

**Rainbow Children's Hospital - Banjara Hills**

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad
,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : <https://rainbowhospitals.in>

ADMISSION SHEET**Registration Details :**

Admission No : IP5-00175979

Admit Date : 05-Jul-2026

Admit Time : 12:48 AM UHID : BAH-00513069

Patient Details :

Patient Name : Master CHENNOJI AARAV KRISHNAA

Age : 3 Y 11 M 27 D

Guardian : Mr SAIKRISHNA CHENNOJI

DOB : 08-07-2022

Gender : Male

Religion :

Occupation :

Marital Status : Single

Address (It) : H.NO 15-127/A, ,, ROAD NO 03 NBR COLONY
MEERPET RR DISTRICT Meerpet Hyderabad
Telangana INDIA 500097

Phone No : 9052731000/ 8886523177

E-mail :
CHENNOJI.SAIKRISHNA@GMAIL.COM**Admission Details :**

Bed Type : DELUXE ROOM

Bed No : DLX 325

Ward Name : 3F-ZONE C

Room No : DLX 325 327

Admission Type : First Visit

Contact Details :

Name : Mr SAIKRISHNA CHENNOJI

Relationship : Father

Contact Address : H.NO 15-127/A, ,, ROAD NO 03 NBR COLONY
MEERPET RR DISTRICT Meerpet Hyderabad
Telangana INDIA 500097

Phone No : 9052731000 / 8886523177

Signature**Doctor Details :**

Doctor Name : Dr. VENKATA LAKSHMI A

Specialisation : GENERAL PEDIATRICS

Referral Doctor : SELF

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : MEDI ASSIST INSURANCE TPA PVT
LTD

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP _____ ant: _____ Dept : _____

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

Room / Bed No : _____ Wara : _____ gested Billable bed type : _____



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
05/07	11:18 am	EP	327-B	Revised

Cross Consultation Visit

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

[illegible]

Signature

Samshy

Zabba

[illegible]

PROCEDURE				
Date	Procedure	Quantity	Order No.	Signature
05/2	IV Placement	①	88324	Samah

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

Date :Time :Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor

Signature

Samy

ANY OTHER INFORMATION

Prepared By :

Billing Supervisor



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Aarav Krishna

UHID ID:

BAH-00513069 IP5-00175979
Master CHENNOJI AARAV KRISHNAA
08-07-2022 3 Y 11 M 27 D (M)
Dr. VENKATA LAKSHMIA

Department:



Consultant:



Pediatric Multiorgan History & Physical Examination

Name : Aarav Krishna Age/Sex 4/mr

Information given by: mother Relationship

Chief Presenting Complaints & Duration (Chronologically)

Fever x 2 days

History of present illness :

child was apparently alright
2 day back

flb fever since 2 days
high grade
no chills / no cough / cold.

no loose stools , vomiting ⊕

2-3 spi

- after feed

- non projectile

non bilious vomiting

reduced oral intake :: 2 days.

H/o younger sister with similar
history

no H/o travel, outside food intake ⊖.

no antibiotics used.



Pediatric Multiorgan History & Physical Examination

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

nil

Birth & Neonatal History:

Normal perinatal & antenatally.

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

upper middle.

Developmental History :

normally attained for age.

Immunization History :

Immunized as per schedule @ Res.

(P.T.O.)

(P.T.O.)



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Sepsis, dehydration

Desired goals of the treatment:

Dyscussence

Planned Labs:

CBP

CRP

CVE

1 Blood cts extra plain

Urine cts

Planned Management

① 2ij ceftriaxone

② IVF DWS

③ 2ij Pantoprazole

④ 2ij Paracetamol.

