

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175898 Admit Date : 03-Jul-2026 Admit Time : 03:16 AM UHID : BAH-00660542

Patient Details :

Patient Name	: Baby DIYA	Age	: 2 Y 5 M 27 D
Guardian	: Mr P.PRATYUSHA	DOB	: 06-01-2024
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H.NO-3-53/1 VILLAGE:BEGUPETMANDAL : RAMAGIRI LAKKARAM PEDDAPALLI Telangana INDIA 505212	Phone No	: 9390676866/ 9394359138
		E-mail	: NO@GAMIL.COM

Admission Details :

Bed Type : SEMI PRIVATE Bed No : SPVT 104 Ward Name : 1F-VIBGYOR
Room No : SPVT 104 Admission Type : First Visit

Contact Details :

Name	: Mr P.PRATYUSHA	Relationship	: MOTHER
Contact Address	: H.NO-3-53/1 VILLAGE:BEGUPETMANDAL :RAMAGIRI LAKKARAM PEDDAPALLI Telangana INDIA 505212	Phone No	: 9390676866 / 9394359138

P. Pratyusha
Signature

Doctor Details :

Doctor Name	: Dr. NALINIKANTA PANIGRAHY	Specialisation	: GENERAL PEDIATRICS
Referral Doctor	: SELF	Phone No	:
Co-Consultant	:		

Payment Details :

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

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No. : _____ t: _____ Dept : _____

Date of Admission: _____ Discharge : _____ Time: _____

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

BAH-00660542 IP5-00175898
Baby DIYA
06-01-2024 2 Y 5 M 27 D (F)
Dr. NALINIKANTA PANIGRAHY



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
03/01/26	4:05 am	ER	104.	Nurmaid.

Cross Consultation Visit

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

[illegible]

[illegible]

PROCEDURE

[illegible]

ANY OTHER INFORMATION

x-ray - ①
2D Echo - ①

Date : 8/8/21

Time :

Prepared By : *Dr. [Signature]*

Staff Nurse

Winger

Shift / Ward

Billing Assistant

Billing Supervisor



PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Diya

UHID ID:

BAH-00660542

IP5-00175898

Baby DIYA

06-01-2024

2 Y 5 M 27 D

(F)

Dr. NALINIKANTA PANIGRAHY

Department:



Consultant:

**Pediatric Multiorgan History & Physical Examination**

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

c/o fever :: 5d.

c/o rashes over body :: 3d.

History of present illness :

Premorbidly well child,

(28/6)

developed fever - 5d ago, initially low grade
with erythematous rash over back.

↓

subsided in 1 day with medications

↓

3d ago, developed high grade fever with raised
rashes all over body. not subsiding i medication
on 30/6 - got admitted. received ceftriaxone, avil.

↓

afebrile on 1/6 and rashes settled.

d/c on 2/6

↓

rashes & fever since yesterday evening (2/7).

no insect bites, not a K/c/o allergy/asthma.

no H/o travel / introduction to new food / medicine.

no breathing difficulty.

no pain during micturition.

Oral no throat pain

oral intake fair

CBP - 12.8 k.

✱

**Pediatric Multiorgan History & Physical Examination****Past History :** (Including details of any previous investigation or treatment)

⑦

Birth & Neonatal History:RD @ birth, NICU stay for 7d.
FT / LSCS / 2.8kg.**Birth & Socio Economic History:**

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Developed as per age

Immunization History :

Immunised as age.



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 13kg (Centile _____)

On Examination :

Temperature : 99°F Pulse Rate : 130/min B.P. 118/68 mmHg SPO2 97% RA

Resp. rate and type of breathing : 26/min • urticarial rash seen (raised) all over body. blanchable.

Rash → • erythematous rash seen in cheeks bl.

Lymphadenopathy ⊖

Oedema : ⊖ throat - not congested.

Allergies (if any): ⊖ one pustule on hard palate

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BAC ⊕

Any addles sounds : ⊖

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S1 S2 ⊕

Any murmur : ⊖

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

Per Abdomen :

Inspection multiple raised urticarial rashes ⊕

Palpation : Soft, NT.

Auscultation : BS ⊕

Spine : _____ External Genitalia : ⊖

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: NAD

Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Intact

Bladder / Bowel : Regular

Clinical Summary & Diagnostic:

Acute febrile illness = urticaria



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Sepsis

Desired goals of the treatment :

Hemodynamic stability

Planned Labs:

CBP

CRP

S. Elect

Blood c/s

+1 extra plain

CVE.

R/V to send mycoplasma IgM
T/m after rounds

Planned Management

Inj CEFTRIAXONE.

Syp AZITHROMYCIN

Inj ESOMEPRAZOLE

Fever management.

Syp RelentHistafer.

ATARAX lotion

Atarax syrup

NB ~~Unaid~~
03/07/24

Signature of the Doctor:

Name of the Doctor: Nalinikanta Panigrahy

Date & Time: 3/7/26 3 AM.

Signature of the Consultant:

Name of the Consultant: Dr. [Signature]

Date & Time: 3/7/26 12 noon



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



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date & Time	Progress Notes	Doctor's Order
3/2/26 4pm	SIB Resident 1: AFI with urinary Rath	Plan. (1) cont medications as per Chart.
	fever spike (1) 11:30 Am - 100.6°F	(2) chest X-ray (3) trace Mycoplasma IgM S-IgG
OIC -	WHS alert vital stable RU - RUAC (1) Clear Cus / (2) NA -	(4) Send CSE (5) wif fever (6) Inform pos.
		ending

BAH-00660542
Baby DIYA
06-01-2024
Dr. NALINIKANTA PANIGRAHY

IP5-00175898
2 Y 5 M 28 D
(F)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/9/26 3pm	S/B Resident A: Aft c Rash fever spikes (+) 3 spikes (+) Rash (+) urticarial. no other issues. O/G. Child alert vitals stable Es- BLUE (+) Cvs- S1S2 (+)	plan. (1) continue IV Antibiotics Azee (2) continue same medication as per chart (3) wif fever. (4) (R/v) LFT/Widal. (R/v) PFT (5) monitor vitals (6) Inform cos. (7) trace dengue
4/9/26 5pm	S/B Dr. Nalinikanta fever spikes (+) Rash (+) Child alert vitals stable	Madhura plan. (1) ESR. to send (if same sample) (2) B Evon SYRUP. (on tomorrow) (3) ZYTEE gel. (4) Send LFT/and widal PFT ESR LFT PFT Widal } to send in same sample If sample not sufficient 1 extra plain to send Tim at 6Am (tomorrow)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/17/26 4:30 PM	Seen by Resident	plan
	A: AFI ↓ Evaluation	① continue ceftriaxone azithromycin
	3 fever spikes (+)	② wif fever
	RAH better	③ Trace widal, dengue
	no other issues	④ monitor vitals
		⑤ Inform sos
	O/E child alert Vitals stable	
	Re-BIL AC (+) clear	
	CUS / normal PLA	
	BS 5/17/26	plan: Cardiac 1) 2DEcho And Consultation tomorrow morning

IP5-00175898

2 Y 5 M 28 D

(F)

Dr. NALINIKANTA PANIGRAHY



**Rainbow[®]
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
6/17/26 8:30 AM	SIB Resident Δ: AFI & Evaluation 3 mod-high grade fever spikes (F) in 24 hours. 0/6- Child alert vitals stable M - Bilateral ap. entry present CvS - S1/2 (S) PIA - soft	plan. (1) continue ceftriaxone Azithromycin (2) medications as per chart (3) trace vital (4) 2D Echo today at PCH
6/17/26		plan 2D echo on 8/7 CBP, CRP, ESR → 8/20/26 → Dermatology opinion.

