

ADMISSION SHEET

Registration Details :

Admission No : IP5-00175948

Admit Date : 04-Jul-2026

Admit Time : 12:35 AM **UHID :** BAH-00634042

Patient Details :
Patient Name : Master MOHAMMED HUSSAIN KHAN

Age : 6 Y 3 M 30 D

Guardian : Mr YUNIS KHAN

DOB : 04-03-2020

Gender : Male

Religion :
Occupation :
Martial Status : Single

Address (H) : ROOM NO 2 MANAGEMENT TRAINEE HOSTEL
 ACC COLONY Wadi Gulbarga Karnataka INDIA
 585225

Phone No : 7710848763

E-mail : nomailid@gmail.com

Admission Details :
Bed Type : PRIVATE ROOM

Bed No : PVT 239

Ward Name : 2F-SECOND FLOOR

Room No : PVT 239

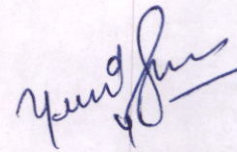
Admission Type : First Visit

Contact Details :
Name : Mr YUNIS KHAN

Relationship : Father

Contact Address : ROOM NO 2 MANAGEMENT TRAINEE
 HOSTEL ACC COLONY Wadi Gulbarga
 Karnataka INDIA 585225

Phone No : 7710848763


Signature
Doctor Details :
Doctor Name : Dr. FAISAL B NAHDI

Specialisation : GENERAL PEDIATRICS

Referral Doctor : Self

Phone No :
Co-Consultant : Dr. UJJWALA DESAI

Payment Details :
Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : FAMILY HEALTH PLAN INSURANCE
 TPA LTD

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP : **BAH-00634042** **IP5-00175948** Int: _____ Dept: _____
Master **MOHAMMED HUSSAIN KHAN**
04-03-2020 6 Y 3 M 30 D (M)

Date of Admission: _____ Discharge : _____ Time: _____
Dr. **FAISAL B NAHDI**



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
4/7/26	1:15 Am	ER	239	B
4/7/26	2:10 Am	2nd floor	319	B

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. A Muchandane	4/7/26	9687966	Soukhavini
2	Dr. A Muchandane	7/7/26	9692529	Kalyani
3				
4				
5				
6				
7				
8				
9				
10				

IP5-00175948

04-03-2020 6 Y 3 M 30 D (M)

6 Y 3 M 30 D

(M)

Dr. FAISAL B NAHDI

[illegible]

[illegible]



Sammy

[illegible]

Billing Supervisor



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PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00634042 IP5-00175948
Master MOHAMMED HUSSAIN KHAN
04-03-2020 6 Y 3 M 30 D (M)
Dr. FAISAL B NAHDI



Patient Name:

Hussain

UHID ID:

Department:

Consultant:

По условию: динамика

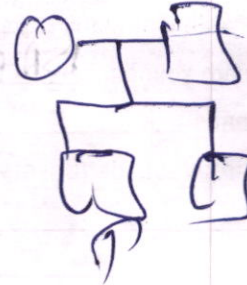


Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Term / Asphy



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

As per age

Immunization History :

As per age



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 19 kg (Centile _____)

On Examination :

Temperature : 102.5°F Pulse Rate : 136/n B.P. 106/52 SP02 100%

Resp.rate and type of breathing : 24/n

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

cernial UN ⊕
throat congested ⊕
AD pus
puncts

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : SAE ⊕, clear

Any addes sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : SS ⊕

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : soft

Ausculation : 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 : (2)

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : (2)

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars (2)

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

AFPLD5



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Sepsis

Desired goals of the treatment: H-stability

Planned Labs:

CRP
CRP
S/E
Shodils
extra protein
WBC
MS
Shodils
4/7/26

Planned Management

Augmentin
w/ fluid
Paracetamol
8 M Mucine g.i. Smeal O
fever MS

Signature of the Doctor: Ahmed

Name of the Doctor: Ahmed

Date & Time: 4/7/26

Signature of the Consultant: Dr. Faisal B Nahdi

Name of the Consultant: Dr. Faisal B Nahdi

Date & Time: 4/07

DR. FAISAL B NAHDI
Registration No. 66228

BAH-00634042 IP5-00175948
Master MOHAMMED HUSSAIN KHAN
04-03-2020 6 Y 4 M 4 D (M)
Patient: Dr. FAISAL B NAHDI

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1+1			
4	Patient Transfer form	2			
5	In-patient Medical record	1			
6	Doctors progress sheets	5			
7	Nursing plan of care and handover sheets	8			
8	Consultation sheet	1			
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	5			
30	Intake and Out take chart (fluid chart)	3			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	2			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
Total No. of Pages		22 + 2 + 1			

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



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	fever (AFI). c Acute gastritis Poor Intake.	Pla
4/3 8am	Chf. Shul Afebrile.	Cerm. Sam. Medicat 5 viral panel Dengue NSI + IgM
4/3 1:10 PM	Seen by Resident. AFI c acute gastritis c/o throat pain & difficulty to swallow. Poor Oral intake. no drooling O/E child alert, afebrile hemodynamically stable. no neck rigidity. moving neck in all directions. throat not congested.	Plan 1. Continue AUGMENTIN DI. 2. continue IV fluids @ 100%. 3. R/V Xray neck lateral view. R/V 4. Regular round the clock pain control. 5. Monitor vitals & inform SOS. 6. Trace Adeno, Dengue IgM, NSI, Blood C/S <u>Labathi</u>
		Hold * Chest xray Now; Xray abdomen erect. * Neotomic Enema * Xray erect abdomen & Xray Neck lateral view * ENT consultation.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/20 9 AM	Seen by Resident. ACin-AFI = acute ulcerative laryngitis. Coughing fever spikes. Last fever - 11 PM 101°F. Oral intake poor. O/E Child alert, afebrile Hemodynamically stable. Chest clear abdomen soft. Hydration fair	Plan. 1. Continue AUGMENTIN CLARITHROMYCIN- 2. monitor vitals & inform SOS \$ Sahitri
5/7: (10:30) am	Child's AFI C Ate gaster. C Tracheitis. (foules ++).	Plan. C Contin Cephalexin Clamoxylon. A.B. Soubhasini