NB urine

Signature of the Doctor:

Soheli

Name of the Doctor:

Dr. Soheli

Date & Time:

05/07/26

11:00am

Signature of the Consultant:

Name of the Consultant:

Date & Time:

DR. VENKATA LAKSHMIA
Registration No. 50115



EFFICIENCY CHECK LIST OF CASE SHEET

29

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
5/26 9:30 AM	Seen by Resident Ser - AFI (D3). last fever - 100°f @ 2 AM oral intake poor. urine output adequate. O/E child asleep, afebrile hemodynamically stable Chest clear. abdomen hydration soft. fair throat healthy.	Plan 1. Continue Ceftriaxone. 2. Trace CUE 3. Gastro diet. NIB Latta @ 9:30 AM J. Sanilw



**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
6/7 9:30am	<u>C/S/B Resident</u> <u>Δ: AFI (D4)</u> -afebrile for 24h O/E: alert vitals stable chest clear no rash abdomen soft	<u>Adv:</u> 1) (D) today Akshita



Aarav Krishna

MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From: ER

Shifted to: 2nd floor

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

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Saheli (Saheli)

Date & Time: 5/9/26 11:00 am

Nurse Name & Signature: [Signature]

Date & Time: 05/09/26 @ 1 am

BAH-00513069 IP5-00175979
Master CHENNOJI AARAV KRISHNAA
08-07-2022 3 Y 11 M 27 D (M)
Dr. VENKATA LAKSHMI A



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	5/7/26				
Time	1:14AM				
Hb	11.7				
PCV	34.8				
RBC	4.72				
WBC	6.090				
N/L	72.3/24.0				
Platelets	298				
CRP	16				
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date	5/7					
Time						
CUE - Alb	0					
CUE - Sugar	0					
CUE - Ketones	0					
CUE - PUS Cells	2-3					
CUE - RBC Cells	0					
CUE	(P)					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :



DRUG CHART

Date of Admission: 5/7/26 Drug Allergies: — ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG : <u>SYP IBUGESIC</u>				Date Time
Dose <u>7ml</u>	Route <u>PO</u>	Frequency <u>SOS</u>	Start Date <u>5/7</u>	
Doctor's Signature <u>Sohel</u>		Valid Period	Pharm. <u>pe</u>	
Additional Instructions: <u>Temp > 101 F (max 3 times daily)</u>				
DRUG : <u>Syp PARACETAMOL</u>				Date Time
Dose <u>4.5ml PO</u>	Route <u>PO</u>	Frequency <u>SOS</u> <u>6H.</u>	Start Date <u>5/7</u>	
Doctor's Signature <u>Sainthi</u>		Valid Period	Pharm. <u>pe</u>	
Additional Instructions: <u>temp > 100 F (5/240)</u> <u>max 6Hrly.</u>				
DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				



REGULAR PRESCRIPTIONS

Weight. 14.3 Ward.

VERIFIED

DRUG : <u>5ij CEFTRIAXONE</u>				Date Time	<u>5/7/26</u>
Dose <u>100mg</u>	Route <u>IV</u>	Frequency <u>BID</u>	Start Date <u>5/7</u>	<u>6AM 2AM</u> <u>made 803</u> <u>5/7/26</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Soheli</u>				<u>6PM</u>	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign				<u>g A</u>	

VERIFIED

DRUG : <u>5ij PANTOPRAZOLE</u>				Date Time	<u>5/7/26</u>
Dose <u>15mg</u>	Route <u>IV</u>	Frequency <u>OD</u>	Start Date <u>5/7</u>	<u>6AM 2AM</u> <u>made 803</u> <u>5/7/26</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Soheli</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign				<u>g L</u>	

VERIFIED

DRUG : <u>5ij PARACETAMOL</u>				Date Time	<u>5/7</u>
Dose <u>140mg</u>	Route <u>IV</u>	Frequency <u>TID</u>	Start Date <u>5/7</u>	<u>6AM 2AM</u> <u>made 803</u> <u>5/7/26</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Soheli</u>				<u>2PM</u>	
Additional Instructions:				<u>10pm</u>	
Daily Doctor's Endorsement by a Sign				<u>g</u>	

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

I.V. FLUIDS CHART

Weight. 14.3kg Ward.