Date & Time	Progress Notes	Doctor's Order
6/7/28 5:45pm	C/S/B Resident A: AFI (D8)	
	urticarial rash used oral intake better afebrile today	Adv: 1) Dermatology opinion t/b
	O/E: stable vitals chest clear. no organomegaly.	2) CBP / CRP / ESR on Wednesday 3) To repeat 2D Echo on Wed
		4) W/f fever spikes 5) Change Change IV canna Shirley

Date & Time	Progress Notes	Doctor's Order
7/7/26 9:20 AM	C/S/b Resident AFI E Mando-papular rash ↓ evaluation. Thrombocytosis. - Afebrile ∴ 24 hours. - No fresh complaints O/E Active vitals - stable S/E - NAD.	Plan: - Dermatology consult today. - CBP, CRP, ESR 2D-ECHO - Drugs as per chart. Jahid Rahim
7/7/26 3 PM	SIB Resident ↓: AFI with Rash no fever Rash better O/P - good O/E. WBC alert vitals stable RS - B/L A/E (F) CVS - S/S 2 (N) PIA - good	Plan: 1) medication as per chart 2) monitor vitals 3) w/o fever 4) CBP CRP ESR 2DECHO } → tomorrow 5) Inform SOS 6) dermatology consultation madhum
7/7/26	Withhold = 2DECHO CBP, CRP, ESR - Tm.	7) if reports normal, to plan discharge tomorrow

Docu. No.: RCHBH/FRM/CLINICAL/088

BAH-00660542
Baby DIYA
06-01-2024
Dr. NALINIKANTA PANIGRAHY
IP5-00175898
2 Y 6 M 0 D
(F)

Rainbow®
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
8/7/26 9:30 AM	SIB Resident	plan.
	A: AFI c faw	(1) trace CRP
	no fever	(2) medication as per Chart
	Rash better	(3) monitor vitals
	oli-fair.	(4) plan PIC after ESR
	OK	
	Child alert	
	vitals stable	
	h ew PIA	normal
		PIC today
		ceftriaxone
		lotion
		anti-histamine
		Benon
		moisturiser
		zylker gel
		Repeat ESR on Monday
		flu on Monday

MAHENDRANTA PANIGRAHY



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



CROSS CONSULTATION FORM

Doctor Name : Date : 6/1/26 Time : 9:0

Diagnosis : RAI AFI 2. Path J Evaluation

Hospital : RCH Bagara

Type of Referral :

- ☐ Emergency
☐ Urgent
☐ Non Urgent

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

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

AFI with Path

Signature: Nalinikanta

Findings and Recommendations :

c/o fever x 10 days
do conjunctival congestion
c/o micro-cutaneous
involvement
S₁ - (N) S₂ - (N) NO murmur
chest - clear.

LMCA - 1.9 (-0.25)

WAP - 1.5 (-0.10)

RIA - 1.4 (-0.91)

(N) sized cl

CPRVSA

(N) WUB CoA

JW

Consultant :

Name : Signature : Date & Time :

plt - 6.5 lak.

ESR - 120.

~~no~~ No clinical flook

Adv But high grade fever $\oplus$.

Adv

→ CBC, CRP.

→ R/A. 3 days to assess involving charges.

Plan
for smile

BAH-00660542 IP5-00175898
 Baby DIYA
 06-01-2024 2 Y 5 M 27 D (F)
 Dr. NALINIKANTA PANIGRAHY



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

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

RESULT SHEET

Date	3/7	5/7	8/12/26		
Time					
Hb	12.3		11.2		
PCV	39.9		35.2		
RBC	5.3		4.84		
WBC	12.86		9640		
N/L	41/54.6		28.1/65.9		
Platelets	6.59 L		5.31 lakh		
CRP	5		5		
ESR		120 ↑			
PCT					
RBS					
Na	136	135			
K	4.8	5.4			
Cl	100	103			
Ca/Mg					
Phosphate					
Urea		21			
Creatinine		0.4			
ALP		130			
SGPT		18			
SGOT		29			
T.Bill/Conj		0.2/0.1			
T.Protein		8.3			
S.Albumin		4.1			
S.Globulin		4.2			
A/G Ratio		0.9			
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

CARDIOLOGY REQUISITION FORM

Name: <i>Mya</i>	Age: <i>4yr - 5 months</i>
Sex: <i>CU</i>	Date: <i>06/07/2020</i>
UHID No: <i>BM1-0060542</i>	Weight: <i>13 kgs</i>

DIAGNOSIS:

SILENT CLINICAL FINDINGS:

IMPORTANT LAB PARAMETERS:

AFI 2 Risk
with sinus
not negative
ESP - 120
3/2/20
12.3 / 12.1860 / 6.59 kcm
41/54.6

INDICATION FOR ECHO & REQUIRED INFORMATION:

CONSULTANT NAME: *Dr. Nalin Kumar*

RESIDENT SIGNATURE: *Madhine*

BAH-00660542
Baby DIYA
06-01-2024 2 Y 5 M 27 D (F)
Dr. NALINIKANTA PANIGRAHY



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 (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	<u>lyp ATORAX</u>	<u>2.5ml</u>	<u>PO</u>	<u>TID</u>	<u>2/7/26</u>	☐ C ☒ DC
	<u>CALAMINE lotion</u>	<u>LA</u>	<u>LA</u>	<u>TID</u>	<u>2/7/26</u>	☐ C ☒ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Salvini

Date & Time: 3/7/26 3AM

Nurse Name & Signature: Reena

Date & Time: 3/7/26 4AM



BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Weight 13kg. Ward

BAH-00660542 IP5-00175898
Baby DIYA
06-01-2024 2 Y 6 M 0 D (F)
Dr. NALINIKANTA PANIGRAHY

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 : SUPROP. BEVON				Date Time
Dose 5ml	Route ORAL	Frequency OD	Start Dt. 4/7/26	4/7/26 5/26/26
Name & Signature of the Doctor Starting the Drugs: Madhusri				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : ZYTEE GEL				Date Time
Dose -	Route HA	Frequency TID	Start Dt. 4/7/26	4/7/26
Name & Signature of the Doctor Starting the Drugs: Madhusri				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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

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

Signature

VERIFIED BY : Name



DRUG CHART

Date of Admission: Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG : SYRUP. CROUN DS				Date Time																
Dose	Route	Frequency	Start Date																	
4ml	PO	SOS	3 Feb		12:30 PM	5:12 PM	5:17 PM	6:17 PM												
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:																				
max 6th July SOS for fever																				

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

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



REGULAR PRESCRIPTIONS

Weight. 13kg. Ward.

