

CONSENT FOR HEMATOPOIETIC STEM CELL TRANSPLANTATION

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWKA
11-02-2022 4 Y 4 M 19 D (F)
Dr. SIRISHA RANI



w
n's
al
It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name: GARIGANTI RITHWKA Age: 4y 4m Gender: Male ☐ Female ☒

UHID No: 648830

Diagnosis: MPS type I

Type of Transplant: Allogeneic Disease Status at the time of Transplant: in

matched sibling donor HCT

Treatment Summary:

You/your child have a disease for which bone marrow/stem cell transplant is not the only cure. There may be several alternate options available to you/ your child at this stage, which you should have already discussed with your treating physician.

This treatment uses high dose therapy with transplantation of donor / autologous stem cells from either bone marrow or peripheral blood. For many patients who undergo such transplants (Bone Marrow Transplant), cells are used from the patient themselves (autologous transplant) or from related donor (brother/sister/other related donor) or unrelated donor who is matched by tissue typing. You should already have been given, read through and discussed the separate information sheet on Bone Marrow Transplant.

Factors affecting the success of the graft include the type of disease for which transplant is planned, type of transplant donor and recipient health status, HCA matching status etc. These have been discussed with you in-detail by your care provider.

All types of Bone Marrow Transplant can be followed by complications. The most important of these are:

- 1. Rejection of the Transplant :** This is uncommon for transplants, but more likely with an unrelated or mismatched donor. Where possible and appropriate back-up stem cells will be collected and stored from the patient. In the event rejection of the transplant, availability of these cells does not offer any guarantee that patient will recover.
- 2. Graft-Versus-Host Disease (GVHD):** This is the result of the donor cells reaction against the patient cells. It can be severe, and is more likely to be life-threatening after mismatched transplant. The main sites affected are the skin, gut and liver. We try and minimize its development by use of T cells and B Cell depletion protocol and by use of immunosuppressant drugs such as cyclosporine, methotrexate, Antithymocyte Globulin or steroids.
- 3. Infections:** Bacterial viral and fungal other infections occur frequently after Bone Marrow Transplant. Part of this is related to graft-versus-host disease and its treatment. Close observation for any of infection is an important part of patient management after Bone Marrow Transplant. Various methods are used to try and avoid infections occurring, and will vary with the Individual case, but include prophylactic antibiotic, anti-viral agents, antifungals and selection of blood products. IV immuno-globulin is used wherever it is required. With the application of T-Cell depletion, the risk of infection is reported to be high, so the child is monitored for these viral infection for few months post-Bone Marrow Transplant.
- 4. Organ Toxicity:** The patient's underlying condition together with the powerful treatment used before and after the transplant inevitably damage many tissues of the body. Most or all of the damage may be reversible long term morbidity is possible in some cases, rarely the patient may die as a result, this is called transplant-related mortality (TRM).
- 5. Long Term Complications:** These may be some long term complications of the procedure and it is very likely that you/your child will become sterile after transplant. There is also small risk of developing secondary malignancy due to the treatment received.
- 6. Psychological effects** though uncommon in very young children, may be seen in adolescents.

No guarantee of success can be given any transplant, success rate will be discussed as per literature case to case basis. Once the pre-Bone Marrow Transplant therapy is given, the patient is committed to undergoing Bone Marrow Transplant. It is essential to understand the benefit of transplant risk involved and the possible outcome. The post transplant survival rate (1 year) depend upon the underlying condition for which transplant is planned, the type of transplant (Autologous or Allergenic) and donor availability.

Before we can perform the Bone Marrow Transplant all your questions should have been answered . Please ask these, either of your primary hematologist or one of the Bone Marrow Transplant consultants. You should only sign the consent form when you are satisfied you have received sufficient information. We will give you a copy of this treatment summary.

My signature (patient/ authorized representative) below consultant my acknowledgment that:

1. I have read, understand and agree to the foregoing and it has been explained to me in the language understood by me.
2. All my questions have been satisfactory answered and I have all the desired information to give an informed consent.
3. I hereby give my informed consent with /without any coercion or undue influence after understanding the benefits, risk and possible complications in my complete senses.

I here by give my consent for Bone Marrow Transplant, procedure involved in it, necessary investigations , usage of anti-microbial and blood products as and when required to the treating Doctor.

I have been explained the details of the procedure, alternative risk, benefits, possibility of complications with me in the language that I have understood.

If patient is unable to consent or case of minor, authorized representative can give consent. If I am the authorized representative (relative/ patient guardian in case of minor) I agree that I have read this form, understood the information and have no further questions.

Patient / Parents / Guardian:

Signature: *Kavitha*

Name: *Kavitha*

Relationship with Patient: *Mother*

Date & Time: *26/6/26 7pm*

Patient / Parents / Guardian
Left Hand Thumb Impression

Doctor (who is taking the consent) :

Signature : *A*

Name : *SARANI*

Date & Time : *26/6/26 7pm*

Witness / Interpreter if applicable:

Signature : *Kavitha*

Name : *Kavitha*

Date & Time : *26/6/26 7pm*

Nursing Staff:

Signature : *Sarani*

Name : *Sarani*

Date & Time : *26/6/2026 at 7pm*

ACTIVITY RECORD FOR BILLING

Name : _____

BAH-00848830 IP5-00175554

Baby GARIGANTI RITHWIKA

11-02-2022 4 Y 4 M 13 D (F)

UHID No. : _____

Dr. SIRISHA RANI



Date of Admissio

Consultant: _____

Dept : _____

Date of Discharge : _____

Time: _____

Room / Bed No : _____

Ward : _____

Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
24/6/26	2:30 PM	ER	135	Nurse
25/6/26	5:30	OT	135	Nurse

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Nambata k	25/6/26	96742/3	Nurse
2				
3				
4				
5				
6				
7				
8				
9				
10				

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
24/6/16	R Placement	1	72826	Dan
25/6	PAC	①	9679439	Sing
26/6/16	Chemotherapy	①	9679432	Sing
25/6	Chemotherapy	①	9679439	Sing
4/5	Blood Transfusion	①	96886146	de
	(PABC)			
3/6	Blood transfusion	①	9685430	Sing
	(Stem cells)			
8/7	IVIG (W)	①	9694161	A
10/7	Blood transfusion	①	9696772	A
	(SDD)			
18/7	Blood Transfusion	①	9709939	de
	PABC & SDD			

ANY OTHER INFORMATION

Date: 21/7/16

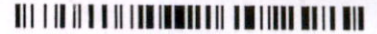
Time: 11AM

Prepared By:

Veeng

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Veeng	Day shift Oncology		

ADMISSION SHEET


Registration Details :

Admission No : IP5-00175554 **Admit Date :** 24-Jun-2026 **Admit Time :** 01:38 PM **UHID :** BAH-00648830

Patient Details :

Patient Name :	Baby GARIGANTI RITHWIK	Age :	4 Y 4 M 13 D
Guardian :	Mr GARIGANTI MURALI KRISHNA	DOB :	11-02-2022
Gender :	Female	Religion :	
Occupation :		Martial Status :	Single
Address (H) :	H NO - 56-20, VAJPAO NAGAR , QUTHBULLAPUR Chintal Hyderabad Telangana INDIA 500054	Phone No :	9063188305/ 8096770388
		E-mail :	NOMAIL@GMAIL.COM

Admission Details :

Bed Type : FOUR SHARING **Bed No :** FSW 135 **Ward Name :** 1F-HEMATO-ONCOLOGY
Room No : FSW 135 **Admission Type :** First Visit

Contact Details :

Name : Mr GARIGANTI MURALI KRISHNA **Relationship :** Father
Contact Address : H NO - 56-20, VAJPAO NAGAR ,
QUTHBULLAPUR Chintal Hyderabad Telangana
INDIA 500054 **Phone No :** 9063188305 / 8096770388

Kareetha
Signature

Doctor Details :

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

Payment Details :

Payment Mode : Cash **Deposit Amount :** 0.00
Payor Name : CENTRE FOR DNA FINGERPRINTING
AND DIAGNOSTICS (CDFD)

**Rainbow[®]
Children's
Hospital**

It takes a lot to treat the little.

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWIK
11-02-2022 4 Y 4 M 13 D (F)
Dr. SIRISHA RANI



Docu. No. : RCHBH / FRM / GENERAL / 065

(P.T.O.)

Sensory System : _____

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

12/10 MPS type I

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWIK (F)
11-02-2022 4 Y 4 M 13 D
Dr. SIRISHA RANI



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile _____)
Weight (kgs) 10.20kg (Centile _____)

On Examination :

Temperature : 98.4°F Pulse Rate : 101/min B.P. 98/46/56 SP02 100%

Resp.rate and type of breathing : _____

Rash _____

Lymphadenopathy _____

Oedema : _____

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWIK (F)
11-02-2022 4 Y 4 M 13 D
Dr. SIRISHA RANI



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Prevent complications.

Desired goals of the treatment : H⁺ stabilize

Planned Labs:

CBP

Planned Management

NAC infusion
zefcl
DOXA
ACSP
NS Unassat.

Signature of the Doctor: [Signature] Signature of the Consultant: [Signature]

Name of the Doctor: T. Pavani Name of the Consultant: Dr. Sirisha Rani

Date & Time: 24/06/2022 2:20pm Date & Time: _____

Dr. Anurag Reddy
24/6/22 @ 4pm



①

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/6/20 3:50pm	Evening rounds by Dr. Sandhya	
	Minipolycanthrosis Type 1	
	Alert, active Feeding fair Vibly table	As
	S/E → PNF, CFT, etc	1) Diarrid
	WS	chlorhexidine
	R/L	2) Othenpale skt
	P/S	3) skt Udi liv
		4) skt NAE
		5) Dental review
		6) GSW GSW
		Line 1/1m 1:30pm
		7) 25 END
		8) XR
		9) VEG Abs
		10) surveillance
		11) to send
		12) perminisim
		test on Friday
	stayed by 10/3/21 at 9pm	Ahanbhan
		Dr. Sandhya
		24/6
		Dr. SANDHYA VADDADI
		Reg. No: 71064

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/26 9am	MPC Type I / admitted	for MCD RECT.
	No fever	
		Plan
		1. To send surveillance cultures today
		2. USG abdomen today
		3. Start conditioning today
		4. Episthomy line in OT today
		5. Dental review today
		6. To send. preTx chimerism today
		diarr
		<i>[Signature]</i>
		25/6
		DR. SANDHYA VADDADI
		Reg. No. 71664
		Noted by 25/6/26
		Gargathou
		Jpr

3

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	DONOR (manaswini)	RECIPIENT
	Blood grouping: B positive.	B positive.
	CBP 10.9 $\frac{10,800}{54/41}$ 3.2	11.5 $\frac{13770}{58/32}$ 3.2
	LFT: AL: 198, remain N.	ALP: 168, remaining Normal.
	creat: 0.3	0.6
	HbsAg, uLV, uLV Negative. Hepatitis antibody	Negative.
	cmv IgG positive IgM Negative.	positive negative.
	US abd -	splenomegaly.
	CXR. - (H)	(H) cardiomegaly oval shaped ribs
	2D Echo. Normal	LVM.
	Pelvic chineim	sent



(A)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26 9am	mps type I / admitted for MSD HCT	
	No fever	
	devoiding done nasal infusion ✓	Plan 1. To send preTx chimerism today 2. To start conditioning today 3. dental review today by Dr. KRIVAS. 4. 2D Echo today
	<i>Dr. Anurag</i> 43499 CG 9:50am Dr. Anurag Reddy	havi
26/6/26 4pm	<u>Exmp notes</u> mps type I / admitted for MSD HCT	N/B ch-pooja. @ 2pm
	NO fever.	Plan: - 1st supportive care - conditioning to ct. - 1 W/P fever / vomit - 2d Echo today
	O/E: Chest clear PLA: 8057	



5

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6/26 8:30 am	ming notes ASIS: mps type I / admitted for MSD HSC T D-6 NO fever OLE: Chest clear PLA: soft Vitals stable	Plan: → Conditioning as per chart → Trace pre transplant chimerism → 1st supportive care → Trace 2d Echo report
27/6/26 3 pm	ASIS: mps type I / admitted for MSD HSC T D-6 NO fever OLE: Chest clear PLA: soft Vitals stable 2d Echo SLO LUH.	Plan: → Conditioning as per chart → 1st supportive care → Review 2d Echo → Trace pre transplant chimerism

Dr. Anurag Reddy
4355505:30 AM

NIB Goutham
27/6/26
12 PM

NIB Debnath
01st ac
27/6/26
4 PM

Alis withof

Alis withof



Date & Time	Progress Notes	Doctor's Order
27/6/26 11 PM	Seen by Resident: Dr Sahithi Discussed with Hematology Team. 88y - MPS type I admitted for MSD HSC.	
	child alert, on room air BP - 130/80 → 126/83 mmHg HR - 120/min perfusion good. Passing adequate urine chest clear, abdomen soft.	Plan 1. Cont T. AMLODIPINE 2.5 mg 1/2 Tab stat 2. To optimise Anti hypertensives T/m after round 3. Continue other medication 4. Monitor BP Q3H & uniform SOS NB Susm to 27/06 @ 11:20pm Sahithi



Date & Time	Progress Notes	Doctor's Order
8/1/26 8:45 AM	Morning rounds	
	MPS type 1 for MSD-HSCT D-5	1) ^{Pho} cont conditioning
	Afebrile, Alert	2) monitor BP 3 rd hr
	had HTN → Reimmed	3) cont medications
	Amblo - now settled.	4) cont Enprom SOS
		5) have surveillance cls.
	No other issues.	6) add ct Amiodipine
	doing well.	
	vitals: ②	N/B
	SLE-S, MWF, CTCL 3 rd hr	Anusadha
	avg	Ahanuethu
	MS	
	PK ②	
		Dr. SANDHYA VADDADI Reg. No: 71664



8

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/6/22 9am	Mp type 1 / for MCD HCT	Day -4
	No fever	
		Same
	vitals stable	1. Continue conditioning as per chart 2. Lug AML methyl pred] from today evening
		3. continue Amiodipine 4. Trace surveillance cultures.
		5-CBP LFT, creat, benzoylplan] Tms. havei
		if BP still high to add Enalapril.
29/6/22 9am	CSB Dr. Sandhya MPS 1 / MCD HCT Day -4 Alert, active No fever BP - 100/55 mmHg S/G - (K)	1) CBP LFT, uric acid / thr 2) if BP persistently ↑ to start enalapril, 3) cont rest
		Thank you

NIB
 Gantalla 29/6/22
 6am



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/26 9 AM	MPS type 1 for MED HCT Day (3) hypertension No fever vitals stable	wt: Plan 1. Continue conditioning as per chart. 2. Trace CBP 3. dry fever, loose stools ↓ Start 100 mg ceftriaxone. 4. check weight
	50 1000 ml 0 1300 ml V.O.P. 5-4 cc/kg/hr. Stools - Klebsiella → to ceftriaxone Urine cl- no growth.	to send home CBP.
		Noted by Nephro 30/6/26 @ 1 PM
30/6/26 3 PM	Klebsiella MPS type I for MED HCT Day (3) hypertension. No stool / fever O/E: Chest clear RA: soft	Plan: → conditioning as per chart → W/F fever / loose stools → if supportive care



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/22 AM	MPS-II for MED HCT	Day-0
	No fever	wt:-
	No vomiting	
		Plan
		1. stem cell infusion today
		2. CBP
	Gfmaxone-Dt Voi	Calm, electrolytes / Tlm meat
	Valaidoni	3. PRBC Tx Tlm SOS
		4. ct hypotensive care.
		5. methotrexate Tlm.
		Start
		Dr. Sandhya Vaddadi 3/7/22 @ 10 am
		Dr. SANDHYA VADDADI Reg. No: 7160018 3/7/22 @ 10 am

13

2/18
Page 9
3/7/76
EPR

Date & Time	Progress Notes	Doctor's Order
4/2/14 9 AM	MP type 1 / Post MID	nsct. Day 0 (+1)
	No fever No vomiting	wt: 10.1 kgs
	5/ 932 ml 0/ 1350 ml	
	u.op: 5.4 cal/hr	
	cyproaxone - D5 vbi valacyclovir	
		Plan 1. Trace CBP. 2. Check weight daily 3. Methotrexate today 4. PRBC Today / TIm 5. I/O charting 6. CBP Colony extra plan on 6/7/26 Infer I/O after 6hr ros lenix
	Noted by Sourya @ 4/7 02/211 @ 10:30 am	 Sourya
		DR. INDRA VADDAR REG. NO. 11644 4/2/14 11:30 AM
	NIB Debra 4/17/26	— PRBC transfusion to be started tonight.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/26 9am	mpe type 1 Post	med HCT Day (+2)
	No fever	wt - 10.3kg ↑ 200gm
	3 stools	
	$\frac{5}{2} \left \begin{array}{l} 900 \text{ ml} \\ 1100 \text{ ml} \end{array} \right.$ v-op = 4.5 cell/kg/hr.	<u>Plan</u> 1. lq folinic acid today 2. ct iv fluids 3. ct iv antibiotic 4. CBP SE, colureb } Tlm 5. lq vitamin K, B12 today Add Amikacin S/S upgrade to p/ptax of ongoing LMB Chanai
	ceftriaxone - D6 Vori Valaciclovir o/c pt T° US 8/27 P/A BS ↓↓ DHS BA (+)	 5/7/26 DR. SANDHYA VADDADI Reg. No: 71664 N.B Moomita 5/7/26 10AM



16

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 9 AM	MPS type 1 MSD HSCCT.	Day 13
	No fever No vomity stools - 1 episode.	wt = 9.8 kg ↓ 500gms Recheck wt:
	$\begin{array}{r} 5 \text{ } 904 \text{ ml} \\ 0 \text{ } 770 \text{ ml} \\ \hline \end{array}$ U-op = 3.1 ctk/ml.	
	Pictar Amikacin } D ₂ Van Valacyclovir	Plan 1. continue IV fluids 2. ct IV antibiotics 3. Methotrexate Today 4. Trace labs 5. IV Ig on 8/7/26.
	- PBS + Dr. Sirisha Rani 9:55 AM @ 8:30 AM	Plan - live chemistry today - MPS today. - liquid diet.
		M.B. Moomita 6/7/26 @ 10 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/22 9:30 AM	Morning rounds MPS-1/MSD HSCIT - D+4 Afebrile, Alert 1 ep of vomiting @ poor intake @ wt - 9.3 kg (↓ 500g range) vitals (w) 9/7/22 9:00	Adv Hold cefepime every 6hrs ↓ dex from 1/1m → ct rest same → SOS ↑ amiodipine to 1 BD (2.5mg) → fohine resume to sleep IVig today 1/1m <i>[Signature]</i> Dr. SANDHYA MADADI Reg. No. 71004 (15/02/22)
8/7/22 4 PM	MPS-1/MSD - HSCIT - D+4 Afebrile, Alert BP - 115/60 mmHg v/o 3wml. 1/1c SWS Ms/1/1c	Adv 10 AM 1) (R/V) 9 Amlo chas 2) CBP S/E t/m. LFT creatmore 3) IVIG t/m. 4) Rist same 5) Duftm SOS <i>[Signature]</i> N. B. Mounita 717126 10 AM



19

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26 9am	MPS-I MSD HCT Day (+5)	
	No fever	wt - 9.3 kg
	1 stool passed. No vomity	
	$\begin{array}{r} \text{I} 784 \text{ ml} \\ \text{O} 1130 \text{ ml} \end{array}$	
	U.op - 4-7 ccl/kg/h.	
		Plan
		1. Trace labs
		2. ct IV antibiotics
		3. IUIg Today ✓
		4. No choling - 2pm, 8pm to inform
		Quadrized ✓
8/9/26 11:00pm	MPS-I MSD HCT Day +5	NB Rajamani 8/7/26 @ 10:50AM
	No fever.	
	No vomity.	
	Vital stable. $\frac{0}{e}$	
	Child Alert & Active. (U: 6/10) (P: 10/10)	
	M: B/L (A/P)	
	P/A: 6/4	
	CNI: NAB	Plan
		- Continue IV antibiotics
		- monitor vital
		- Inform (201)

NB
 Razan



37

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26 9 AM	Mps type 1 MED HCT	Day (+8)
		wt - 9.9 kgs
	No fever	
	$\begin{array}{r} 1224 \text{ ml} \\ 1200 \text{ ml} \\ \hline 24 \text{ ml} \end{array}$ u.op = 5 cc/kg/hr.	
	piper amitacin } 0.4 vor valaciclovir	<u>Plan</u> 1. ct IV fluids 2. ct IV antibiotics 3. lig G-CSF today 4. Amitacin last dose today 5. CBP Extra plain } Tlm.
	10/7 wbc = 102	
		848 cyclophosphamide 0.2nd kg Sharai
	 11/7/26 9:10 AM	NIB 11/7/26 11/7/26 10:30 AM



23

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/7/20 8:30 AM	MPS-1 / MSD HSC D+9.	
	Wt - 10 kg (1100 grams)	Ad.
	$\begin{array}{r} F 1372 \\ \hline O 1190 \end{array}$	1) ct 178 2) drugs as per chart 3) have CRP / SG. 4) monitor vitals 5) Inform SAs 6) GCSF t/m
	No fever No vomiting No urination No stool	
	Pipha Dg Voriconazole Valacyclovir	12/7 - CRP, SG, Co levels, LFT, sent. Ahsanulhasan
	Dr. Anurag	M.B. Maumita 12/7/20 10 AM

BAH-00648830 IPS-00175554
 Baby GARIGANTI RITHWIKA
 11-02-2022 4 Y 5 M 2 D (F)
 Dr. SIRISHA RANI



25

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/2/22 4:30pm	MPS-1/MSD HCCT - D+10	
	No issues	1) CBP S/E
	No fever	W level. } Hm.
	Vital (2)	LFT
	S/E - ACS	2) Daily ACSF from today
	Ms	3) Vent ext
	P/O	4) monitor vitals
		Shankha
		M.B. Moumita
		13/2/22
		5PM
		Dr. SADDHA VADDADI
		Reg. No: 71664



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/2/26 9am	MPC type 1 / MID HSC	day (+11)
		wt: 9.9 kg
	5 1222 ml 0 1380 ml	↑ 200 gms.
	U-op, 6.3 cc/kg	
	No fever No vomiting	Plan
		1. Ct IV fluids
		2. Metronidazole today
		3. Folic acid 1mg
		4. Trace labs.
		Daily ACSF
		T. Phenexa
	8/ptal - pro vui Valaciclovir	
		M.D. Mounita 14/2/26 10 AM
		Sub Sandhya V 14/2 @ 9:30am
		Dr. SANDHYA VADDADI Reg. No: 71664



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/2/22 8.20am	MPI Type 1 / MSD HSC	Day 13
	Afebrile	
	wt - 9.9 kg (9100g varus)	1) (RIN) SDP PARC
	F 1144 O 1300	2) cont rest
	U/O - 5.4 ul/kg/hr	3) monitor vitals
	BP - 104/41 mmHg	4) Infuse SCS
	No fever/vomiting	HB Lapineum
	Piper D 12	
	Valacyclovir Vaccinology	→ mammal counts & platelets → PCR J fever → cultures + new penem 500mg IV TDS
	Col level on 14/7 → 01	HB Dehydration 16/2/22 11AM
	<i>[Signature]</i> 2.2.22	

Date & Time	Progress Notes	Doctor's Order
17/7/26 8:45 AM	MPS type - I/MSD wt - 10 kg (↑ 100 gram).	HSCF - D + 1/4
	$\begin{array}{r l} I & 1064 \\ \hline 0 & 1044 \end{array} \quad (-376 \text{ ml})$	Asu 1) cont supportive care 2) monitor I/O charting 3) Inform SLS 4) CBP t/m SB LFT, urea. 2 extra Gona
	U/O - 6 ul/kg/hr BP - 103/70 mmHg. Afebrile No vomiting Piptaz D3. → (RTU). Valamylam Voriconazole	Noted by Gerson 17/7 11:00 AM
18/7/26 4 PM	Evening rounds No fresh issues Doing well. Vitals (2). S/e → wsg Ref. (2) PR Not SLS 1:15 AM 2:45 AM	Asu D. CBP BSE LFT Urea/mine 2 extra places

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/07/26 8:40 AM	Morning rounds	
	MPS - I / not MSD - HSCF - D+15	
	wt - 10.2 kg (↑ 200g now)	Adv
	I / 1508 (balance ⊕ 150ml) O / 1350	1) RRR PRSC today
	U/O - 6.3 u/kg/hr.	2) wt not
	No fever	3) w/f from
	No vomiting	wt. suppress
	stool ✓	5)
	Entire fine	Monday CBP / Co levels / enter GDTA Monday
	Prophylaxis D14 (RV) to stop. - 3. Ceftriaxone for T1.	Gap to continue
	Valganciclovir	
	Valsartan	* Bmr unit panel. today
	Cidapronin 4mg/kg/day	Noted by Susmita. 18/07/26 @ 12pm
	<i>[Signature]</i> 6:30 PM @ 10:05 AM	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/20 8:30 AM	MPS-1 / post MSD-HSCT-D +16.	
	wt - 10.1 kg (2100gms)	1) CBP SG CO level. / time. extra EDTA
	I / 1099 (balance - 430ml) O / 1530 → u/o 6.2 u/kg/day.	2) stop Pipt start Cyproavon 3) have viral panel
	BP-100/62 mmHg.	4) ct rest 5) ct supp. lab
	No fever No vomiting	6) Enfirm sos
	sl & scus / nls / ⊕. PIA /	Shoulder - trace viral panel
	Cyproavon D, Valganciclovir Voriconazole.	W/P Rayamani 19/7/20 @ 11 AM
	Ciclosporin	



32

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26 9 AM	Morning rounds	
	MPS-1/ net MSD - HSC - D+17	1) At supine
	wt - 10.2kg (Two grand)	2) Bare as level
	F 1084	3) monitor vitals
	O 1420	4) Bare V vital record
	O/O - 5-8 ul/hg/hr	Trace to level
SV	No fever No wheezing	Stop IV fluids Trace to level
	Ceftriaxone (RIN) D ₂	Change Ceftriaxone to Cefixime
	Valganciclovir	GRF today last
	Voriconazole	to send diarrhea today
	Cefixime	plan o/c Tm
	ACB	
	urinal panel neg	
	(18/7/26)	
	2 grand	
	434e	
	9245P	
	ALB	
	Ganyathin	
	20/7/26	
	1 pm	

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIKA
 11-02-2022 4 Y 5 M 10 D (F)
 Dr. SIRISHA RANI



33

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26 amv.	1 mps - I MID NECT - Day (+13)	
		wt - 10.2 kg
	$\begin{array}{r} 940 \text{ ml} \\ 0 \end{array}$ $\begin{array}{r} 1300 \text{ ml} \end{array}$	
	u.op = 5 cell like	
	No fever.	Plan
		1. ct supportive care
		2. Trace CBP
		plem d/c today
	chimerin ✓ sent	
	1vlg on 8/7/26.	B - cefime
		V - valaciclovir
		F. vor
	(18/7/26 - viral panel - ne)	CMMO - Udoxone
	20/7 Colch - 127.	Uditi, Amlopidine / Cantide
		Rlv omnacortil.
		Rlv valganciclovir.
		Syp Omnacortil (5ml/5mg)
		7.5ml — 7.5ml x 5 days
		5ml — 5ml x 5 days
		5ml — 5ml x 5 days
		Cap valganciclovir 1/4 — 1/4.

21/7/26
 Gariga
 Clear

RW on 27/7
 CBP, wheel, SG, RAS
 UFT creat

Dr. RANITHA VADDADI
 Reg. No. 71664

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWIK
11-02-2022 4 Y 4 M 13 D (F)
Dr. SIRISHA RANI



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No:

REGULAR PRESCRIPTIONS

Weight 10kg

Ward Onuq

DRUG	Date	Time	Start Dt	End Dt	Frequency	Remarks
CANDID MOUTH PAINT	24/6					
	25/6					
	26/6					
	27/6					
	28/6					
	29/6					
	30/6					
	1/7					
	2/7					
	3/7					
	4/7					
	5/7					
	6/7					
	7/7					
	8/7					
	9/7					
	10/7					
	11/7					
	12/7					
	13/7					
	14/7					
	15/7					
	16/7					
	17/7					
	18/7					
	19/7					
	20/7					
	21/7					
	22/7					
	23/7					
	24/7					
	25/7					
	26/7					
	27/7					
	28/7					
	29/7					
	30/7					
	31/7					
	1/8					
	2/8					
	3/8					
	4/8					
	5/8					
	6/8					
	7/8					
	8/8					
	9/8					
	10/8					
	11/8					
	12/8					
	13/8					
	14/8					
	15/8					
	16/8					
	17/8					
	18/8					
	19/8					
	20/8					
	21/8					
	22/8					
	23/8					
	24/8					
	25/8					
	26/8					
	27/8					
	28/8					
	29/8					
	30/8					
	31/8					
	1/9					
	2/9					
	3/9					
	4/9					
	5/9					
	6/9					
	7/9					
	8/9					
	9/9					
	10/9					
	11/9					
	12/9					
	13/9					
	14/9					
	15/9					
	16/9					
	17/9					
	18/9					
	19/9					
	20/9					
	21/9					
	22/9					
	23/9					
	24/9					
	25/9					
	26/9					
	27/9					
	28/9					
	29/9					
	30/9					
	1/10					
	2/10					
	3/10					
	4/10					
	5/10					
	6/10					
	7/10					
	8/10					
	9/10					
	10/10					
	11/10					
	12/10					
	13/10					
	14/10					
	15/10					
	16/10					
	17/10					
	18/10					
	19/10					
	20/10					
	21/10					
	22/10					
	23/10					
	24/10					
	25/10					
	26/10					
	27/10					
	28/10					
	29/10					
	30/10					
	31/10					
	1/11					
	2/11					
	3/11					
	4/11					
	5/11					
	6/11					
	7/11					
	8/11					
	9/11					
	10/11					
	11/11					
	12/11					
	13/11					
	14/11					
	15/11					
	16/11					
	17/11					
	18/11					
	19/11					
	20/11					
	21/11					
	22/11					
	23/11					
	24/11					
	25/11					
	26/11					
	27/11					
	28/11					
	29/11					
	30/11					
	1/12					
	2/12					
	3/12					
	4/12					
	5/12					
	6/12					
	7/12					
	8/12					
	9/12					
	10/12					
	11/12					
	12/12					
	13/12					
	14/12					
	15/12					
	16/12					
	17/12					
	18/12					
	19/12					
	20/12					
	21/12					
	22/12					
	23/12					
	24/12					
	25/12					
	26/12					
	27/12					
	28/12					
	29/12					
	30/12					
	31/12					

648830 IP5-00175554
GARIGANTI RITHWIK
02-2022 4 Y 4 M 14 D (F)
Dr. SIRISHA RANI

CROSS CONSULTATION FORM

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Doctor Name : DR NAMRATA K.