Concentration of I.V. Fluid
(If concentration, infusion ml/hr = Mcg/kg/min. etc)

Route

Flow Rate
ml/hr

Doctor
Sign

Nurse
Sign

Date of
Stopping

Doctor
Sign

Nurse
Sign

5/7

1:50 AM

IVF DNS

I.V

50

Solubility
Pain

6/7

A

Re
cy

Signature

VERIFIED BY : Name

BAH-00513069 IP5-00175979
Master CHENNOJI AARAV KRISHNAA
08-07-2022 3 Y 11 M 27 D (M)
Dr. VENKATA LAKSHMI A

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

P
P



..... 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		
08/07	12:30 a	5	medication	F	1	0	1	1	nr	puer
5/7/26	10:30 am	9	gastro diet	M, F	1	0	1	1	-	Sainy

Part - III: CODES

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

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

API

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
5/7 11:00am	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Ac febrile illness	H. stability	IVF IV antibiotics	Sohel	☐ Nursing ☐ Others:
05/07 12:30 a	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	API	H. stability	-IVF -IV med	Rusul	☐ Medical ☐ Others:
5/7/26 10:30 am	☐ Medical ☐ Nursing ☒ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	API	gastro diet	<u>RDA</u> E → 1300kcal/d P → 22gm/d	Saima	☐ 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:

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Aarav Krishna Age : 4 yrs Gender: ☒ Male ☐ Female
Date : 5/7/26 Time of Arrival : 12:48 AM Triage Completion Time : 12:50 AM
Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): nil ☐ Not known any drug Allergies
Source of Information : ☒ Parents ☐ Others (Specify) _____
Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance ☒ Normal ☐ Sick Looking	Work of Breathing ☒ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea	☒ Stable ☐ Unstable : ☐ Not - Life - Threatening ☐ Life - Threatening
Circulation / Colour ☒ Normal ☐ Abnormal ☐ Bleeding		

Initial Vital Signs: Temp: 100.1 F PR: 152 bpm BP: 109/26 (83) RR: 24 bpm SpO₂: 99% RA

Chief Complaints: fever x 2 days

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Mr. Lachel

Date & Time : 5/7/26 @ 12:50 AM

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

Signature of Triage Nurse : [Signature]

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 05/07/20 Time of arrival : 12:51 am

Chief Complaints: Fever x 2 days, RBS: —

Height : — Weight : 14.3 kg BMI : — Head Circumference (<2 years) : —

Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: —

If yes, identify : —

Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker

☐ Character : — ☐ Location : — ☐ Frequency : — ☐ Duration : —

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

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

Social History: Lives With : Parly

Siblings in household ☒ Yes ☐ No (if yes How Many?) 2 Sisters

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

Time of Initial assessment completed by ER Nurse : 12:53 am

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

Time	Nursing Notes
01:18 AM	Dr. Sohela assessed the child / spongy given. - IV placed - clean - Sample sent - Guedel to room.

Samples collected by: /Shantika
Samples sent by :

Time: /1:15 am.
Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
05/01/18 12:55 am	Syp. Mettal	PO	7.5 ml	<i>[Signature]</i>	Kenny

Condition of patient at time of shift - out :	Details of Shift - out
HR: 140 bpm BP: 93/58 CFT: 2.5 sec RR: 25 bpm SPO ₂ : 98% - 12h GCS: 5/15 Temperature: 99.8°F Pain Score: 0/10 Repeat RBS (if applicable): <i>none</i>	Shift - out from ER to: 327 Time of Shift - out: 1:18 am Handover given to: (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): *IV placed*

Name of the Nurse : *[Signature]* Signature of the Nurse : *[Signature]*

Date & Time : 05/01/18 @ 1 am

BAH-00513069 IP5-00175979
Master CHENNOJI AARAV KRISHNAA
08-07-2022 3 Y 11 M 27 D (M)
Dr. VENKATA LAKSHMIA



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 11:18 AM Mode of Arrival: while happy Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Body Weight: 14.3 Kg

..... Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>NA</u>	<u>NA</u>	<u>NA</u>

Family History:

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

If yes please list,

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

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

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

Observations: Weight: 14.3 Length: Head Circumference (< 2 years):

Temp.: 99.8 HR: 120b/m RR: 32b/m BP: 105/60

Pain Score: 0/10 Specify Site: lower side (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☒ Yes ☐ No Score: 11 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 25) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☐ Yes ☒ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker

Character of Pain Location Frequency Duration

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

Inform consultant for positive criteria

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

Inform consultant for positive criteria

Psychological Screening:☒ No Significant FindingsUnusual concerns about patient's Psychological Status: ☐ Yes ☒ No

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☐ Yes ☐ No if Yes specify Inform consultant for positive criteria.**Social History:** Lives WithSiblings in household ☒ Yes ☐ No (if yes How Many?)All Information Obtained From ☐ Patient ☒ Mother ☒ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach: ☒ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump: ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ NoInformation given to *parents*Nurse Signature: *Pujy*Nurse Name: *Pujy*Date: *11/12/25*Time: *2 AM*

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :		Time:	
Doctor / Nurse / Family Concern?		2 AM	6 AM
Temperature (F)	104		
	103		
	102		
	101		
	100		
	99		
	98	97.5 F	97.5 F
	97	*	*
	96		
	95		
94			
Heart Rate (bpm)	190		
	180		
	170		
	160		
	150		
	140		
	130		
	120		
	110		
	100		
and Blood Pressure (mmHg) *	90		
	80		
	70		
	60		
	50		
	104		
	102		
	97		
	95		
	93		
Note: BP does not score in early waking scoring			
Heart Rate (Number)	115/104	120/93	
Resp. Rate (bpm) (Over 1 Minute) *	70		
	60		
	50		
	40		
	30		
	20		
	10		
Resp Rate (Number)	20/16	30/16	
Resp Distress	Mod/ Severe	None / Mild	
Receiving O ₂ (l/min)			
O ₂ Saturations (%)	99%	100%	
Conscious Level	Normal	Altered	
GCS *	15/15	15/15	
TOTAL SCORE			
Number of shaded boxes	0	0	
Pain Score	0	0	
Observer's Initials	AB	AB	

* 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)



5/7/26

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	10Am	2pm	6PM	10 PM
Doctor / Nurse / Family Concern?		2 Am	6 Am		PM
Temperature (F)	104				
	103				
	102				
	101				
	100	100.0°F			
	99				
Heart Rate (bpm)	190				
	180				
	170				
	160				
	150				
	140				
Blood Pressure (mmHg) *	130				
	120				
	110				
	100				
	90				
	80				
Note: BP does not score in early warning scoring	70				
	60				
	50				
	105	109	103	110	114
	60	72	66	65	62
	129b/m	116b/m	130b/m	127b/m	120b/m
Resp. Rate (bpm) (Over 1 Minute) *	70				
	60				
	50				
	40				
	30				
	20				
Resp Rate (Number)	30b/m	28b/m	28b/m	30b/m	30b/m
Resp Mod/ Severe Distress None / Mild	N	N	N	N	N
Receiving O ₂ (l/min) O ₂ Saturations (%)	100%	99%	99%	100%	100%
Conscious Level Normal Altered	N	N	N	N	N
GCS *	12/16	16/16	15/15	15/15	15/15
TOTAL SCORE	0	0	0	0	0
Pain Score	0	0	0	0	0
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	BACKGROUND : 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-00513069 IP5-00175979
 Master CHENNOJI AARAV KRISHNAA
 08-07-2022 3 Y 11 M 27 D (M)
 Dr. VENKATA LAKSHMIA

Patient Sticker

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. :

08/07/22

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			
	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			50ml							0		Lungs High Lungs High Lungs
	03:00 am	D		50ml			1			✓	0		
	04:00 am	N wake		50ml			NP				0		
	05:00 am	S		50ml						✓	0		
	06:00 am			50ml			1			✓	0		
	07:00 am			50ml						✓	0		
Total Intake : Taken 300ml						Total Output : 5 3 m=0							
Total 24 hrs. Intake			Taken			Total 24 hrs. Output			5 3 m=0				

BAH-00513069
Master CHENNOJI AARAV KRISHNAA
08-07-2022 3 Y 11 M 27 D (M)
Dr. VENKATA LAKSHMIA

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. :