VERIFIED

DRUG : <u>Syn CEFTRIAXONE</u>				Date Time	<u>3/7</u>	<u>4/7</u>	<u>5/7</u>	<u>6/7</u>	<u>7/7</u>	<u>8/7</u>
Dose	Route	Frequency	Start Date							
<u>650mg</u>	<u>IV</u>	<u>BD</u>	<u>3/7</u>							
Name & Signature of the Doctor Starting the Drugs: <u>\$</u> <u>Sahithi</u>				<u>6 AM</u> <u>12 PM</u> <u>5 PM</u> <u>8 PM</u> <u>11 PM</u> <u>Sun</u> <u>Sun</u> <u>Sun</u> <u>Sun</u> <u>Sun</u>						
Additional Instructions: <u>@ 100mg/kg/dose</u>				<u>10 AM</u> <u>2 PM</u> <u>5 PM</u> <u>8 PM</u> <u>11 PM</u> <u>Sun</u> <u>Sun</u> <u>Sun</u> <u>Sun</u> <u>Sun</u>						
Daily Doctor's Endorsement by a Sign				<u>\$</u> <u>\$</u>						

VERIFIED

DRUG : <u>Syn AZITHROMYCIN</u>				Date Time	<u>3/7</u>	<u>4/7</u>	<u>5/7</u>	<u>6/7</u>	<u>7/7</u>	<u>8/7</u>
Dose	Route	Frequency	Start Date							
<u>3.5mg</u>	<u>PO</u>	<u>OD</u>	<u>3/7</u>							
Name & Signature of the Doctor Starting the Drugs: <u>\$</u> <u>Sahithi</u>				<u>10 AM</u> <u>12 PM</u> <u>5 PM</u> <u>8 PM</u> <u>11 PM</u> <u>Sun</u> <u>Sun</u> <u>Sun</u> <u>Sun</u> <u>Sun</u>						
Additional Instructions: <u>@ 10mg/kg/dose</u> <u>(200mg/5ml)</u>				<u>10 AM</u> <u>12 PM</u> <u>5 PM</u> <u>8 PM</u> <u>11 PM</u> <u>Sun</u> <u>Sun</u> <u>Sun</u> <u>Sun</u> <u>Sun</u>						
Daily Doctor's Endorsement by a Sign				<u>\$</u> <u>\$</u>						

VERIFIED

DRUG : <u>Syn ESOMEPRAZOLE</u>				Date Time	<u>3/7</u>	<u>4/7</u>	<u>5/7</u>	<u>6/7</u>	<u>7/7</u>	<u>8/7</u>
Dose	Route	Frequency	Start Date							
<u>15mg</u>	<u>IV</u>	<u>OD</u>	<u>3/7</u>							
Name & Signature of the Doctor Starting the Drugs: <u>\$</u> <u>Sahithi</u>				<u>6 AM</u> <u>12 PM</u> <u>5 PM</u> <u>8 PM</u> <u>11 PM</u> <u>Sun</u> <u>Sun</u> <u>Sun</u> <u>Sun</u> <u>Sun</u>						
Additional Instructions: <u>@ 1mg/kg/dose</u>				<u>6 AM</u> <u>12 PM</u> <u>5 PM</u> <u>8 PM</u> <u>11 PM</u> <u>Sun</u> <u>Sun</u> <u>Sun</u> <u>Sun</u> <u>Sun</u>						
Daily Doctor's Endorsement by a Sign				<u>\$</u> <u>\$</u>						

DRUG : <u>Syn HTS TAFREE</u>				Date Time	<u>3/7</u>					
Dose	Route	Frequency	Start Date							
<u>2.5ml</u>	<u>PO</u>	<u>BD</u>	<u>3/7</u>							
Name & Signature of the Doctor Starting the Drugs: <u>\$</u> <u>Sahithi</u>				<u>10 AM</u> <u>11 AM</u>						
Additional Instructions: <u>@ 1-2mg/kg/dose</u> <u>5ml/20mg</u>				<u>10 PM</u>						
Daily Doctor's Endorsement by a Sign										



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
03/07/26	3:54 am	Amj-AVIL @ 0.5mg/kg	6.5mg	IV	[Signature]	Shruti Patel
03/07/26	9:20 am	Amj-AVIL	10mg	IV	[Signature]	[Signature]
03/07/26	9:30 am	Amj+HYDROCORTISONE	25mg	IV	[Signature]	[Signature]
4/7/26	6:48 am	SYROP. METAL	6ml	ORAL	[Signature]	Apparajitha
5/7/26	9:30 am	LEVOLIN Neb	0.63mg	Neb	[Signature]	Deepa
6/7/26	9:50 am	SYR PEDICLOROL	11mg	PO	[Signature]	Deepa Rautwar

BAH-00660542 IP5-00175898
Baby DIYA
06-01-2024 2 Y 5 M 27 D (F)
Dr. NALINIKANTA PANIGRAHY

I.V. FLUIDS CHART

Weight. 13 kg Ward.



sition of I.V. Fluid
on ml./hr = Mcg/kg/min. etc)

Route

Flow Rate
ml/hr

Doctor
Sign

Nurse
Sign

Date of
Stopping

Doctor
Sign

Nurse
Sign

Signature

VERIFIED BY: Name

Handwritten signature/initials



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 7/2 Time: 6 AM		10 AM		1 PM		6 PM		10 PM		2 AM		
Doctor / Nurse / Family Concern?												
Temperature (°F)	104											
	103											
	102											
	101											
	100											
	99											
	98											
	97											
	96											
	95											
94												
Heart Rate (bpm)	190											
	180											
	170											
	160											
	150											
	140											
	130											
	120											
	110											
	100											
Blood Pressure (mmHg) *	130											
	120											
	110											
	100											
	90											
	80											
	70											
	60											
	50											
	40											
Note: BP does not score in early warning scoring												
Heart Rate (Number)		102 bpm		128 bpm		117 bpm		118 bpm		106 bpm		
Resp. Rate (bpm) (Over 1 Minute) *	70											
	60											
	50											
	40											
	30											
	20											
	10											
	Resp Rate (Number)		28 bpm		26 bpm		28 bpm		28 bpm		28 bpm	
	Resp Mod/ Severe Distress None / Mild											
	Receiving O ₂ (l/min) O ₂ Saturations (%)		100%		99%		100%		98%		100%	
Conscious Level Normal / Altered												
GCS *		15/15		15/15		15/15		15/15		15/15		
TOTAL SCORE												
Number of shaded boxes		1		1		1		1		1		
Pain Score		2		0		0		0		0		
Observer's Initials		D		D		D		D		D		

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



Children's Observation & Early Warning Scoring Chart



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Đã 11/11/2016.

Temperature
(°F)

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00660542 IP5-00175898
Baby DIYA
06-01-2024 2 Y 5 M 29 D (F)
Dr. NALINIKANTA PANIGRAHY



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

PRESCHOOL (1-5 years)

Children's Observation &
Early Warning Scoring Chart

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 6/1/24	Time: 1 PM	5 PM	10 PM	9 AM											
Doctor / Nurse / Family Concern?															
Temperature (F)	104	103	102	101	100	99	98	97	96	95	94				
Heart Rate (bpm)	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50
Blood Pressure (mmHg) *	120	110	100	90	80	70	60	50							
Note: BP does not score in early warning scoring															
Heart Rate (Number)															
Resp. Rate (bpm) (Over 1 Minute) *	70	60	50	40	30	20	10								
Resp Rate (Number)															
Resp Mod/ Severe Distress None / Mild															
Receiving O ₂ (l/min) O ₂ Saturations (%)															
Conscious Level Normal Altered															
GCS *															
TOTAL SCORE															
Number of shaded boxes															
Pain Score															
Observer's Initials															

ACTIONS

NB: Scores 3 should be
recorded overleaf

Score 1 : Continue normal observation by staff nurse

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

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

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 01/11/2024	Time:	9:30 pm	10 pm	2am	6am
Doctor / Nurse / Family Concern? 8:10pm					
Temperature (F)	104 103 102 101 100 99 98 97 96 95 94	100.8 F	98.2 F	97.8 F	97.5 F
Heart Rate (bpm)	190 180 170 160 150 140 130 120 110 100 90 80 70 60 50	93	110	101	
Blood Pressure (mmHg) *		69/52	72/68	71/59	
Note: BP does not score in early warning scoring					
Heart Rate (Number)		102bpm	100bpm	102bpm	
Resp. Rate (bpm) (Over 1 Minute) *	70 60 50 40 30 20 10	28	28	23	
Resp Rate (Number)		28	28	23	
Resp Distress	Mod/ Severe None / Mild				
Receiving O ₂ (l/min) O ₂ Saturations (%)		99%	99%	99%	
Conscious Level	Normal Altered				
GCS *		15/14/5	15/14/5	15/14/5	
TOTAL SCORE		1	1	1	
Number of shaded boxes		0	0	0	
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.