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7 8:45am	C/S/B Resident. Δ: AFI / acute ulcerative laryngitis Adv:	
	- no pain ⊕ - poor oral intake not passing stools	1) Augmentin D3 Clarithromycin 2-3
	O/E: child alert vitals stable throat inflamed chest clear abd: NT/soft	2) Add laxatives. 3) Cont full maintenance fluids
		Ashile
6/7	Child @ AFI @ Acute laryngitis.	Plan..
Amul (Cath) (@ 450cc)	Amul stool	✓ Rem i RNT (toman)
		CBP / CRP (toman)
		DR. FAISAL B NAHDI Registration No: 66228
		10/3/2020



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7 5pm	C/S/B Dr. Faisal C/S/B Resident Δ: Acute ulcerative laryngitis afebrile oral intake - better stools - small qty O/E: alert no distress S/E: NAD.	Adv: 1) Encourage orally 2) Continue antibiotic 3) IVF ↓ to 30ml/h 4) CBP / CRP t/m 6am Stable NB Seem
7/7	DR. FAISAL B NAHDI Registration No: 66228 Cerecl c AFI c Augmentin c Hachem	Plan Contn same Rpt. Check by dr. Chandana
8/7		DR. FAISAL B NAHDI Registration No: 66228 End



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/3/26 12:35pm		cl/b/w Dr. Chendens mrm
		Plan
		Shift to OPD on wall.
		By
		H. B. Souhaimi
7/4 3pm	Qs/B Resident	
	Δ: acute ulcerative laryngitis	Adv:
	afebrile	1) ENT consultation
	good oral intake	pending
	not passed stools	2) Plan (D) 4m
	O/E: comfortable child	3) if IV cannula out
	vitals stable	do not place
	chest clear	new cannula.
	abdomen soft	4) Encourage orally
	throat (N)	5) Dulcoflex suppository
		Stabile
		NS Seema



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7	cl/s @ Resident	
	Dr. Acute ulcerative laryngitis.	
	cl	
	episodes of stool in the night. Normal in consistency, non blood stained.	den - 4 ¹ / ₂ (D) today
	O/E	- Smooth x 2w
	cut h ₂ G ₁	Mucous x 2m
	fla - (A) exp. cut - 2 sec	Clarithromycin 1500mg x 3 d
	Oral mucosa - wet	Succal O.
		2 SOS Paracetamol.
8/7	Child Ate FI.	
	E Ate kangaroo.	Syp clamp ind forte
Child		Sul BD x 3dy.
(8:30)	Syp - 2 copy Buti	Syp Clantemycin (125)
		Sul — BD 12dy.
	Nofer	Syp Relent
		Sul BD x 3dy.
		Rob kangaroo 15g (DT)
		1 BDP — sel
		Mucous { 3ody
		Smullen
		Flu next week c.m. #

Mr. FAISAL B NAHDI



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



CROSS CONSULTATION FORM

Doctor Name: Dr. Ali Chandana Date: 4/7/26 Time:

Diagnosis: AFI ± Throat pain + evaluation

Hospital: Act1-BH

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:

Throat pain + evaluation.

Signature: _____

Findings and Recommendations :

ASIS - AFI ± throat pain.
No severe throat pain: 5d, more severe since 2d.
poor oral intake: 2d
no drooling, C/O not swallowing saliva,
no voice change
no restriction / painful neck movements.

O/E

child alert, active
hemodynamically stable.
throat - (N), no congestion.

(L) SM nodes - tender
Neck movements normal
voice hoarse

Plan

flexible laryngoscopy.

Xray - lateral Neck
airway - (N)
prevertebral thickening
of soft tissue
adj to - post cricoid.
C4 - C6

Consultant :

Name: Signature: Date & Time: 4/7/26

flexible laryngoscopy

Nose - normal

NP - grade 1-2 adenoids / no post pharyngeal wall bulge

- multiple ulcerations over arytenoids / AE folds
cord movements - normal

- pooling (+) ps

2/2/20 R/V
pain ↓ / feeding - taking orally.
no further fevers

NE
throat / VLS - ↓ ulcers, (n) cord movements
no pooling
w/c 7m intact
nodes ↓
nose - dry

Ach
- CST
- voice rest
- anti reflux
- gargles

Imp: Acute Ulcerative Laryngitis.

Ach (D/w Dr. FAISAL

- start Zyg; Clarithromycin
- Betadine gargle
- Expectorant for Culture and Sensitivity
- R/V SOS

[Signature]

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RESULT SHEET

Date	4/7/16	7/7/16			
Time	8:30 AM	7 AM			
Hb	12.6	11.6			
PCV	38.5	36.2			
RBC	4.66	4.32			
WBC	4.60	8.50			
N/L	59.3/35.7	22.0/67.7			
Platelets	219	231			
CRP	11.0	8.0			
ESR					
PCT					
RBS					
Na	135				
K	4.2				
Cl	102				
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date	4/7					
Time						
CUE - Alb	0					
CUE - Sugar	0					
CUE - Ketones	3+					
CUE - PUS Cells	5-6					
CUE - RBC Cells	0					
CUE <i>leucocytes</i>	<i>Trace</i>					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : *flu A, B, RSV, cox - Negative*
Adeno - negative
Dengue negative

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI

Others (ECG, Contrast Studies etc.) :

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Master MOHAMMED HUSSAIN KHAN
04-03-2020 8 Y 3 M 30 D (M)
Dr. FAISAL B NAHDI



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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
						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