5/7/26

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			
	08:00 am			50 ml			1			✓	0	Hatta	
	09:00 am	D	water	50 ml							0		
	10:00 am						NP			✓	0	Hatta	
	11:00 am	N		50 ml							0		
	12:00 pm		water	50 ml			1			✓	0	Hatta	
	01:00 pm	S		50 ml							0		
Total Intake :						Total Output :						0 - 34 - 0	
	02:00 pm			-							0	Hatta	
	03:00 pm	D	water	50 ml			1			✓	0		
	04:00 pm	N		50 ml			NP				0	Hatta	
	05:00 pm			50 ml							0		
	06:00 pm	S		-			1			✓	0	Hatta	
	07:00 pm			-							0		
Total Intake : 200 ml						Total Output : 14 - 0						0 - 2	
5/7/26	08:00 pm			50 ml							0	Piyas	
	09:00 pm	D	water	50 ml							0		
	10:00 pm	N		50 ml							0	Piyas	
	11:00 pm	S		50 ml							0		
	12:00 am		water	50 ml							0	Piyas	
	01:00 am			50 ml							0		
Total Intake :						Total Output :						0 - 2	
5/7/26	02:00 am			50 ml							0	Piyas	
	03:00 am	D	water	50 ml							0		
	04:00 am	N		50 ml							0	Piyas	
	05:00 am	S		50 ml							0		
	06:00 am		water	50 ml							0	Piyas	
	07:00 am			50 ml							0		
Total Intake :						Total Output :						0 - 2	
Total 24 hrs. Intake			Total 24 hrs. Output										



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 05/07/2022 1:30 AM

Assessment: Baby having fever

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	→ assess the general condition of the baby and check vitals.	8:00 AM	→ Assessed the general condition of the baby and checked vitals.	Baby is stable
9 AM	→ Giving medication as advised.	9:00 AM	→ Given medication as advised.	
10 AM	→ Continue IV fluid as advised.	10:00 AM	→ Continued IV fluid as advised.	
11 AM	→ maintaining good nutritional status.	11:00 AM	→ maintained good nutritional status.	
12 PM	→ check of urine output.	12:00 PM	→ checked urine output.	
1 PM	→ Ensure safety.	1:00 PM	→ Ensured safety.	

Re-Assessment: Fever reduced (under observation)

Special Notes: Three Lab Reports

Nurse Signature: *Pijs*

Nurse Name: *Pijs*

Date & Time: 05/07/2022 8 AM



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/7/26

Assessment: Baby T AFI

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	* Assess the general condition	8:10am	* Assessed the general condition	Baby is stable
9am	* monitor vitals and Record	9:10am	* monitored vitals and Recorded	
10am	* maintain IV fluids	10:10am	* maintained IV fluids	
11am	* medication administered as per chart	11:10am	* medication administered as per chart	
12pm	* Comfortable position	12:10pm	* comfortable position	
2pm	* Ensure safety	2:10pm	* Ensured safety	

Re-Assessment:

Baby is doing well no temperature

Special Notes:

trace labs

Signature: Lakta

Nurse Name: Lakta

Date & Time: 5/7/26 @ 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/7

Assessment: Baby is here with AF 2

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2PM	* Assess the general condition of Baby.	2:10PM	* Assessed the baby condition.	Baby is stable now
4PM	* Monitor vital signs	4:15PM	* vitals checked & documented	
	* maintain I/O chart		* I/O chart maintained	
6PM	* Administer the medications.	6:10PM	* Administered the medications.	
8PM	* Ensure safety.	8PM	* Ensured safety	

Re-Assessment: Baby is comfortable now.

Special Notes: Tracheal reports

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 5/7 @ 8PM



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/1/25 @ 8 PM

Assessment: Baby 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
8 AM	→ assess the general condition of the baby and checking vitals.	8:00 AM	→ assessed the general condition of the baby and checked vitals.	Baby is stable
10 AM	→ Giving medications as advised.	10:00 AM	→ Given medication as advised.	
12 AM	→ Continue IV fluid 50ml/hr. as advised.	12:00 AM	→ Continued IV fluid 50ml/hr as advised.	
4 AM	→ Trace Lab Report.	4:00 AM	→ Trace Lab Reports.	
6 AM	→ Maintaining good nutritional status.	6:00 AM	→ maintained good nutritional status.	
8 AM	→ checking urine output.	8:00 AM	→ checked urine output.	
8 AM	→ Ensure safety.	8:00 AM	→ Ensured safety.	