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 06-01-2024	Time : 6:00 am	6:40 am	8:55 AM	10:10 AM	12:30 pm	1:50 pm
Doctor / Nurse / Family Concern?						
Temperature (F)	99.2 F	100.4 F	98.6 F	97.4 F	101.6 F	100.4 F
Heart Rate (bpm)						
Blood Pressure (mmHg) *						
Heart Rate (Number)						
Resp. Rate (bpm) (Over 1 Minute) *						
Resp Rate (Number)						
Resp Mod/ Severe Distress						
Receiving O ₂ (l/min)						
O ₂ Saturations (%)						
Conscious Level						
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.

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 4/12/24	Time: 5:45 PM	180	8 PM	9:20 PM	10:30 PM	2 AM	
Doctor / Nurse / Family Concern?							
Temperature (F)	104						
	103						
	102						
	101						
	100						
	99						
	98						
	97						
	96						
	95						
	94						
Heart Rate (bpm)	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
	90						
and Blood Pressure (mmHg) *	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
	90						
	80						
Note: BP does not score in early warning scoring	70						
	60						
	50						
	40						
	30						
	20						
	10						
	Heart Rate (Number)	117 bpm					110 bpm
	Resp. Rate (bpm) (Over 1 Minute) *	70					
		60					
		50					
40							
30							
20							
10							
Resp Rate (Number)		25 bpm					24 bpm
Resp Mod/ Severe Distress None / Mild							
	Receiving O ₂ (l/min) O ₂ Saturations (%)						
Conscious Level Normal / Altered							
	GCS *						
TOTAL SCORE							
	Number of shaded boxes						
Pain Score							
	Observer's Initials						

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00660542

IP5-00175898

Baby DIYA

2 Y 5 M 27 D

(F)

06-01-2024

Dr. NALINIKANTA PANIGRAHY



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

PRESCHOOL (1-5 years)

Children's Observation &
Early Warning Scoring Chart
 Pratiksha
Rainbow
Children's
Hospital
It takes a lot to treat the little.

 BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 04/01/24 Time : 10:40 am		11:40 am		12:00 am		
Doctor / Nurse / Family Concern?						
Temperature (F)	104					
	103					
	102					
	101					
	100					
	99					
	98					
	97					
	96					
	95					
	94					
Heart Rate (bpm)	190					
	180					
	170					
	160					
	150					
	140					
	130					
	120					
	110					
	100					
	90					
and Blood Pressure (mmHg) *	180					
	170					
	160					
	150					
	140					
	130					
	120					
	110					
	100					
	90					
	80					
70						
60						
50						
Note: BP does not score in early warning scoring						
Heart Rate (Number)						
Resp. Rate (bpm) (Over 1 Minute) *	70					
	60					
	50					
	40					
	30					
	20					
	10					
	Resp Rate (Number)					
	Resp	Mod/ Severe				
	Distress	None / Mild				
	Receiving O ₂ (l/min)					
O ₂ Saturations (%)						
Conscious	Normal					
Level	Altered					
GCS *						
TOTAL SCORE						
Number of shaded boxes						
Pain Score						
Observer's Initials						

ACTIONS

NB: Scores 3 should be recorded overleaf

Score 1 : Continue normal observation by staff nurse

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

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

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 3/12/26	Time: 11:30 AM	5:30 PM	6 PM	11:20 AM	2 PM	6:30 PM	
Doctor / Nurse / Family Concern?							
Temperature (F)	104						
	103						
	102	102.7					
	101						
	100			100.6			
	99		98.5				
	98				98.5		
	97						
	96						
	95						
94							
Heart Rate (bpm)	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
Blood Pressure (mmHg) *	90						
	80						
	70						
	60						
	50						
	102						
	100						
	98						
	96						
	94						
Note: BP does not score in early warning scoring							
Heart Rate (Number)			102bpm	100bpm	109bpm	101bpm	
Resp. Rate (bpm) (Over 1 Minute) *	70						
	60						
	50						
	40						
	30						
	20						
	10						
	Resp Rate (Number)			28bpm	22bpm	20bpm	28bpm
	Resp Distress	Mod/ Severe					
	None / Mild						
Receiving O ₂ (l/min)							
O ₂ Saturations (%)			100%	98%	99%	100%	
Conscious Level	Normal						
Altered							
GCS *			15/15	15/15	15/15	15/15	
TOTAL SCORE							
Number of shaded boxes			1	1	1	0	
Pain Score			2	3	1	0	
Observer's Initials			0	0	1	0	

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00660542 IP5-00175898
 Baby DIYA
 06-01-2024 2 Y 5 M 27 D (F)
 Dr. NALINIKANTA PANIGRAHY



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


BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

FLUID CHART

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.

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

Total 24 hrs. Intake

Total 24 hrs. Output

BAH-00860542 IP5-00175898
 Baby DIYA
 06-01-2024 2 Y 5 M 27 D (F)
 Dr. NALINIKANTA PANIGRAHY

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. : 52

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse		
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine				
			Mouth	I.V	N.G									
3/7	08:00 am	No LVP		-		/				/		0	w	
	09:00 am			-										0
	10:00 am			-				✓			✓			0
	11:00 am			-										0
	12:00 pm			-										0
	01:00 pm			-										
Total Intake :						Total Output :								
3/7	02:00 pm	No LVP				/				/		0	Chad	
	03:00 pm													0
	04:00 pm													0
	05:00 pm													0
	06:00 pm													0
	07:00 pm													
Total Intake :						Total Output :								
3/7/16	08:00 pm	No LVP				/				/		0	sh	
	09:00 pm													0
	10:00 pm													0
	11:00 pm													0
	12:00 am													0
	01:00 am													
Total Intake :						Total Output :								
4/7/16	02:00 am	No LVP				/				/		0	sh	
	03:00 am													0
	04:00 am													0
	05:00 am													0
	06:00 am													0
	07:00 am													
Total Intake :						Total Output :								
Total 24 hrs. Intake			Total 24 hrs. Output											

FLUID CHART

Sheet No. : 3

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

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	
			Mouth	I.V	N.G						
	08:00 am					/	✓			✓	0
	09:00 am					/					0
	10:00 am					/					0
	11:00 am					/					0
	12:00 pm					/					0
	01:00 pm					/					0

Total Intake :

Total Output :

	02:00 pm					/	✓				0
	03:00 pm					/	✓				0
	04:00 pm					/					0
	05:00 pm					/					0
	06:00 pm					/					0
	07:00 pm					/					0

Total Intake :

Total Output :

	08:00 pm					/					0
	09:00 pm					/					0
	10:00 pm					/					0
	11:00 pm					/					0
	12:00 am					/					0
	01:00 am					/					0

Total Intake :

Total Output :

	02:00 am					/					0
	03:00 am					/					0
	04:00 am					/					0
	05:00 am					/					0
	06:00 am					/					0
	07:00 am					/					0

Total Intake :