Date 25/06/26

Time : 12:18 PM

Diagnosis : EARLY CHILDHOOD CARIES

Hospital :

Type of Referral :

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

☐ Emergency

☐ Urgent

☐ Non Urgent

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

Findings and Recommendations :

Signature:

K/c/o MPS Type I.

O/E:-

Root stumps on 54, 51, 52, 61, 62

Dental caries on 64, 74, 84, 85

Early childhood caries [ECC]

- Previous H/O Pulp therapy + Restorations [fillings] Done elsewhere

PLAN:- Extractions

Pulp therapy

NAMRATA K

Signature : Namrata

Date & Time : 25/06/26

12:20 PM

M / CLINICAL / 049



Sheet No:

REGULAR PRESCRIPTIONS

Weight 10 kg

Ward Dme

DRUG : Cyp OFM

Dose 5ml Route PO Frequency BD Start Dt. 25/6

Name & Signature of the Doctor Starting the Drugs: *hanani*

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : Cyp CACCIMAX PWS

Dose 5ml Route PO Frequency OD Start Dt. 27/6

Name & Signature of the Doctor Starting the Drugs: *hanani*

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : Tab COBAMAM

Dose 1/2 Route PO Frequency OD/AM Start Dt. 28/6

Name & Signature of the Doctor Starting the Drugs: *ghemelly*

Additional Instructions:

1 tab = 2.5mg

Daily Doctor's Endorsement by a Sign

DRUG : Iy AML

Dose 0.3ml Route IV Frequency BD Start Dt. 29/6

Name & Signature of the Doctor Starting the Drugs: *hanani*

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Docu. No. : RCHBH / FRM / CLINICAL / 108

(PT.O)

Radiology:

USG :

X-Ray:

2/2 - shadows - CR2. coli seen

ECHO:

CT:

MRI

Others (ECG, Contrast Studies etc.):



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : <u>100 mg METHYL PREDNICOLONE</u>				Date Time	29/6/2022	11-2/2
Dose	Route	Frequency	Start Dt.			
100 mg	IV	BD	29/6			
Name & Signature of the Doctor Starting the Drugs:				 		
Additional Instructions:				 		
Daily Doctor's Endorsement by a Sign				 		
DRUG : <u>Tab AMLODIPINE</u>				Date Time	29/6/2022	11/2
Dose	Route	Frequency	Start Dt.			
1/2 tab	PO	OD	29/6			
Name & Signature of the Doctor Starting the Drugs:				 		
Additional Instructions:				 		
Daily Doctor's Endorsement by a Sign				 		
DRUG : <u>100 mg ONDANSETRON</u>				Date Time	30/6/2022	1/2 2/2 3/2 4/2 5/2 6/2 7/2 8/2 9/2 10/2 11/2 12/2 13/2 14/2 15/2
Dose	Route	Frequency	Start Dt.			
3mg	IV	BD	30/6			
Name & Signature of the Doctor Starting the Drugs:				 		
Additional Instructions:				 		
Daily Doctor's Endorsement by a Sign				 		
DRUG : <u>100 mg CEFTRIAXONE</u>				Date Time	30/6/2022	1/2 2/2 3/2 4/2 5/2
Dose	Route	Frequency	Start Dt.			
500mg	IV	BD	30/6			
Name & Signature of the Doctor Starting the Drugs:				 		
Additional Instructions:				 		
Daily Doctor's Endorsement by a Sign				 		

Signature

VERIFIED BY : Name

BAH-00648830 IPS-00175554
 Baby GARIGANTI RITHWIK
 11-02-2022 4 Y 4 M 19 D (F)
 Dr. SIRISHA RANI



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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

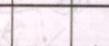
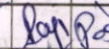
DRUG : Tab VORICONAZOLE				Date Time	1/7	2/7	3/7	4/7	5/7	6/7	7/7	8/7	9/7	10/7	11/7	12/7	13/7	14/7
Dose	Route	Frequency	Start Dt.															
1/2 tab	PO	OD	1/7															
Name & Signature of the Doctor Starting the Drugs:				Signature: [Signature]														
Additional Instructions:				1 tab = 200mg														
Daily Doctor's Endorsement by a Sign				[Signatures]														

DRUG : Tab VALACICLOVIR				Date Time	1/7	2/7	3/7	4/7	5/7	6/7	7/7	8/7	9/7	10/7	11/7	12/7	13/7	14/7
Dose	Route	Frequency	Start Dt.															
1/2 tab	PO	BD	1/7															
Name & Signature of the Doctor Starting the Drugs:				Signature: [Signature]														
Additional Instructions:				(1 tab = 500mg)														
Daily Doctor's Endorsement by a Sign				[Signatures]														

DRUG : Tab CICLOSPORINE				Date Time	2/7	3/7	4/7	5/7
Dose	Route	Frequency	Start Dt.					
20mg	IV	BD	2/7					
Name & Signature of the Doctor Starting the Drugs:				Signature: [Signature]				
Additional Instructions:				dose changed.				
Daily Doctor's Endorsement by a Sign				[Signatures]				

DRUG : Tab AMLODIPINE				Date Time	2/7	3/7	4/7	5/7	6/7	7/7	8/7	9/7	10/7	11/7	12/7	13/7	14/7	15/7	16/7
Dose	Route	Frequency	Start Dt.																
1/2 tab	PO	BD	2/7																
Name & Signature of the Doctor Starting the Drugs:				Signature: [Signature]															
Additional Instructions:				(1 tab = 2.5mg)															
Daily Doctor's Endorsement by a Sign				[Signatures]															

Weight Ward

DRUG :	<i>inj amikacin</i>						Date Time	<i>5/7 6/7 7/7 8/7 9/7 10/7 11/7</i>	Weight	Ward
Dose <i>150mg</i>	Route <i>IV</i>	Frequency <i>OD</i>	Start Dt. <i>5/7.</i>							
Name & Signature of the Doctor Starting the Drugs: <i>Saner</i>				<i>2PM AM</i> 						
				<i>AM PM AM PM AM</i> 						
Additional Instructions:										
										
Daily Doctor's Endorsement by a Sign										
										

DRUG : 100 CICLESPORINE				Date: 6/7/21	Time: 4/1
Dose 20mg	Route IV	Frequency BD	Start Dt. 6/7	6 AM	Shree Son
Name & Signature of the Doctor Starting the Drugs: Anan				An An	
				dose bed An	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

[illegible]

DRUG : <u>1mg EUROSEN MDL</u>				Date
Dose	Route	Frequency	Start Dt.	Time
<u>5mg</u>	<u>W</u>	<u>BD</u>	<u>1/2</u>	<u>6/17</u>
Name & Signature of the Doctor Starting the Drugs: <u>Shankhaya</u>				<u>9/17</u>
				<u>10/17</u>
Additional Instructions:				<u>11/17</u>
				<u>12/17</u>
Daily Doctor's Endorsement by a Sign				<u>1/18</u>
				<u>2/18</u>



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : INT CICLOSPORINE				Date Time	8/7/20	10/2/20														
Dose	Route	Frequency	Start Dt.	8/7/20	10/2/20															
15mg	IV	BD	8/7/20																	
Name & Signature of the Doctor Starting the Drugs:				Dr. Pratikshu Additional Instructions:																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				Dr. Pratikshu																

DRUG : SUP SEPTAN				Date Time	9/7	10/7	11/7	12/7	13/7	14/7	15/7	16/7	17/7	18/7	19/7	20/7	21/7	22/7	23/7	24/7
Dose	Route	Frequency	Start Dt.	8/7/20																
2.5ml	P/O	12Hrly	8/7/20																	
Name & Signature of the Doctor Starting the Drugs:				Dr. Pratikshu Additional Instructions:																
Additional Instructions:				mod wed. Friday.																
Daily Doctor's Endorsement by a Sign				Dr. Pratikshu																

DRUG : Domperidone Injection				Date Time	9/7	10/7	11/7	12/7	13/7	14/7	15/7	16/7	17/7	18/7	19/7	20/7	21/7	22/7	23/7	24/7
Dose	Route	Frequency	Start Dt.	8/7/20																
2.5ml	P/O	12Hrly	8/7/20																	
Name & Signature of the Doctor Starting the Drugs:				Dr. Pratikshu Additional Instructions:																
Additional Instructions:				mod wed. Friday.																
Daily Doctor's Endorsement by a Sign				Dr. Pratikshu																

DRUG : SUP. UNIV				Date Time	9/7	10/7	11/7	12/7	13/7	14/7	15/7	16/7	17/7	18/7	19/7	20/7	21/7	22/7	23/7	24/7
Dose	Route	Frequency	Start Dt.	8/7/20																
5ml	P/O	12Hrly	8/7/20																	
Name & Signature of the Doctor Starting the Drugs:				Dr. Pratikshu Additional Instructions:																
Additional Instructions:				mod wed. Friday.																
Daily Doctor's Endorsement by a Sign				Dr. Pratikshu																



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : Tab Ir-Lan 20 CF				Date Time	11/2	12/2	13/2	14/2	15/2	16/2	17/2	18/2	19/2	20/2
Dose 1 tab	Route PO	Frequency OD	Start Dt. 10/2											
Name & Signature of the Doctor Starting the Drugs: Sarani														
Additional Instructions: (1 tab = 15mg)														
Daily Doctor's Endorsement by a Sign														
DRUG : INT TRANEXAMIC ACID				Date Time	11/2	12/2	13/2	14/2	15/2	16/2	17/2	18/2	19/2	20/2
Dose 100mg	Route IV	Frequency BD	Start Dt. 10/2											
Name & Signature of the Doctor Starting the Drugs: Sarani														
Additional Instructions:														
Daily Doctor's Endorsement by a Sign														
DRUG : Iry A-CEF.				Date Time	11/2	12/2	13/2	14/2	15/2	16/2	17/2	18/2	19/2	20/2
Dose 500mg	Route IV	Frequency OD	Start Dt. 11/2											
Name & Signature of the Doctor Starting the Drugs: Sarani														
Additional Instructions: with 20ml 5% D.														
Daily Doctor's Endorsement by a Sign														
DRUG : Syb Carelmax PWS				Date Time	11/2	12/2	13/2	14/2	15/2	16/2	17/2	18/2	19/2	20/2
Dose 5ml	Route PO	Frequency OD	Start Dt. 11/2											
Name & Signature of the Doctor Starting the Drugs: Sarani														
Additional Instructions:														
Daily Doctor's Endorsement by a Sign														

Signature

VERIFIED BY : Name



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : Tob cloxazum				Date Time																
Dose 1 tab	Route PO	Frequency OD	Start Dt. 11/7	11/7	12/7	13/7	14/7	15/7	16/7	17/7	18/7	19/7	20/7	21/7	22/7	23/7	24/7	25/7	26/7	27/7
Name & Signature of the Doctor Starting the Drugs: harani				8 PM 9 PM 10 PM 11 PM 12 PM 1 PM 2 PM 3 PM 4 PM 5 PM 6 PM 7 PM 8 PM 9 PM 10 PM 11 PM 12 PM 1 PM 2 PM 3 PM																
Additional Instructions: 1 tab - 2.5mg																				
Daily Doctor's Endorsement by a Sign				11/7 12/7 13/7 14/7 15/7 16/7 17/7 18/7 19/7 20/7 21/7 22/7 23/7 24/7 25/7 26/7 27/7 28/7 29/7																

DRUG : Syo ciccospoRINE				Date Time																
Dose 0.2ml	Route PO	Frequency BD	Start Dt. 11/7	11/7	12/7	13/7	14/7	15/7	16/7	17/7	18/7	19/7	20/7	21/7	22/7	23/7	24/7	25/7	26/7	27/7
Name & Signature of the Doctor Starting the Drugs: harani				8 PM 9 PM 10 PM 11 PM 12 PM 1 PM 2 PM 3 PM 4 PM 5 PM 6 PM 7 PM 8 PM 9 PM 10 PM 11 PM 12 PM 1 PM 2 PM 3 PM																
Additional Instructions: 1ml/100mg																				
Daily Doctor's Endorsement by a Sign				11/7 12/7 13/7 14/7 15/7 16/7 17/7 18/7 19/7 20/7 21/7 22/7 23/7 24/7 25/7 26/7 27/7 28/7 29/7																

DRUG : ly ONOANCEETRON				Date Time																
Dose 3mg	Route IV	Frequency BD	Start Dt. 14/7	14/7	15/7	16/7	17/7	18/7	19/7	20/7	21/7	22/7	23/7	24/7	25/7	26/7	27/7	28/7	29/7	30/7
Name & Signature of the Doctor Starting the Drugs: harani				8 PM 9 PM 10 PM 11 PM 12 PM 1 PM 2 PM 3 PM 4 PM 5 PM 6 PM 7 PM 8 PM 9 PM 10 PM 11 PM 12 PM 1 PM 2 PM 3 PM																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				14/7 15/7 16/7 17/7 18/7 19/7 20/7 21/7 22/7 23/7 24/7 25/7 26/7 27/7 28/7 29/7 30/7 31/7 1/8																

DRUG : T. VALACYCLOVIR				Date Time																
Dose 1/4th	Route PO	Frequency BD	Start Dt. 14/7	14/7	15/7	16/7	17/7	18/7	19/7	20/7	21/7	22/7	23/7	24/7	25/7	26/7	27/7	28/7	29/7	30/7
Name & Signature of the Doctor Starting the Drugs: Shankhesh				8 PM 9 PM 10 PM 11 PM 12 PM 1 PM 2 PM 3 PM 4 PM 5 PM 6 PM 7 PM 8 PM 9 PM 10 PM 11 PM 12 PM 1 PM 2 PM 3 PM																
Additional Instructions: 1 tab = 500mg																				
Daily Doctor's Endorsement by a Sign				14/7 15/7 16/7 17/7 18/7 19/7 20/7 21/7 22/7 23/7 24/7 25/7 26/7 27/7 28/7 29/7 30/7 31/7 1/8																

VERIFIED BY : Name Signature

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG :				Date
Dose				Time
Route				
Frequency				
Start Dt.				
Name & Signature of the Doctor				
Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date
Dose				Time
Route				
Frequency				
Start Dt.				
Name & Signature of the Doctor				
Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date
Dose				Time
Route				
Frequency				
Start Dt.				
Name & Signature of the Doctor				
Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date
Dose				Time
Route				
Frequency				
Start Dt.				
Name & Signature of the Doctor				
Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date
Dose				Time
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: 24/6/28 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 :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature				Valid Period	Pharm.														
Additional Instructions:																			

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

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



REGULAR PRESCRIPTIONS

Weight. 10.19kg Ward. One

DRUG : <u>Ini ONDENSETRON</u>				Date/Time	24/6	25/6	26/6	27/6	28/6	29/6	30/6									
Dose	Route	Frequency	Start Date																	
3mg	IV	TID	24/6/2022																	
Name & Signature of the Doctor Starting the Drugs:				T. Panwar 2pm x 1000mg 10pm x 1000mg 24/6/2022																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				A d d d d d d d d d d d d d d d d d d																

DRUG : <u>Ini PANTOPRAZOLE</u>				Date/Time	24/6	25/6														
Dose	Route	Frequency	Start Date																	
10mg	IV	24/6/2022	24/6/2022																	
Name & Signature of the Doctor Starting the Drugs:				T. Panwar 2pm x 1000mg 10pm x 1000mg 24/6/2022																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				A d d d d d d d d d d d d d d d d d d																

DRUG : <u>5UP. UDILIV</u>				Date/Time	24/6	25/6	26/6	27/6	28/6	29/6	30/6	1/7	2/7	3/7	4/7	5/7	6/7	7/7	8/7
Dose	Route	Frequency	Start Date																
4ML	PO	BD	24/6																
Name & Signature of the Doctor Starting the Drugs:				A. Shankar 2pm x 1000mg 10pm x 1000mg 24/6/2022															
Additional Instructions:				5ml = 125mg															
Daily Doctor's Endorsement by a Sign				A d d d d d d d d d d d d d d d d d d															

DRUG : <u>CHLOXHEXIDINE MOUT</u>				Date/Time	24/6	25/6	26/6	27/6	28/6	29/6	30/6	1/7	2/7	3/7	4/7	5/7	6/7	7/7	8/7
Dose	Route	Frequency	Start Date																
mouth wash	PO	QID	24/6																
Name & Signature of the Doctor Starting the Drugs:				A. Shankar 2pm x 1000mg 10pm x 1000mg 24/6/2022															
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign				A d d d d d d d d d d d d d d d d d d															

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIK
 11-02-2022 4 Y 4 M 13 D (F)
 Dr. SRISHA RANI



Weight. 10 kg Ward. Onco

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
24/6	5pm	Syr. ALBENDAZOLE (5ml = 200mg)	10 mL	PO	Al	Moomita Dirya
27/6/26	11pm	T. AMLODIPINE 2.5 mg	1/2 Tab	PO	Al	Pooja Dirya.
3/7/26	11:30AM	STEM CELLS	150ml	IV over 1 hour	Al	Blk Pooja
3/7/26	11:30AM	inj AVIL	0.4ml	IV	Al	Blk Pooja
3/7/26	12:00	inj CASIX	5mg	IV	Al	Blk Pooja
4/7/26	9pm	Inj. AVIL	5mg	IV	R	Sonam Am
4/7/26	9pm	Inj. PRBC	200ml IV over 4 hrs.	IV	R	Sonam Am
5/7/26	12AM	Inj. hanc	5mg	IV	R	Sonam Am

(midway)



STAT / ONCE ONLY DRUGS

Name:

Weight: kgs

Sheet No:

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
5/2/26	1PM	Inj VITAMIN-K	3mg	IV	d	Moumita	Divya
5/2/26	12:30PM	Inj VITAMIN B ₁₂	500mcg	IV	d	Moumita	Divya
5/7/26	3pm	INT FOLINIC ACID	9mg	IV	R	Moumita	Divya
5/9/26	12pm	Inj CASIX	5mg	IV	d	Moumita	Divya
2/7	1pm	INT FOLINIC ACID	9mg	IV	R	Moumita	Divya
8/8/24	11:15AM	Inj. AVIL	5mg	IV	R	Rajamani	Veena
10/2	1pm	Inj folinic Acid	9mg	IV	d	Sonam	Pooja
10/2	2:30PM	SDP 1/20 (modulated)		IV	R	Aam	Aam
10/2	2pm	INT VITAMIN K	3mg	IV	R	Sonam	Pooja
12/07	1PM	Tri vitamin B ₁₂	500mcg	IV	R	Moumita	Divya
15/07	1PM	Tri FOLINIC ACID	9mg	IV	R	Susmita	Pooja
16/7	8pm	Inj AVIL	5mg	IV	R	Wase	Divya
16/2	8:5PM	SDP	1/2 unit	IV	R	Wase	Divya
18/7	3:15PM	Inj AVIL	5mg	IV	R	Susmita	Anu
18/2	3:15PM	ARBe	200ML	IV	R	Susmita	Anu
18/2	7:45PM	Inj FUROSEMIDE	5mg	IV	R	Susmita	Anu
19/2	12PM	Inj VITAMIN K	3mg	IV	R	Baji	Divya
19/2	1:30pm	Inj Vitamin B ₁₂	500mcg	IV	R	Goya	Anuach

MEDICATION RECONCILIATION FORM

Drug Allergies: NO ☒ 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: Once ward

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

* C- Continue, DC - Discontinue

HISTORY RECORDED / VERIFIED BY

Signature: [Signature]
24/06/26
 Signature: [Signature]
24/6/26 @ 2pm

012



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

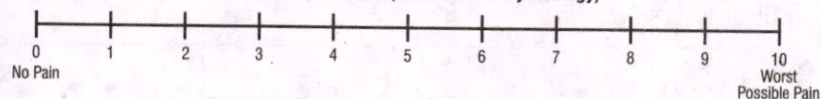
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

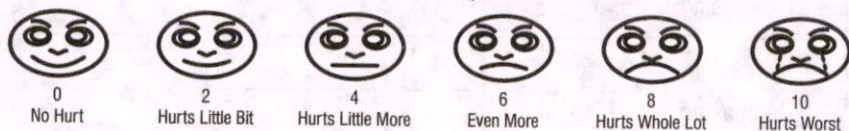
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIKA
 11-02-2022 4 Y 5 M 5 D (F)
 Dr. SIRISHA RANI



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

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
18/7	6am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sany
18/7	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Susmita
18/7	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sany
19/7	6am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sany
19/7	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rajames
19/7	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sany
20/7	6am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Gourav
20/7	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	R
20/7	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sany
21/7	6am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sany

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.
 - Within 30 - 60 minutes after pain relief intervention.

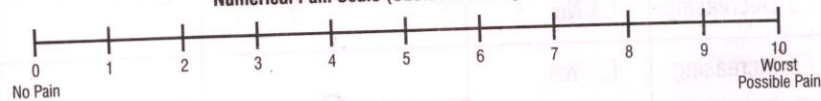
(PT.O)

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

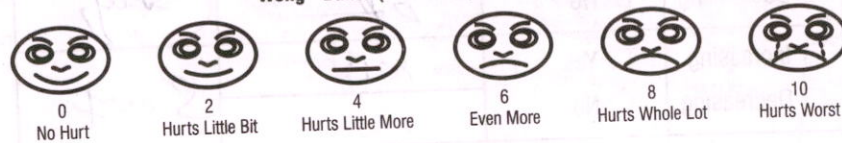
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWIKA
11-02-2022 4 Y 4 M 28 D (F)
Dr. SIRISHA RANI



PAIN ASSESSMENT FORM

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/2	2pm	0	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NO	Say
11/2	1pm	0	NM	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NR	G
12/2	6am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	G
12/2	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	MB
12/2	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	MA	2
13/2	6am	0	MA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	MA	3
13/2	2pm	0	MA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	MA	MB
13/2	10pm	0	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NO	bluy
14/2	6am	0	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	MB
14/2	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	MA	MB

Re-assessment Frequency:

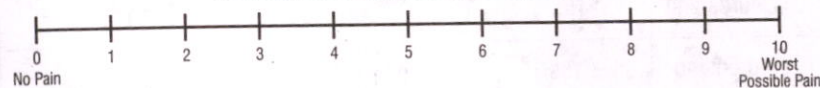
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

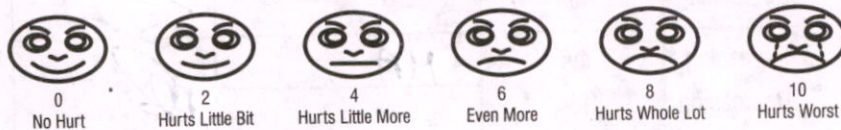
Numerical Pain Scale (Obstetric and Gynecology)



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



8

PAIN ASSESSMENT FORM

Date	Time	(0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
8/7	6am	0	WB	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	WB	Shy
8/7	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Raji
8/7	10pm	0	N/A	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	N/A	Arum
9/7	6am	0	N/A	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	N/A	Arum
9/7	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Pooja
10/7	10am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	WB	Shy
10/7	8pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sona
10/7	4pm	0	N/A	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	N/A	Arum
10/7	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shy
11/7	6am	0	WB	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	WB	Shy

Re-assessment Frequency:

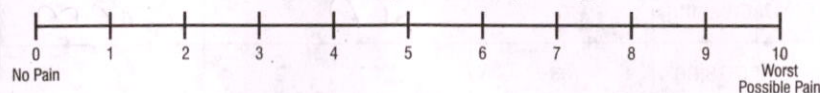
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

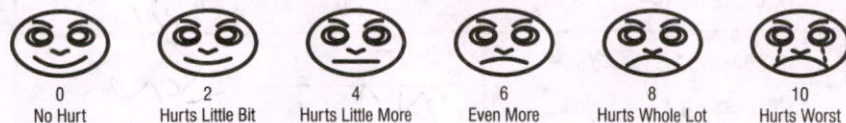
Numerical Pain Scale (Obstetric and Gynecology)



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	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
4/7/20	6pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pchls
5/7	2AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	S
5/7	10AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	moumita
5/7	6PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	moumita
6/7	2AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sonam
6/7	10AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	moumita
6/7	6pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	EL
7/7	2AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	EL
7/7	10AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
7/7	6PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	

Re-assessment Frequency:

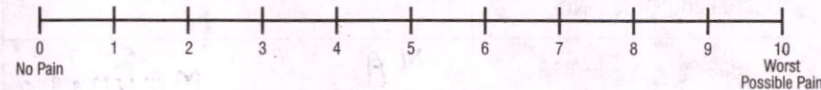
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after-pain relief intervention.

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

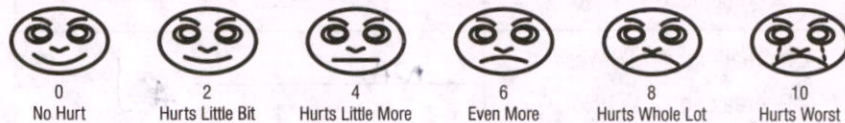
Numerical Pain Scale (Obstetric and Gynecology)



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	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
1/7	6am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	et
1/7	3pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shruti
1/7	11pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	et
2/7	7am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	et
2/7	6pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shruti
2/7	2am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Adm
3/7	10am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shruti
3/7	6pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pooja
4/7	2am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sonam
4/7	10am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sonam

Re-assessment Frequency:

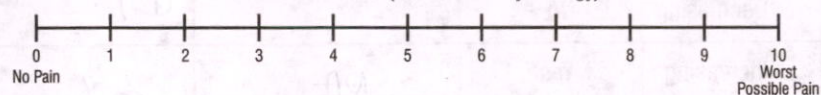
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

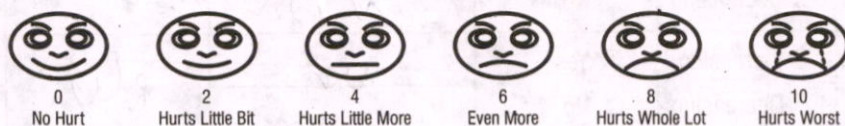
Numerical Pain Scale (Obstetric and Gynecology)



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





21

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
28/6	12am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Pin
28/6	2am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Pin
28/6	4pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pin
28/6	10PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pin
29/6	6AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pin
29/6	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pin
29/6	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pin
30/6	6pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pin
30/6	3pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pin
30/6	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pin

Re-assessment Frequency:

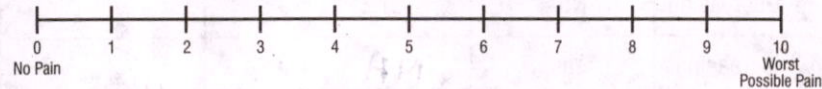
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

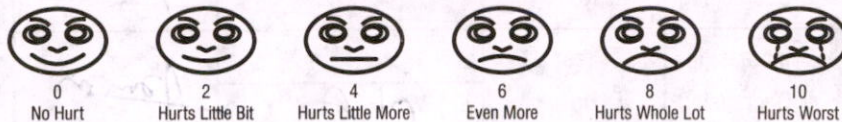
Numerical Pain Scale (Obstetric and Gynecology)



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 - slow recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIKA
 11-02-2022 4 Y 4 M 13 D (F)
 Dr. SIRISHA RANI



PAIN ASSESSMENT FORM

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
24/6/22	2pm	0	nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NK	aswath
24/6	10PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
25/6	6am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
25/6	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
25/6	10PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
26/6	6AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
26/6	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
26/6	10PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rayi
24/6	8AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
28/6	4pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]

Re-assessment Frequency:

Every eight hours for all hospitalized patients.

For surgical patients, patients with chronic pain, patient with severe pain:

a) Every 2 hours for the first 24 hours

b) Then every 4 hours

c) After intervention.

d) Within 30 - 60 minutes after pain relief in

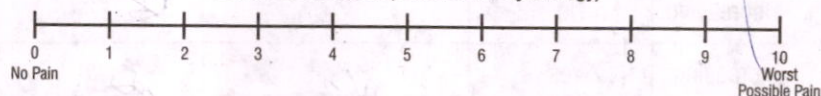
ion.