Re-Assessment: Fever reduced now

Special Notes: Trace Lab Reports

Nurse Signature: Rija

Nurse Name: Rija

Date & Time: 5/1/25 @ 8 AM



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. V. K. Department: Paed Date of Admission: 05/07/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
	AFI						
BACKGROUND	Area	Shift Time	EP. 11:30a	3rd Floor 2PM-8PM	3rd Floor 8PM-2PM	1st Floor 8PM-8PM	3rd Floor 8PM-8PM
	Medical Condition (Any special condition to be noted):		nil	na	NA	NA	na
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:	99.8°F	97.5°F	97.1°F	97.1°F	97.3°F
	Res:	30b/m	30b/m	30b/m	30b/m	30b/m	
	SpO ₂ :	99%	100%	99%	99%	100%	
	Pulse:	130b/m	118b/m	122b/m	124b/m	122b/m	
	BP:	99/62	109/62	110/62	112/70	101/53	
	Fall Risk Score:	11	11	11	11	11	
Pain Score:	0	0/10	0/10	0/10	0/10		
Recommendations	Safety Needs:	yes	yes	yes	side rails	side rails	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	nil	na	NA	NA	na	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	nil	na	NA	NA	na	
Post Operative Procedure Special Orders:		nil	na	NA	NA	na	
Handed Over By Name :		Pijy	Pijy	Latha	Pijy	Pijy	
Signature :		Pijy	Pijy	Latha	Pijy	Pijy	
Date:		05/07	5/7/26	5/7	5/7	6/7/26	
Time:		11:25a	8AM	2PM	8PM	8AM	
Taken Over By Name :		Pijy	Latha	Pijy	Pijy	Pijy	
Signature :		Pijy	Latha	Pijy	Pijy	Pijy	
Date:		05/07	5/7	5/7	5/7	6/7	
Time:		8AM	2PM	8PM	8PM	8AM	



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	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ 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	☐ Yes ☐ No	
	Others Specify:								
	Special Diet:	☐ Yes ☐ No	☐ 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:									

BRADEN 'Q' SCALE

					Date :	05/07	5/7	5/7	5/7
					Time :	12:30a	10am	8pm	4pm
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	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 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 mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23									
Docu. No. : RCHBH /FRM / CLINICAL / 119									
					TOTAL SCORE	28	28	28	28
					Evaluator's Name	muw	latta	but	hijz

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 :				
					Time :				
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.					
"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.					
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.					
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.					
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."					
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.					
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.					
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE				
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name				

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

Patient Stic

BAH-00513069 IP5-00175979
Master CHENNOJI AARAV KRISHNAA
08-07-2022 3 Y 11 M 27 D (M)
Dr. VENKATA LAKSHMIA



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

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

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes	✓	yes	
Call device within reach	yes	yes	✓	yes	
Wheels Locked	yes	yes	✓	yes	
Room free of clutter	yes	yes	✓	yes	
Adequate Lighting	yes	yes	✓	yes	
Wheel Chair Support	no	NA	x	NA	
Other Intervention(s) Specify	no	NA	x	NA	
Nurse's Name :	hup	Lalita	Lalita	Pige	
Signature :	[Signature]	Lalita	Lalita	Pige	
Date :	05/07	5/7	5/7	5/7	
Time :	12:30 am	10:00 am	2:00 PM	10:00 AM	

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	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 cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-	-	-				
Signature of the Nurse						Pijy	lata	Dev	Pijy				

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

DATE: 10/10/2010 TIME: 10:00 AM

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

10/10/2010

rainbow®
Children's
Hospital
treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Attention	Sign
C	Presnell
A	Latta
7	Latta
	Paul
	Ryan
	Ryan

DISCHARGE PLANNING FORM

Nationality: Indian

NURSE within (24) hours of admission.

