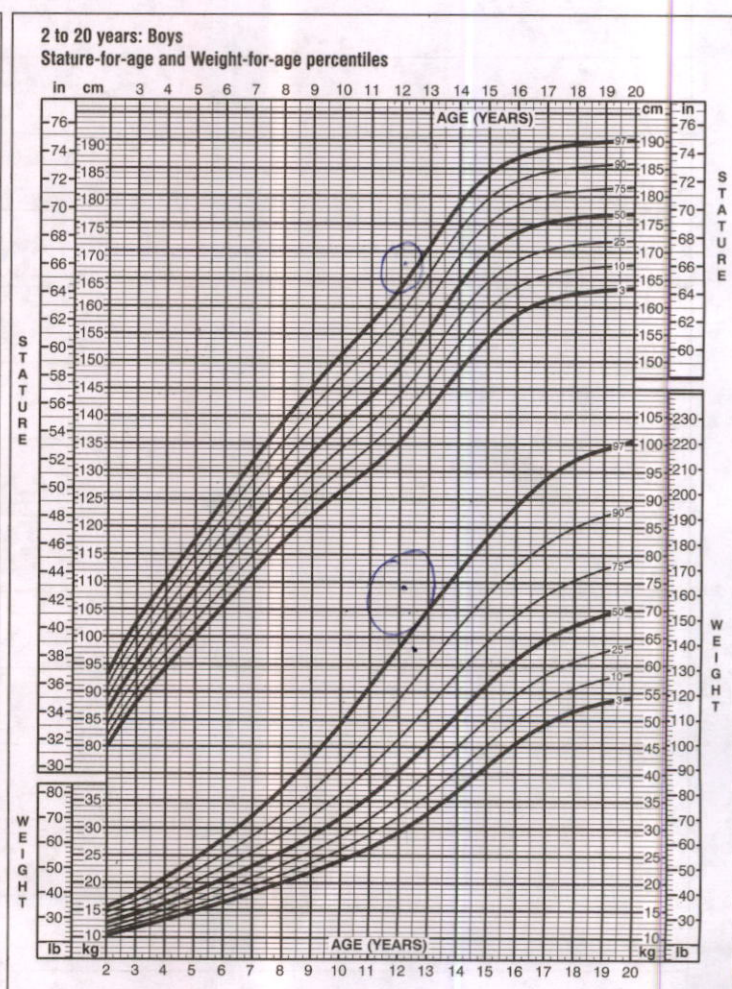
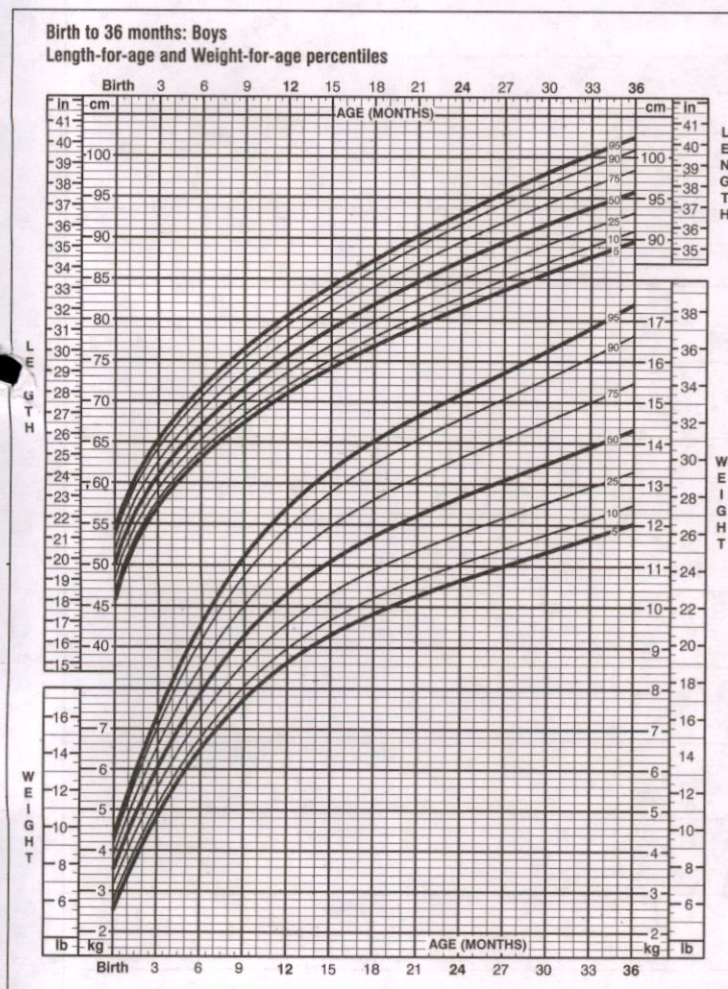
Food Allergies: NO Veg/Non-veg: Non-veg