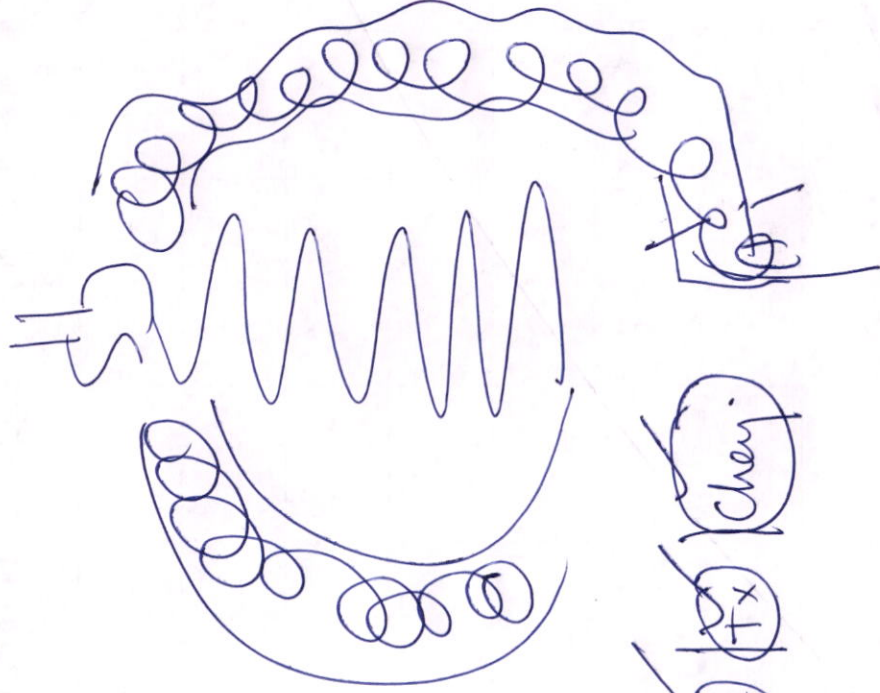
MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : [Signature]

Date & Time : 4/2/20

Nurse Name & Signature: Bhavai

Date & Time : 4/2/20 @ 12 pm



Mix Det Tx Chay

BAH-00634042 IP5-00175948
 Master MOHAMMED HUSSAIN KHAN
 04-03-2020 6 Y 4 M 1 D (M)
 Dr. FAISAL B NAHDI

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Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : <u>1g CLARITHROMYCIN</u>				Date Time																
Dose	Route	Frequency	Start Dt.																	
140mg	IV	BID	04/07																	
Name & Signature of the Doctor Starting the Drugs:				Not available.																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Syp CLARITHROMYCIN</u>				Date Time																
Dose	Route	Frequency	Start Dt.																	
6ml	PO	BID	04/07																	
Name & Signature of the Doctor Starting the Drugs:				Sohel																
Additional Instructions:				7.5mg/kg 5ml/125mg																
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Syp. Inj PARACETAMOL</u>				Date Time																
Dose	Route	Frequency	Start Dt.																	
300mg	IV	BID	6/7																	
Name & Signature of the Doctor Starting the Drugs:				Sohel																
Additional Instructions:				6pm																
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Mucot powder</u>				Date Time																
Dose	Route	Frequency	Start Dt.																	
	PO	HS	7/7																	
Name & Signature of the Doctor Starting the Drugs:				Sohel																
Additional Instructions:				3 scoops in 180 ml at night																
Daily Doctor's Endorsement by a Sign																				



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : SUP SMUTH				Date Time															
Dose	Route	Frequency	Start Dt.																
10ml	PO	QID	7/7																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Dt.																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Dt.																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Dt.																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
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 CHART

Date of Admission: 4/12/20 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 : <u>SYP. CROCODIN DS</u>				Date Time	<u>4/12/20</u>															
Dose	Route	Frequency	Start Date																	
<u>6 ML</u>	<u>PO</u>	<u>6th hly</u>	<u>4/7</u>																	
Doctor's Signature		Valid Period	Pharm.																	
<u>[Signature]</u>																				
Additional Instructions:																				
<u>T > 100°F</u>																				

DRUG : <u>SYP. MEFTAL</u>				Date Time	<u>4/12/20</u>															
Dose	Route	Frequency	Start Date																	
<u>8 ML</u>	<u>PO</u>	<u>8th hly</u>	<u>4/7</u>																	
Doctor's Signature		Valid Period	Pharm.																	
<u>[Signature]</u>																				
Additional Instructions:																				
<u>acc severe T > 102°F pain</u>																				

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



REGULAR PRESCRIPTIONS

Weight. 19.15kg Ward.

DRUG : <u>Augmentin</u>				Date Time	<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>600mg</u>	<u>IV</u>	<u>TID</u>	<u>4/7</u>	<u>6am</u>	<u>2pm</u>	<u>8pm</u>	<u>10pm</u>	<u>2am</u>	<u>4am</u>
Name & Signature of the Doctor Starting the Drugs:				<u>Shankar</u>					
Additional Instructions:									
Daily Doctor's Endorsement by a Sign									
DRUG : <u>Pantoprazole</u>				Date Time	<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>20mg</u>	<u>IV</u>	<u>OD</u>	<u>4/7</u>	<u>6am</u>	<u>2pm</u>	<u>8pm</u>	<u>10pm</u>	<u>2am</u>	<u>4am</u>
Name & Signature of the Doctor Starting the Drugs:				<u>Shankar</u>					
Additional Instructions:									
Daily Doctor's Endorsement by a Sign									
DRUG : <u>Syr. Sucralo.</u>				Date Time	<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>5ml</u>	<u>PO</u>	<u>TID</u>	<u>4/7</u>	<u>6am</u>	<u>2pm</u>	<u>8pm</u>	<u>10pm</u>	<u>2am</u>	<u>4am</u>
Name & Signature of the Doctor Starting the Drugs:				<u>Shankar</u>					
Additional Instructions:									
Daily Doctor's Endorsement by a Sign									
DRUG : <u>Naso Clear Drops</u>				Date Time	<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>20</u>	<u>nasal</u>	<u>QID</u>	<u>4/7</u>	<u>6am</u>	<u>2pm</u>	<u>8pm</u>	<u>10pm</u>	<u>2am</u>	<u>4am</u>
Name & Signature of the Doctor Starting the Drugs:				<u>Shankar</u>					
Additional Instructions:									
Daily Doctor's Endorsement by a Sign									

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
4/7	12:46 PM	NS	100ML	IV	Ah	forikul
4/7	4PM	NEOTOMIC enema.	1unit	PR	g	Shavani
5/7	12:45 PM	PROCTOCLYSIS enema	1unit	PR	g	Shavani
6/7	2:20 PM	PROCTOCLYSIS theme	1unit	PR	g	Shavani
7/7		Dulcolax suppositories	10mg	PR	g	Shavani