1. Discharge: 06/07/2006

2. Discharge Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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 |

need assistance

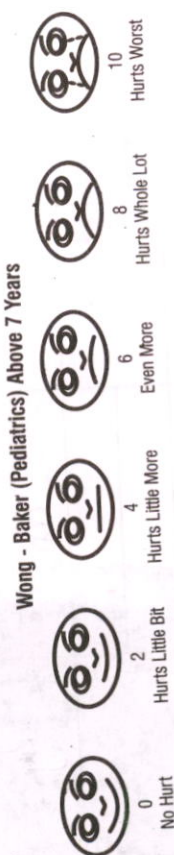
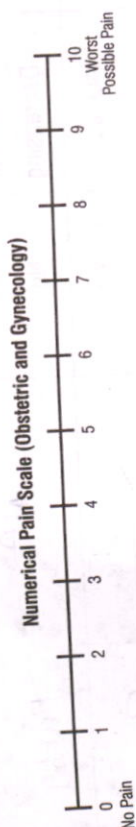
FLACC PAI

CATEGORY	0
Face	No Particular expression or s
Legs	Normal Position or Relaxed
Activity	Laying quietly normal position moves easily
Cry	No Cry (Awake or asleep)
Consolability	Content, relaxed

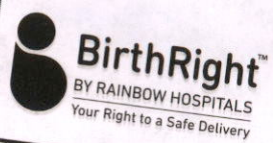
Neonatal Pain,

Assessment Criteria	Sedation	
	-2	-1
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with stimuli
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally Little spontaneous movement
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone
Vital Signs HR, RR, BP, SaO ₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli

PAIN ASSESSMENT TOOLS



PATIENT TRANSFER FORM



Patient Name & UHID No.

BAH-00513069 IP5-00175979
Master CHENNOJI AARAV KRISHNAA
08-07-2022 3 Y 11 M 27 D (M)
Dr. VENKATA LAKSHMI A



Date & Time of Admission

05/07/26 @ 12:48 am

Date & Time of Transfer Order

05/07/26 @ 1:18 am

Transfer Ordered by

Dr. Sohela.

Reason for Transfer

Delusional.

From Unit

ER

To Unit

327

Information to Attendant

Yes ☒ No ☐

Number of Sheets in Clinical File

19

Number of Imaging Films

nil

Personal belongings including clinical documents. If any handed over to attendant

Yes ☒ No ☐

op file. If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Sample	10
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐

Name & Signature of Person who is Transferring

Dr. Mr. Chandra

Name of Person Ordered Transfer

Dr. Sohela.

Patient & Clinical Records Received by :

Dr. 05/07/2026 @ 1:30 Am

Date & Time of Patient Received :
Transfer order time & room no.
Bed

If time is more than 30 minutes, please tick the reason mentioned below :

☐ Not Available

☐ Available Bed not ready

BRITISH

Children's
Hospital

TRANSFER

100

100

100

100

100

100

100

100

100

100

100

100

100

100

BAH-00513069 IP5-00175979
Master CHENNOJI AARAV KRISHNAA
08-07-2022 3 Y 11 M 27 D (M)
Dr. VENKATA LAKSHMIA



327B

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Weight: 14.3kg's Centile: >10th Date: 5/7/26 Time: 10am
Height: 96cm Centile: >10th

Inference: Underweight child

RDA: — Calories: 1300kcal/d Protein: 22gm/d

Diet Recommendations: gastro diet (avoid wheat, eggs, milk, oats, Nuts)

Re-Assessment: citrus fruits & fruit Juices can have Rice based food, sago water, poha