Diagnosis: Kilo B-AE

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: parent's don't need dietitian. Don't charge for now

### GROWTH CHART (BOYS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha



[illegible]



| Date & Time     | Progress Notes                                                                                                                                 | Doctor's Order                                                                                                                                                                                                                              |
|-----------------|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 20/7.<br>6:10pm | <p><u>Evening rounds</u></p> <p>Call Aufmann for chemotherapy.</p> <p>No fresh issues<br/>Vitals (N)<br/>sl &amp; sws /<br/>me /<br/>110 /</p> | <p><u>Ad</u></p> <ol style="list-style-type: none"> <li>1) eve thm</li> <li>2) went seat</li> <li>3) have WET CDP.</li> <li>4) monitor vitals</li> <li>5) inform SOS</li> </ol> <p>N.B</p> <p>Sonam<br/>015347<br/>@yfr</p> <p>Ahambhar</p> |





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

[illegible]





## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes                                                                                                                                                                                                                                                       | Doctor's Order       |
|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
| 20/3/24     | <p><u>procedure notes</u></p> <p>After taking written consent, under strict aseptic precautions, under local anaesthesia lumbar puncture done and subarachnoid chemotherapy given.</p> <p>procedure Uneventful</p> <p>Vitals stable</p> <p>child shifted to ward</p> |                      |
| 20/3/24     | <p><u>Evening rounds</u></p> <p>Reckless</p> <p>Child alert</p> <p>Euthermic</p> <p>Vitals stable</p> <p>cr<br/>Hb<br/>Rb } (A)</p>                                                                                                                                  | <p><u>Wishwa</u></p> |
|             | <p>Plan</p> <ol style="list-style-type: none"> <li>1) continue supportive care</li> <li>2) Monitor Vitals</li> </ol> <p>informing</p>                                                                                                                                |                      |
|             | <p>N.B</p> <p>Serum</p> <p>O/S 4</p>                                                                                                                                                                                                                                 | <p><u>Wishwa</u></p> |







VIH-00203199 IP5-00175642  
Master AEVIN NASH EARL  
27-03-2014 12 Y 3 M 24 D (M)  
Dr. SANDHYA VADDADI



(3)

## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time      | Progress Notes                                                                                                                  | Doctor's Order                                                                                                                                  |
|------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|
| 27/2/26<br>9 AM. | <u>Morning rounds</u><br>Well Bu / Probed - M<br>Afebrile<br>No vomiting<br>Vitals (N)<br>Stable<br>MS / (N)<br>PK              | <u>Adm</u><br>1) ct chemotherapy<br>2) folinic rescue Policy<br>3) <del>start</del> from 3pm<br>3) UBP<br>MTX level<br>electrolysis<br>Shankhar |
|                  | <u>Dr. Anuraag Reddy</u><br>4:35 PM 23/3/26<br>MBBS, MD, FIAP (PHO),<br>Fellowship in Paediatric BMT<br>Reg. No: TSMC/FMR/44399 | <u>MB</u><br><u>Ganyathu</u><br>22/7/26<br>12 PM                                                                                                |