Total Output :

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

BAH-00660542

IP5-00175898

Baby DIYA

06-01-2024

2 Y 5 M 28 D

(F)

Dr. NALINIKANTA PANIGRAHY



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

		Intake			Output					IV Site	Sign.
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	Nurse
			Mouth	I.V	N.G						
5/7	08:00 am	No IVF	1214						✓	0	J. App
	09:00 am									0	
	10:00 am				NA	✓				0	
	11:00 am								✓	0	
	12:00 pm									0	
	01:00 pm										
Total Intake :					Total Output :						
5/7	02:00 pm	No IVF								0	Ry
	03:00 pm								✓	0	
	04:00 pm					NP				0	
	05:00 pm								✓	0	
	06:00 pm									0	
	07:00 pm									✓	
Total Intake :					Total Output :						
5/7	08:00 pm	No IVF								0	J. App
	09:00 pm									0	
	10:00 pm					NP				0	
	11:00 pm									0	
	12:00 am									0	
	01:00 am									0	
Total Intake :					Total Output :						
6/7	02:00 am	No IVF								0	J. App
	03:00 am									0	
	04:00 am					NP			✓	0	
	05:00 am									0	
	06:00 am									0	
	07:00 am									0	
Total Intake :					Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 04/07/26

Assessment: pt having fever

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess The pt General condition	9pm	* Assessed the pt General condition	pt is coop
10pm	* check the pt all vitay	11pm	* checked the pt all vitay	
12am	* maintain sio chart	2am	* maintained sio chart	
4am	* provide comfortable position	6am	* provided comfortable position	
7am	* administer all medication given after doctor o	8am	* administered all medication given as per doctor order	

Re-Assessment:

Special Notes: CSE pending

Nurse Signature:

Nurse Name: Shanthi

Date & Time: 04/07/26 8am

BAH-00660542

IP5-00175898

Baby DIYA

06-01-2024

2 Y 5 M 28 D

(F)

Dr. NALINIKANTA PANIGRAHY



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: 4/12/24

Assessment: Baby Having Pressure

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
10am	→ Assess the Baby General condition, monitor vitals & record	10:20am	→ Assessed the Baby General condition, monitored vitals & recorded	By All this down pt condition is improved
11am	→ provide comfortable position	11:30am	→ provided comfortable position	
12pm	→ send sample for 12:15pm	12:30pm	→ Done sample for 12:15pm	
1pm	→ Administer medication as per doctor order	2pm	→ Administered medication as per doctor order	

Re-Assessment:

Syr was given then Reduces

Special Notes:

Nurse Signature:

Nurse Name: Aparajitha (021256)

Date & Time: 4/12/24 2pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 4/7

Assessment: Baby having Rashesh

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 baby general Condition	2:10pm	→ Assessed the baby general Condition	baby Condition is Normal
3PM	→ monitor the vital's	3:10pm	→ monitored the vital's	
4PM	→ Provide Comfortable Position	4:10pm	→ Provided Comfortable Position	
6PM	→ Administer medication as Per doctor order's	6:10pm	→ Administered medication as Per doctor order	

Re-Assessment:

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Dixi

Date & Time: 4/7 @ 8PM



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/17/26

Assessment: Baby having proctia

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the general condition of the child	8:10 PM	→ Assessed the general condition of the child.	Baby condition is improved.
10am	→ Monitor the vital signs	10:15 am	→ Monitored the vital signs.	
12am	→ provide comfortable position	2am	→ provided comfortable position.	
6am	→ Maintain I/Q chart	6:30 am	→ Maintained I/Q chart	
7:30 am	→ Administer medication as per doctor order.	8am	→ Administered medication as per doctor order.	

Re-Assessment: Fever was reduced

Special Notes:

Nurse Signature:

Nurse Name: Swarna

Date & Time: 4/17/26 @ 8am

BAH-00660542 IP5-00175898
 Baby DIYA
 06-01-2024 2 Y 5 M 28 D (F)
 Dr. NALINIKANTA PANIGRAHY



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: 5/7/26

Assessment: Baby Having pyrexia

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
10am	→ Assess the Baby General Condition, monitor vitals & Record	10:10am	→ Assessed the Baby General Condition, monitored vitals & Recorded	By All this done in condition is improved
11am	→ provide comfortable position	11:10am	→ provided comfortable position	
12pm	→ watch for fever spikes	12:30pm	→ watched for fever spikes	
1pm	→ Administered medication as per doctor order	3pm	→ Administered medication as per doctor order	

Re-Assessment:

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Aparajitha (021960)

Date & Time: 5/7/26 3pm

IP5-00175898
 BAH-00660542
 Baby DIYA
 06-01-2024
 Dr. NALINIKANTA PANIGRAHY
 2 Y 5 M 29 D (F)

NURSING CARE RECORD



Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 5/07/26

Assessment: Baby having pyrexia

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the baby general condition & monitor the vital sign.	2:30 pm	→ Assessed the baby general condition & monitored the vital sign.	Baby condition is improved
4pm	→ provide the comfortable position.	4:30 pm	→ provided the comfortable position.	
5pm	→ Administer the medication as per doctor order	5:30 pm	→ Administered the medication as per doctor order	
6pm	→ watch for fever spikes	7pm	→ watched for fever spikes	

Re-Assessment: monitor vital

Special Notes:

Nurse Signature: V. Rawina

Nurse Name: V. Rawina (QOT779)

Date & Time: 5/7/26 @ 8pm

BAH-00680542
Baby DIYA
06-01-2024
Dr. NALINIKANTA PANIGRAHY
IPS-00175898
2 Y 5 M 29 D
(F)

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: 5/7/26

Assessment: Baby having pyrexia

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the general condition of the patient	9pm	Assessed the general condition of the patient	Baby condition is good
10pm	monitor the vitals signs	11pm	monitored the vitals signs	
12am	maintain I/O chart	2am	maintained I/O chart	
3am	Administer medication as per as chart	5am	Administered medication as per as chart	
6am	ensure the patient safety	7am	ensured the patient safety	

Re-Assessment:

Special Notes: 2D echo

Nurse Signature: [Signature]

Nurse Name: Nikita

Date & Time: 5/7/26 @ 8am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 6/1/26

Assessment: Baby having low activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	* Assess the baby general condition. monitor vital signs	9 AM	* Assessed the pt general condition	By done all implementation as per order
9 AM	* Doctor advice to do 2DEcho	10 AM	- monitor vital signs	
10 AM	* provide comfortable position	11 AM	- 2decho done	
11 AM	* Administer medication as per order	12 PM	- provide comfortable position	
12 PM	provide Hand hygiene	1 PM	- Administered medication as per order	
			provided Hand hygiene	

Re-Assessment:

2decho done

Special Notes:

w/f fever

Nurse Signature:

(Signature)

Nurse Name:

Sushma 01/2/26

Date & Time:

6/1/26 @ 2 PM

BAH-00680542 IP5-00175898
 Baby DIYA 2 Y 5 M 29 D (F)
 06-01-2024 Dr. NALINIKANTA PANIGRAHY

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
6/12	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm	to 1 hr						1	1				
	01:00 pm							NP					
Total Intake :						Total Output :							
6/12	02:00 pm												
	03:00 pm												
	04:00 pm	chepathi											
	05:00 pm	100 milk											
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
6/12	08:00 pm												
	09:00 pm												
	10:00 pm	100 milk											
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
6/12	02:00 am												
	03:00 am												
	04:00 am	100 milk											
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
7/7/24	08:00 am	NO I.V	Tali								0	Sub	
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
7/7	02:00 pm	NO I.V									0	Sub	
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
7/7	08:00 pm	NO I.V									0	Arora	
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
8/7	02:00 am	NO I.V									0	Arora	
	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										

BAH-00660542 IP5-00175898

Baby DIYA
06-01-2024 2 Y 5 M 27 D (F)
Dr. NALINIKANTA PANIGRAHY

NURSING CARE RECORD

Rainbow®
Children's
Hospital
It takes a lot to treat the little.BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe DeliveryShift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/26

Assessment: Pt having pyrexia

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
4AM	→ Assess the Pt General condition	4AM	→ Assessed pt General condition	Baby condition is improved
5AM	→ monitor vital signs	5AM	→ monitored vital signs	
6AM	→ maintained I/O chart	6AM	→ maintained I/O chart	
8AM	→ Administered the medications as per doctors orders.	8AM	→ Administered the medications as per doctors orders.	