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FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site 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			60ml							60		
	03:00 am			60ml							0		
	04:00 am			60ml							6		
	05:00 am			60ml							0		
	06:00 am			60ml							0		
	07:00 am			60ml							0		
Total Intake :						Total Output :							
Total 24 hrs. Intake													
Total 24 hrs. Output													



FLUID CHART

Sheet No. :

4/7/2020

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		
4/7/20	08:00 am										0	✓
	09:00 am	DNR		60ml						✓	0	✓
	10:00 am		h2o	60ml			NP				0	✓
	11:00 am			60ml							0	✓
	12:00 pm			60ml							0	✓
	01:00 pm									✓	0	✓
Total Intake :						m -	u -	Total Output : m-0u-2				
4/7	02:00 pm			60ml							0	✓
	03:00 pm									✓	0	
	04:00 pm		h2o								0	
	05:00 pm						✓				0	
	06:00 pm	DNR								✓	0	
	07:00 pm	DNR		60ml							0	
Total Intake :						Total Output : m-0u-2						
4/7	08:00 pm			60ml							0	✓
	09:00 pm		h2o	60ml							0	
	10:00 pm			60ml					✓		0	
	11:00 pm	DNR		60ml			NP				0	
	12:00 am			60ml					✓		0	
	01:00 am			60ml							0	
Total Intake :						Total Output : m-0 u-2						
5/7	02:00 am										0	✓
	03:00 am		h2o								0	
	04:00 am			60ml					✓		0	
	05:00 am	DNR		60ml			NP				0	
	06:00 am			60ml							0	
	07:00 am			60ml							0	
Total Intake :						Total Output : m-0 u-1						

Total 24 hrs. Intake

Total 24 hrs. Output m-1
u-2



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.

5/7/28

		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								
<i>5/7</i>	08:00 am			—							0	<i>South</i> <i>cannula</i> <i>changed</i>	
	09:00 am			—						✓	0		
	10:00 am	<i>DNS</i>	<i>H2O</i>	<i>60ml</i>			<i>little</i>				0		
	11:00 am			—							0		
	12:00 pm	<i>DNS</i>		<i>60ml</i>					✓	0			
	01:00 pm			<i>60ml</i>			<i>little</i>				0		
	Total Intake :						Total Output :						<i>m-2 u-2</i>
<i>5/7</i>	02:00 pm			<i>60ml</i>						✓	0	<i>sema</i>	
	03:00 pm			<i>60ml</i>							0		
	04:00 pm	<i>D</i>	<i>H2O</i>	<i>60ml</i>			<i>1</i>			✓	0		
	05:00 pm	<i>N</i>		<i>60ml</i>			<i>1</i>				0		
	06:00 pm	<i>S</i>		<i>60ml</i>					✓	0			
	07:00 pm		<i>H2O</i>	<i>60ml</i>							0		
	Total Intake :						Total Output :						<i>m-0 u-3</i>
<i>5/7</i>	08:00 pm			<i>60ml</i>							0	<i>Diya</i>	
	09:00 pm			<i>60ml</i>							0		
	10:00 pm			<i>60ml</i>			<i>1</i>				0		
	11:00 pm	<i>DNS</i>		<i>60ml</i>			<i>1</i>		✓	0			
	12:00 am			<i>60ml</i>						0			
	01:00 am			<i>60ml</i>							0		
	Total Intake :						Total Output :						<i>m-0 u-1</i>
<i>6/7</i>	02:00 am			<i>60ml</i>							0	<i>Diya</i>	
	03:00 am			<i>60ml</i>					✓	0			
	04:00 am			<i>60ml</i>			<i>1</i>				0		
	05:00 am	<i>DNS</i>		—					✓	0			
	06:00 am			—						0			
	07:00 am			<i>60ml</i>							0		
	Total Intake :						Total Output :						<i>m-0 u-2</i>
Total 24 hrs. Intake						Total 24 hrs. Output						<i>m-2 u-8</i>	

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FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
6/7/26	08:00 am	DMS		60ml							0	Saad
	09:00 am			—					✓	0		
	10:00 am			—					✓	0		
	11:00 am			60ml					✓	0		
	12:00 pm			—					✓	0		
	01:00 pm			60ml					✓	0		
Total Intake :						Total Output : M-0 U-3						
6/7/26	02:00 pm	DMS		60ml						✓	0	Saad
	03:00 pm			60ml					✓	0		
	04:00 pm			60ml					✓	0		
	05:00 pm			60ml					✓	0		
	06:00 pm			—					✓	0		
	07:00 pm			—					✓	0		
Total Intake :						Total Output : M-10 U-3						
6/7/26	08:00 pm	DMS		30ml						✓	0	Saad
	09:00 pm			30ml					✓	0		
	10:00 pm			30ml					✓	0		
	11:00 pm			—					✓	0		
	12:00 am			—					✓	0		
	01:00 am			—					✓	0		
Total Intake :						Total Output : M-0 U-2						
7/7/26	02:00 am	DMS		—						✓	0	Saad
	03:00 am			30ml					✓	0		
	04:00 am			30ml					✓	0		
	05:00 am			30ml					✓	0		
	06:00 am			—					✓	0		
	07:00 am			—					✓	0		
Total Intake :						Total Output : M-0 U-3						
Total 24 hrs. Intake						Total 24 hrs. Output			M-1 U-11			



FLUID CHART

Sheet No. :

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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										
7/7/26	08:00 am			30ml							0	S. M. A.			
	09:00 am			—						—	0				
	10:00 am	DNS	H ₂ O	—			NP			—	0				
	11:00 am			30ml						—	0				
	12:00 pm			30ml						—	0				
	01:00 pm			30ml						—	0				
Total Intake :						Total Output :						M-0 U-3			
7/7	02:00 pm			—							0	S. M. A.			
	03:00 pm	D	H ₂ O	—						—	0				
	04:00 pm	N	H ₂ O	—						—	0				
	05:00 pm			—						—	0				
	06:00 pm	S		—						—	0				
	07:00 pm			—						—	0				
Total Intake :						Total Output :						M-0 U-2			
7/7	08:00 pm			—			✓			—	0	S. M. A.			
	09:00 pm			30ml						—	0				
	10:00 pm			30ml			✓			—	0				
	11:00 pm	DNS		30ml			✓			—	0				
	12:00 am			30ml			✓			—	0				
	01:00 am			—						—	0				
Total Intake :						Total Output :									
8/7	02:00 am			—							0	S. M. A.			
	03:00 am			—							0				
	04:00 am			—							0				
	05:00 am	DNS		—			NP				0				
	06:00 am			—						—	0				
	07:00 am			—						—	0				
Total Intake :						Total Output :									
Total 24 hrs. Intake												Total 24 hrs. Output		M=5, U=9	