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

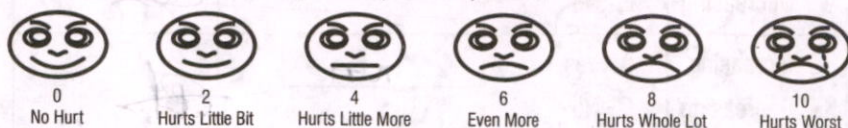
Numerical Pain Scale (Obstetric and Gynecology)



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 baseline, SaO ₂ equal to

Wong - Baker (Pediatrics) Above 7 Years



2. For post-operative pain, use the Wong-Baker FACES Pain Rating Scale. At least every 15 minutes. ILM / CLINICAL / 152



PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/7 Time:														
Doctor / Nurse / Family Concern?														
Wt: 10.2kg Hgt: 47cm Temperature (F)	104													
	103													
	102													
	101													
	100													
	99													
	98													
	97													
	96													
	95													
94														
Heart Rate (bpm) and Blood Pressure (mmHg) *	190													
	180													
	170													
	160													
	150													
	140													
	130													
	120													
	110													
	100													
Note: BP does not score in early warning scoring	90													
	80													
	70													
	60													
	50													
	Heart Rate (Number)													
	Resp. Rate (bpm) (Over 1 Minute) *	70												
		60												
		50												
		40												
30														
20														
10														
Resp Rate (Number)														
Resp Distress		Mod/ Severe												
		None / Mild												
Receiving O ₂ (l/min)														
O ₂ Saturations (%)														
Conscious Level	Normal													
	Altered													
GCS *														
TOTAL SCORE														
Number of shaded boxes														
Pain Score														
Observer's Initials														

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

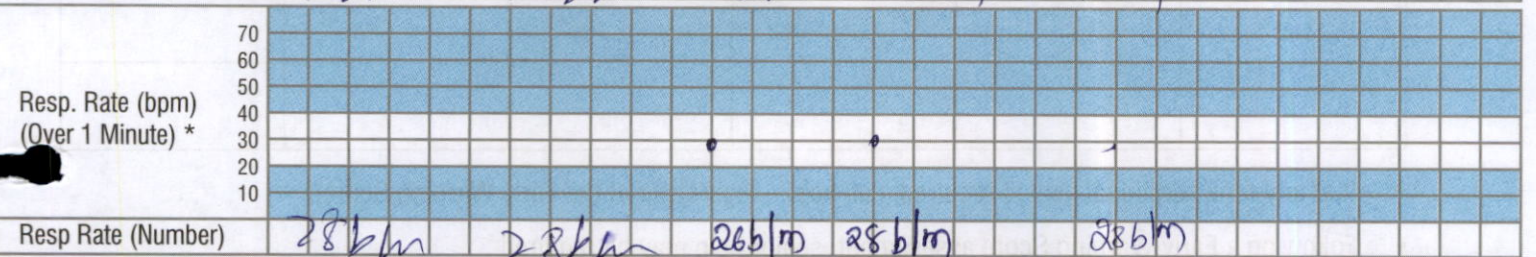
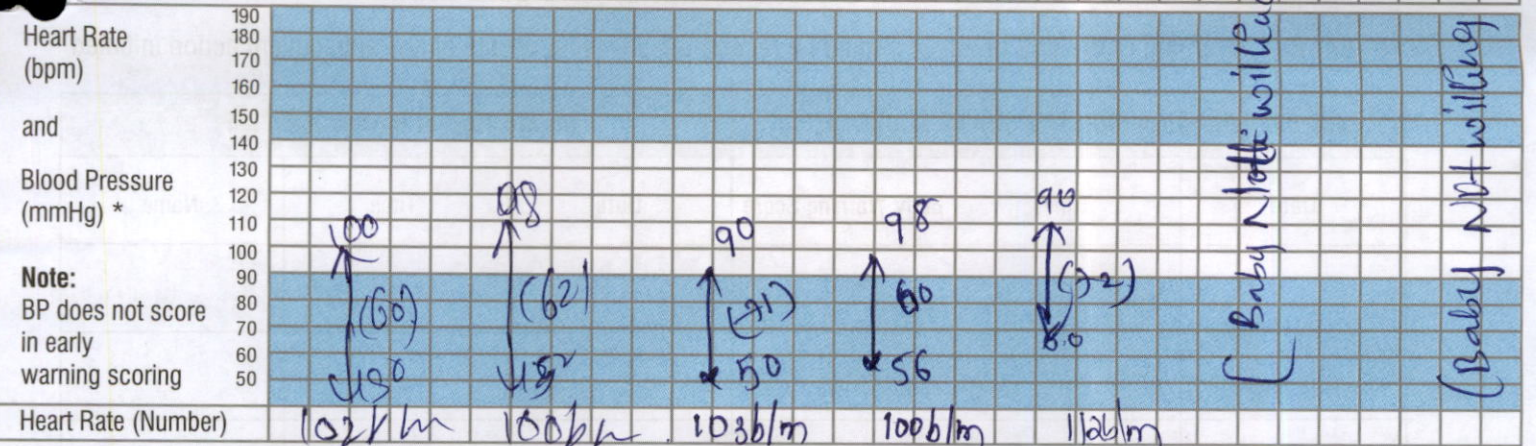
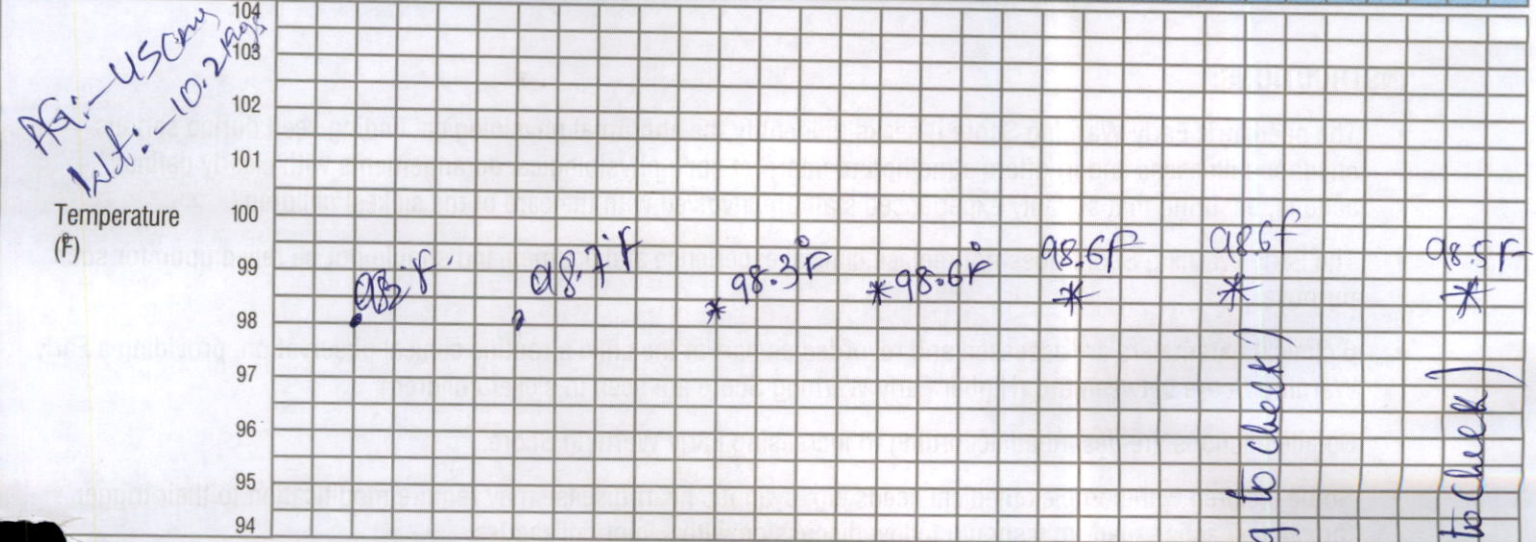
I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection).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



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 20/2 Time: 9am 1pm 4pm 7pm 10pm 3am 6am
 Doctor / Nurse / Family Concern?



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

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

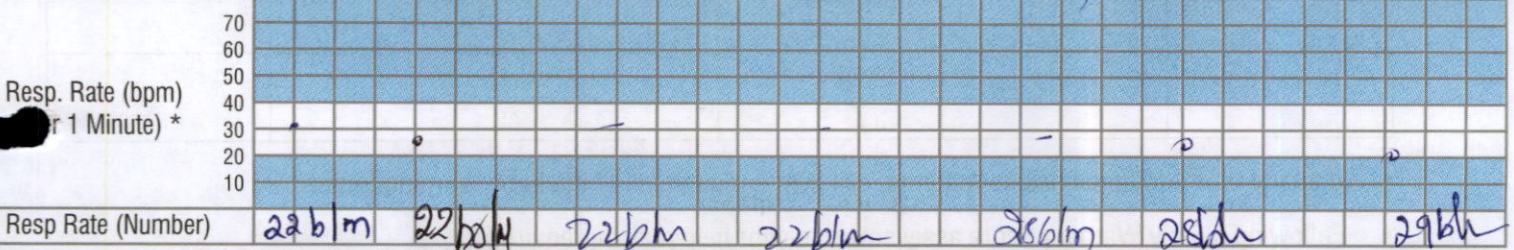
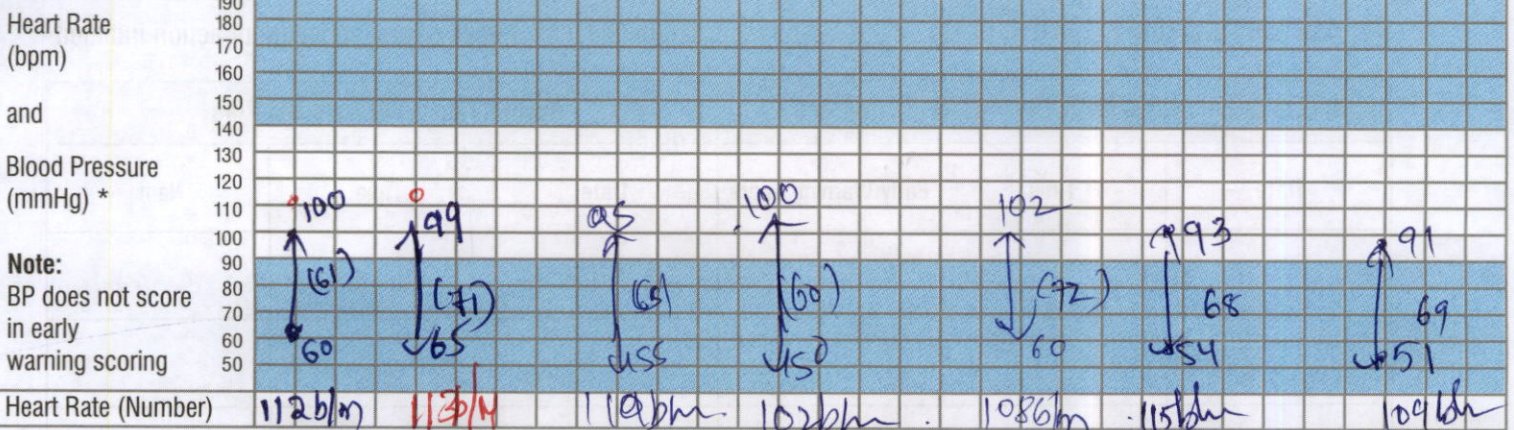
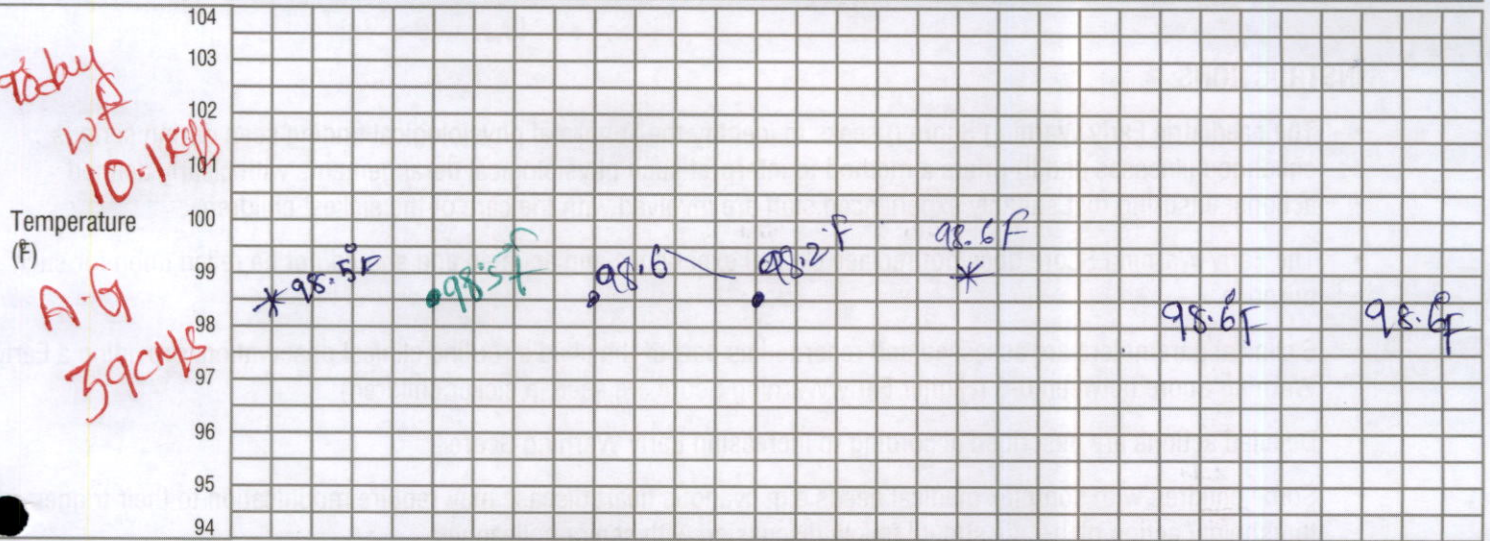


(27)

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/2 Time: 9am 1pm 4pm 7pm 10pm 3am 6am
 Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe	None / Mild					
Receiving O ₂ (l/min)							
O ₂ Saturations (%)	100%	100%	100%	100%	100%	100%	100%
Conscious Level	e	c	c	c	c	c	c
GCS *	15/15	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE	0	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0
Observer's Initials	AS	AS	AS	AS	AS	AS	AS

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

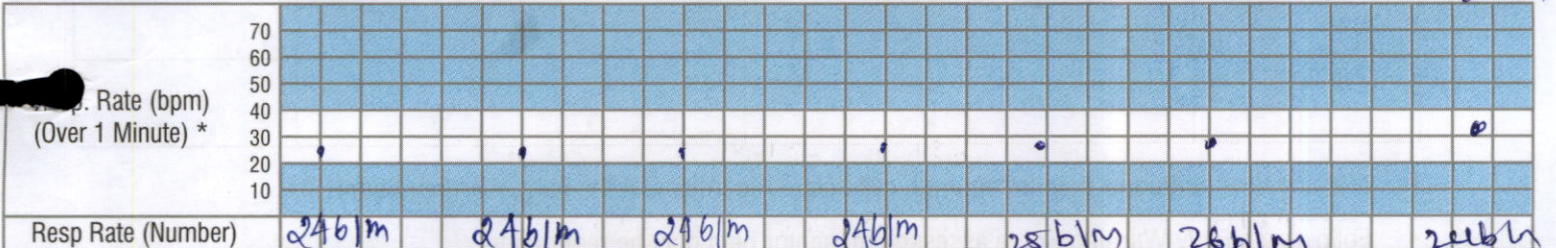
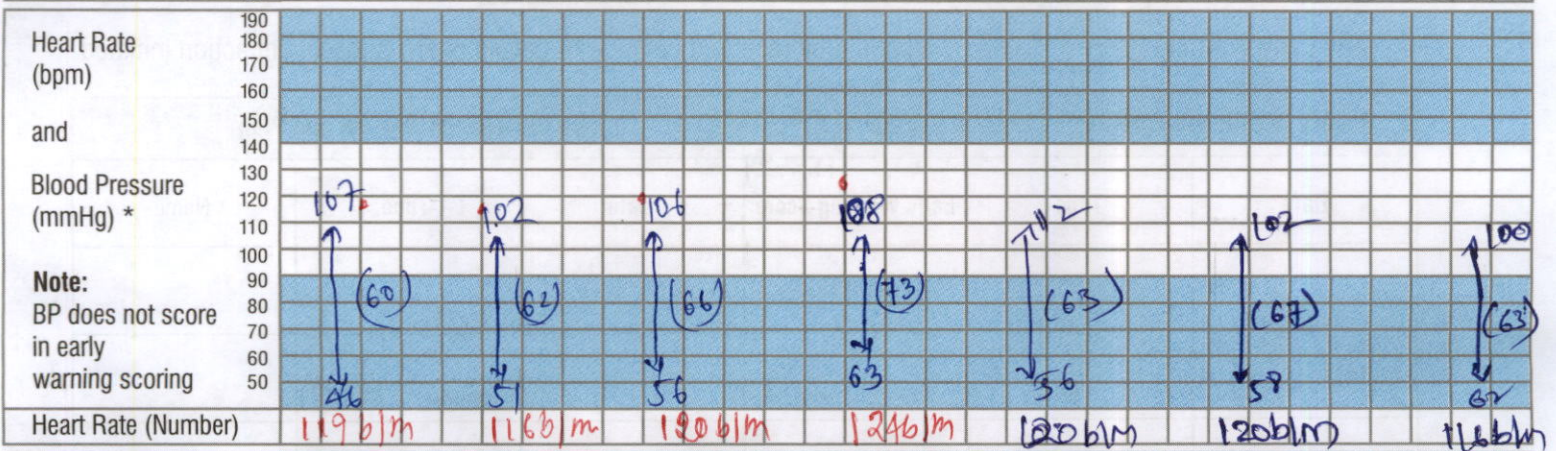
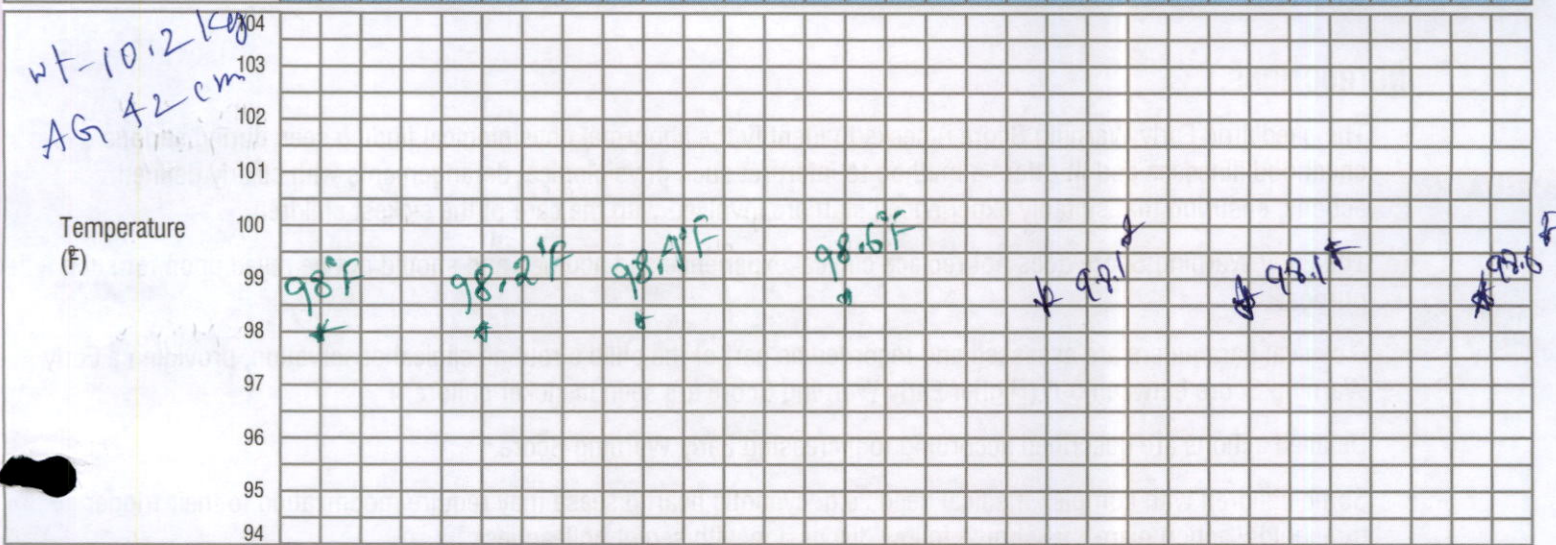


PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 18/2 Time: 9 AM 1 PM 4 PM 7 PM 10 PM 3 AM 6 AM

Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																	</
---------------	-------------	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	----

TOTAL SCORE																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																				
-------------	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 17/2	Time: 9AM	1PM	4PM	7PM	10PM	3am	6am
Doctor / Nurse / Family Concern?							
AG:- 42cm wt:- 10kg Temperature (F)	104						
	103						
	102						
	101						
	100						
	99						
	98	98.6F	98.8F	98.1F	98.5F	98.6F	98.5F
	97						
	96						
	95						
	94						
Heart Rate (bpm)	190						
and	180						
Blood Pressure (mmHg) *	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100	100	98	93	86	100	98
	90	(62)	(62)	(61)	(59)	(62)	(62)
	80	62	60	57	53	60	60
	70						
	60						
	50						
Note: BP does not score in early warning scoring							
Heart Rate (Number)		112b/m	120b/m	106b/m	103b/m	112b/m	102b/m
Resp. Rate (bpm)	70						
1 Minute) *	60						
	50						
	40						
	30						
	20						
	10						
Resp Rate (Number)		24b/m	24b/m	25b/m	26b/m	28b/m	29b/m
Resp Mod/ Severe Distress							
None / Mild							
Receiving O ₂ (l/min)							
O ₂ Saturations (%)		99%	99%	100%	99%	100%	98%
Conscious Level							
Normal Altered							
GCS *		15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE							
Number of shaded boxes		0	0	0	0	0	0
Pain Score		0	0	0	0	0	0
Observer's Initials		g	k	f	f	f	f

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

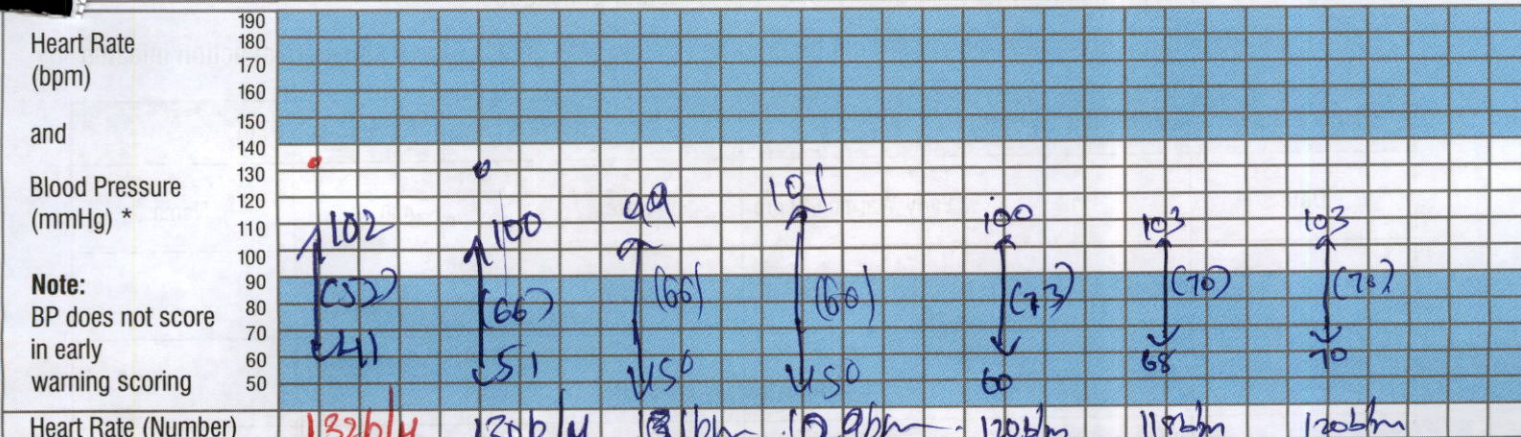
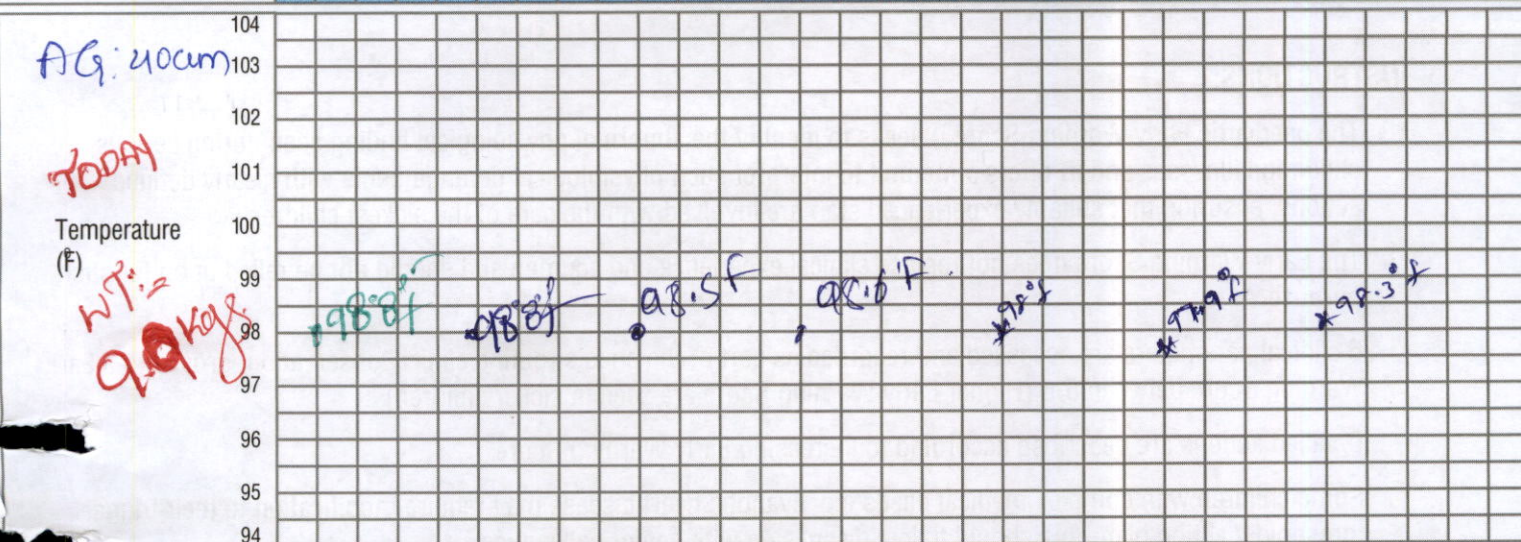
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 16/7 Time: 9AM 1PM 2PM 7PM 10PM 3PM 6PM
 Doctor / Nurse / Family Concern?



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

100% 100% 100% 100% 100% 100% 100%

C C C C C C C

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

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

- 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.

For 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)



(23)

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

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

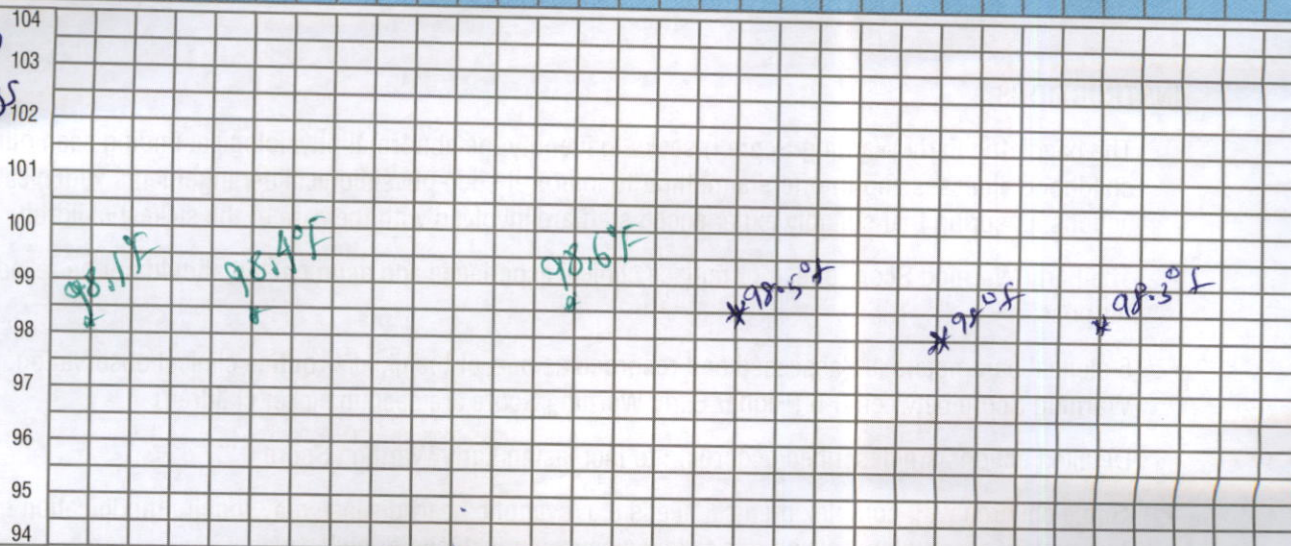
BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 15/2 Time: 9Am 1Pm 6Pm 10Pm 3Am 6Am
Doctor / Nurse / Family Concern?