Re-Assessment: well

Special Notes:

Nurse Signature:

Nurse Name: sooravanthi

Date & Time: 3/7/26 8AM

BAH-00560542
Baby DIYA
06-01-2024 2 Y 5 M 27 D
Dr. NALINIKANTA PANIGRAHY (F)

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: 3/7/24

Assessment: pt having dull activity

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the pt General Condition	2:10pm	→ Assessed the pt General Condition	
4pm	→ Check the vital signs	4:10pm	→ Checked the vital signs	
	→ plan for administration medication		→ providing medication as per doctor order	
6pm	→ plan for I/O Chart	6:10pm	→ maintaining I/O Chart	pt is stable
8pm	→ plan for Comfortable position	8:10pm	→ providing the comfortable position	

Re-Assessment: Re-Assessment Every 4th hrs

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Chendona

Date & Time: 3/7/24 @ 8pm

BAH-00660542 IP5-00175898
Baby DIYA
06-01-2024 2 Y 6 M 0 D (F)
Dr. NALINIKANTA PANIGRAHY



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: 6/7

Assessment:

Baby having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
3 PM	→ Assess the baby general condition	3:10 PM	→ Assessed the baby general condition	baby condition is stable
4 PM	→ monitor the vital's	4:10 PM	→ monitored the vital's	
5 PM	→ Provide comfortable position	5:10 PM	→ Provided comfortable position	
6 PM	→ Administer medication as per doctor order's	6:10 PM	→ Administered medication as per doctor order's	

Re-Assessment:

Special Notes:

Nurse Signature:

[Signature]

Nurse Name:

[Signature]

Date & Time:

6/7

@ 8 PM

BAH-00650542

IP5-00175898

Baby DIYA

2 Y 6 M 0 D

(F)

06-01-2024

Dr. NALINIKANTA PANIGRAHY



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: 6/7/26

Assessment: Pt having discomfort

Goals

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

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

Re-Assessment: N/A

Special Notes:

Nurse Signature:

Nurse Name: S. S. Sathya

Date & Time: 6/7/26

BAH-00660542 IP5-00175898
 Baby DIYA
 06-01-2024 2 Y 6 M 0 D (F)
 Dr. NALINIKANTA PANIGRAHY



NURSING CARE RECORD

**Rainbow's
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: 7/7/26

Assessment: Baby having due activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	* Assess the baby general condition. monitor vital signs.	8:30 am	* Assessed the baby general condition & monitored vital sign.	Baby condition is improved.
10am	* provide the comfortable position	10:30 am	* provided the comfortable position.	
11am	* Administered the medication as per doctor order	11:30 am	* Administered the medication as per doctor order	
12pm	* Maintain the I/O chart	12:30 pm	* Maintained the I/O chart	
1pm	* Maintain the personal hygiene.	1 pm	* maintained the personal hygiene.	

Re-Assessment:

Special Notes:

CBP, CRP, ESR, 2D-Echo tomorrow.

Nurse Signature:

[Signature]

Nurse Name:

Surekha (021056)

Date & Time:

7/7/26 2pm

BAH-00660542
Baby DIYA
06-01-2024
Dr. NALINIKANTA PANIGRAHY
IP5-00175898
2 Y 6 M 0 D (F)

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: 7/2/24

Assessment: baby having full activity.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2p	* Assess the general condition of the patient.	2p	* Assessed the general condition of the patient.	By above all the procedures the patient can be stable.
4p	* maintain personal hygiene.	4p	* maintained personal hygiene.	
5p	* monitor vitals.	5p	* monitored vitals.	
6p	* maintain special nutrition	6p	* maintained special nutrition.	

Re-Assessment: Monitor vitals.

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Divya [Signature]

Date & Time: 7/2/24 @ 8p

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 7/7/26

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	Assess the general condition of the baby	8AM	Assessed the general condition of the baby	by done all these to improve baby condition.
10AM	monitor vital signs & record. Provide comfortable position.	10AM	monitored vital signs & record. provided comfortable position	
6AM	Administer medication as per doctor orders.	6AM	Administred medication as per doctor orders.	

Re-Assessment:

Special Notes:

CBP, CRP, ESR t/m. ID echo after sounds. dermatologist consult.

Nurse Signature: Aruna

Nurse Name: Aruna

Date & Time: 8/7/26

BAH-00660542 IP5-00175898
Baby DIYA
06-01-2024 2 Y 6 M 2 D (F)
Dr. NALINIKANTA PANIGRAHY



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

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

BAH-00660542
Baby DIYA
06-01-2024
Dr. NALINIKANTA PANIGRAHY
IP5-00175898
2 Y 5 M 27 D
(F)

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Nalinikanta Department: paed. Date of Admission: 03/07/20

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	<u>AFI</u>							
BACKGROUND	Area	Shift Time	ER	1st floor ward 501	1st floor ward 502	1st floor ward 503	1st floor ward 504	1st floor ward 505
	Medical Condition (Any special condition to be noted):		<u>Nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:		<u>98.14</u>	<u>98.2</u>	<u>98.37</u>	<u>98.14</u>	<u>98.08</u>
		Res:	<u>28b/m</u>	<u>28b/m</u>	<u>28b/m</u>	<u>28b/m</u>	<u>28b/m</u>	<u>26b/m</u>
		SpO ₂ :	<u>97%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>	<u>99%</u>	<u>98.1%</u>
		Pulse:	<u>130b/m</u>	<u>120b/m</u>	<u>119b/m</u>	<u>116b/m</u>	<u>110b/m</u>	<u>112b/m</u>
		BP:	<u>109/63</u>	<u>105/51</u>	<u>118/63</u>	<u>111/63</u>	<u>100/60</u>	<u>100/60</u>
	Fall Risk Score:		<u>14</u>	<u>14</u>	<u>14</u>	<u>0/10</u>	<u>0/10</u>	<u>14</u>
Pain Score:		<u>0</u>	<u>0</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	
Recommendations	Safety Needs:	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>Nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>Nil</u>	<u>Nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>Nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Nalinikanta</u>	<u>Saundhya</u>	<u>Nikita</u>	<u>Chendran</u>	<u>Shanthi</u>	<u>Appo</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>03/07/20</u>	<u>03/07/20</u>	<u>3/7</u>	<u>3/7</u>	<u>03/07/20</u>	<u>03/07/20</u>	
Time:		<u>2 AM</u>	<u>6 AM</u>	<u>2 PM</u>	<u>2 PM</u>	<u>2 PM</u>	<u>2 PM</u>	
Taken Over By Name :		<u>Saundhya</u>	<u>Nikita</u>	<u>Chendran</u>	<u>Shanthi</u>	<u>Aparajita</u>	<u>Shruti</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>03/07/20</u>	<u>3/07</u>	<u>3/7</u>	<u>03/07/20</u>	<u>03/07/20</u>	<u>03/07/20</u>	
Time:		<u>9 AM</u>	<u>3 AM</u>	<u>2 PM</u>	<u>2 PM</u>	<u>2 PM</u>	<u>2 PM</u>	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR: NP Department: pediatry Date of Admission: 31/12/26