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

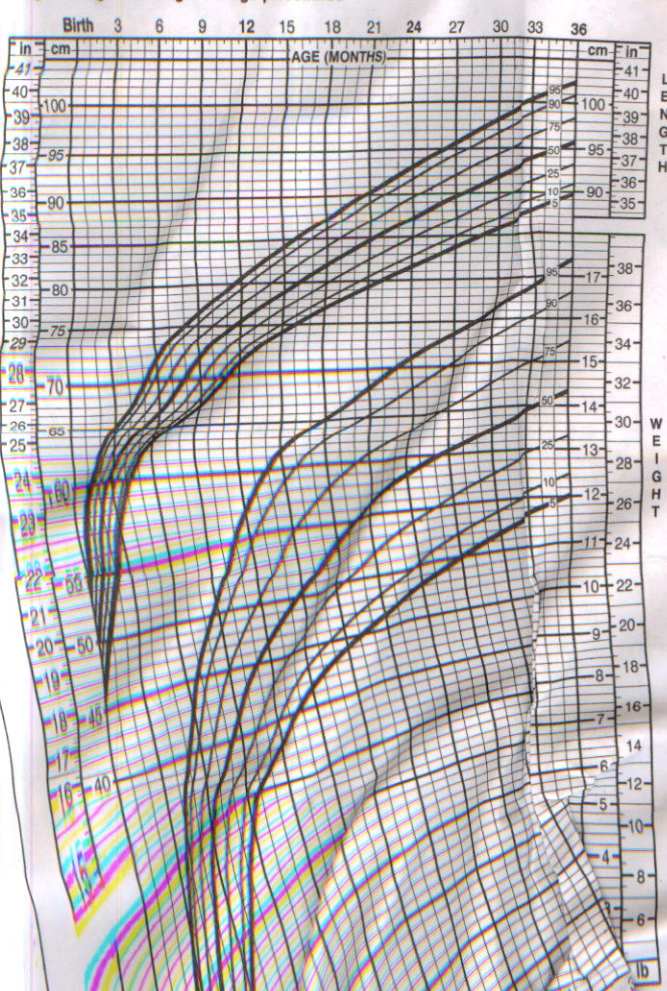
Diagnosis: AFI (D3)

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

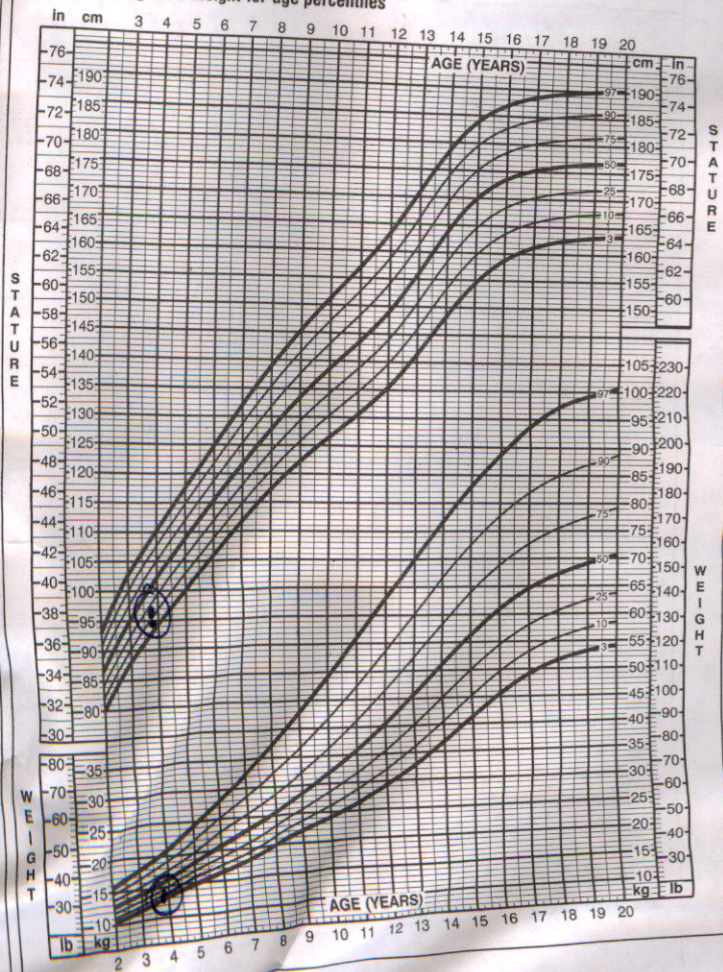
Patient's Signature: D. Nishu

GROWTH CHART (BOYS)

Birth to 36 months: Boys
Length-for-age and Weight-for-age percentiles



2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles



Dietician's Signature: Saima

(P.T.O.)

Daily Notes:

[illegible]