AG: 40cm
WT: 9.8Kgs

Temperature
(F)

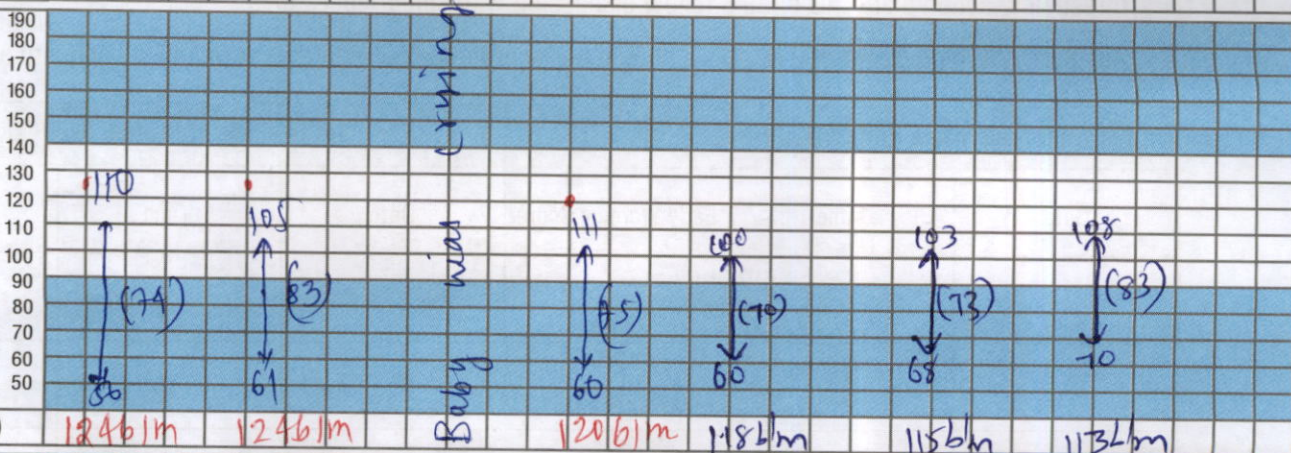


Heart Rate
(bpm)

and

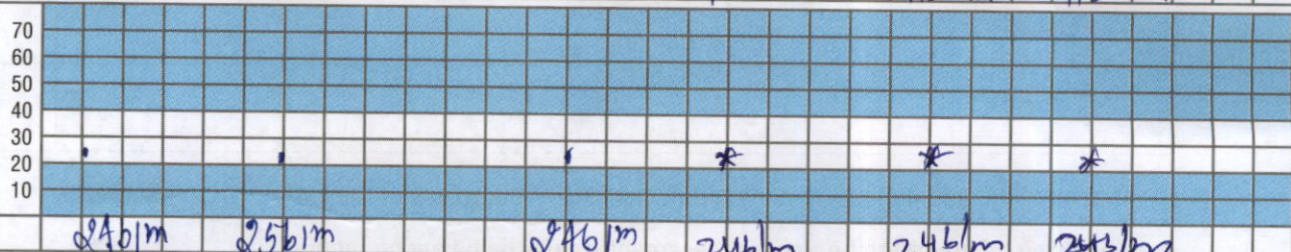
Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring



Heart Rate (Number)

Resp. Rate (bpm)
(over 1 Minute) *



Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

Receiving O₂ (l/min)
O₂ Saturations (%)

Conscious Level
Normal Altered

GCS *

Resp Mod/ Severe Distress	None	Mild	None	Mild	None	Mild
Receiving O ₂ (l/min)	0	0	0	0	0	0
O ₂ Saturations (%)	100%	100%	98%	100%	100%	100%
Conscious Level	C	C	C	C	C	C
GCS *	15/15	15/15	15/15	15/15	15/15	15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

Number of shaded boxes	0	0	1	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	P	P	P	P	P	P

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



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

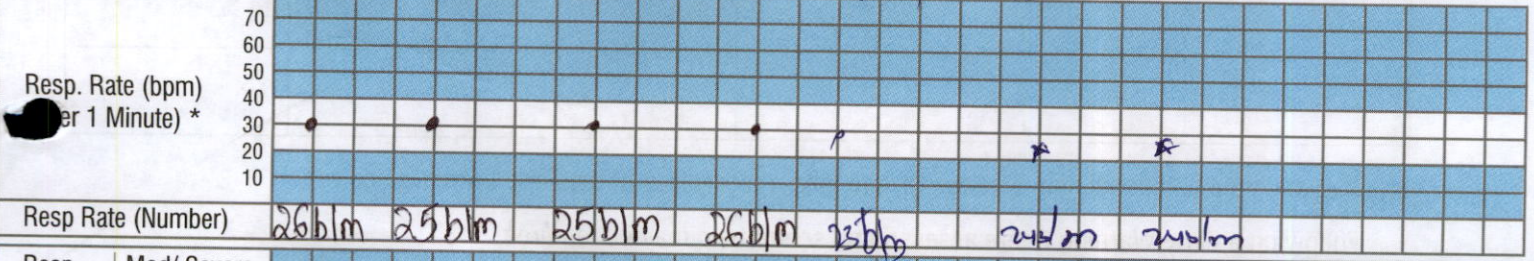
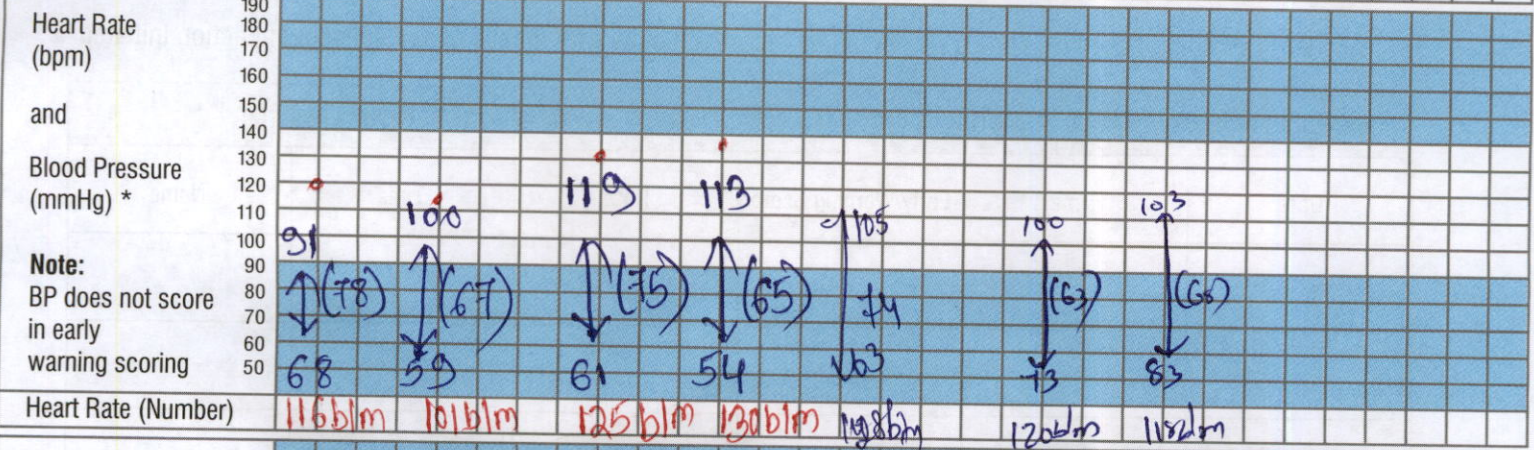
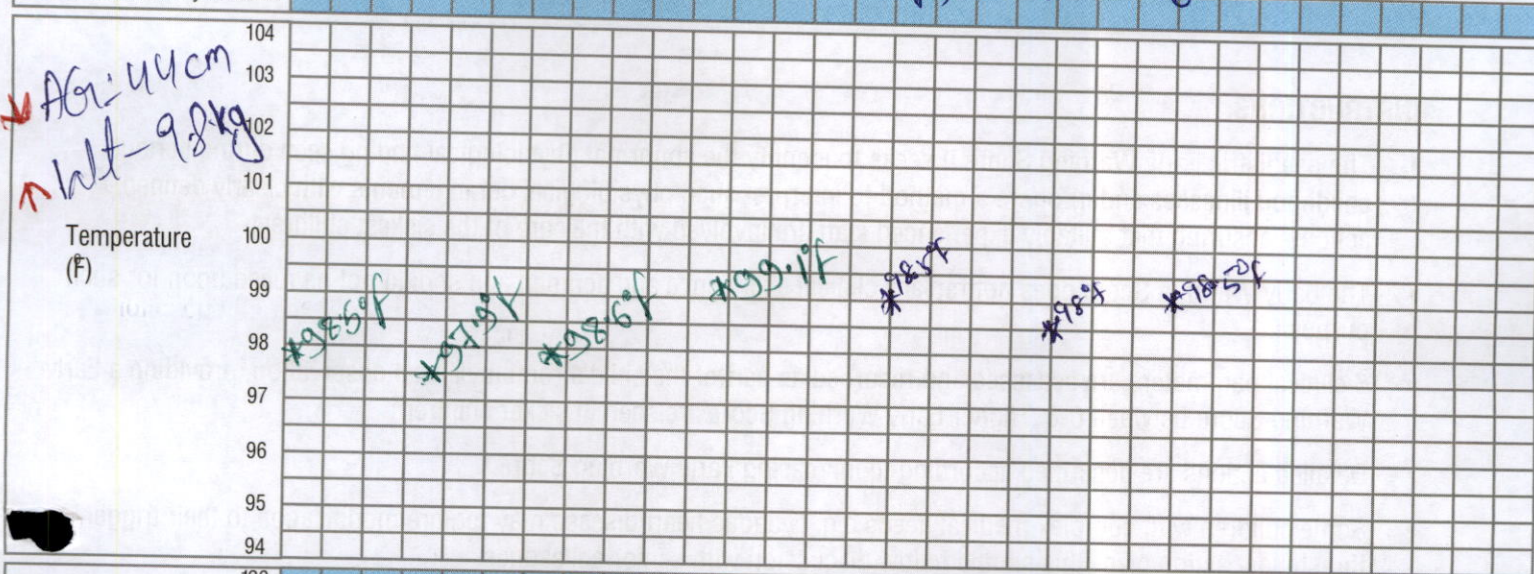
PRESCHOOL (1-5 years)
 Children's Observation &
 Early Warning Scoring Chart

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 14/2/2022 Time: 10 AM 1 PM 4 PM 7 PM 10 PM 3 AM 6 AM
 Doctor / Nurse / Family Concern?



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

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

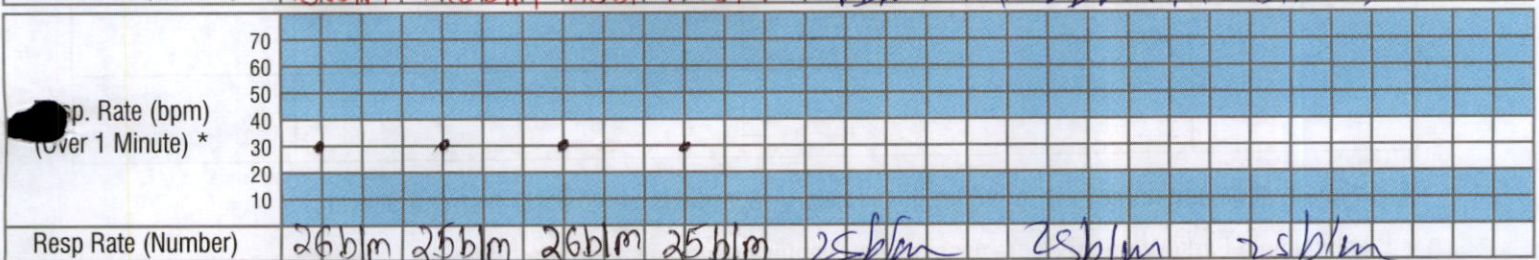
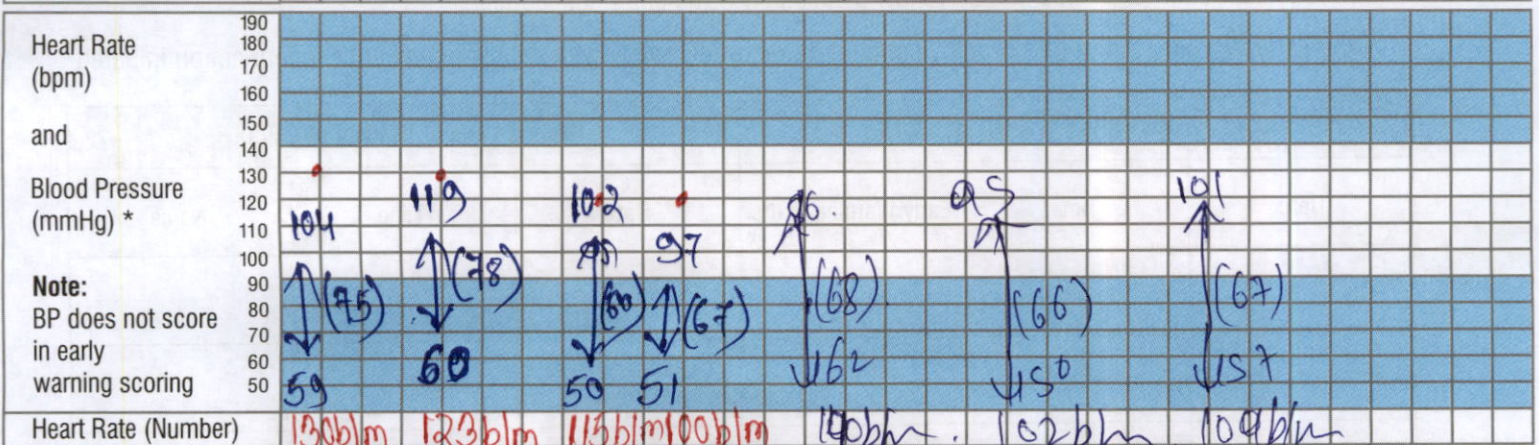
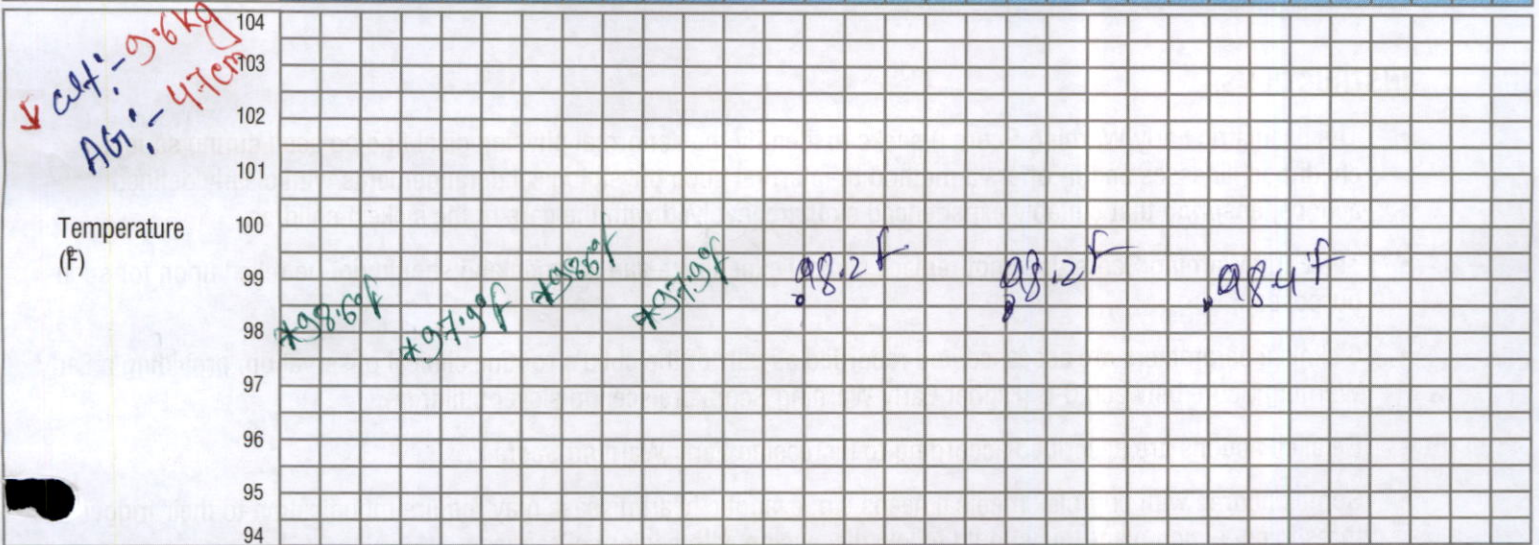
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 13/2 Time: 9AM 1PM 4PM 7PM 10PM 3AM 6AM
Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)		
O ₂ Saturations (%)	100%	100%
Conscious Level	Normal	Altered
GCS *	15/15	15/15

TOTAL SCORE	0	0	0	0	0	6	0
Number of shaded boxes	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0
Observer's Initials	SB	SB	SB	SB	SB	SB	SB

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

NB: Scores 3 should be recorded overleaf

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



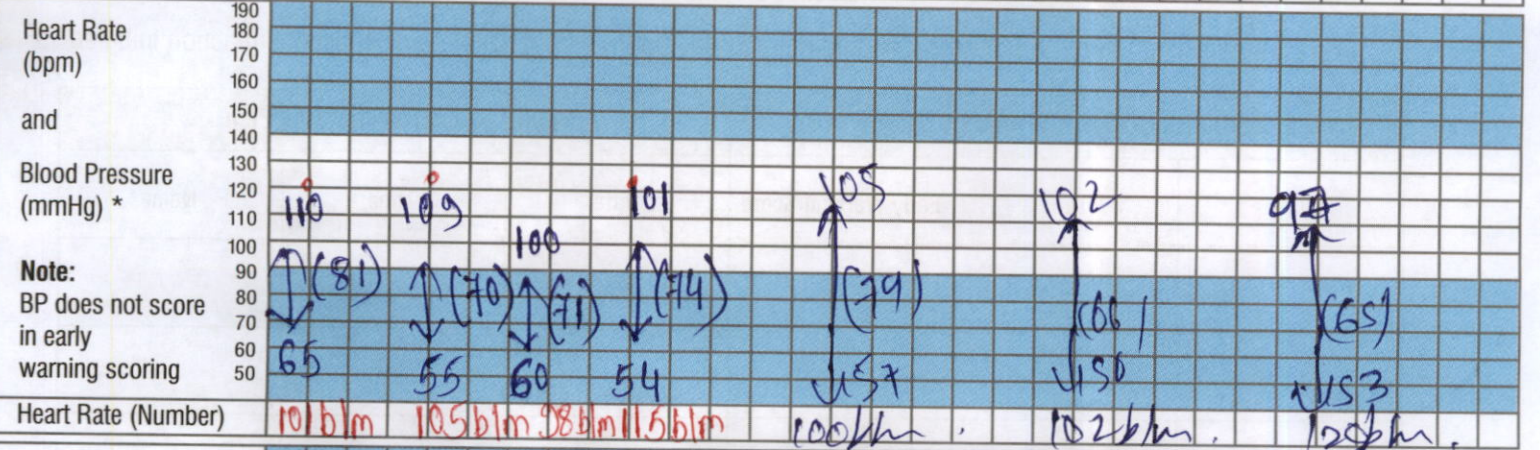
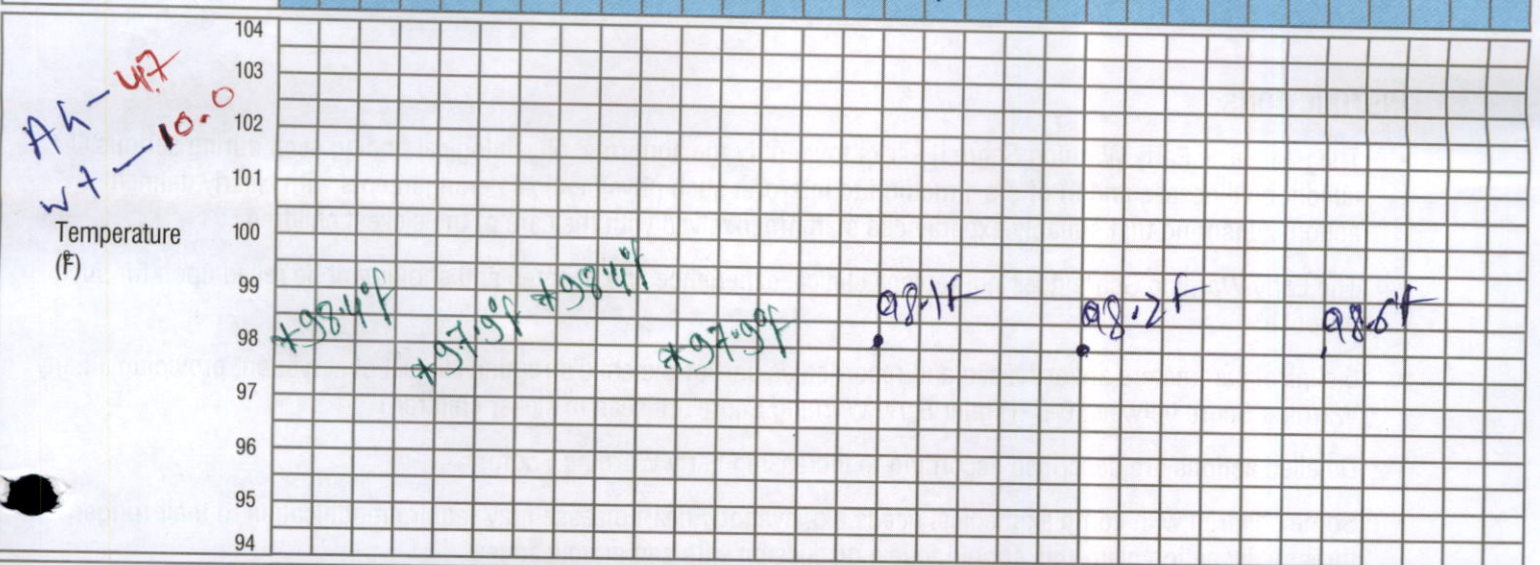
PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11-02-2022 Time: 9 AM 1 PM 4 PM 7 PM 10 PM 3 AM 6 AM

Doctor / Nurse / Family Concern?



Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%)

100% 100% 100% 100% 100% 100% 100%

Conscious Level Normal / Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



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

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

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/2 Time: 9 AM 1 PM 4 PM 6 PM 10 PM 8 AM 6 AM
 Doctor / Nurse / Family Concern?

AGI - 47
 1st - 9.9

Temperature (F)	104						
	103						
	102						
	101						
	100						
	99						
	98	98.6f	98.6f	98.4f	98.4f	98.1f	98.2f
	97						
	96						
	95						
	94						

Heart Rate (bpm)	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
	90						
	80						
	70						
	60						
	50						
Heart Rate (Number)		122b/m	119b/m	109b/m	101b/m	109b/m	113b/m

Resp. Rate (bpm) (Over 1 Minute) *	70						
	60						
	50						
	40						
	30						
	20						
	10						
Resp Rate (Number)		30b/m	30b/m	27b/m	27b/m	27b/m	27b/m

Resp	Mod/ Severe						
Distress	None / Mild						

Receiving O ₂ (l/min)							
O ₂ Saturations (%)		100%	100%	100%	100%	100%	100%

Conscious Level	Normal						
	Altered						
GCS *		15/15	15/15	15/15	15/15	15/15	15/15

TOTAL SCORE							
Number of shaded boxes		0	0	0	0	0	0
Pain Score		0	0	0	0	0	0
Observer's Initials							

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

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)



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

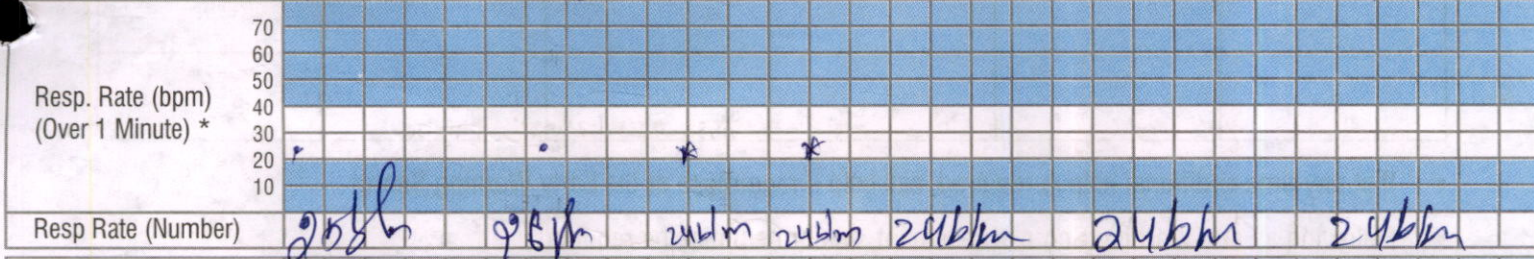
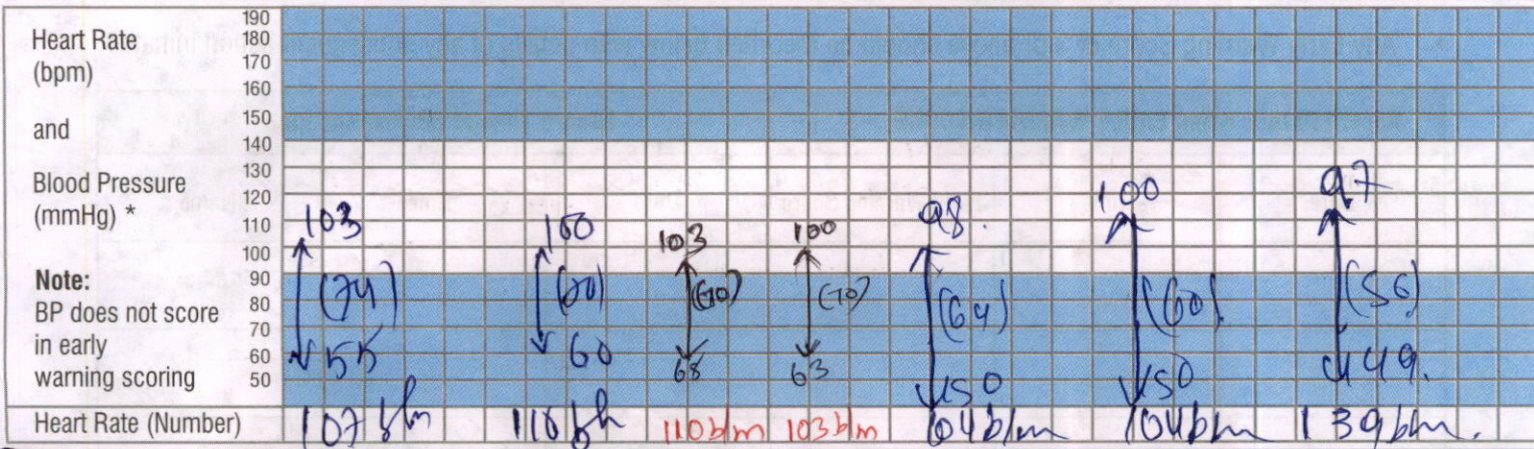
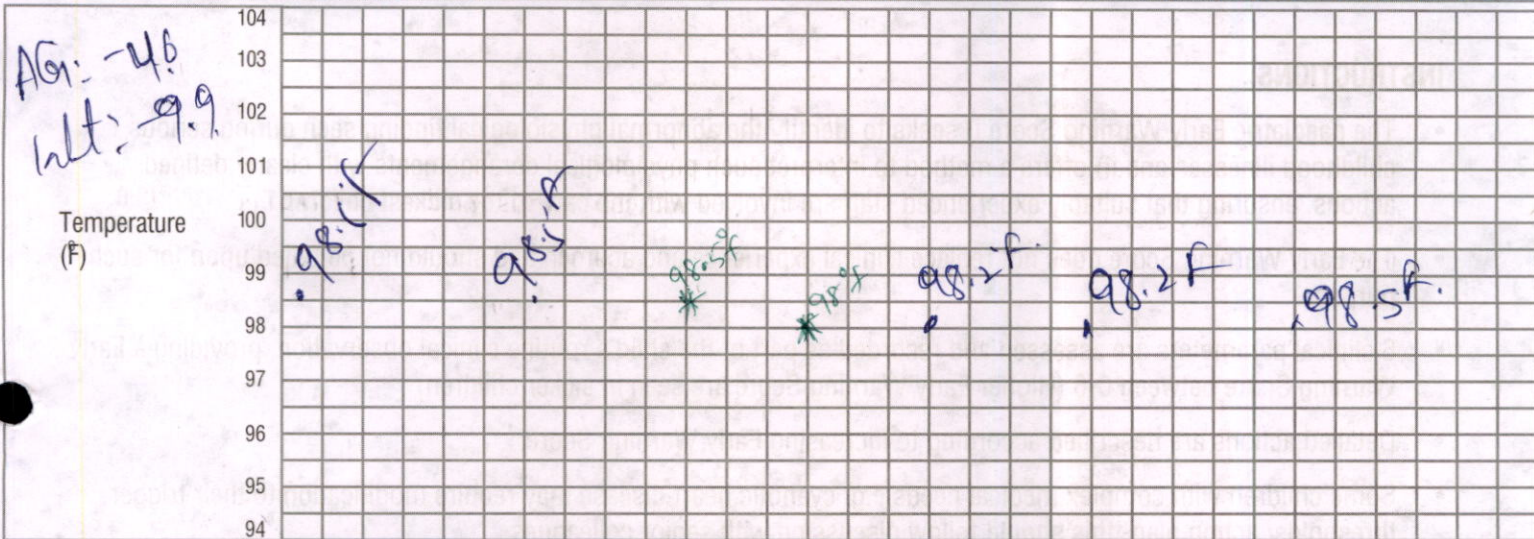
PRESCHOOL (1-5 years)
Children's Observation &
Early Warning Scoring Chart

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/2 Time: 9Am 1Pm 3pm 7pm 10pm 3Am 6Am
 Doctor / Nurse / Family Concern?



Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%)

Conscious Level Normal / Altered

GCS *

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

ACTIONS
 NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

(17)

No. : RCH/ FRM / CLINICAL / 125

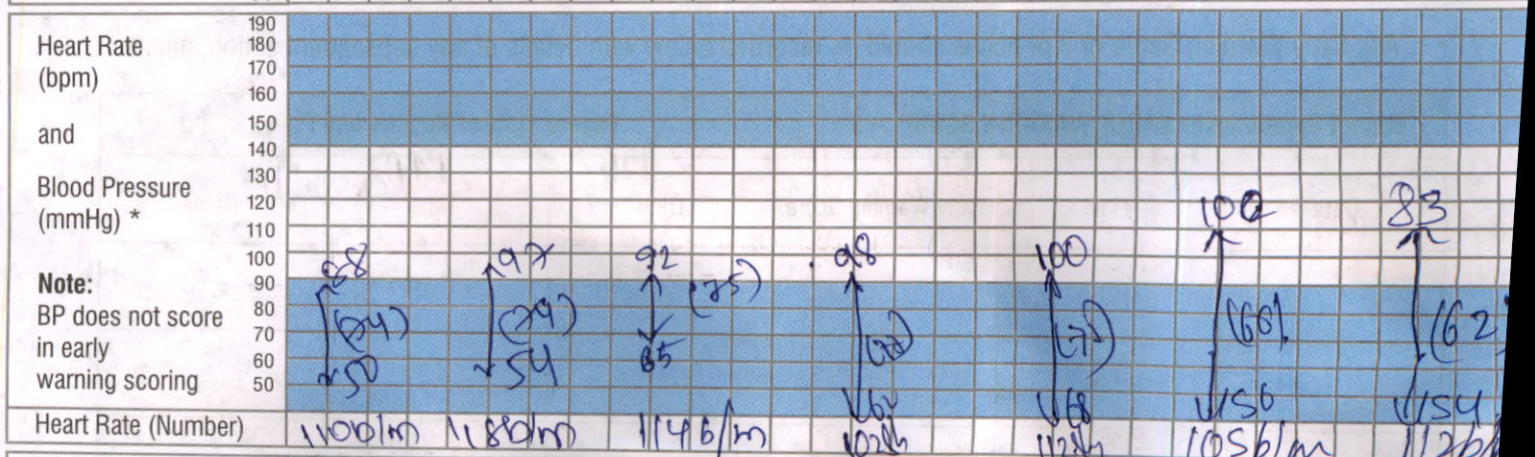
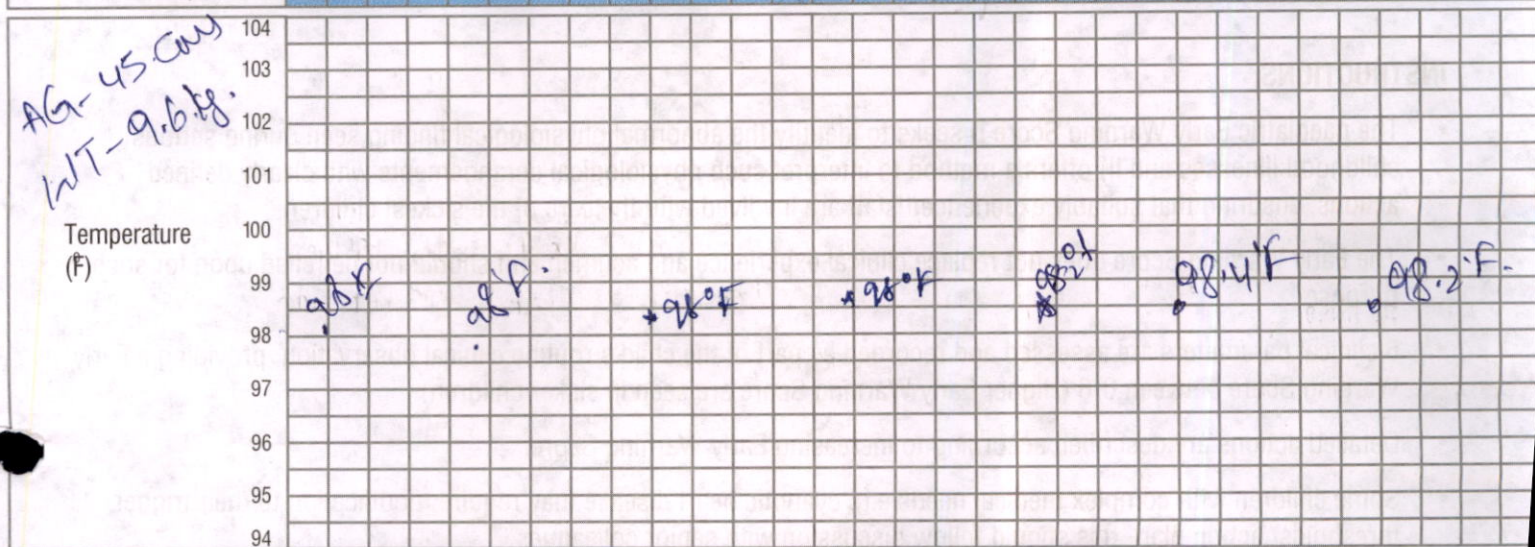
PRE-SCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9/1/26 Time: 9am 1pm 4PM 7PM 10PM 3Am 6Am
 Doctor / Nurse / Family Concern?



Resp Rate (Number)

Time	Resp Rate (Number)
9am	26
1pm	24
4PM	24
7PM	24
10PM	20
3Am	20
6Am	20

Resp Mod/ Severe Distress None / Mild

Time	Resp Mod/ Severe Distress
9am	None
1pm	None
4PM	None
7PM	None
10PM	None
3Am	None
6Am	None

Receiving O₂ (l/min) O₂ Saturations (%)

Time	O ₂ (l/min)	O ₂ Saturations (%)
9am	100%	100%
1pm	100%	100%
4PM	100%	100%
7PM	100%	100%
10PM	100%	100%
3Am	100%	100%
6Am	100%	100%

Conscious Level Normal / Altered

Time	Conscious Level
9am	Normal
1pm	Normal
4PM	Normal
7PM	Normal
10PM	Normal
3Am	Normal
6Am	Normal

GCS *

Time	GCS
9am	15/15
1pm	15/15
4PM	15/15
7PM	15/15
10PM	15/15
3Am	15/15
6Am	15/15

TOTAL SCORE

Time	TOTAL SCORE
9am	0
1pm	0
4PM	0
7PM	0
10PM	0
3Am	0
6Am	0

Number of shaded boxes

Time	Number of shaded boxes
9am	0
1pm	0
4PM	0
7PM	0
10PM	0
3Am	0
6Am	0

Pain Score

Time	Pain Score
9am	0
1pm	0
4PM	0
7PM	0
10PM	0
3Am	0
6Am	0

Observer's Initials

Time	Observer's Initials
9am	SR
1pm	SR
4PM	SR
7PM	SR
10PM	SR
3Am	SR
6Am	SR

ACTIONS

Score	Action
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 in
Score 4	: Shift in charge AND treating consultant (till 8 PM) or On call night duty consultant to be informed
Score 5 & 6	: Shift in charge AND PICU fellow or PICU consultant to be informed

NB: Scores 3 should be recorded overleaf

Score is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform

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

S

A

R

IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)

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)

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)

ASSESSMENT: I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am worried about what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.

ACTION: I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to (e.g. stop the fluid/ repeat observation)

ACTIVITY RECORD FOR BILLING

Name : _____

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWIK
11-02-2022 4 Y 4 M 13 D (F)
Dr. SIRISHA RANI

UHID No. : _____ Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
24/6/20	08:30 PM	ER	135	[Signature]
25/6/20	08:30	OT	135	[Signature]

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Namrata K	25/6/20	96742/3	[Signature]
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
24/6/16	CBP	63526	Dinesh
25/6/16	USG	31572	Pooja
25/6/16	chest-X-ray	031735	§
28/6	2D Echo	032075	Gayathri
29/6	Pre BMT workup.	26064308	Gayathri
30/6	CBP, LFT, creatin	26068340	Nimra
30/6	Blood c/s	26065550	Singh
	2D Echo		
4/7/16	CBP, S.E, calcium, creatinine.	26066843	Amrada
6/7	CBP, Elec, CO-levels	67407	Arun
6/7	S/E	26067727	§
7/7	Stool culture	26068057	§
8/7	CBP, LFT, Electrolyte, Creat	26068126	Dinesh
10/7	CBP, SE, C-level	26068843	§
12/7	CBP, SE	26069681	§
13/7			
14/7	CBP, SE, LFT, CO-levels	26070383	Dinesh
16/7	CBP, Creat	26071138	Dinesh
18/7	CBP, LFT, creat, S/E	26071923	Nasheem
20/7	CBP, Electrolyte, Creatinine	26072548	Gayathri
21/7	CBP	26072976	Dinesh

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
24/6/16	R Placement	1	72826	Dan
25/6/16	PAC	①	9679434	Sing
26/6/16	Chemotherapy	①	9679212	Sing
25/6	aspirin	①	9679434	Sing
4/5	Blood transfusion	①	96886146	de
	(PABC)			
3/6	Blood transfusion	①	9685430	Sing
	(Stem cells)			
8/7	IVIG (W)	①	9694161	de
10/7	Blood transfusion	①	9696772	de
	(SDD)			
18/7	Blood transfusion	①	9709939	de
	PABC & SDD			

ANY OTHER INFORMATION

Date: 21/7/16

Time: 11AM

Prepared By: Veng

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Veng	Day shift Oncology		



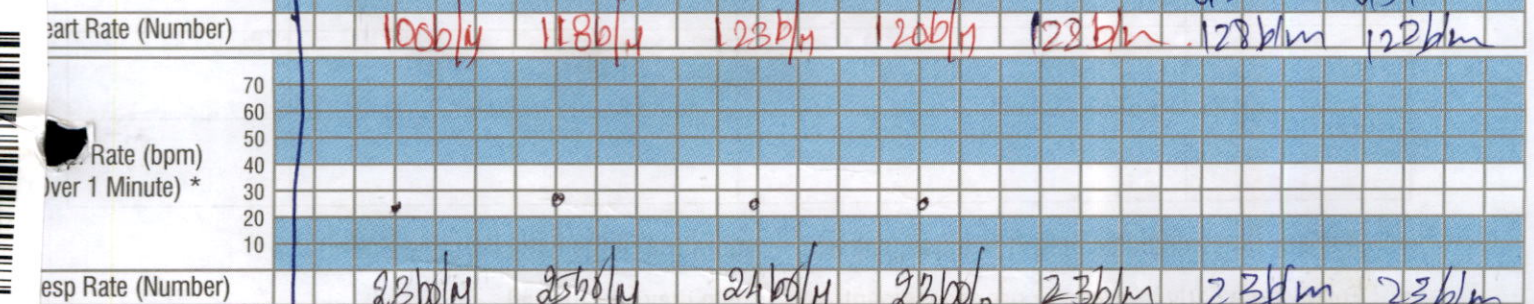
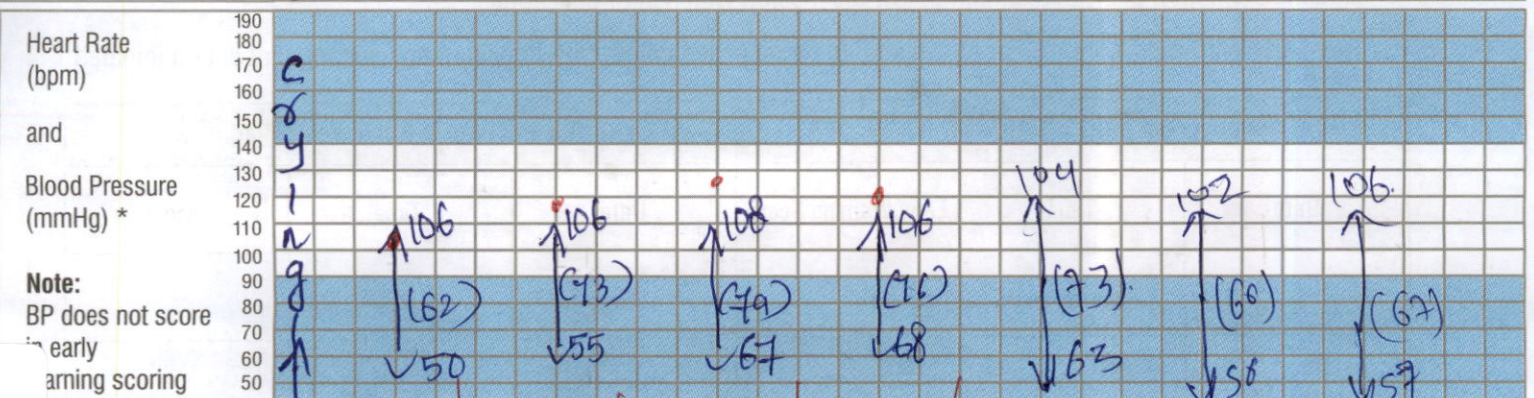
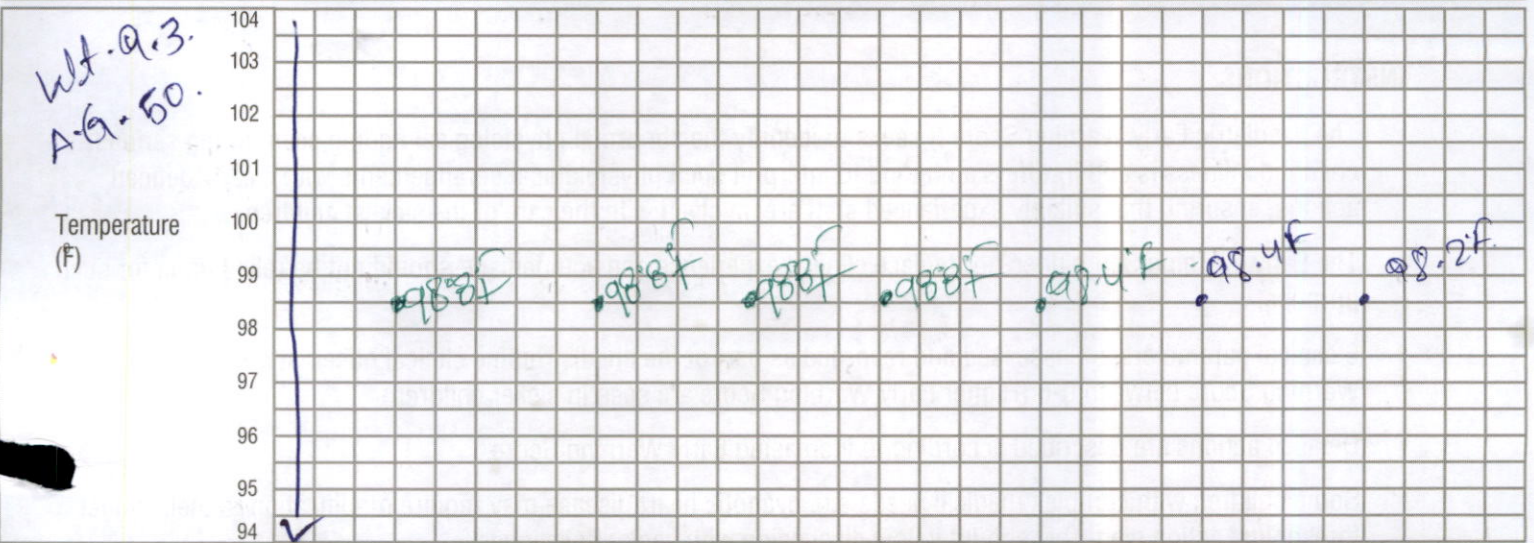
16

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 8/2/24 Time: 9 AM 10:15 AM 1 PM 4:20 PM 7 PM 10 PM 3 AM 6 AM
 Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		
Conscious Level	Normal	Altered
GCS *		
TOTAL SCORE		
Number of shaded boxes		
Min Score		
Server's Initials		

- 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.

or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

Children's Observation & Early Warning Scoring Chart



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 7/7 Time: 9AM 1pm 4pm 7pm 10pm 3Am 6Am

Doctor / Nurse / Family Concern?

Temperature
(°F)

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

Resp. Rate (bpm)
(Over 1 Minute) *

Resp Rate (Number)

Resp	Mod/ Severe
Distress	None / Mild

Receiving O ₂ (l/min)	O ₂ Saturations (%)
10	95.0
15	95.0
20	95.0
25	95.0
30	95.0
35	95.0
40	95.0
45	95.0
50	95.0
55	95.0
60	95.0
65	95.0
70	95.0
75	95.0
80	95.0
85	95.0
90	95.0
95	95.0
100	95.0

conscious	Normal
el	Altered

SCORE

of shaded boxes

Initials

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.

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

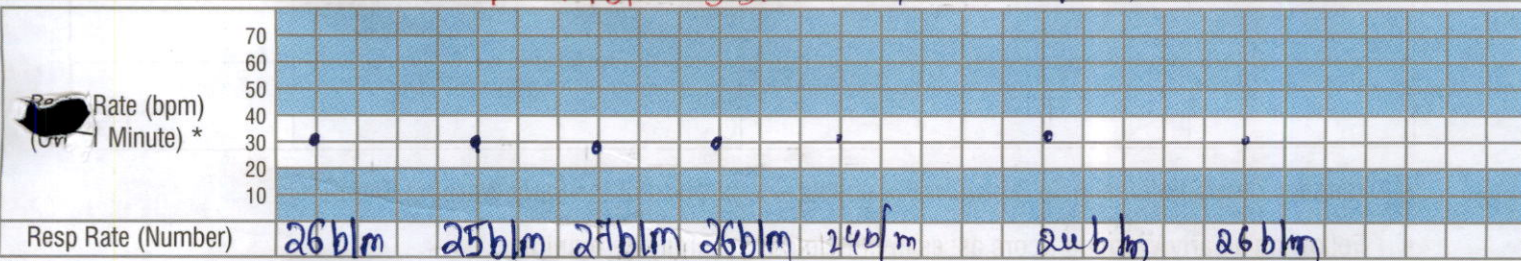
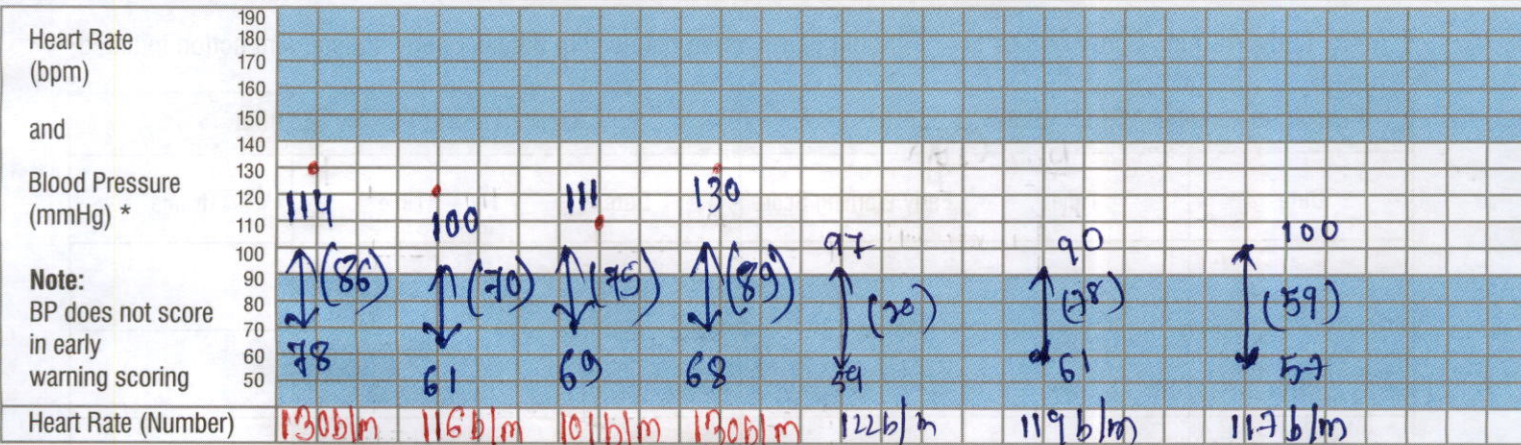
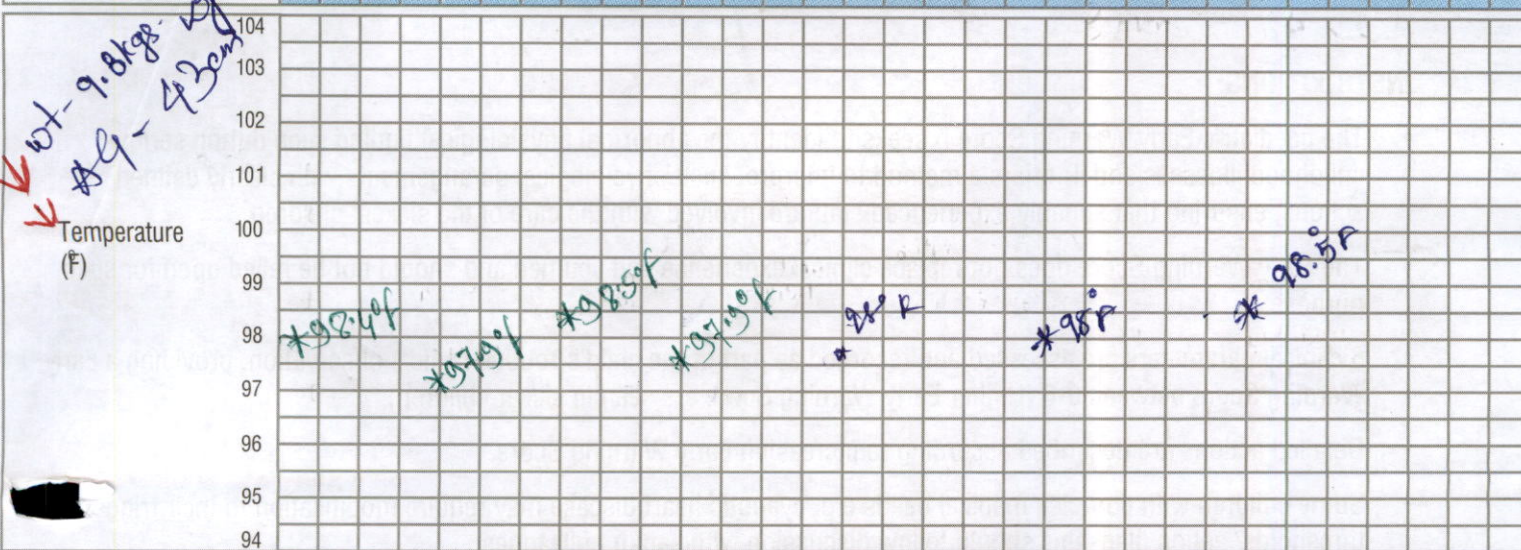
- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/2/2022 Time: 9AM 1PM 4PM 7PM 10PM 3AM 6AM
Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe	None / Mild

Receiving O₂ (l/min) O₂ Saturations (%)

Time	O ₂ (l/min)	O ₂ Saturations (%)
9AM	100%	100%
1PM	100%	100%
4PM	100%	100%
7PM	100%	100%
10PM	99%	99%
3AM	98%	98%
6AM	100%	100%

Conscious Level

Time	Conscious Level
9AM	C
1PM	C
4PM	C
7PM	C
10PM	C
3AM	C
6AM	C

GCS *

Time	GCS
9AM	15/15
1PM	15/15
4PM	15/15
7PM	15/15
10PM	15/15
3AM	15/15
6AM	15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be recorded overleaf

Score 1 : Continue normal observation by staff nurse

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

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

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



13

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 5/7	Time: 9AM	1pm	6pm	7pm	10pm	3AM	6AM
Doctor / Nurse / Family Concern?							
Weight: 10.3kg Age: 44cm							
Temperature (F)	98.5f	98.4f	98.4f	98.4f	98.5f	98.5f	98.5f
Heart Rate (bpm)	111	100	120	121	116	120	118
Blood Pressure (mmHg) *	69/45	61/40	66/46	68/48	68/48	68/48	68/48
Note: BP does not score in early warning scoring							
Heart Rate (Number)	105blm	100blm	95blm	121blm	116blm	120blm	118blm
Resp Rate (bpm) 1 Minute *	25	26	27	26	27	27	26
Resp Rate (Number)	25blm	26blm	27blm	26blm	27blm	27blm	26blm
Resp Mod/ Severe Distress None / Mild							
Receiving O ₂ (l/min)							
O ₂ Saturations (%)	100%	100%	100%	100%	99%	96%	95%
Conscious Level Normal Altered	C	C	C	C	C	C	C
GCS *	15/15	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE	0	0	0	0	0	0	0
Number of shaded boxes							
Pain Score							
Observer's Initials							

- 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.

If the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 4/2	Time: 10 am	1 pm	3 pm	5 pm	10 pm	3 am	6 am
Doctor / Nurse / Family Concern?							
T.Wt 10.1kg Temperature (F)	104						
	103						
	102						
	101						
	100						
	99	98.4°F	98.2°F	98.0°F	97.5°F	*98.5°F	*98.5°F
	98	*	*	*	*	*	*
	97						
	96						
	95						
94							
Heart Rate (bpm) and Blood Pressure (mmHg) * Note: BP does not score in early warning scoring	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
90							
80							
70							
60							
50							
Heart Rate (Number)	130b/min	122b/min	120b/min	124b/min	120b/min	120b/min	122b/min
Resp. Rate (bpm) (1 Minute) *	70						
	60						
	50						
	40						
	30	*	*	*	*	*	*
	20						
	10						
	Resp Rate (Number)	24b/min	24b/min	24b/min	24b/min	24b/min	24b/min
	Resp Distress	Mod/ Severe	Mod/ Severe	Mod/ Severe	Mod/ Severe	Mod/ Severe	Mod/ Severe
	None / Mild	*	*	*	*	*	*
Receiving O ₂ (l/min)							
O ₂ Saturations (%)	100%	99%	100%	99%	98%	100%	
Conscious Level	Normal	Normal	Normal	Normal	Normal	Normal	
Altered							
GCS *	15/15	15/15	15/15	15/15	15/15	15/15	
TOTAL SCORE							
Number of shaded boxes	0	0	0	0	0	0	
Pain Score	0	0	0	0	0	0	
Observer's Initials	R	R	R	R	R	R	
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.					

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



EARLY WARNING SCORE: CHILDREN'S UNIT

[illegible]

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 9Am 1Pm 3Pm 7Pm 10Pm 3Am 6Am

Doctor / Nurse / Family Concern?