SITUATION		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:						
BACKGROUND	Area							
	Shift Time	1st floor 2pm-8pm	1st floor 8pm-2am	1st floor 2am-8am	1st floor 8am-2pm	1st floor 2pm-8pm	1st floor 8pm-2am	
ASSESSMENT	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	NA	NA	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ASSESSMENT	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	98.5°F	98.5°F	99.6°F	98.1°F	98°F	98.2°F
		Res:	25b/m	26	28b/m	26b/m	22b/m	28
		SpO ₂ :	99%	100%	99%	100%	99%	99%
		Pulse:	107b/m	110	129b/m	126b/m	109b/m	102
		BP:	101/60	105/64	98/62	105/65	110/69	109/60
	Fall Risk Score:	14	11	11	11	11	11	
	Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10	
Recommendations	Safety Needs:	yes	yes	yes	yes	yes	yes	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NA	NA	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Swarup	Swarup	Aparajita	Ravina	Nikita	Sushang	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		4/12	5/12	5/12	5/12	5/12	6/12	
Time:		8pm	8am	2pm	8pm	8am	2pm	
Taken Over By Name :		Swarup	Appu	Ravina	Nikita	Sushang	Swarup	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		31/12/26	5/12	5/12	5/12	6/12	6/12	
Time:		8pm	8am	2pm	2pm	8am	2pm	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. NP Department: Needs Date of Admission: 3/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	<u>ATI</u>							
BACKGROUND	Area	Shift Time	<u>1st Floor 8pm-8pm</u>	<u>1st Floor 8pm-8pm</u>	<u>1st Floor 8pm-8pm</u>	<u>1st Floor 8pm-8pm</u>	<u>1st Floor 8pm-8pm</u>	
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.3°F</u>	<u>98.3°F</u>	<u>98.1°F</u>	<u>98.3°F</u>	<u>98.0°F</u>	
		Res:	<u>25b/m</u>	<u>22b</u>	<u>26b/m</u>	<u>22b</u>	<u>26b/m</u>	
		SpO ₂ :	<u>99.1</u>	<u>99.1</u>	<u>100%</u>	<u>99.1</u>	<u>99.1</u>	
		Pulse:	<u>105</u>	<u>102b</u>	<u>111b/m</u>	<u>102b</u>	<u>101</u>	
		BP:	<u>101/60</u>	<u>102/60</u>	<u>99/68</u>	<u>99/68</u>	<u>101/62</u>	
	Fall Risk Score:	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>		
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>			
Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>		
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :		<u>Sorisha</u>	<u>Suram</u>	<u>Ravina</u>	<u>Diyg</u>	<u>Arung</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>6/7</u>	<u>7/7</u>	<u>7/7</u>	<u>7/7</u>	<u>8/7</u>		
Time:		<u>8pm</u>	<u>9am</u>	<u>8pm</u>	<u>8pm</u>	<u>8am</u>		
Taken Over By Name :		<u>Suram</u>	<u>Suekha</u>	<u>Diyg</u>	<u>Arung</u>	<u>Diyg</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>6/7</u>	<u>7/7</u>	<u>7/7</u>	<u>7/7</u>	<u>8/7</u>		
Time:		<u>8pm</u>	<u>8am</u>	<u>9am</u>	<u>8pm</u>	<u>8am</u>		

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

BAH-00660542

IP5-00175898

Baby DIYA

06-01-2024

2 Y 6 M 0 D

(F)

Dr. NALINIKANTA PANIGRAHY


**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

8/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4				
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1				
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1				
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1				
	History of Falls or Infant - Toddler Placed in Bed	4	4				
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	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				
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				
TOTAL			14				

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes					
Call device within reach	yes					
Wheels Locked	yes					
Room free of clutter	yes					
Adequate Lighting	yes					
Wheel Chair Support	no					
Other Intervention(s) Specify	no					
Nurse's Name :	Asuna					
Signature :	Anura					
Date :	8/7					
Time :	6AM					



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	0	1	1	1
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive mpairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4	4	4	4	4	4
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	1
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
TOTAL			14	14	14	14	14

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes	✓	yes	yes
Call device within reach	yes	yes	✓	yes	yes
Wheels Locked	yes	yes	✓	yes	yes
Room free of clutter	yes	yes	✓	yes	yes
Adequate Lighting	yes	yes	✓	yes	yes
Wheel Chair Support	no	no	✗	no	no
Other Intervention(s) Specify	no	no	✗	no	no
Nurse's Name :		meenu	meenu	meenu	meenu
Signature :		[Signature]	[Signature]	[Signature]	[Signature]
Date :		03/07	03/07	03/07	03/07
Time :		3:40	4:00	5:12	6:12

BRADEN 'Q' SCALE

					Date :	7/12	8/17		
					Time :	6:47	6 AM		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4			
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4			
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4			
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4			
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4			
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4			
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE		28	28	
Docu. No. : RCHBH / FRM / CLINICAL / 119					Evaluator's Name		Aruna		

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

BAH-00660542
Baby DIYA
06-01-2024
Dr. NALINIKANTA PANIGRAHY
2 Y 6 M 27 D
IP5-00175898
(F)

BRADEN 'Q' SCALE

		Date :	03/07	4/10/21	5/7	6/2		
		Time :	4am	1am	6am	8am		
Mobility	1. Mobile: Patient in slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
TOTAL SCORE					28	28	28	28
Evaluator's Name					Nalinika	5	28	Nalinika

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

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

BAH-00660542 IP5-00175898
 Baby DIYA 2 Y 5 M 29 D (F)
 06-01-2024
 Dr. NALINIKANTA PANIGRAHY



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	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/7	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Per
7/7	4AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Per
7/7	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Per
7/7	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Per
8/7	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Aruna.
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

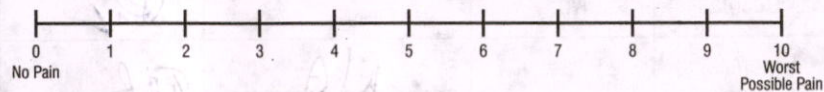
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



BAH-00680542
Baby DIYA
06-01-2024

IP5-00175898

2 Y 5 M 27 D

Dr. NALINIKANTA PANIGRAHY

(F)

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	Age	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
03/01/26	4am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Mika
3/1	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Mika
3/1/26	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chondam
4/07/26	1am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shant
4/1	10am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Sh
5/1	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	O
5/7/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	A
5/7/26	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	P
6/7/26	4am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Nikit
7/7	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	R

Re-assessment Frequency:

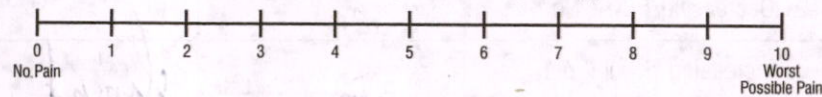
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

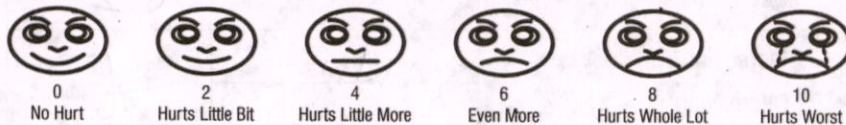
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