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Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						



NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 4/7/26 Time: 8am

Weight: 19.15kg Centile: 25th

Height: 90cm Centile: 25th

Inference: 100% child

RDA: — Calories: 1450kcal/d Protein: 25g/d

Diet Recommendations: Soft diet

Re-Assessment: Avoid spic, chilled & outside foods

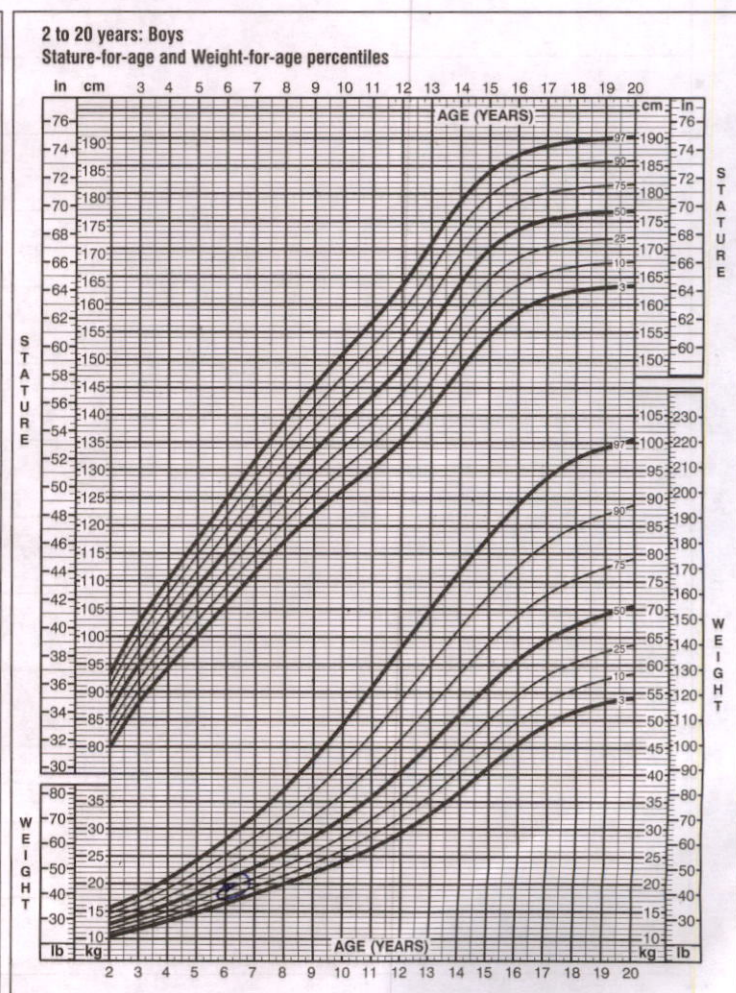
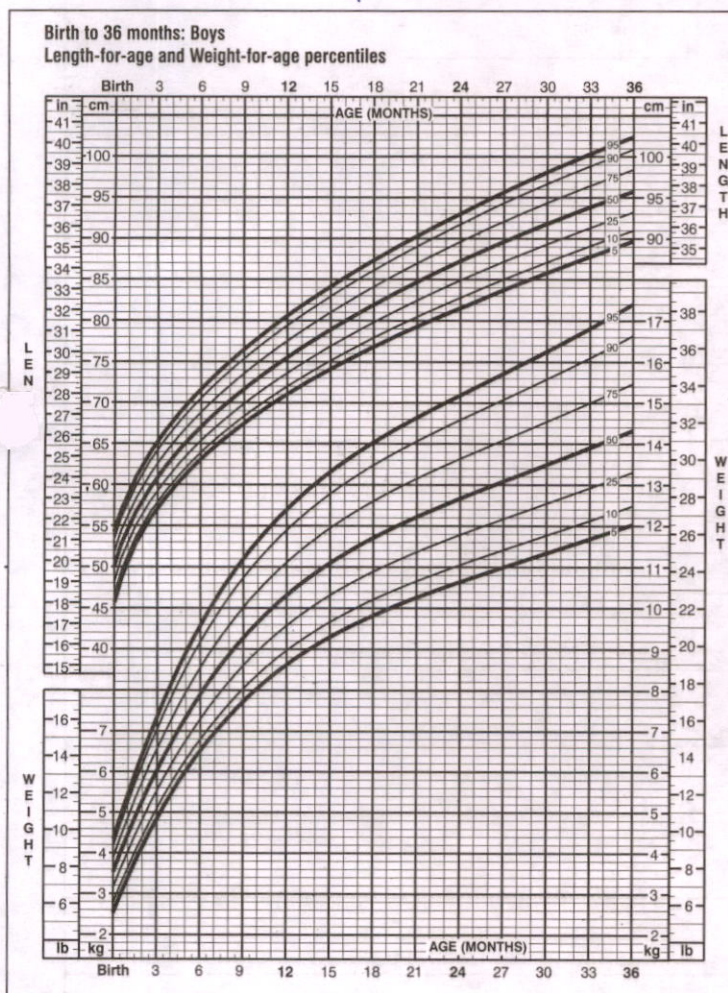
Food Allergies: No Veg/Non-veg Non-veg

Diagnosis: Acute gastritis

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: [Signature]

Dietician's Signature: [Signature]

Daily Notes:

5/7/26

child is stable, oral intake is optimal

12pm

continue soit d'ici

Shirone

6/7/26

child is stable, oral intake is better

10:30 am

continue soft diet

Nikhil

7/7/26

child is stable, oral intake is good

11:25
am

continue soft diet

Salome

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Assessment: ☒ Night

Date: 3/7/26

Assessment: patient having fever

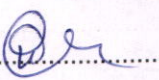
Goals

- ☐ 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
2 AM	⇒ Assess the patient General Condition	2:10 AM	⇒ Assessed the patient General condition	patient is stable
4 AM	⇒ Assess the patient vitals signs	4:10 AM	⇒ Assessed the patient vitals sign	
6 AM	⇒ To maintain I/O chart	6:10 AM	⇒ maintained I/O chart	
8 AM	⇒ To provide comfortable position	8:10 AM	⇒ provided comfortable position	

Re-Assessment: patient is comfortable

Special Notes: cut is done

Nurse Signature:  Nurse Name: Deepa

Date & Time: 3/7/26 @ 8 AM

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6 Y 3 M 30 D



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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 4/7/2026

Assessment: patient having fever and discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8:30 AM	Plan Assess the patient general condition	8:40	Assessed the patient General condition on bed.	→ patient is stable
10 AM	⇒ To monitor vitals	11 AM	⇒ monitored patient vitals	
2 PM	⇒ To monitor I/O chart	3 PM	⇒ monitored patient I/O chart	
	⇒ To provide comfortable position	5 PM	⇒ Provided patient comfortable position	
4 PM	⇒ To plan IV fluids		⇒ concealed IV fluids 1 hour	
6:30 PM	⇒ To maintain personal hygiene	7 PM	⇒ maintained patient personal hygiene	

Re-Assessment:

Reassessment after 1 hr fever coming down

Special Notes:

DR. Chandana consultation done

Nurse Signature: Shishisha

Nurse Name:

Shishisha

Date & Time:

4/7/26 @ 8 PM

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Dr. FAISAL B NAHDI



Shift: ☐ Morning ☒ Night

Date: 4/7/26

Assessment: patient 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 patient General condition	8:10 PM	→ Assessed the patient General condition	patient is comfortable
10 PM	→ Assess the patient vitals signs	10:10 PM	→ Assessed the patient vitals signs	
12 AM	→ To maintain I/O chart	12:10 AM	→ Maintained I/O chart	
2 AM	→ To encourage oral intake	2:10 AM	→ Encourage oral intake	
4 AM	→ provide comfortable position	4:10 AM	→ provided comfortable position	
6 AM	→ maintain IV fluids	6:15 AM		

Re-Assessment: patient is comfortable

Special Notes: continue IV fluids continue Antibiotics

Nurse Signature: [Signature] Nurse Name: [Signature] Date & Time: 5/7/26 @ 8 AM

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/7/26

Assessment: pain in throat related to sore

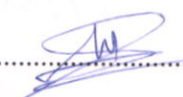
Goals

- ☒ 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 patient condition	8:10 am	Assessed the pt on sleep	
9am	Maintain y/o chart.	9:15 am	Maintained y/o chart.	
10am	monitor vitals		monitored vitals.	
11am	plan to give enema	11am	enema given for motion.	patient well
12pm	plan to continue iv fluid	12pm	continue administered iv fluid & iv antibiotic	
1pm	plan to encourage orally	1:30pm	patient taking soft food	
	Antibiotic to continue.			

Re-Assessment: Reassessment after 2 hr pt well

Special Notes: At iv antibiotic & iv fluid

Nurse Signature: 

Nurse Name: Jacobhasini

Date & Time: 5/7/26 @ 9pm

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Assessment: ☒ Morning ☒ Afternoon ☐ Night

Date: 5/7/20

Assessment:

patient 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
2pm	* Assess the patient condition	2:30 pm	* Assessed the patient condition, patient is stable.	* patient is stable.
3pm	* plan to monitor vitals			
4pm	* plan to maintain I/O Chart.	3:10 pm	* monitor vitals stable.	
		4:30 pm	* maintain I/O Chart	
6pm	* plan to C.T. IVF DRS	6:10 pm	* C.T. IVF DRS Com/laug going on.	
7pm	* plan to wlf Fevers spike	7:30 pm	* patient	
8pm	* plan to medication.	8pm	* Given medication as per doctor orders.	

Re-Assessment:

provide comfortable position

Special Notes:

Nurse Signature:

(Signature)

Nurse Name:

seema

Date & Time:

5/7/20 @ 8pm

BAH-00634042 IP5-00175948
Master MOHAMMED HUSSAIN KHAN
04-03-2020 6 Y 4 M 1 D (M)
Dr. FAISAL B NAHDI



NURSING CARE RECORD

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BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 05/7/26

Assessment: Patient having throat pain

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	=> Assess the patient General Condition	8:10pm	=> Assessed the patient General condition	Patient is comfortable
10pm	=> Assess the patient vitals	10:20 pm	=> Assessed the patient vitals	
11 Am	=> To maintain I/O chart	11:15 Am	=> maintained I/O chart	
12 Am	=> To encourage oral intake	12:10 Am	=> Encouraged oral intake	
4 Am	=> To continue IV fluids	4:10 Am	=> continue IV fluids	
6 Am	=> ensure safety	6:10 Am	=> ensure safety	

Re-Assessment: Patient is Good

Special Notes: continue Antibiotic

Nurse Signature: [Signature] Nurse Name: Aliya

Date & Time: 06/7/26 @ 8 Am

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Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 6/7/2026

Assessment:

patient having Throat pain, 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
8Am	TO Assist the child on bed	8:15 Am	Assisted the patient on bed lying comfortable	patient comfortable
	Observed for throat pain		IV fluid going on	
	Encourage orally.	9:15 Am	V/S checked & recorded	
	Continue ABX &	10Am	due meds given AS per chart.	
	IV fluid support.	12pm	continue IV antibiotic	
2pm	proctolysis Enema monitor - temperature.	1pm	proctolysis to be given	
		2:00pm		

Re-Assessment:

Reassessment after 2 hrs pt well

Special Notes:

NA.