Temperature (F)	104						
	103						
	102						
	101						
	100						
	99	98.4	98.4	98.2	98.8	98.5	98.5
	98						
	97						
	96						
	95						
	94						

Heart Rate (bpm)	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100	99 (60)	95 (65)	92 (72)	92 (75)	91 (80)	99 (85)
	90						
	80						
	70						
	60						
	50						
Heart Rate (Number)		102b/m	103b/m	102b	112b	109b/m	116b/m

Resp. Rate (bpm) (Over 1 Minute) *	70						
	60						
	50						
	40						
	30						
	20						
	10						
Resp Rate (Number)		22b/m	22b/m	20b	22b	23b/m	23b/m

Resp Distress	Mod/ Severe						
	None / Mild	r	r	r	r	r	r
Receiving O ₂ (l/min)							
O ₂ Saturations (%)		99%	99%	100%	98%	99%	98%
Conscious Level	Normal	C	C	C	C	C	C
	Altered						
GCS *		15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE		6	6	6	6	6	6
Number of shaded boxes							
Pain Score		0	0	0	0	0	0
Observer's Initials		S	S	e	c	e	R

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

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)

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

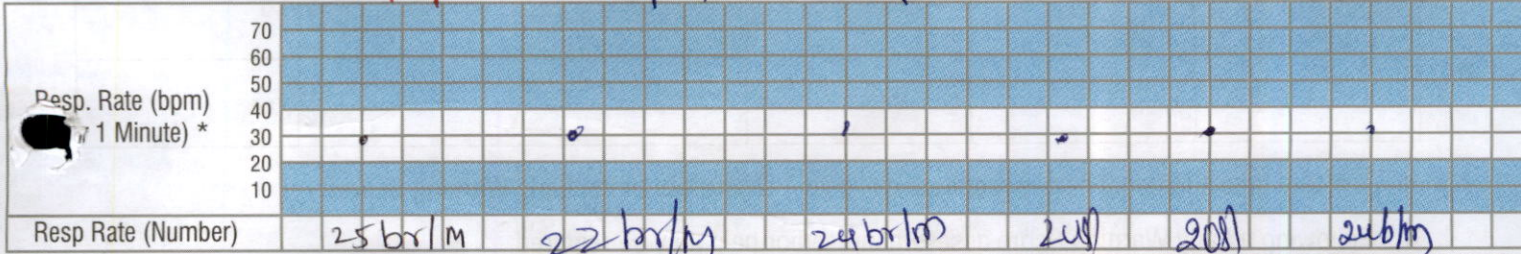
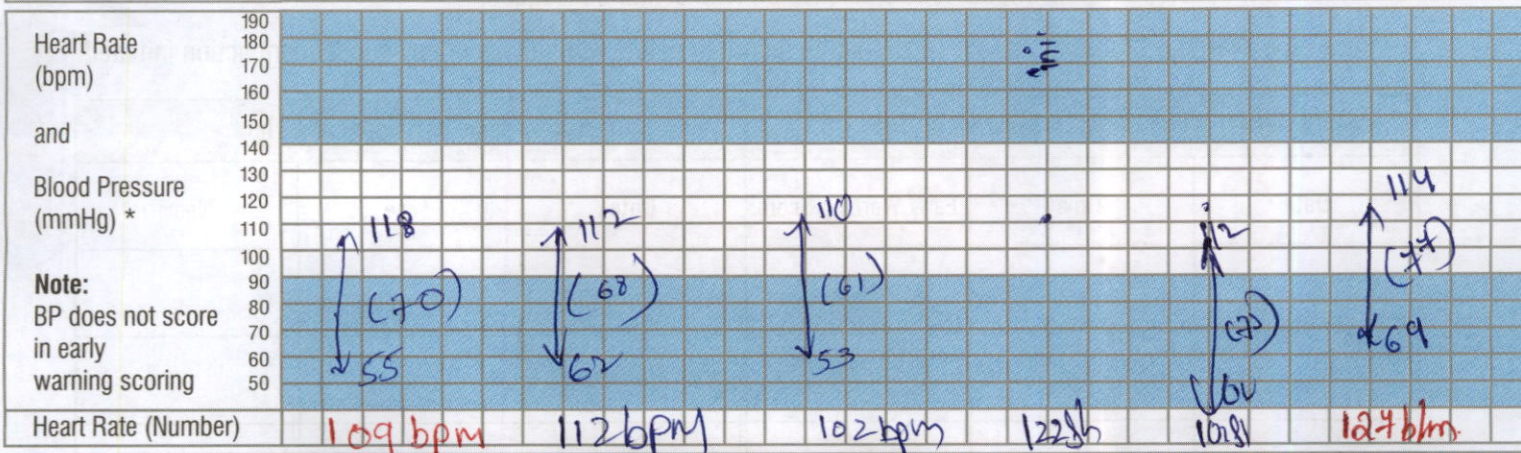
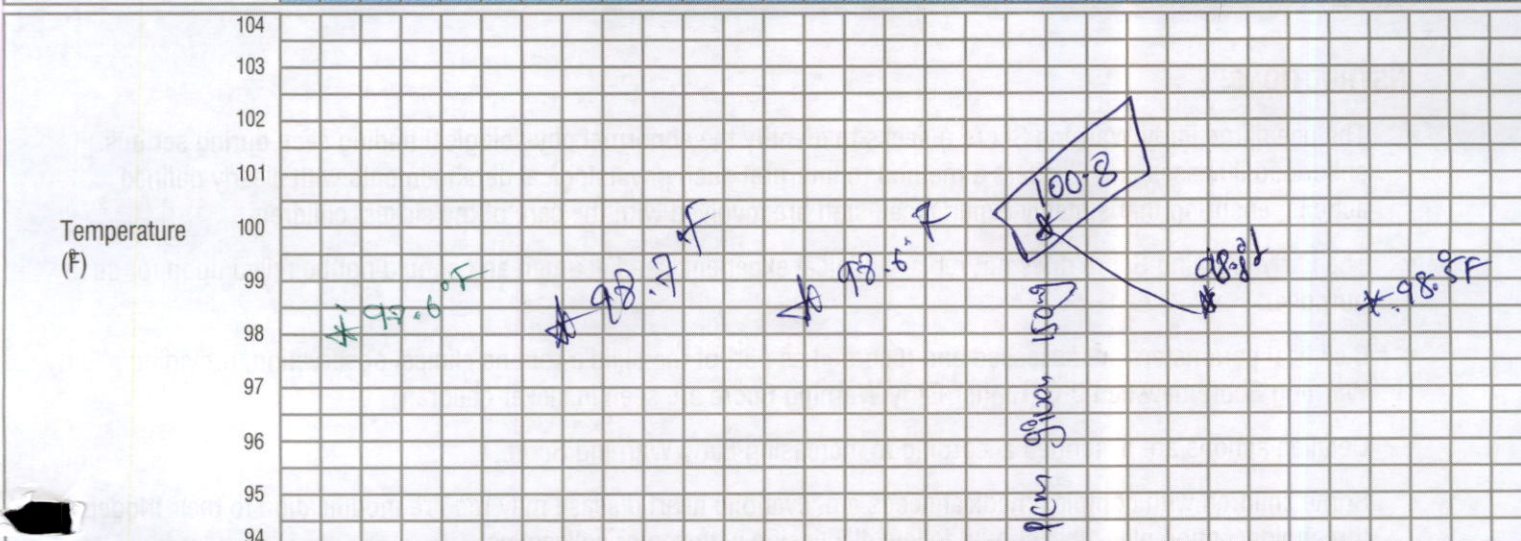


PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/2/20	Time: 9AM	1PM	4PM	6:30PM	7:30PM	10PM
Doctor / Nurse / Family Concern?						



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

TOTAL SCORE	0
Number of shaded boxes	0
Pain Score	0
Observer's Initials	[Signature]

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWIKA
11-02-2022 4 Y 4 M 19 D (F)
Dr. SIRISHA RANI



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

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

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/02/2022	Time: 9 AM	1 PM	4 PM	5 PM	7 PM	10 PM	2 PM	6 AM
Doctor / Nurse / Family Concern?								
Temperature (F)	104							
	103							
	102							
	101							
	100							
	99							
	98							
	97							
	96							
	95							
94								
Heart Rate (bpm)	190							
	180							
	170							
	160							
	150							
	140							
	130							
	120							
	110							
	100							
Blood Pressure (mmHg) *	90							
	80							
	70							
	60							
	50							
	40							
	30							
	20							
	10							
	0							
Heart Rate (Number)	125 bpm	125 bpm	125 bpm	118 bpm	119 bpm	110 bpm	110 bpm	110 bpm
	125 bpm	125 bpm	125 bpm	118 bpm	119 bpm	110 bpm	110 bpm	110 bpm
	125 bpm	125 bpm	125 bpm	118 bpm	119 bpm	110 bpm	110 bpm	110 bpm
	125 bpm	125 bpm	125 bpm	118 bpm	119 bpm	110 bpm	110 bpm	110 bpm
	125 bpm	125 bpm	125 bpm	118 bpm	119 bpm	110 bpm	110 bpm	110 bpm
	125 bpm	125 bpm	125 bpm	118 bpm	119 bpm	110 bpm	110 bpm	110 bpm
	125 bpm	125 bpm	125 bpm	118 bpm	119 bpm	110 bpm	110 bpm	110 bpm
	125 bpm	125 bpm	125 bpm	118 bpm	119 bpm	110 bpm	110 bpm	110 bpm
	125 bpm	125 bpm	125 bpm	118 bpm	119 bpm	110 bpm	110 bpm	110 bpm
	125 bpm	125 bpm	125 bpm	118 bpm	119 bpm	110 bpm	110 bpm	110 bpm
Resp. Rate (bpm) (Over 1 Minute) *	25 bpm	25 bpm	25 bpm	25 bpm	28 bpm	24 bpm	26 bpm	26 bpm
	25 bpm	25 bpm	25 bpm	25 bpm	28 bpm	24 bpm	26 bpm	26 bpm
	25 bpm	25 bpm	25 bpm	25 bpm	28 bpm	24 bpm	26 bpm	26 bpm
	25 bpm	25 bpm	25 bpm	25 bpm	28 bpm	24 bpm	26 bpm	26 bpm
	25 bpm	25 bpm	25 bpm	25 bpm	28 bpm	24 bpm	26 bpm	26 bpm
	25 bpm	25 bpm	25 bpm	25 bpm	28 bpm	24 bpm	26 bpm	26 bpm
	25 bpm	25 bpm	25 bpm	25 bpm	28 bpm	24 bpm	26 bpm	26 bpm
	25 bpm	25 bpm	25 bpm	25 bpm	28 bpm	24 bpm	26 bpm	26 bpm
	25 bpm	25 bpm	25 bpm	25 bpm	28 bpm	24 bpm	26 bpm	26 bpm
	25 bpm	25 bpm	25 bpm	25 bpm	28 bpm	24 bpm	26 bpm	26 bpm
Resp Mod/ Severe Distress None / Mild								
Receiving O ₂ (l/min) O ₂ Saturations (%)	99%	100%	99%	100%	99%	99%	99%	99%
	99%	100%	99%	100%	99%	99%	99%	99%
	99%	100%	99%	100%	99%	99%	99%	99%
	99%	100%	99%	100%	99%	99%	99%	99%
	99%	100%	99%	100%	99%	99%	99%	99%
	99%	100%	99%	100%	99%	99%	99%	99%
	99%	100%	99%	100%	99%	99%	99%	99%
	99%	100%	99%	100%	99%	99%	99%	99%
	99%	100%	99%	100%	99%	99%	99%	99%
	99%	100%	99%	100%	99%	99%	99%	99%
Conscious Level Normal / Altered	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
GCS *	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0
	0	0	0	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	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)



6

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 29/6	Time: 9Am	1pm	4pm	7pm	10 PM	3Am	6Am
Doctor / Nurse / Family Concern?							
Temperature (F)	104						
	103						
	102						
	101						
	100						
	99	98.1 F	98.4 F	98.6 F	98.7 F	98.0 F	
	98						
	97						97.8 F
	96						
	94						
Heart Rate (bpm)	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
Blood Pressure (mmHg) *	130						
	120						
	110						
	100						
	90						
	80						
	70						
	60						
	50						
	50						
Heart Rate (Number)	102 bpm	103 bpm	102 bpm	102 bpm	128 bpm	120 bpm	112 bpm
Resp. Rate (bpm) (Over 1 Minute) *	70						
	60						
	50						
	40						
	30						
	20						
	10						
	10						
	10						
	10						
Resp Rate (Number)	26 bpm	26 bpm	26 bpm	26 bpm	24 bpm	22 bpm	24 bpm
Resp Distress	Mod/ Severe	None / Mild					
Receiving O ₂ (l/min)							
O ₂ Saturations (%)	100%	100%	100%	100%	100%	99%	99%
Conscious Level	Normal	Altered					
GCS *	15/15	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE							
Number of shaded boxes	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0
Observer's Initials	SL	SL	SL	SL	SL	SL	SL

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 28/6	Time: 6AM	1pm	4pm	7pm	9PM	1AM	6AM
Doctor / Nurse / Family Concern?							
Temperature (F)	104						
	103						
	102						
	101						
	100						
	99						
	98	98.5°F	98.6°F	98.6°F	97.5°F	98.5°F	98.4°F
	97						
	96						
	95						
94							
Heart Rate (bpm)	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
Blood Pressure (mmHg) *	130						
	120						
	110						
	100						
	90						
	80						
	70						
	60						
	50						
	40						
Note: BP does not score in early warning scoring	101						
	100						
	98						
	102						
	96						
	100						
	118						
	100						
	96						
	101						
Heart Rate (Number)	88b/m	125b/m	108b/m	116b/m	117b/m	95b/m	125b/m
Resp. Rate (bpm) (Over 1 Minute) *	70						
	60						
	50						
	40						
	30						
	20						
	10						
Resp Rate (Number)	26b/m	28b/m	29b/m	28b/m	25b/m	25b/m	26b/m
Resp Mod/ Severe Distress None / Mild							
Receiving O ₂ (l/min) O ₂ Saturations (%)	100%	100%	100%	100%	100%	100%	100%
Conscious Level Normal Altered	C	C	C	C	C	C	C
GCS *	15/15	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0
Observer's Initials							
ACTIONS	Score 1 : Continue normal observation by staff nurse						
	Score 2 : Shift in charge nurse to be informed and continue hourly observations						
	Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.						
	Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see						
	Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.						

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 23/6/22	Time: 9 AM	1 PM	3 PM	7 PM	9 PM	12:30 AM
Doctor / Nurse / Family Concern?						
Temperature (°F)	98.4°F	98.6°F	98.8°F	98.5°F	98.8°F	98.8°F
Heart Rate (bpm)	102 bpm	102 bpm	110 bpm	112 bpm	106 bpm	104 bpm
Blood Pressure (mmHg) *	99/60	100/60	100/60	90/59	130/86	111/50
Resp. Rate (bpm)	24 bpm	24 bpm	26 bpm	26 bpm	25 bpm	20 bpm
Receiving O ₂ (l/min)	100%	100%	99%	99%	100%	100%
Conscious Level	C	C	C	C	C	C
GCS *	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	S.R.	S.R.	S.R.	S.R.	S.R.	S.R.

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



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

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

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 26/06/26 Time: 9AM 1PM 4PM 7PM 10PM 1AM 6AM
 Doctor / Nurse / Family Concern?

Temperature (F)	104							
	103							
	102							
	101							
	100							
	99	*98.5P						
	98		*98P	98.1F	98.4F	98.4F	97.9F	*98.6F
	97							
	96							
	95							
94								

Heart Rate (bpm)	190							
	180							
	170							
	160							
	150							
	140							
	130							
	120							
	110							
	100							
Blood Pressure (mmHg) *	90							
	80							
	70							
	60							
	50							
	80	80	90	99	95	100	106	105
	70	(56)	(42)	(60)	(68)	(70)	(68)	(71)
	60	49	50	50	55	60	60	65
	50							
	40							
Note: BP does not score in early warning scoring								
Heart Rate (Number)	96b/m	98b/m	102b/m	102b/m	103b/m	100b/m	125b/m	

Resp. Rate (bpm) (Over 1 Minute) *	70							
	60							
	50							
	40							
	30							
	20							
	10							
	Resp Rate (Number)	24b/m	24b/m	24b/m	24b/m	25b/m	24b/m	24b/m

Resp Distress	Mod/ Severe							
	None / Mild							
Receiving O ₂ (l/min)								
O ₂ Saturations (%)		99%	100%	100%	100%	100%	100%	100%
Conscious Level	Normal	C	C	C	C	C	C	C
	Altered							
GCS *		15/15	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE		0	0	0	0	0	0	0
Number of shaded boxes		0	0	0	0	0	0	0
Pain Score		0	0	0	0	0	0	0
Observer's Initials		Si	e	g	4	Q	10	10

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

[illegible]

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIK
 11-02-2022 4 Y 5 M 8 D (F)
 Dr. SIRISHA RANI



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. : 21/7

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

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
21/7	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



FLUID CHART

Sheet No. : 24

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		
20/7	08:00 am			20+5+1								
	09:00 am			20+5+1			✓					
	10:00 am	H ₂ O 100ml		20+5+1								
	11:00 am			20+5+1								
	12:00 pm			20+5+1						250ml		
	01:00 pm			20+5+1								
	Total Intake : 256ml					Total Output : 250ml						
	02:00 pm			20+5+1								
	03:00 pm			20+5+1						100ml		
	04:00 pm	H ₂ O 100ml		20+5+1								
	05:00 pm			20+5+1						150ml		
	06:00 pm	Pop 100ml		20ml						150ml		
	07:00 pm			20ml								
	Total Intake : 240ml					Total Output : 400ml						
	08:00 pm			20+5+1						200ml		
	09:00 pm	Blue		20ml								
	10:00 pm	H ₂ O 100ml		20ml								
	11:00 pm			20ml								
	12:00 am			20ml								
	01:00 am			20ml						200ml		
	Total Intake : 220ml					Total Output : 400ml						
	02:00 am			20ml						150ml		
	03:00 am			20ml								
	04:00 am			20ml								
	05:00 am			20ml								
	06:00 am			20ml								
	07:00 am			20ml						20ml		
	Total Intake : 120ml					Total Output : 250ml						

Total 24 hrs. Intake

940 :- 92.15cc/kg

Total 24 hrs. Output

1,300 :- 5.13cc/kg



FLUID CHART

Sheet No. : 23

- All measurements in ml.
- 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		
10/2	08:00 am	ceclac		20+5+1			✓ (S)			300ml		
	09:00 am	peptan 100ml		20+5+1								
	10:00 am			20+5+1								
	11:00 am			20+5+1			✓ (S)			200ml		Raji
	12:00 pm			20+5+1								
	01:00 pm			20+5+1						340 ml		
Total Intake :				336ml		Total Output :					340 ml - M(2)	
	02:00 pm	peptan		20+5+1								
	03:00 pm		100ml	20+5+1								
	04:00 pm			20+5+1						150ml		Gaya3.
	05:00 pm			20+5+1								
	06:00 pm	80ml		20+5+1								
	07:00 pm			20+5+1						200ml		
Total Intake :				316 ml		Total Output :					350ml	
	08:00 pm	ldiy		20+5+1								
	09:00 pm	ceclac		20+5+1						150ml		
	10:00 pm	420 20ml		20+5+1								
	11:00 pm			20+5+1						100ml		Shy
	12:00 am			20+5+1								
	01:00 am			20+5+1						150ml		
Total Intake :				256ml		Total Output :					400ml	
	02:00 am			20+5+1								
	03:00 am			20+5+1						150ml		
	04:00 am			20+5+1								
	05:00 am			20+5+1								
	06:00 am			20+5+1								
	07:00 am			20+5+1						150ml		
Total Intake :				176ml		Total Output :						

Total 24 hrs. Intake

1.084 ÷ 107.3 cc/kg/day

Total 24 hrs. Output

1.420 ÷ 5.8 cc/kg/day/kg



FLUID CHART

Sheet No. : 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.
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		
18/7	08:00 am	Saralac		15+5+1			✓			80ml		
	09:00 am	water	100ml	15+5+1								
	10:00 am			15+5+1			✓			120ml		
	11:00 am			15+5+1			✓					
	12:00 pm	water	60ml	15+5+1						200ml		
	01:00 pm	Saralac	2pc	15+5+30+1								
Total Intake :			316 ml			Total Output :					400ml + M (3)	
	02:00 pm	Saralac		15+5+1								
	03:00 pm			50ml								
	04:00 pm	water	100ml	50ml						220ml		
	05:00 pm			50ml								
	06:00 pm	water	60ml	50ml			✓			180ml		
	07:00 pm	Saralac		50ml								
Total Intake :			431 ml			Total Output :					400ml + M (1)	
	08:00 pm	Idly		15+5+1ml						180ml		
	09:00 pm	Idly	100ml	15+5+1ml								
	10:00 pm			15+5+1ml								
	11:00 pm			15+5+1ml								
	12:00 am			15+5+1ml								
	01:00 am			15+5+1ml						200ml		
Total Intake :			226ml			Total Output :					380ml	
	02:00 am			15+5+1ml						200ml		
	03:00 am			15+5+1ml								
	04:00 am			15+5+1ml								
	05:00 am			15+5+1ml								
	06:00 am			15+5+1ml								
	07:00 am			15+5+1ml						150ml		
Total Intake :			126ml			Total Output :					350ml	

Total 24 hrs. Intake

1,099 - 10,77 cal/kg

Total 24 hrs. Output

1,530 - 6,25 cal/kg



FLUID CHART

Sheet No. : 21

- All measurements in ml.
- 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		
17/2	08:00 am			20+5+1			✓		150ml	180ml		J.
	09:00 am	Milk	50ml	20+5+1								
	10:00 am	H ₂ O	100ml	20+5+1			✓					
	11:00 am			20+5+1								
	12:00 pm	H ₂ O	90ml	20+5+1					150ml	150ml		
	01:00 pm			20+5+1								
Total Intake :			390ml			Total Output : 330ml + 2ml						
	02:00 pm	Water	200ml	20+5+1ml								Soman
	03:00 pm			20+5+1ml								
	04:00 pm	H ₂ O	100ml	20+5+1ml								
	05:00 pm	Water	150ml	20+5+1ml			✓					
	06:00 pm			20+5+1ml								
	07:00 pm	H ₂ O	100ml	20+5+1ml						420ml		
Total Intake :			406ml			Total Output : 420ml + 1ml						
	08:00 pm	Water		20+5+1ml								Sury
	09:00 pm	H ₂ O	100ml	20+5+1ml								
	10:00 pm			20+5+1ml								
	11:00 pm			20+5+1ml								
	12:00 am			20+5+1ml								
	01:00 am			20+5+1ml						330ml		
Total Intake :			256ml			Total Output : 330ml						
	02:00 am			20+5+1ml								Horn
	03:00 am			20+5+1ml								
	04:00 am			20+5+1ml								
	05:00 am			20+5+1ml								
	06:00 am			20+5+1ml								
	07:00 am			20+5+1ml						270ml		
Total Intake :			156ml			Total Output : 270ml						

Total 24 hrs. Intake

1,508 - 15,08cc/kg

Total 24 hrs. Output

1,350; 6.3cc/kg/hr



FLUID CHART

Sheet No. : 20

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
16/7	08:00 am	10g		30+5+1						270ml		
	09:00 am			20+5+1								
	10:00 am	H2O 100ml		20+5+1								
	11:00 am			20+5+1								
	12:00 pm	H2O 140ml		20+5+1						280ml		
	01:00 pm			20+5+1								
Total Intake :				396ml	Total Output :				550ml - MD			
	02:00 pm			20+5+1								
	03:00 pm		100ml	20+5+1								
	04:00 pm			20+5+1								
	05:00 pm			20+5+1								
	06:00 pm			20+5+1								
	07:00 pm			20+5+1						300ml		
Total Intake :				256ml	Total Output :				300ml			
	08:00 pm	H2O 100ml		20+5+1								
	09:00 pm			20+5+1								
	10:00 pm			20+5+1								
	11:00 pm			20+5+1								
	12:00 am			20+5+1						280ml		
	01:00 am			20+5+1								
Total Intake :				206 ml	Total Output :				280ml			
	02:00 am			20+5+1								
	03:00 am			20+5+1								
	04:00 am			20+5+1								
	05:00 am			20+5+1								
	06:00 am			20+5+1						310ml		
	07:00 am	H2O 100ml		20+5+1								
Total Intake :				206 ml	Total Output :				310ml			

Total 24 hrs. Intake : 1,064; 107cc/kg

Total 24 hrs. Output : 1,440; 6cc/kg

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIKA
 11-02-2022 4 Y 5 M 3 D (F)
 Dr. SIRISHA RANI



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. : 19

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.

15/7		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	gluc 1 PC	5+20+				✓ Hard			170ml	Susmita.
	09:00 am	milk 40ml	5+20+								
	10:00 am		5+20+								
	11:00 am	water 100ml	5+20+				✓ (Hard)				
	12:00 pm		5+20+							120ml	
	01:00 pm		5+20+150								
Total Intake :			346 ml			Total Output :					290 ml + M(2)
	02:00 pm	Sorala 50ml	5+20+130								Susmita.
	03:00 pm		5+20+								
	04:00 pm	water 100ml	5+20+								
	05:00 pm		5+20+								
	06:00 pm		5+20+								
	07:00 pm		5+20+							380ml	
Total Intake :			336 ml			Total Output :					380ml
	08:00 pm	H ₂ O 100ml	20+5+1								Arum
	09:00 pm		20+5+1								
	10:00 pm	H ₂ O 50ml	20+5+1								
	11:00 pm		20+5+1								
	12:00 am		20+5+1							280ml	
	01:00 am		20+5+1								
Total Intake :			306 ml			Total Output :					280ml
	02:00 am		20+5+1								Arum
	03:00 am		20+5+1								
	04:00 am		20+5+1								
	05:00 am		20+5+1								
	06:00 am		20+5+1							350ml	
	07:00 am		20+5+1								
Total Intake :			156 ml			Total Output :					

Total 24 hrs. Intake

1,142 ; 116 cc/kg

Total 24 hrs. Output

1,300 ; 5.4 cc/kg/hr



FLUID CHART

Sheet No. : 18

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 Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
14/7/26	08:00 am	Melton	2evp	20+5+1								
	09:00 am			20+5+1					200ml			
	10:00 am	Banana	1 Piece	20+5+1								
	11:00 am	H2o	100ml	20+5+1								
	12:00 pm			20+5+1					60ml			
	01:00 pm	Banana	1 Piece	50+5+1								
	Total Intake :			256ml			Total Output :					260ml
02:00 pm	Idli	1 Piece	20+5+1									
03:00 pm	H2o	100ml	20+5+1									
04:00 pm	Banana	1 Piece	20+5+1									
05:00 pm	H2o	60ml	20+5+1									
06:00 pm			20+5+1									
07:00 pm			20+5+1						300ml			
Total Intake :			316ml			Total Output :					300ml	
08:00 pm	H2o	100ml	20+5+1									
09:00 pm	Banana	1 Piece	20+5+1									
10:00 pm	H2o	100ml	20+5+1									
11:00 pm			20+5+1						150ml			
12:00 am			20+5+1									
01:00 am			20+5+1									
Total Intake :			356ml			Total Output :					150ml	
02:00 am			20+5+1									
03:00 am			20+5+1									
04:00 am			20+5+1									
05:00 am			20+5+1									
06:00 am			20+5+1									
07:00 am	H2o	100ml	20+5+1						210ml			
Total Intake :			256ml			Total Output :					210ml	

Total 24 hrs. Intake

1,184 ; 49 cc/hr

Total 24 hrs. Output

920 ; 3.9 cc/kg/hr

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIK
 11-02-2022 4 Y 5 M 1 D (F)
 Dr. SIRISHA RANI



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. : 18

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
12/2	08:00 am			20+5+1			✓				180ml 100ml	[Signature]
	09:00 am	Mestum	1 cup	20+5+1								
	10:00 am	Rice		20+5+1								
	11:00 am	H2O	100ml	20+5+1								
	12:00 pm			20+5+1						100ml		
	01:00 pm			20+5+1								
Total Intake :			256ml			Total Output :			280ml			
13/2	02:00 pm			20+5+1							350ml	[Signature]
	03:00 pm	Mestum	1 cup	20+5+1								
	04:00 pm	Rice		20+5+1								
	05:00 pm	Milk	100ml	20+5+1								
	06:00 pm	H2O	100ml	20+5+1			✓					
	07:00 pm			20+5+1								
Total Intake :			356ml			Total Output :			350ml			
13/2	08:00 pm	Milk		20+5+1							350ml	[Signature]
	09:00 pm	Rice	100ml	20+5+1								
	10:00 pm	Milk	100ml	20+5+1								
	11:00 pm			20+5+1								
	12:00 am			20+5+1								
	01:00 am			20+5+1								
Total Intake :			320ml			Total Output :			350ml			
14/2	02:00 am			20+5+1							400ml	[Signature]
	03:00 am			20+5+1								
	04:00 am			20+5+1								
	05:00 am			20+5+1								
	06:00 am			20+5+1								
	07:00 am		70ml	20+5+1								
Total Intake :			290ml			Total Output :			400ml			

24 hrs. Intake

1222 ÷ 135.77cc/kg

Total 24 hrs. Output

1380 ÷ 6.38cc/kg



FLUID CHART

Sheet No. : 16

- All measurements in ml.
- Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
- 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							
12/1	08:00 am			20+5+1								[Signature]
	09:00 am	Mestum Rice	1cup	20+5+1								
	10:00 am			20+5+1								
	11:00 am	H2O	100ml	20+5+1								
	12:00 pm	Idli	1 piece	20+5+1								
	01:00 pm			20+5+1								
Total Intake :		256ml			Total Output :		300ml					
12/2	02:00 pm	serolac	1cup	20+5+1								[Signature]
	03:00 pm			20+5+1								
	04:00 pm	Idli	1 piece	20+5+1								
	05:00 pm	H2O	50ml	20+5+1								
	06:00 pm	H2O	100ml	20+5+1								
	07:00 pm			20+5+1						250ml		
Total Intake :		306ml			Total Output :		250ml					
12/3	08:00 pm	Idli		20+5+1								[Signature]
	09:00 pm			20+5+1								
	10:00 pm			20+5+1								
	11:00 pm	H2O	100ml	20+5+1								
	12:00 am			20+5+1						200ml		
	01:00 am			20+5+1								
Total Intake :		256ml			Total Output :		200ml					
13/2	02:00 am			20+5+1								[Signature]
	03:00 am			20+5+1								
	04:00 am			20+5+1								
	05:00 am			20+5+1								
	06:00 am			20+5+1						300ml		
	07:00 am	H2O	100ml	20+5+1								
Total Intake :		256ml			Total Output :		300ml					
Total 24 hrs. Intake		1074 ÷ 4.0cc/kg			Total 24 hrs. Output		1050 ÷ 4.0cc/kg					

m=2



FLUID CHART

Sheet No. : 15

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	breast	1 cup	20+5+1ml						150ml	
	09:00 am			20+5+1ml			✓				
11/2	10:00 am	milk	50ml	20+5+1ml							
	11:00 am	H2O	100ml	20+5+1ml							
	12:00 pm			20+5+1ml							
	01:00 pm			20+5+1ml						180ml	
Total Intake : 306ml					Total Output : 330ml					F1-time (m)	
	02:00 pm	breast	40ml	20+5+1ml							
	03:00 pm	H2O	100ml	20+5+1ml							
	04:00 pm			20+5+1ml							
	05:00 pm			20+5+1ml							
	06:00 pm			20+5+1ml							
	07:00 pm			20+5+1ml						320ml	
Total Intake : 256ml					Total Output : 320ml						
	08:00 pm	breast		20+5+1ml							
	09:00 pm			20+5+1ml							
	10:00 pm		200ml	20+5+1ml							
	11:00 pm			20+5+1ml							
	12:00 am			20+5+1ml							
	01:00 am			20+5+1ml						300ml	
Total Intake : 1356ml					Total Output : 300ml						
	02:00 am			20+5+1ml							
	03:00 am		100ml	20+5+1ml							
	04:00 am			20+5+1ml							
	05:00 am			20+5+1ml							
	06:00 am			20+5+1ml							
	07:00 am		100ml	20+5+1ml						240ml	
Total Intake : 356ml					Total Output : 240ml						