BAH-00660542 IP5-00175898
Baby DIYA
06-01-2024 2 Y 5 M 29 D (F)
Dr. NALINIKANTA PANIGRAHY



CHECKLIST FOR THROMBOPHLEBITIS

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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

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

Signature of Shift In Charge :

Signature : Pulekesh Name : Pulekesh

Signature of Ward In Charge :

Signature : Neeraj Name : Neeraj



CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature : Name :

Signature of Ward In-Charge :

Signature : Name :



DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: as per doctors orders

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☒ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☒ Medication	☐ Yes	☐ No
☐ Bathing	☐ Yes	☒ No
☐ Eating	☐ Yes	☒ No
☐ Walking	☐ Yes	☒ No
☐ Dressing	☐ Yes	☒ No
☐ Toileting	☐ Yes	☒ No

Explain to mother

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Personal hygiene

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: Di

Nurse Name: Saxena

Date and Time: 31/7/26

EFFICIENCY CHECK LIST OF CASE SHEET

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

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

BAH-00660542
Baby DIYA
06-01-2024 2 Y 5 M 27 D (F)
Dr. NALINIKANTA PANIGRAHY



MULTI-DISCIPLINARY PLAN OF CARE FORM

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Diagnosis

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
3/7/26 3 AM	☒ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fever = urticaria	hemodynamic stability	IV antibiotics	\$ Santosh	☐ Nursing ☐ Others:
03/07/26 3:50 am	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fever.	Stable	IV fluids IV medication	Murad	☐ Medical ☐ Others:
3/7/26 9 am	☐ Medical ☐ Nursing ☒ Others: dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	AFI = urticaria	soft diet	RDA:- E:- 1250 kcal/d P:- 21 g/d	Mounica	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Signature: *[Signature]*

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		
03/01/24	4am	5	medication.	F	1	0	1	1	N/A	[Signature]
31/01/24	9am	9	soft diet	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

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 3/12/26 Time: 9 am

Weight: 13 kgs Centile: >50th

Height: 89 cms Centile: >50th

Inference: Well child

RDA: — Calories: 1250 kcal/d Protein: 21 g/d

Diet Recommendations: soft diet

Re-Assessment: Avoid spicy, chilly & outside foods

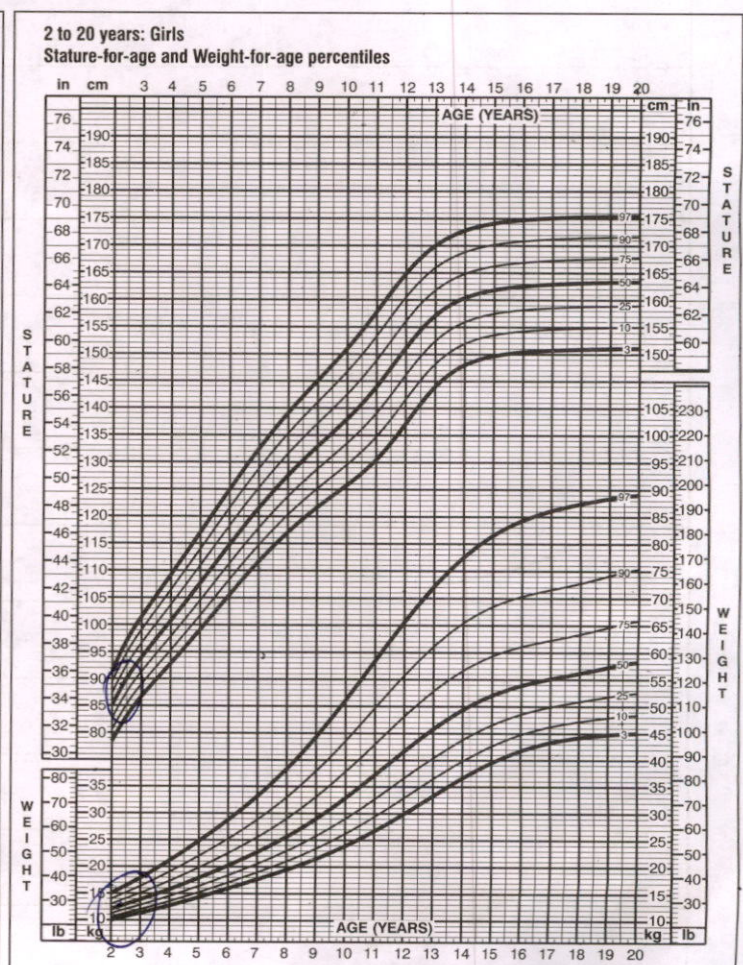
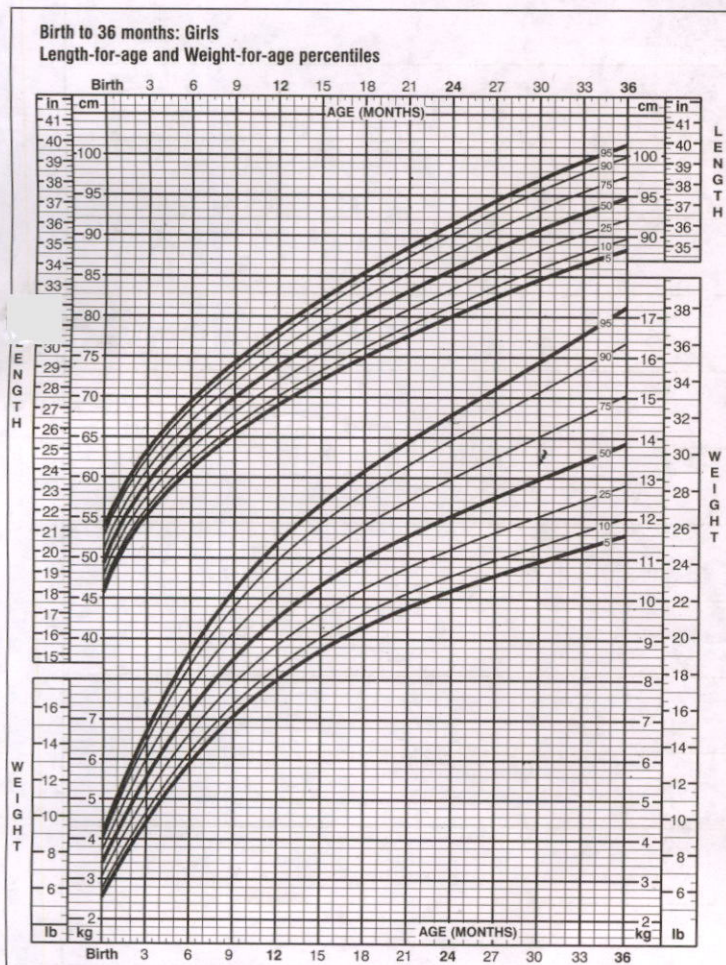
Food Allergies: No Veg/Non-veg: veg

Diagnosis: AFI C ulceration

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: P. Prathensha

GROWTH CHART (GIRLS)



Dietician's Name: maunika

Dietician's Signature: maunika

Daily Notes:

~~5/12/26~~
8am

Child is stable. Intake is fair
continue on soft diet Nichols

~~6/12/26~~
11am

child is stable. oral intake is optimal
continue on soft diet - morning.

~~7/12/26~~
10am

child is stable. oral intake is normal
continue on soft diet - Nichols.