Nurse Signature:

[Signature]

Nurse Name:

Soubhasini

Date & Time:

6/7/26 @ 2pm

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 6/7/20

Assessment: patient having throat pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	* Assess the patient condition	2:30 pm	* Assessed the patient condition, patient is stable.	* patient is stable.
3pm	* plan to monitor vitals	3:10 pm	* monitor vitals stable.	
4pm	* plan to maintain I/O chart.	4:00 pm	* maintain I/O chart	
5pm	* plan to c.t. IVF DMS	5:10 pm	* c.t. IVF DMS 30ml hours going on.	
6pm	* plan to w/r fever spikes	6:30 pm	* patient not having fever till now.	
8pm	* plan to medication.	8pm	* Given medication as per doctor orders.	

Re-Assessment: provide comfortable position.

Special Notes: CBP, CRP T/M, ENT reviewed T/M

Nurse Signature:

Nurse Name: Seema

Date & Time: 6/7/20 @ 8pm

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 06/7/26

Assessment: patient having discomfort for hospitalization

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 patient General condition	8:10 pm	⇒ Assessed the patient General condition	patient is patient
10pm	⇒ Assess the patient vitals	10:20 pm	⇒ Assessed the patient vitals	
12am	⇒ To maintain I/O chart	12:15 Am	⇒ To maintain I/O chart	
2am	⇒ To encourage oral intake	2:10 Am	⇒ To encourage oral intake	
4am	⇒ To provide comfortable position	4:20 Am	⇒ provided comfortable position	
6am	⇒ Ensure safety	6:10 pm	⇒ Ensure safety.	

Re-Assessment: patient is comfortable

Special Notes: ~~all~~ - @ 1 BP, RRP: Done

Nurse Signature: [Signature] Nurse Name: [Signature] Date & Time: 07/6/26 @ 8 Am

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 7/7/2026

Assessment: patient having throat pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	* Assess the patient condition	2:30 pm	* Assess the patient condition	* Baby is stable.
3pm	* plan to monitor vitals		* patient is stable.	
4pm	* plan to maintain I/O chart.	3:10 pm	* monitor vitals stable.	
5pm	* plan to c.t. IVF Dils	4:20 pm	* maintain I/O chart	
6pm	* plan to ENT consultation	5:30 pm	* c.t. IVF Dils 30ml/hourly going on.	
7pm	* plan to encourage orally	6:10 pm	* patient not having fever till now.	
8pm	* plan to medication.	7:20 pm	* patient taken orally good.	
		8pm	* Given medication as per doctor orders.	

Re-Assessment:

provide comfortable position

Special Notes:

Nurse Signature:

Nurse Name: Soubhasini

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



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 28/2/26

Assessment: patient having Acute pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the pt general condition and vitals	8pm	→ Assessed the pt general condition and vitals	Ensure safety
10pm		30		
12Am	→ Relieve pain + Discomfort	10pm	→ Relieved pain + Discomfort	
2Am	→ Maintain fluid balance	12Am	→ maintained fluid balance	
4Am	→ Encourage orally	2Am	→ Encouraged orally	
6Am	→ Administer medication as per chart	4Am	→ Administered medication as per chart	
8Am		6Am		
		8Am		

Re-Assessment:

Special Notes: Reduce pain
If cannula out don't place another
D/C Tlm

Nurse Signature: balyani

Nurse Name: balyani

Date & Time: 28/2 @ 8Am

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Shift: ☐ Morning ☐ 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:

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Faisal B Nahdi Department: EC Date of Admission: 4/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	<u>AFI</u>							
BACKGROUND	Area	Shift Time	<u>EC</u> <u>11:5A</u>	<u>2nd floor</u> <u>8AM</u>	<u>3rd floor</u> <u>8PM</u>	<u>3rd floor</u> <u>8AM</u>	<u>3rd floor</u> <u>2PM</u>	<u>3rd floor</u> <u>8PM</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>AFI</u>	<u>AFI</u>	<u>AFI</u>	<u>AFI</u>	<u>AFI</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>98.2°</u>	<u>98.3°</u>	<u>99.9°</u>	<u>98.0°</u>	<u>98.3°</u>	<u>97.5°</u>
	Res:		<u>24b/m</u>	<u>28b/m</u>	<u>26</u>	<u>28b/m</u>	<u>26</u>	<u>27b/m</u>
	SpO ₂ :		<u>100%</u>	<u>99%</u>	<u>98</u>	<u>99%</u>	<u>99</u>	<u>100%</u>
	Pulse:		<u>142b/m</u>	<u>150b/m</u>	<u>128</u>	<u>130b/m</u>	<u>110</u>	<u>99b/m</u>
	BP:		<u>102/52</u>	<u>100/62</u>	<u>107/66/46</u>	<u>105/72</u>	<u>108/85/43</u>	<u>101/76</u>
	Fall Risk Score:		<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</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>yes</u>	<u>no</u>	<u>NA</u>	<u>NA</u>	<u>m</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>no</u>	<u>NA</u>	<u>NA</u>	<u>m</u>	<u>NA</u>
Post Operative Procedure Special Orders:		<u>NA</u>	<u>no</u>	<u>NA</u>	<u>NA</u>	<u>m</u>	<u>NA</u>	
Handed Over By Name :		<u>Blumai</u>	<u>Devi</u>	<u>Saulhami</u>	<u>Devi</u>	<u>Saulhami</u>	<u>Seema</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	
Time:		<u>11:5A</u>	<u>8AM</u>	<u>8PM</u>	<u>8AM</u>	<u>2PM</u>	<u>8PM</u>	
Taken Over By Name :		<u>Dipansika</u>	<u>Chirsha</u>	<u>Devi</u>	<u>Saulhami</u>	<u>Seema</u>	<u>[Signature]</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	
Time:		<u>1:30PM</u>	<u>8AM</u>	<u>9PM</u>	<u>8PM</u>	<u>3PM</u>	<u>8PM</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Faisal Department: 3rd floor Date of Admission: 4/7/26