Total 24 hrs. Intake

1,372 ÷ 152 kcal/kg

Total 24 hrs. Output

1,190 ÷ 5.509 kcal/kg

m-10



FLUID CHART

Sheet No. : 17

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		
10/2	08:00 am	Milk		20+5+1ml								
	09:00 am	H2O	150ml	20+5+1ml								
	10:00 am			20+5+1ml								
	11:00 am	Oral		20+5+1ml								
	12:00 pm	H2O	150ml	20+5+1ml								
	01:00 pm			20+5+1ml						250ml		
Total Intake : 456ml						Total Output : 250ml						
	02:00 pm	H2O	150ml	20+5+1								
	03:00 pm			20+5+1								
	04:00 pm			20+5+1								
	05:00 pm			20+5+1								
	06:00 pm			20+5+1								
	07:00 pm	H2O	150ml	20+5+1						350ml		
Total Intake : 456ml						Total Output : 350ml						
	08:00 pm	Belly		20+5+1								
	09:00 pm			20+5+1								
	10:00 pm			20+5+1								
	11:00 pm			20+5+1								
	12:00 am			20+5+1						300ml		
	01:00 am			20+5+1								
Total Intake : 156ml						Total Output : 300ml + 10ml						
	02:00 am			20+5+1								
	03:00 am			20+5+1								
	04:00 am			20+5+1								
	05:00 am			20+5+1								
	06:00 am			20+5+1						300ml		
	07:00 am			20+5+1								
Total Intake : 156ml						Total Output : 300ml						

Total 24 hrs. Intake

1224 ÷ 51cc/kg

Total 24 hrs. Output

1200.25cc/kg



FLUID CHART

Sheet No. : 16

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

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	
			Mouth	I.V	N.G						
9/7	08:00 am		2	20+1+5							
	09:00 am	correlac 1cup		20+1+5						200ml	
	10:00 am			20+1+5							
	11:00 am	H ₂ O 100ml		20+1+5							
	12:00 pm			20+1+5							
	01:00 pm			50ml						400ml	
Total Intake : 280 ml					Total Output : 600ml						
9/7	02:00 pm			20+1+5							
	03:00 pm	correlac 1cup		20+1+5							
	04:00 pm	H ₂ O 100ml		20+1+5							
	05:00 pm	Banana		20+1+5							
	06:00 pm			50ml							
	07:00 pm			20+1+5						190ml	
Total Intake : 285 ml					Total Output : 190ml						
9/7	08:00 pm		abcku	20+1+5							
	09:00 pm	H ₂ O 100ml		20+1+5							
	10:00 pm			20+1+5							
	11:00 pm			20+1+5							
	12:00 am			20+1+5							
	01:00 am			20+1+5							
Total Intake : 256ml					Total Output : 300ml						
10/7	02:00 am			20+1+5							
	03:00 am			20+1+5							
	04:00 am			20+1+5							
	05:00 am			20+1+5							
	06:00 am	H ₂ O 200ml		20+1+5							
	07:00 am			20+1+5						620ml	
Total Intake : 356ml					Total Output : 620ml						

Total 24 hrs. Intake

1177 ÷ 49.04ml/kg

Total 24 hrs. Output

1510 ÷ 6.99ml/kg



empty diaper weight: 20 kg

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. : 15

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		
8/2/26	08:00 am	Celelac		20+5+1								
	09:00 am	30ml		20+5+1								
	10:00 am	H ₂ O	170ml	20+5+1								
	11:00 am			14.2						190ml		
	12:00 pm			14.2								
	01:00 pm			14.2								
Total Intake :			316ml			Total Output : 190ml						
8/2/26	02:00 pm	Celelac		14.2								
	03:00 pm			14.2								
	04:00 pm	H ₂ O	120ml	14.2								
	05:00 pm			14.2						110ml		
	06:00 pm	Banana	1/2	14.2								
	07:00 pm			14.2								
Total Intake :			231ml			Total Output : 110ml						
	08:00 pm	Celelac	30ml	40ml								
	09:00 pm			40ml								
	10:00 pm			40ml								
	11:00 pm			40ml						190ml		
	12:00 am	H ₂ O	100ml	40ml								
	01:00 am			40ml						110ml		
Total Intake :			370ml			Total Output : 300ml						
	02:00 am			40ml						150ml		
	03:00 am			40ml								
	04:00 am			40ml								
	05:00 am			40ml								
	06:00 am			40ml								
	07:00 am			40ml						210ml		
Total Intake :			240ml			Total Output : 360ml						

Total 24 hrs. Intake 157; 124cc/kg.

Total 24 hrs. Output 960ml; 4.1cc/kg



FLUID CHART

Sheet No. : (14)

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
7/2	08:00 am			20+1+5				1+0+8				I	[Signature]
	09:00 am	ORS	10ml	20+1+5				1+0+8	1ml	2+0			
	10:00 am			20+1+5				1+0+8					
	11:00 am			20+1+5				1+0+8					
	12:00 pm	Pepitamin Junior	30ml	20+1+5				1+0+8					
	01:00 pm			30+1+5			(loose)	1+0+8		300ml			
	Total Intake : 206ml					Total Output : 300ml							
7/2	02:00 pm			20+1+5				1+0+8	1ml	2+0		I	[Signature]
	03:00 pm	H2O	5ml	20+1+5				1+0+8					
	04:00 pm			20+1+5				1+0+8	1ml	2+0			
	05:00 pm			20+1+5				1+0+8					
	06:00 pm	Nestum Rice	1/2 cup	20+1+5				1+0+8					
	07:00 pm			20+1+5				1+0+8		230ml			
	Total Intake : 166ml					Total Output : 230ml							
7/2	08:00 pm			20+1+5				2+1+8				I	[Signature]
	09:00 pm			20+1+5				2+1+8					
	10:00 pm	Milk	100ml	20+1+5				2+1+8					
	11:00 pm			20+1+5				2+1+8					
	12:00 am			20+1+5				2+1+8					
	01:00 am			20+1+5				2+1+8		320ml			
	Total Intake : 256ml					Total Output : 320ml							
8/2	02:00 am			20+1+5				2+1+8				I	[Signature]
	03:00 am			20+1+5				2+1+8					
	04:00 am			20+1+5				2+1+8					
	05:00 am			20+1+5				2+1+8					
	06:00 am	H2O	200ml	20+1+5				2+1+8					
	07:00 am			20+1+5				2+1+8		280ml			
	Total Intake : 356ml					Total Output : 280ml							
Total 24 hrs. Intake		784 ÷ 320cc/kg											
Total 24 hrs. Output		1130 ÷ 4070cc/kg											



FLUID CHART

Sheet No. : 13

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

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage			Urine
			Mouth	I.V	N.G							
6/2	08:00 am			20+1			✓					I
	09:00 am	ORS	10ml	20+1								
	10:00 am			20+1								
	11:00 am			20+1								
	12:00 pm			50+1			✓					
	01:00 pm			20+1						230ml		
Total Intake : 166ml					Total Output : 230ml							
6/2	02:00 pm	ORS	20ml	20+1								I
	03:00 pm			20+1								
	04:00 pm	ORS	30ml	20+1								
	05:00 pm			20+1								
	06:00 pm			20+1+5								
	07:00 pm			20+1+5						500ml		
Total Intake : 186ml					Total Output : 500ml							
6/2	08:00 pm			20+1+5								I
	09:00 pm	H2O	50ml	20+1+5								
	10:00 pm			20+1+5								
	11:00 pm			20+1+5								
	12:00 am			20+1+5								
	01:00 am			20+1+5								
Total Intake : 206 ml					Total Output :							
6/2	02:00 am			20+1+5								I
	03:00 am			20+1+5								
	04:00 am			20+1+5								
	05:00 am			20+1+5								
	06:00 am			20+1+5								
	07:00 am			20+1+5								
Total Intake : 156 ml					Total Output : 170 ml							

Total 24 hrs. Intake

714 ÷ 72.8cc/kg/day.

Total 24 hrs. Output

900 ÷ 3.67cc/kg



FLUID CHART

Sheet No. : 2

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
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																		
5/2	08:00 am	Tdli	2Pie	20+1				1+08			I	M											
	09:00 am	H2O	60ml	20+1			✓	1+08	1+08	0.12													
	10:00 am			20+1				1+08	1+08	0.12													
	11:00 am			20+1				1+08															
	12:00 pm			50+1				1+08															
	01:00 pm			20+1				1+08	250ml														
Total Intake : 216ml					Total Output : 270ml																		
5/2	02:00 pm			20+1				1+08	1+08	0.12	I	M											
	03:00 pm	H2O	50ml	20+1				02	1+08	0.12													
	04:00 pm	ORS	100ml	20+1				02															
	05:00 pm	H2O	50ml	20+1				1+08															
	06:00 pm			20+1				1+08															
	07:00 pm			20+1				1+08	250ml														
Total Intake : 326ml (542ml)					(520ml) Total Output : 250ml M-①																		
5/2	08:00 pm			20+1				1+08			I	M											
	09:00 pm	ORS	60ml	20+1				1+08															
	10:00 pm	H2O	50ml	20+1				1+08	1+08	0.12													
	11:00 pm			20+1				1+08															
	12:00 am			20+1				1+08	100ml														
	01:00 am			20+1				1+08															
Total Intake : 236 ml					Total Output : 100ml																		
5/2	02:00 am			20+1				1+08			I	M											
	03:00 am			20+1				1+08															
	04:00 am			20+1				1+08															
	05:00 am			20+1				1+08															
	06:00 am			20+1				1+08	150 ml														
	07:00 am			20+1				1+08															
Total Intake : 126 ml					Total Output : 150ml																		
Total 24 hrs. Intake		904 ÷ 87.7 cckg/day										Total 24 hrs. Output		770 ÷ 3.1 cckg/hr									



FLUID CHART

Sheet No. : 11

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			
4/2			Mouth	I.V	N.G								
	08:00 am	1 1/2 Lsg		40+1							I } panya		
	09:00 am	H ₂ O	50ml	40+1									
	10:00 am	milk	50ml	20+1									
	11:00 am			20+1			✓						
	12:00 pm			20+1									
	01:00 pm			20+1			✓			230ml			
Total Intake : 260 ml.					Total Output : M-2 , 230ml.								
	02:00 pm	milk	50ml	20+1			✓				I } Debuta		
	03:00 pm	H ₂ O	50ml	50									
	04:00 pm			50									
	05:00 pm			20+1									
	06:00 pm			20+1									
	07:00 pm			50+1						200ml			
Total Intake : 314 ml.					Total Output : 200ml + M ①								
	08:00 pm			50+1							I } pooja		
	09:00 pm			20+1						320			
	10:00 pm	H ₂ O	50ml	20+1									
	11:00 pm			20+1						150ml			
	12:00 am			20+1									
	01:00 am			20+1									
Total Intake : 206 ml					Total Output : 170ml								
	02:00 am			20+1							I } pooja		
	03:00 am			20+1									
	04:00 am			20+1									
	05:00 am			20+1									
	06:00 am			20+1						200ml			
	07:00 am			20+1									
Total Intake : 126 ml					Total Output : 200ml								

Total 24 hrs. Intake

906 ÷ 85.42 ckg

Total 24 hrs. Output

1700 ÷ 4.5 ckg/hr.

BAH-0648830 IP5-00175554
 Baby GARIGANTI RITHWIKA
 11-02-2022 4 Y 4 M 20 D (F)
 Dr. SIRISHA RANI

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. : 10

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am		20+1	20+1								}	
	09:00 am		20+1	20+1						200ml			
	10:00 am	mls	100ml	20+1			✓						
	11:00 am		20+1	20+1									
	12:00 pm		150ml	20+1									
	01:00 pm		20+1	20+1			✓			100ml			
Total Intake : 934						M-② Total Output : 320ml							
	02:00 pm		20+1	20+1								}	
	03:00 pm		20+1	20+1									
	04:00 pm	tho	100ml	20+1									
	05:00 pm		20+1	20+1									
	06:00 pm		20+1	20+1									
	07:00 pm		20+1	20+1						630ml			
Total Intake : 226 ml						Total Output : 630ml							
	08:00 pm		20+1	20+1								}	
	09:00 pm		20+1	20+1						320			
	10:00 pm	tho	100ml	20+1									
	11:00 pm		20+1	20+1						150ml			
	12:00 am		20+1	20+1									
	01:00 am		20+1	20+1									
Total Intake : 226 ml						Total Output : 440ml						150ml	
	02:00 am		20+1	20+1								}	
	03:00 am		20+1	20+1									
	04:00 am		20+1	20+1									
	05:00 am		20+1	20+1									
	06:00 am		20+1	20+1						250ml			
	07:00 am		20+1	20+1									
Total Intake : 126 ml						Total Output : 250ml							

Total 24 hrs. Intake

932 ÷ 90.5 cckg/day

Total 24 hrs. Output

1350 ÷ 5.4 cckg/hr



FLUID CHART

Sheet No. : ①

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

		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						
2/7	08:00 am			20+						250ml	900ml
	09:00 am			20+							
	10:00 am	pinbow 100ml		20+							
	11:00 am			50ml						190ml	
	12:00 pm			50ml							
	01:00 pm			20+							
Total Intake : 280ml					Total Output : 440ml						
2/7	02:00 pm			20+							300ml
	03:00 pm			20+							
	04:00 pm	milk 100ml		20+						300ml	
	05:00 pm	H2O 100ml		20+							
	06:00 pm			20+							
	07:00 pm			20+						250ml	
Total Intake : 320ml					Total Output : 550ml						
2/7	08:00 pm			20+							320ml
	09:00 pm			20+						200ml	
	10:00 pm	H2O 100ml		20+							
	11:00 pm			20+						120ml	
	12:00 am			20+							
	01:00 am			20+							
Total Intake : 220ml					Total Output : 320ml						
3/7	02:00 am			20+							40ml
	03:00 am			20+						30ml	
	04:00 am			20+							
	05:00 am			20+						30ml	
	06:00 am			20+							
	07:00 am			20+						10ml	
Total Intake : 120ml					Total Output : 70ml						

Total 24 hrs. Intake

962ml ; 90cc/kg

Total 24 hrs. Output

1380 ÷ 5.5cc/kg/hr.

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWKA
 11-02-2022 4 Y 4 M 19 D (F)
 Dr. SIRISHA RANI



FLUID CHART

Sheet No. : 8

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								
11/4/24	08:00 am		20+1								}	pm	
	09:00 am		20+1										
	10:00 am	H ₂ O 200ml	20+1										
	11:00 am	mlw.	20+1										
	12:00 pm		20+1										
	01:00 pm		20+1						350ml				
Total Intake : 340ml						Total Output : 350ml							
	02:00 pm	snack	20+1								}	John	
	03:00 pm		20+1										
	04:00 pm	H ₂ O 100ml	20+1										
	05:00 pm		20+1										
	06:00 pm		20+1										
	07:00 pm		20+1						400ml				
Total Intake : 315ml						Total Output : 400ml							
	08:00 pm		20+1								}	poor	
	09:00 pm		20+1										
	10:00 pm	H ₂ O 100ml	20+1										
	11:00 pm		20+1										
	12:00 am		20+1										
	01:00 am		20+1						250ml				
Total Intake : 226 ml						Total Output : 250ml							
	02:00 am		20+1								}	poor	
	03:00 am		20+1										
	04:00 am		20+1										
	05:00 am		20+1										
	06:00 am		20+1										
	07:00 am		20+1						250ml				
Total Intake : 126 ml						Total Output : 250ml							

Total 24 hrs. Intake

1007 ÷ 97.8 c/kg/day

Total 24 hrs. Output

1,250 ÷ 5.106 c/kg



FLUID CHART

Sheet No. : 9

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		
30/6/20	08:00 am			1+20ml						120	12ml	[Signature]
	09:00 am	tho 100ml		1+20ml								
	10:00 am	idli 1		3ml								
	11:00 am			3ml								
	12:00 pm			3+20						330ml		
	01:00 pm			3+20								
Total Intake :			94 ml			Total Output : 350ml						
	02:00 pm			3+20								[Signature]
	03:00 pm	tho 50ml		3+20				✓				
	04:00 pm			15ml								
	05:00 pm			3+20								
	06:00 pm			3+20						150ml		
	07:00 pm			3+20								
Total Intake :			180ml			Total Output : 150ml + 0.1						
	08:00 pm	galli		50ml								[Signature]
	09:00 pm			50ml						100ml		
	10:00 pm	H ₂ O 60ml		20+1ml								
	11:00 pm			20+1ml								
	12:00 am			20+1ml								
	01:00 am			20+1ml						150ml		
Total Intake :			244 ml			Total Output : 250ml						
	02:00 am			20+1ml								[Signature]
	03:00 am			20+1ml						150ml		
	04:00 am			20+1ml								
	05:00 am			20+1ml								
	06:00 am			20+1ml						150ml		
	07:00 am			20+1ml								
Total Intake :			126 ml			Total Output : 300 ml						

Total 24 hrs. Intake

644; 63 cc/kg.

Total 24 hrs. Output

1050; 4.05 cc/kg

FLUID CHART

Sheet No. : 6

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		
29/8	08:00 am			20+1						150ml		Gayas.
	09:00 am			20+1								
	10:00 am		100ml	50ml								
	11:00 am			50ml								
	12:00 pm	H ₂ O		50ml						200ml		
	01:00 pm			50ml								
Total Intake : 342ml						Total Output : 350ml						
	02:00 pm			20+1								Gayas
	03:00 pm			20+1						150ml		
	04:00 pm		100ml	20+1								
	05:00 pm			20+1								
	06:00 pm			20+1						100ml		
	07:00 pm			20+1								
Total Intake : 226ml						Total Output : 250ml						
	08:00 pm	Rev		20+1ml								Sonam
	09:00 pm		100ml	20+1ml						150ml		
	10:00 pm	H ₂ O		20+1ml								
	11:00 pm	meat	150ml	20+1ml								
	12:00 am			20+1ml								
	01:00 am			20+1ml						150ml		
Total Intake : 326 ml						Total Output : 300ml						
	02:00 am			20+1ml								Sonam
	03:00 am			20+1ml								
	04:00 am			20+1ml								
	05:00 am			20+1ml								
	06:00 am			20+1ml								
	07:00 am			20+1ml						400ml		
Total Intake : 126 ml						Total Output : 400ml						

Total 24 hrs. Intake

1020: 102cc/kg

Total 24 hrs. Output

1300: 5.41cc/kg



FLUID CHART

Sheet No. : (5)

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

		Intake			Output						IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
28/6	08:00 am		20+1									
	09:00 am	100ml	20+1									
	10:00 am		20+1									
	11:00 am		50ml									
	12:00 pm		50ml									
	01:00 pm		50ml							250ml		
	Total Intake : 313ml					Total Output : 250ml + m (1)						
	02:00 pm		50ml									
	03:00 pm		50ml									
	04:00 pm	100ml	50ml									
	05:00 pm	100ml	20+1									
	06:00 pm		20+1									
	07:00 pm		20+1							180ml		
	Total Intake : 313ml					Total Output : 180ml						
	08:00 pm		20+1									
	09:00 pm	100ml	20+1							120ml		
	10:00 pm	100ml	20+1									
	11:00 pm		20+1									
	12:00 am		20+1							100ml		
	01:00 am		20+1									
	Total Intake : 226ml					Total Output : 220ml						
	02:00 am		20+1									
	03:00 am		20+1									
	04:00 am		20+1									
	05:00 am		20+1									
	06:00 am		20+1							200ml		
	07:00 am		20+1									
	Total Intake : 226ml					Total Output : 200ml						
Total 24 hrs. Intake		978 ÷ 97.8cc/kg										
Total 24 hrs. Output		850 ÷										



FLUID CHART

Sheet No. : 4

- All measurements in ml.
- 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		
27/10	08:00 am	Jelli.		20+1						100ml		Gayaz
	09:00 am			20+1				(N)				
	10:00 am		80ml	20+1								
	11:00 am			50ml				(N)				
	12:00 pm			50ml						150ml		
	01:00 pm			20+1								
Total Intake : 264 ml.						Total Output : 250 ml. + M (2)						
	02:00 pm	Jelli.		50ml								Debnath
	03:00 pm	H2O 100ml		50 ml				(N)				
	04:00 pm			20+1								
	05:00 pm			20+1								
	06:00 pm			20+1				(N)				
	07:00 pm			20+1						300ml		
Total Intake : 284 ml.						Total Output : 300 ml + M (2)						
	08:00 pm			20+1						100 ml		M
	09:00 pm	Jelli 2 piece		20+1								
	10:00 pm	H2O 100ml		20+1								
	11:00 pm			20+1								
	12:00 am			20+1						100ml		
	01:00 am			20+1								
Total Intake : 226 ml						Total Output : 210 ml						
	02:00 am			20+1								
	03:00 am			20+1								
	04:00 am			20+1								
	05:00 am			20+1								
	06:00 am			20+1								
	07:00 am			20+1						210ml		
Total Intake : 126 ml						Total Output : 210 ml						

Total 24 hrs. Intake

900 ÷ 90cc/kg
 ml

Total 24 hrs. Output

970 ÷ 3.9cc/kg/day

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWKA
 11-02-2022 4 Y 4 M 15 D (F)
 Dr. SIRISHA RANI

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. : 3

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
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			
26/6	08:00 am			20+1								13	[Signature]
	09:00 am			20+1					200ml				
	10:00 am	H ₂ O 100ml		20+1									
	11:00 am			20+1									
	12:00 pm			20+1					100ml				
	01:00 pm			20+1									
Total Intake : 226ml						Total Output : 300ml							
	02:00 pm			25+1								13	[Signature]
	03:00 pm			25+1					150ml				
	04:00 pm	100ml		50ml									
	05:00 pm			50ml					150ml				
	06:00 pm			25+1									
	07:00 pm			25+1									
Total Intake : 254ml						Total Output : 300ml							
	08:00 pm			20+1								13	[Signature]
	09:00 pm	100ml		20+1					200ml				
	10:00 pm	H ₂ O 100ml		20+1									
	11:00 pm	H ₂ O 150ml		20+1									
	12:00 am			20+1					100ml				
	01:00 am			20+1									
Total Intake : 376ml						Total Output : 300ml							
	02:00 am			20+1								13	[Signature]
	03:00 am			20+1					150ml				
	04:00 am			20+1									
	05:00 am			20+1					150ml				
	06:00 am			20+1									
	07:00 am			20+1									
Total Intake : 126 ml						Total Output : 300 ml							
Total 24 hrs. Intake		982 ÷ 26.2cc/kg/day				Total 24 hrs. Output		1200 ÷					



FLUID CHART

Sheet No. : ②

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
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						
	08:00 am			1ml						200ml	
	09:00 am			1ml							
	10:00 am	H ₂ O		1ml							
	11:00 am			1ml						100ml	
	12:00 pm			1ml							
	01:00 pm			1ml							

Total Intake : 526 ml

Total Output : 300 ml

	02:00 pm		NBM								
	03:00 pm	BL	NBM								
	04:00 pm	BL	NBM								
	05:00 pm		water								
	06:00 pm									100ml	
	07:00 pm										

Total Intake :

Total Output : 100ml

	08:00 pm			1ml							
	09:00 pm	Joli	2pie	1ml							
	10:00 pm	H ₂ O	100ml	1ml						100ml	
	11:00 pm			1ml							
	12:00 am			1ml							
	01:00 am			1ml						120ml	

Total Intake : 106ml

Total Output : 220ml

	02:00 am			1ml							
	03:00 am			1ml						130ml	
	04:00 am			1ml							
	05:00 am			1ml							
	06:00 am			1ml							
	07:00 am			1ml						180ml	

Total Intake : 6ml

Total Output : 310ml

Total 24 hrs. Intake	118 ÷ 11.8 cc/kg/day	Total 24 hrs. Output	930 ÷ 3.87 cc/kg/hr
----------------------	----------------------	----------------------	---------------------

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIK
 11-02-2022 4 Y 4 M 13 D (F)
 Dr. SIRISHA RANI



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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

FLUID CHART

Sheet No. : ①

- All measurements in ml.
- 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								
24/9/22	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			2ml					100ml				
	04:00 pm		100ml	1ml									
	05:00 pm			1ml									
	06:00 pm			2ml					150ml				
	07:00 pm			2ml									
Total Intake : 105ml					Total Output : 250ml								
	08:00 pm			1ml									
	09:00 pm		120ml	1ml									
	10:00 pm			1ml					100ml				
	11:00 pm			1ml									
	12:00 am			1ml									
	01:00 am			1ml					90ml				
Total Intake : 126ml					Total Output : 190ml								
	02:00 am			1ml					80ml				
	03:00 am		80ml	1ml									
	04:00 am			1ml									
	05:00 am			1ml									
	06:00 am			1ml					150ml				
	07:00 am			1ml									
Total Intake : 86ml					Total Output : 230ml								
Total 24 hrs. Intake		317 ÷ 30.8 cc/kg/day											
Total 24 hrs. Output		670ml ÷ 3.6 cc/kg/day											



13

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/3/26

Assessment: Patient having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the patient General condition.	8:30pm	→ Assessed the patient General condition	→ Patient feels Better
10pm	→ Maintain Personal hygiene.	10:30pm	→ Maintained personal hygiene.	
12am	→ Maintain Fluid Balance.	12:30am	→ Maintained fluid Balance.	
2am	→ Ensure Safety.	2:30am	→ Provided Side rail	
6am	→ Monitor D/o chest	6:30am	→ Monitored D/o chest	

Re-Assessment: Patient is alive.

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Swathi

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



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 20/7/26

Assessment: patient having chem weakness

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the patient general condition	2:15pm	Assessed the patient general condition	patient is now improved.
3pm	monitor vitals.	3:20pm	monitored vitals	
4pm	maintain personal hygiene	4:15pm	maintained personal hygiene	
5pm	Ensure safety needs	5:30pm	provided side rails	
6pm	maintain good nutritional diet	6:30pm	maintained good nutritional diet	
7pm	Administer medications	8pm	Administered medications	

Re-Assessment: patient feels better

Special Notes:

Nurse Signature: pooja Nurse Name: pooja Date & Time: 20/7/26 @ 8pm

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIK
 11-02-2022 4 Y 5 M 8 D (F)
 Dr. SIRISHA RANI



NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 20/2/2026

Assessment: patient having convulsions

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 patient general condition	9 AM	Assessed the patient general condition	patient feels better
10 AM	check vital	10:30	checked vital	
11 AM	provide side rails	11:30	provided side rails	
12 PM	Maintain I/O chart	12:50	Maintained I/O chart	
2 PM	Administer medication	2 PM	Administered medication	

Re-Assessment: NA

Special Notes: NA

Nurse Signature: [Signature]

Nurse Name: Ganyathar

Date & Time: 20/2/2026 @ 2 PM

10

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 19/7/26

Assessment: Patient having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the patient General condition	8:30pm	→ Assessed the patient condition.	Patient feel Better
10pm	→ Maintain personal hygiene.	10:30pm	→ Maintained personal hygiene.	
12am	→ Maintain fluid Balance.	12:30am	→ Maintained fluid Balance	
2am	→ Ensure Safety.	2:30am	→ Provided Siderails	
6am	→ Monitor D/o chart	6:30am	→ Monitored D/o chart	

Re-Assessment: Patient feel Better

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Savitri

Date & Time: 20/7/26 6am

BAH-00648830 IPS-00175554
Baby GARIGANTI RITHWIKA
11-02-2022 4 Y 5 M 8 D (F)
Dr. SIRISHA RANI



NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 19/7/20

Assessment: patient having weakness

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 general condition	3pm	Assessed the patient general condition	patient feels better
4pm	check vital	4:30	checked vital	
5pm	provide sick rail	5:30	provided sick rail	
6pm	Maintain I/O chart	6:30	Maintained I/O chart.	
7pm	Administer medication	8pm	Administered medication	

Re-Assessment: re-assessment every 1 hourly

Special Notes: NA

Nurse Signature: [Signature]

Nurse Name: Gayathri

Date & Time: 19/7/20 @ 8pm



8

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 19/12

Assessment: Baby having poor oral intake

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 General condition of the baby	8am	assessed General condition of the baby	
8:10am	Monitor vital signs	8:10am	monitored vital signs	
9am	Administer medications as per chart	9am	Administered medications as per chart	
10am	Ensure safety	10am	provided side rails	
11am	Encourage oral intake	11am	Eating well	
12pm	Maintain personal hygiene	12pm	performed hand hygiene	
1pm	Monitor I/O chart	1pm	maintained I/O chart	

Re-Assessment: Baby is eating well

Special Notes:

Nurse Signature: Dayi

Nurse Name: Rajamani

Date & Time: 19/12/20 @ 2pm

NURSING CARE RECORD

Date: 18/7/26

ving weakness

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the patient General condition	8:30pm	→ Assessed the patient General condition	Patient is active
10pm	→ Maintain personal hygiene.	10:30pm	→ Maintained personal hygiene.	
12am	→ Maintain fluid Balance.	12:30am	→ Maintained fluid Balance	
4am	→ Ensure Safety	4:30am	→ Provided Side rails	
6am	→ Monitor Dp chart.	6:30am	→ Monitored Dp chart	

Re-Assessment: Patient is active

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Savi Ulu

Date & Time: 19/7/26



NURSING CARE RECORD

Ch...
Hosp...
It takes a lot to treat...