VIH-00203199 IP5-00176642  
Master AEVIN NASH EARL  
27-03-2014 12 Y 3 M 24 D (M)  
Dr. SANDHYA VADDADI



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

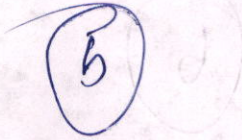


**BirthRight™**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## PHYSICIAN'S NOTES AND DOCTOR'S ORDER

| Date & Time     | Progress Notes                                                                                                                   | Doctor's Order                                                                                      |
|-----------------|----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| 22/7/26<br>5pm. | <u>Evening rounds</u><br><br>B cell au/ Protocol m                                                                               |                                                                                                     |
|                 | No fever<br>No vomiting<br>Vitals stable.                                                                                        | <u>plan</u><br>- Cutac chemotherapy<br>- CRP<br>ratio level } T/m<br>S/E<br>- cutac supportive care |
|                 | AB<br>22/7/26<br>3:30pm.                                                                                                         | <u>Wishwaje</u>                                                                                     |
|                 | Dr. Nalla Anand Babu Reddy<br>MBBS, MD, FACP (FHO)<br>Fellowship in Bone Marrow Transplantation (BMT)<br>Reg. No: TSMC/EM/144333 |                                                                                                     |





| Date & Time        | Progress Notes                                                                                                    | Doctor's Order                       |
|--------------------|-------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| 25/7/20<br>8:30 AM | Morning rounds<br>Call All/Protocol-M                                                                             | Pho<br>1) Low S/E / low<br>Mtr level |
|                    | Afchile<br>No vomiting -                                                                                          | 2) it suppress                       |
|                    | V. file (n)                                                                                                       | 3) fiv → 25/7 E<br>csp, se           |
|                    | S/E → ws<br>Pho / No                                                                                              | 4) M/L today                         |
|                    |                                                                                                                   | <u>Abnormal</u><br>Trace electrolyti |
|                    |                                                                                                                   | no B. Shunt<br>25/7/2008 gay         |
|                    | <br>25/7/2008                  |                                      |
|                    | <b>Dr. Nalla Anuraag Reddy</b><br>MBBS, MD, FIAP (PHO)<br>Fellowship in Paediatric BMT<br>Reg. No: TSMC/FMR/44399 |                                      |



7. SANDHYA VADDADI



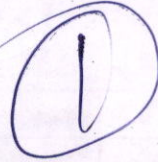
**BirthRight™**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



VIH-00203199 IP5-00176642  
Master Aevin Nash Earl  
27-03-2014 12 Y 3 M 23 D (M)  
Dr. SANDHYA VADDADI



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

**BirthRight<sup>™</sup>**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## RESULT SHEET

|                     |           |         |  |  |  |
|---------------------|-----------|---------|--|--|--|
| Date                | 20/7/26   | 25/7/26 |  |  |  |
| Time                |           |         |  |  |  |
| Hb                  | 9.3       | 8       |  |  |  |
| PCV                 | 28.5      | 24.7    |  |  |  |
| RBC                 | 3.18      | 2.72    |  |  |  |
| WBC                 | 4.18      | 3.25    |  |  |  |
| N/L                 | 54.3/29.7 | 76/20   |  |  |  |
| Platelets           | 1.29L     | 1.08L   |  |  |  |
| CRP                 |           |         |  |  |  |
| ESR                 |           |         |  |  |  |
| PCT                 |           |         |  |  |  |
| RBS                 |           |         |  |  |  |
| Na                  |           |         |  |  |  |
| K                   |           | 4.4     |  |  |  |
| Cl                  |           |         |  |  |  |
| Ca/Mg               |           |         |  |  |  |
| Phosphate           |           |         |  |  |  |
| Urea                |           |         |  |  |  |
| Creatinine          |           |         |  |  |  |
| ALP                 | 96        |         |  |  |  |
| SGPT                | 76        |         |  |  |  |
| SGOT                | 48        |         |  |  |  |
| T.Bill/Conj         | 1/0.4     |         |  |  |  |
| T.Protein           | 5.9       |         |  |  |  |
| S.Albumin           | 3.4       |         |  |  |  |
| S.Globulin          | 2.5       |         |  |  |  |
| A/G Ratio           | 1.3       |         |  |  |  |
| Uric Acid           |           |         |  |  |  |
| S.Amylase           |           |         |  |  |  |
| Sr.Lipase           |           |         |  |  |  |
| Blood Lactate       |           |         |  |  |  |
| S.Cholesterol       |           |         |  |  |  |
| PT/INR              |           |         |  |  |  |
| APTT                |           |         |  |  |  |
| CSF Protein / Sugar |           |         |  |  |  |
| Cells               |           |         |  |  |  |
| N/L                 |           |         |  |  |  |