SITUATION		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:						
BACKGROUND	Diagnosis:	<u>AFI</u>						
	Area	Shift Time						
		<u>3rd floor</u> <u>8am</u>	<u>3rd floor</u> <u>2pm</u>	<u>3rd floor</u> <u>8pm</u>	<u>3rd floor</u> <u>8am</u>	<u>3rd floor</u> <u>2pm</u>	<u>3rd floor</u> <u>8pm</u>	
	Medical Condition (Any special condition to be noted):	<u>AFI</u>	<u>AFI</u>	<u>AFI</u>	<u>AFI</u>	<u>AFI</u>	<u>AFI</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>97.2°F</u>	<u>97.4°F</u>	<u>97.6°F</u>	<u>97.2°F</u>	<u>97.1°F</u>	<u>97.5°F</u>
		Res:	<u>22b/m</u>	<u>26</u>	<u>22b/m</u>	<u>28b/m</u>	<u>26</u>	<u>22b/m</u>
		SpO ₂ :	<u>99.1</u>	<u>99</u>	<u>100.1</u>	<u>99.1</u>	<u>99</u>	<u>99.1</u>
		Pulse:	<u>100b/m</u>	<u>100</u>	<u>100b/m</u>	<u>75b/m</u>	<u>99</u>	<u>117b/m</u>
		BP:	<u>105/72</u>	<u>108/65(75)</u>	<u>110/78</u>	<u>100/72</u>	<u>96/59(62)</u>	<u>112/65</u>
		Fall Risk Score:	<u>-</u>	<u>11</u>	<u>11</u>	<u>+</u>	<u>11</u>	<u>11</u>
Pain Score:	<u>-</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>NA</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>NA</u>	<u>NA</u>	<u>CBP/CRP</u> <u>TLM</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>ENT</u> <u>Hx+M</u>	<u>ENT</u> <u>R/V TLM</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Alsy</u>	<u>Soubhani</u>	<u>Alsy</u>	<u>Alsy</u>	<u>Soubhani</u>	<u>Alsy</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>6/7/26</u>	<u>6/7/26</u>	<u>6/7/26</u>	<u>6/7/26</u>	<u>6/7/26</u>	<u>6/7/26</u>	
Time:		<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	
Taken Over By Name :		<u>Soubhani</u>	<u>Alsy</u>	<u>Alsy</u>	<u>Soubhani</u>	<u>Alsy</u>	<u>Kalyani</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>6/7/26</u>	<u>6/7/26</u>	<u>6/7/26</u>	<u>6/7/26</u>	<u>6/7/26</u>	<u>6/7/26</u>	
Time:		<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. Faisal Department: Paeds Date of Admission: 9/7/20

SITUATION	Diagnosis: <u>AFI</u>		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
BACKGROUND	Area	Shift Time				
	Medical Condition (Any special condition to be noted):	<u>3rd floor Spontaneous</u> <u>NA</u>				
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp: <u>98.6</u>				
	Res:	<u>26b/m</u>				
	SpO ₂ :	<u>98%</u>				
	Pulse:	<u>101b/m</u>				
	BP:	<u>110/71</u>				
	Fall Risk Score:	<u>11</u>				
Pain Score:	<u>0/10</u>					
Recommendations	Safety Needs:	<u>Yes</u>				
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	<u>NA</u>				
	Special Diet:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	<u>NA</u>				
Post Operative Procedure Special Orders:		<u>NA</u>				
Handed Over By Name :		<u>Kalyani</u>				
Signature :		<u>Kalyani</u>				
Date:		<u>9/7/20</u>				
Time:		<u>08AM</u>				
Taken Over By Name :						
Signature :						
Date:						
Time:						

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						
BACKGROUND	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-00634042
Master MOHAMMED HUSSAIN KHAN
04-03-2020 8 Y 3 M 30 D (M)
Dr. FAISAL B NAHDI

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BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
4/7/26	1AM	0/10	✓	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Bhavani
4/7/26	6AM	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Deepa
4/7/26	2pm	0	m	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sauha
4/7/26	6pm	0	m	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sauha
5/7/26	6AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Deepa
5/7/26	7AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Deepa
5/7/26	12pm	0	m	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	under observation	Sauha
5/7/26	4pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Seema
5/7/26	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Seema
6/7/26	6AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Deepa

Re-assessment Frequency:

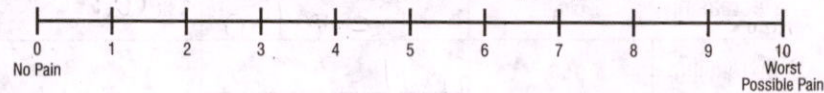
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

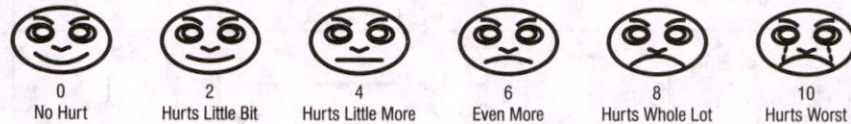
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	(0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
21/7/26	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under Observation	Devi
21/7/26	2pm	0	ms	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Soubhankar
21/7/26	6pm	2/10	SLs	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inf. PCM given	Seema
21/7/26	7pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Seema
21/7/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under check	Kalyani
8/7/26	6am	1/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Observation Inf. PCM given	Kalyani
8/7/26	3 ³⁰ 6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Kalyani
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
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Re-assessment Frequency:

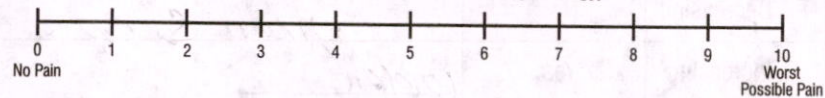
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 - Prior to pain pain-relieving intervention.
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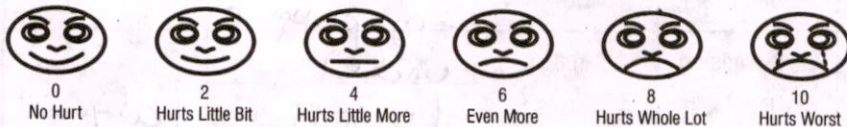
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Wong - Baker (Pediatrics) Above 7 Years



BRADEN 'Q' SCALE

					Date :	5/7	6/7	7/7
					Time :	8:01	8:01	8:01
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	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
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
TOTAL SCORE					4	28	28	28
Evaluator's Name					Shad. P. P. P. P.			

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

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



BRADEN 'Q' SCALE

					Date : 8/12/20			
					Time : 8:00			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:xtremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4			
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4			
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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			
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			
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Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	21		
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Shah		

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