|                 |          |  |  |  |  |  |
|-----------------|----------|--|--|--|--|--|
| Date            | 21/7     |  |  |  |  |  |
| Time            |          |  |  |  |  |  |
| CUE - Alb       |          |  |  |  |  |  |
| CUE - Sugar     | NFL      |  |  |  |  |  |
| CUE - Ketones   | NEGATIVE |  |  |  |  |  |
| CUE - PUS Cells | 3-4      |  |  |  |  |  |
| CUE - RBC Cells | 1-2      |  |  |  |  |  |
| CUE             |          |  |  |  |  |  |
| PH              | 8.0      |  |  |  |  |  |
| EPITHELIAL      | 1-2.     |  |  |  |  |  |
|                 |          |  |  |  |  |  |
| Stool Pus Cell  |          |  |  |  |  |  |
| OVA / Cyst      |          |  |  |  |  |  |
| Occult Blood    |          |  |  |  |  |  |
|                 |          |  |  |  |  |  |
|                 |          |  |  |  |  |  |
|                 |          |  |  |  |  |  |
|                 |          |  |  |  |  |  |
|                 |          |  |  |  |  |  |
|                 |          |  |  |  |  |  |
|                 |          |  |  |  |  |  |
|                 |          |  |  |  |  |  |
|                 |          |  |  |  |  |  |
|                 |          |  |  |  |  |  |

Culture and Sensitivities : .....

.....

.....

.....

Radiology :    USG : .....

                  X-Ray : .....

                  ECHO : .....

                  CT : .....

                  MRI : .....

                  Others (ECG, Contrast Studies etc.,) : .....



Weight 74.5 kg Ward .....



VIH-00203199  
Master AEVIN NASH EARL  
27-03-2014 12 Y 3 M 23 D (M)  
Dr. SANDHYA VADDADI



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

BirthRight™  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

Sheet No: .....

REGULAR PRESCRIPTIONS

Weight .....

Ward .....

| DRUG : Tab. MAGNION                                |       |           |           | Date<br>Time                                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|----------------------------------------------------|-------|-----------|-----------|-------------------------------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Dose                                               | Route | Frequency | Start Dt. |                                                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1 tab                                              | PO    | TID       | 20/7/16   |                                                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor Starting the Drugs: |       |           |           | <div>Dr. Balyi</div>                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                           |       |           |           | <div>1st day 1st dose 1st day 1st dose</div>          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign               |       |           |           | <div>1st day 1st dose 1st day 1st dose</div>          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DRUG : Tab. UDILIV 300mg                           |       |           |           | Date<br>Time                                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                               | Route | Frequency | Start Dt. |                                                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2 tablets                                          | PO    | BD        | 20/7/16   |                                                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor Starting the Drugs: |       |           |           | <div>Dr. Balyi</div>                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                           |       |           |           | <div>Each tab = 300mg</div> <div>Core 2 tablets</div> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign               |       |           |           | <div>1st day 1st dose 1st day 1st dose</div>          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DRUG : Tab. AMLODIPINE                             |       |           |           | Date<br>Time                                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                               | Route | Frequency | Start Dt. |                                                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 5mg                                                | PO    | BD        | 20/7/16   |                                                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor Starting the Drugs: |       |           |           | <div>Dr. Balyi</div>                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                           |       |           |           | <div>1st day 1st dose 1st day 1st dose</div>          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign               |       |           |           | <div>1st day 1st dose 1st day 1st dose</div>          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DRUG : Tab. ALDACTONE                              |       |           |           | Date<br>Time                                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                               | Route | Frequency | Start Dt. |                                                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1 tablet                                           | PO    | OD        | 20/7/16   |                                                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor Starting the Drugs: |       |           |           | <div>Dr. Balyi</div>                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                           |       |           |           | <div>1 tablet = 25mg</div>                            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign               |       |           |           | <div>1st day 1st dose 1st day 1st dose</div>          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |





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

**VERIFIED**

VERIFIED BY : Name



VIH-0203199 IP5-00176642  
Master AEVIN NASH EARL  
27-03-2014 12 Y 3 M 25 D (M)  
Dr. SANDHYA VADDADI



Sheet No: .....

**REGULAR PRESCRIPTIONS**

Weight .....

Ward .....

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

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

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

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

VERIFIED BY : Name ..... Signature .....