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 18/07/2022

Assessment:

Patient's having weakness

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications

- ☐ Relieve Pain & Discomfort
- ☒ Prevent Infection
- ☐ Any Others. Specify.....

- ☒ Maintain Fluid Balance
- ☐ Meet Elimination Needs

- ☐ Improve Activity Tolerance
- ☐ Ensure Safety

- ☒ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety

- ☐ Maintain Skin Integrity
- ☐ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
8Am	Assess the patient condition	9Am	Assessed the patient condition	Patient's condition is now improved
10Am	To check vital signs.	11Am	checked vital signs and recorded	
12pm	To maintain good nutritional status.	1pm	Provided good nutritional diet.	
2pm	To maintain fluid balance	3pm	Maintained fluid balance	
4pm	To prevent infection.	5pm	Administered medications as per doctors order.	
6pm	To maintain I/O chart.	7pm	Maintained I/O chart.	

Re-Assessment:

Patient is stable

Special Notes:

Nil -

Nurse Signature:

[Signature]

Nurse Name:

Sumita

Date & Time:

18/7/2022 @ 8pm

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIK
 11-02-2022 4 Y 5 M 6 D (F)
 Dr. SIRISHA RANI



NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 17/2

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
8pm	→ Assess the patient	8:30pm	→ Assessed the patient	Patient feel Better
10pm	General condition.	10:30pm	General condition	
12am	→ Maintain personal hygiene.	12:30am	→ Maintained personal hygiene.	
4am	→ Maintain fluid balance	4:30am	→ Maintained fluid balance.	
6am	→ Ensure Safety	6:30am	→ Provided Siderails	
	→ Monitor I/O chart		→ Monitored I/O chart	

Re-Assessment: Patient is active

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Savithri

Date & Time: 18/2/2022



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 17/4/26

Assessment: Patient having wheezing

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 pm	Assess the general condition of the patient.	2:30 pm	Assess the general condition of the patient.	Patient felt better
3 pm	Monitor vital signs.	3:30 pm	Monitored vital signs.	
4 pm	Provide side rails.	4:30 pm	Moved side rails.	
5 pm	Maintain I/O chart.	5:30 pm	Maintained I/O chart.	
6 pm	Administer medication.	6:30 pm	Administered medication.	
7 pm	Maintain I/O chart.	8 pm	Maintained I/O chart.	

Re-Assessment: Patient felt better

Special Notes: CB, SE, LFT & creat & excre 2 days Th

Nurse Signature: [Signature]

Nurse Name: Sonam

Date & Time: 17/4 @ 8 pm

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIKA
 11-02-2022 4 Y 5 M 5 D (F)
 Dr. SIRISHA RANI



NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 17/2

Assessment: Pt having weakness

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 patient general condition.	8 AM	Assessed the patient general condition.	Patient felt comfortable
10 AM	Maintain IO chart.	10 AM	Continue IV fluid.	
12 PM	Monitor vitals.	12 PM	Checked vitals.	
2 PM	Administer medication as per doctor's order.	2 PM	Giving medication as per doctor's order.	

Re-Assessment: Pt felt comfortable

Special Notes:

Nurse Signature: *[Signature]*

Nurse Name: Garzi

Date & Time: 17/2, 2 PM

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWIK
11-02-2022 4 Y 5 M 5 D (F)
Dr. SIRISHA RANI



41

NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 12/18/26

Assessment: Patient having weakness

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	8:30pm	→ Assessed the patient General Condition	Patient is active
10pm	→ Maintain personal hygiene	10:30pm	→ Maintained personal hygiene	
12am	→ Maintain fluid Balance	12:30am	→ Maintained fluid Balance	
2am	→ Ensure Safety	2:30am	→ Monitored I/O chart	
4am	→ monitor I/O chart		→ monitored I/O chart	

Re-Assessment: Patient is active

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Sawitri

Date & Time: 12/18 @ 8pm



40

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 16/7/22

Assessment: Baby has poor oral intake

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 General condition of the baby	8am	assessed General condition of the baby	Baby has sucking reflex
8:10am	Monitor vital signs	8:10am	Monitored vital signs	
9am	Administer medications as per chart	9am	Administered medications as per chart	
11am	Ensure safety	11am	provided side rails	
12pm	Encourage oral intake	12pm	Baby has improved orally	
1pm	Maintain I/O chart	1pm	Maintained I/O chart	

Re-Assessment: Baby looking feed

Special Notes:

Nurse Signature: Ray

Nurse Name: Rayan

Date & Time: 16/7/22 02 PM



39

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 15/7/26

Assessment: patient is having weakness.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	*Assess the general condition	8:30pm	*Assessed the general condition	patient is comfortable
10pm	*Monitor and note vitals	10:30pm	*Monitored and noted vitals	
12Am	*Provide supportive care	12:30Am	*Provided supportive care	
2Am	*Provide comfortable position	2:30Am	*Provided comfortable position	
4Am	*Ensure safety.	4:30Am	*Provided pillows & side rails	
6Am	*Monitor output.	6:30Am	*Monitored output by diaper weight.	
7Am	*Administer medications as per order.	7:30Am	*Administered medications as per order.	

Re-Assessment: patient is comfortable

Special Notes:

Nurse Signature: Arun

Nurse Name: Arun M

Date & Time: 16/7/26 @ 8Am

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWIKA
11-02-2022 4 Y 5 M 3 D (F)
Dr. SIRISHA RANI



NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 15/07/26

Assessment: Patient's having weakness

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 patient condition.	9Am	Assessed the patient condition.	Patient's condition is now improved
10Am	To check vital signs.	11Am.	checked vital signs and recorded.	
12pm	To ensure safety.	1pm	provided side rails.	
2pm.	To maintain fluid balance.	3pm.	Maintained fluid balance.	
4pm	To prevent infection.	5pm.	Administer medication as per doctors order.	
6pm	To maintain I/O chart.	7pm	Maintained I/O chart.	

Re-Assessment:

Patient is stable

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Sumita

Date & Time: 15/7/26 @ 8pm

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIK
 11-02-2022 4 Y 5 M 3 D (F)
 Dr. SIRISHA RANI



NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 14/2/26

Assessment: Baby hungry at hydration feeding good

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 child General condition	9pm	* Assess the child General condition	Patient is comfortable
10pm	* monitor vital signs	11pm	monitored vital signs	
12Am	* monitored the child	1Am	Monitored the child	
2Am	* Administer medication as per order	3am	Administered medication as per order	
4am	* provide comfortable position	6am	provided comfortable position	
7am		7:30AM		

Re-Assessment: 11th hourly with monitoring

Special Notes: watch for fever & any abnormal

Nurse Signature: [Signature]

Nurse Name: Shreya / Anam

Date & Time: 15/2/26 @ 8am

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWKA
 11-02-2022 4 Y 5 M 3 D (F)
 Dr. SIRISHA RANI



80

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 14/7/26

Assessment:

Patient Having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	To Assess the baby condition	9AM	Assessed the baby condition	Patient feel better
10AM	To monitor vitals and Record	11AM	monitored vitals and Recorded	
12pm	To maintain fluid balance	1pm	maintained fluid balanced	
2pm	To Ensure safety	3pm	provided supportive care	
4pm	To maintain Personal Hygiene	5pm	Maintain I/O charting	
6pm	Administer medication as per doctor's order	7pm	Medication given as per drug chart	

Re-Assessment:

Re-assessment done

Special Notes:

Nurse Signature:

Nurse Name: Moumita

Date & Time: 14/7/26 @8PM

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIK
 11-02-2022 4 Y 5 M 3 D (F)
 Dr. SIRISHA RANI



35

NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 13/2/28

Assessment: Baby having a hydration

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 child General condition	9pm	* Assessed the child Gen condition	
10pm	* monitor vitals sign	11pm	* maintain I/O chart	
12am	* Administer medication given as per doctor order	1am	* Administer medication given as per doctor order	
2am		3am		
4am	* provide comfort measures	5am	* provided comfort measures	
6am	* maintain I/O chart	7am	* maintain I/O chart	

Re-Assessment: with hourly vitals monitoring

Special Notes: watch for fever & any abnormal

Nurse Signature: [Signature]

Nurse Name: Shreya

Date & Time: 14/2/2028

BAH-00648830
Baby GARIGANTI RITHWIK (F)
11-02-2022 4 Y 5 M 1 D
Dr. SIRISHA RANI
IP5-00175554

NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 13/7/26

Patient Having weakness

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	To Assess the baby condition	9AM	Assessed the baby condition	Patient feel better
10AM	To monitor vitals and Record	11AM	Monitored vitals and Recorded	
12PM	To maintain fluid balance	1PM	Maintain fluid balance	
2PM	To Ensure safety	3PM	provided supportive care	
4PM	To Give ^{plan} GAST today	5PM	Maintained 10 charting	
6PM	Administer medication as per doctor's order	7PM	Medication given as per doctor's order	

Special Notes:

Nurse Signature:

Nurse Name: Moumita

Date & Time: 13/7/26 8PM



23

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 12/7/26

Assessment: patient having weakness

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	9pm	Assessed the patient	patient feels better.
10pm	check vitals	11pm	checked vitals	
1Am	provide side rail	2Am	provided side rail	
3Am	Maintain S/O chart	4Am	Maintained S/O chart	
5Am	Maintain personal hygiene	6Am	Maintained personal hygiene	
7Am	Administer medication	8Am	Administered medication	

Re-Assessment: NA

Special Notes: NA

Nurse Signature:

Nurse Name: Gayathri

Date & Time: 13/7/26 @ 8Am

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIK
 11-02-2022 4 Y 5 M 1 D (F)
 Dr. SIRISHA RANI

32

NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 12/7/26

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	TO Assess the baby condition	9AM	Assessed the baby condition	Patient feel better
10AM	TO monitor vitals and Recorded	11AM	monitored vitals and Recorded	
12PM	TO maintain fluid balance	1PM	maintained fluid balanced	
2PM	TO maintain Personal Hygiene	3PM	Maintained Personal Hygiene	
4PM	TO Ensure safety	5PM	Maintain I/O charting	
6PM	Administration medication as per doctor's order	7PM	medication given as per doctor's order	

Re-Assessment:

Re-assessment done

Special Notes:

Nurse Signature:

Nurse Name: Moumita

Date & Time: 12/7/26 8PM

31

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 11/17/26

Assessment: patient having meptans

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the patient general.	9pm	Assess the child cervical oedema	
9pm	* monitor vital signs	10pm	* monitor vital signs	* Baby by
11pm	* Administer medication 8pm	12Am	* Administer medication 3	good
2Am	as per doct	4Am	as per doct order	
5am	* provide comfort position	7am	* provided comfort position	
	* ct save touch		* ct seen as per chart	

Re-Assessment: with hourly vitals & meptans

Special Notes: watch for HR & any changes

Nurse Signature: [Signature]

Nurse Name: Shreya

Date & Time: 12/17/26 8pm

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIK
 11-02-2022 4 Y 4 M 28 D (F)
 Dr. SIRISHA RANI



NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 11/7/26

Assessment: the patient having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	to check the vitals	4pm	to check the vitals	3 minutes
2:30pm	maintain 210 club	5pm	maintain 210 club	skin
3pm	maintain 210 club	6pm	maintain 210 club	
4:30pm	administer medicine	6:30pm	administer medicine	
5pm	provide comfort	7pm	provide comfort	

Re-Assessment: the patient

Special Notes: the patient

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 11/7/26 8pm

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIK
 11-02-2022 4 Y 4 M 28 D (F)
 Dr. SIRISHA RANI



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 11/7/22

Assessment: Assess the Patient having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the patient General condition	8:30am	→ Assessed the patient condition	Feel Better
10am	→ Maintain fluid Balance	10:30am	→ Maintained fluid Balance	
11am	→ Maintain personal hygiene	11:30am	→ Maintained personal hygiene	
12pm	→ Administer medication as order	12:30pm	→ Medication given as order	

Re-Assessment: Patient is active

Special Notes: 1m CBP Explain

Nurse Signature:

Nurse Name: Divya

Date & Time: 11/7 @ 2pm

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWIKA
11-02-2022 4 Y 4 M 28 D (F)
Dr. SIRISHA RANI



NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/2/26

Assessment: Baby having ct hydration

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 child's condition	9pm	* Assessed the child's General condition	
10pm	* monitor vital signs	10pm	* monitor 2/0 clamp	
12AM	* Administer medications given as per order	11pm	* Administer medications given as per order	* Baby is
2AM		3am		good
4AM	* Provide comfort per	5am	* Provided comfort per	
6am	* Baby down & asleep	7am	* Baby is very happy	
		with	happy vital signs	

Re-Assessment:

Special Notes: watch for shock & any changes

Nurse Signature: [Signature]

Nurse Name: Shreya

Date & Time: 11/7/26 6am

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIK
 11-02-2022 4 Y 4 M 28 D (F)
 Dr. SIRISHA RANI



NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 10/7/26

Assessment: patient having weakness

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	2:30pm	*Assessed the general condition	patient is comfortable
3pm	*Monitor and note vitals	3:30pm	*monitored and noted vitals	
4pm	*Provide safety.	4:30pm	*Provided side rails & pillow	
5pm	*Educate parents.	5:30pm	*Educated parents on personal hygiene	
6pm	*Monitor output.	6:30pm	*monitored output by diaper weight.	
7pm	*Administer medications	7:30pm	*Administered medications as per order.	

Re-Assessment: patient is comfortable

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Anu m

Date & Time: 10/7/26 @ 8pm



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 10/2/26

Assessment: Patient having Heaviness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	→ Assess the general condition of the patient.	8:10 AM	→ Assessed the general condition of the patient.	Patient felt better
9 AM	→ Monitor vital signs.	9:30 AM	→ Monitored vital signs.	
10 AM	→ Provide side rails.	10:30 AM	→ Provided side rails.	
11 AM	→ Maintain hygiene.	11:30 AM	→ Maintained hygiene.	
12 PM	→ Administer medication.	12:30 PM	→ Administered medication.	
1 PM	→ Maintain Ho chest.	2 PM	→ Maintained Ho chest.	

Re-Assessment: Patient felt better

Special Notes:

Nurse Signature:

Nurse Name: Sonam

Date & Time: 10/2 @ 2 PM

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIKA
 11-02-2022 4 Y 4 M 27 D (F)
 Dr. SIRISHA RANI



NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/26

Assessment: Baby having ct hydration

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 child's current condition	9pm	* assessed the child's condition	
10pm	* monitor vital signs	11pm	* monitor vital signs	
12Am	* maintain 2lo chair	1pm	* maintained 2lo chair	* Baby is
2Am	* Administer medications as per doctor's order	3am	* Administer medications as per doctor's order	good
4am	* provide comfort as per need	6am	* provided comfort as per need	

Re-Assessment: with hourly vital monitoring

Special Notes: watch for diet & any abnormality

Nurse Signature: [Signature]

Nurse Name: Shree

Date & Time: 10/7/26 8am

24

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/7

Assessment: pt having weakness.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2 PM	Assess the pt general condition.	2 PM	Assessed the pt general condition.	
4 PM	Monitor vitals.	4 PM	Monitoring vitals.	
6 PM	Maintain IV fluid.	6 PM	continue IV fluid.	
8 PM	Administer medication as per doctor's order.	8 PM	Giving medication as per doctor's order.	
				pt felt comfortable.

Re-Assessment: pt felt comfortable.

Special Notes:

Nurse Signature: B.

Nurse Name: Gargi

Date & Time: 9/7, 8 PM



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 9/2/26

Assessment: The Patient having wheezes

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	Monitor Vitals	9am	Monitored Vitals	
9am	Administer medication as per doctor advice	10am	Administered medication as per doctor advice Pt felt better	
10am	Provide - Hydration	11am	Provided Hydration	
11am	Provide Supportive Care	12pm	Provided Supportive Care	

Re-Assessment: Pt felt better

Special Notes:

Nurse Signature:

Nurse Name: Pooja

Date & Time: 9/2/26 2pm

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIKA
 11-02-2022 4 Y 4 M 26 D (F)
 Dr. SIRISHA RANI

22

NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/7/26

Assessment: patient is having weakness

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the general Condition	8:30pm	Assessed the general Condition	
10pm	Monitor & note vital	10:30pm	Monitored and noted vital	patient is
12Am	Provide comfortable position	12:30Am	Provided comfortable position	Comfortable
2Am	Provide supportive care	2:30Am	Provided supportive care	
4Am	Ensure safety	4:30Am	Provided side rails & pillow	
6Am	Administer medications	6:30Am	Administered medications as per order.	
7Am	Monitor output	7:30Am	Monitoring output	

Re-Assessment: patient is comfortable

Special Notes:

Nurse Signature: Ann

Nurse Name: Ann m

Date & Time: 9/7/26 @ 8Am

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWIK
11-02-2022 4 Y 4 M 26 D (F)
Dr. SIRISHA RANI



21

NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 8/7/28

Assessment: Baby has nausea related to chemotherapy

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 General condition of the baby	8 AM	Assessed General condition of the baby	Baby has no vomiting sensation
8:10 AM	Monitor vital signs	8:10 AM	monitored vital signs	
10 AM	administer medications as per chart & give IV. prescription	10 AM	administered medications as per chart & given IV. orders	
12 PM	to Ensure safety	12 PM.	provided side rails	
2 PM	Maintain personal hygiene	2 PM	maintained personal hygiene	
4 PM	Maintain fluid balance	4 PM	Maintained fluid balance	
6 PM	Maintain % chert	6 PM	Maintained % chert	

Re-Assessment: Baby has no nausea

Special Notes:

Nurse Signature: Raj

Nurse Name: Rajini

Date & Time: 8/7/28 8 PM



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 7/7/26

Assessment: Baby having good hydration looking good

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 child Consciousness condition	8:30pm	* Assessed the child Consciousness	
9pm	* monitor vital signs	9:10pm	* monitor vital signs	
10pm	* maintain I/O chart	10:20pm	* maintain I/O chart	* Baby looking good
11pm	* Administer medication as per order	12AM	* Administer medication as per order	
1Am	* Baby for stool	3Am	* Baby for stool	
6am		7:30Am	* Baby for stool	

Re-Assessment: with hourly vital monitoring

Special Notes: watch for dark & any changes

Nurse Signature: [Signature]

Nurse Name: Shruen

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

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIK
 11-02-2022 4 Y 4 M 25 D (F)
 Dr. SIRISHA RANI



18

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 7/7/26

Assessment:

Patient Having weakness

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 Assess the baby condition	9AM	Assessed the baby condition	Patient feel better
10AM	TO monitor vitals and Record	11AM	monitored vitals and Recorded	
12AM	TO maintain fluid balance	1PM	Maintained fluid balance	
2PM	TO maintain Personal Hygiene	3PM	Maintained Personal Hygiene	
4PM	TO Give folinic acid today	5PM	Provided supportive care	
6PM	Administer medication as per doctor's order	7PM	Maintained strictly NO chanting	

Re-Assessment:

Re-assessment done

Special Notes:

Nurse Signature:

[Signature]

Nurse Name:

moumita

Date & Time:

7/7/26 8PM



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6/7

Assessment: patient having weakness

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.	9pm	Assessed the patient general condition.	
10pm	monitor vitals	10:15pm	monitored vitals.	
11pm	maintain personal hygiene.	11pm	To explained personal hygiene.	patient feels better
12AM	Ensure safety.	3am	provided side rails	
2AM	administer medication	5am	administered medication	
6AM	maintain I/v chart.	8am	maintained I/v chart	

Re-Assessment: patient is stable

Special Notes:

Nurse Signature: pooja

Nurse Name: pooja

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



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 6/7/26

Assessment: Patient Having dull Activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	To Assess the baby condition	9AM	Assessed the baby condition	Patient feel better
10AM	To monitor vitals and Record	11AM	monitored vitals and Recorded	
12PM	To maintain fluid balance	1PM	Maintained fluid balanced	
2PM	To maintain Personal Hygiene	3PM	Maintained Personal Hygiene	
4PM	To Give methotrexate today	5PM	Given methotrexate today	
6PM	Administer medication as per doctor's order	7PM	Medication given as per drug chart	

Re-Assessment: Re-assessment done

Special Notes:

Nurse Signature:

Nurse Name: Moomita

Date & Time: 6/7/26 @ 8PM



5

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: patient having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the general condition of the patient.	9pm	Assessed the general condition of the patient.	Patient felt better
10pm	Monitor vital signs.	11pm	Monitored vital signs.	
12am	Provide side rails.	1am	Moved to side rails.	
2am	Maintain hygiene.	3am	Maintained bed hygiene.	
5pm	Administer medication.	6pm	Administered medication.	
9pm	Maintain I/O chart.	8pm	Maintained I/O chart.	

Re-Assessment: Patient felt better

Special Notes:

Nurse Signature: \$

Nurse Name: Sonam

Date & Time: 6/7 @ 8am

BAH-10648830 IP5-00175554
 Baby GARIGANTI RITHWIKA
 11-02-2022 4 Y 4 M 23 D (F)
 Dr. SIRISHA RANI



NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 5/7/26

Assessment: Patient Having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	TO Assess the baby condition	9AM	Assessed the baby condition	Patient feel better
10AM	TO Moniton vitals and Recond	11AM	Monitoned vitals and Recorded	
12PM	TO Maintain fluid balanee	1PM	Maintained fluid balaneed	
2PM	TO Ensure safety	3PM	Provided supportive cane	
4PM	main tain Ilo chanting	5PM	Medication given as per docton's order	
8PM	Administer medication as per docton's order	7PM	Striet moniton maintain Ilo chant	

Re-Assessment: Re-assessment done

Special Notes:

Nurse Signature: 

Nurse Name: Moumita

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

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIKA
 11-02-2022 4 Y 4 M 23 D (F)
 Dr. SIRISHA RANI



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7

Assessment: Pt having weakness.

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.	8pm	Assessed the pt general condition.	
10pm	Monitor vitals.	10pm	checked vitals.	
12AM	Maintain I/O chart.	12AM	continue IV fluid.	
5am	Administer medication as per doctor's order.	5am	Giving medication as per doctor's order.	

patient felt better

Re-Assessment: patient felt comfortable

Special Notes:

Nurse Signature: [Signature] Nurse Name: Gargi Date & Time: 5/7, 8AM

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIKA
 11-02-2022 4 Y 4 M 22 D (F)
 Dr. SIRISHA RANI



NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 4.7.2026

Assessment: Patient having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the patient Condition	2pm	Assessed the patient Condition	Patient is comfortable
3pm	Monitor vitals	3pm	checked vitals	
4pm	Ensure safety	4pm	provide side rails	
5pm	Relieve pain	5pm	Given medication	
6pm	Maintain Fluid Balance	6pm	continue IV fluids	
7pm	Maintain Ho chart	7pm	passed urine	
8pm	Maintain personal hygiene	8pm	Maintaining personal hygiene	

Re-Assessment: Re-Assessment 4th Hourly.

Special Notes: NA

Nurse Signature: [Signature]

Nurse Name: Priyanka.

Date & Time: 4.7.2026

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 4/7/26

Assessment: Patient with weakness

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

Time	Plan of Care	Time	Implementation	Evaluation
8:30 am	Assess general condition of patient	9am	Assessed general condition of patient	⇒ Patient is stable no vomitings.
10am	Maintain fluid balance	10:30 am	Maintaining fluid balance	
11am	Improve activity tolerance	11:30 am	Improve activity tolerance	
12pm	Maintain good nutritional status	12:30 pm	Maintaining nutritional status	
1pm	Maintain personal hygiene	1:30 pm	Maintaining personal hygiene	

Re-Assessment: NA

Special Notes: Induction to continue

Nurse Signature: Samra

Nurse Name: Soumya

Date & Time: 4/7/26 @ 2pm

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWIKA
11-02-2022 4 Y 4 M 22 D (F)
Dr. SIRISHA RANI



11

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/26

Assessment: Patient having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the general condition of the patient.	9pm	→ Assessed the general condition of the patient.	Patient felt better
10pm	→ Monitor vital signs.	11pm	→ Monitored vital signs.	
12am	→ Provided side rails.	1am	→ Provided side rails.	
2am	→ Maintain hygiene.	2am	→ Maintained hygiene.	
5am	→ Administer medicines.	6am	→ Administered medicines.	
7am	→ Maintain I/O chart.	8am	→ Maintained I/O chart.	

Re-Assessment: Patient felt better

Special Notes: CBP, SE, cat done

Nurse Signature: \$

Nurse Name: Sonam

Date & Time: 4/7 @ 8am



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 3/2/26

Assessment: The Patient having headache

Goals

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

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

Re-Assessment: Dr felt better

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Poja

Date & Time: 3/2/26 8pm

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 3/7/20

Assessment: Baby born at home

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 child's condition	9am	* Assessed the child's General condition	* Baby for good
10am	* monitor vital signs	12m	* monitor vital signs	
12m	* monitor 2 to 4 changes	12:30p	* monitor 2 to 4 changes	
1pm	* Administer reduced as per doctor's order	1:30m	* Administer reduced as per doctor's order	
2pm	* check same child	2:30m	* check same as per doctor's order	

Re-Assessment: with hourly vital monitoring

Special Notes: watch for dot & any abnormal

Nurse Signature: [Signature]

Nurse Name: Shruel

Date & Time: 3/7/20 2pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 21/2/26

Assessment: Patient having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the general condition of the patient.	9pm	→ Assessed the general condition of the patient.	Patient felt better
10pm	→ Monitor vital signs.	11pm	→ Monitored vital signs.	
12pm	→ Provide side rails.	1 Am	→ Provided side rails.	
2pm	→ Maintain hygiene	3pm	→ Maintained hygiene	
4pm	→ Administer medication	5pm	→ Administered medication	
7pm	→ Maintain I/O chart	8pm	→ Maintained I/O chart	

Re-Assessment: Patient felt better

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Sonam

Date & Time: 3/2 @ 8pm



7

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 2/7/20

Assessment: Baby hungry at 10:00 AM looking good

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 child's condition	2:30pm	* Assessed the child's condition	
3pm	* monitor vitals sign	3:30pm	* monitor vitals sign	
4pm	* maintain D/C chart	4:00pm	* maintained D/C chart	* Baby is
5pm	* Administer medication as per doctor's order	5:00pm	* Administer medication as per doctor's order	Good
6pm	* at same time	7:00pm	* at same time as per chart	

Re-Assessment: at hourly intervals

Special Notes: watch for diet & any changes

Nurse Signature: [Signature]

Nurse Name: Shree

Date & Time: 2/7/20 @ 8pm



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 2/10/24

Assessment: patient is Anxious

Goals

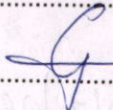
- ☒ Maintain Airway and Oxygenation
- ☒ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ Any Others. Specify.....
- ☒ Maintain Fluid Balance
- ☐ Meet Elimination Needs
- ☒ Improve Activity Tolerance
- ☒ Ensure Safety
- ☒ Maintain Good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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess general condition of the patient	9am	Assessed general condition of the patient	Patient is stable
10am	Monitor vital signs.	11am	monitored vital signs.	
11pm	maintain hygiene	1pm	maintained hygiene	
1:15	administer medications as per order	1:50	administered medications as per order	
1:35	Ensure Safety	1:40	provided Side rail	
1:45	maintain I/O chart	2:00pm	maintain I/O chart	

Re-Assessment:

patient is stable

Special Notes:

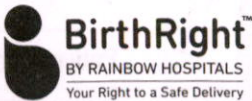
Nurse Signature: 

Nurse Name: Gayathri

Date & Time: 2/10/24 @ 2pm

BAH-00648830
Baby GARIGANTI RITHWIK
11-02-2022 4 Y 4 M 19 D (F)
Dr. SIRISHA RANI

5



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 1/7/28

Assessment: patient heaving weakness

- 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	9pm	Assessed the patient general condition	patient feels better.
10pm	monitor vitals	10:15pm	monitored vitals	
12am	maintain personal hygiene	11am	maintained personal hygiene	
2am	ensure safety needs	3am	provided side rails	
4am	Administer medications	5am	Administered medications	
6am	maintain o/r chart	6am	maintained o/r chart	

Re-Assessment: patient is stable

Special Notes:

Nurse Signature: pooja Nurse Name: pooja Date & Time: 1/7/28 @ 8am

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIKA
 11-02-2022 4 Y 4 M 19 D (F)
 Dr. SIRISHA RANI



14

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

NURSING CARE RECORD

Date: 01/2/20

Shift: ☒ Morning ☒ Afternoon ☐ Night

Assessment: Baby 15 Looking Anxious

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 general condition of the patient.	9am	Assessed general condition of the patient	Patient is stable
10am	monitor vital signs	11am	monitored vital signs	
12pm	maintain hygiene	1pm	maintained hygiene	
2pm	Administer medication	3pm	Administered medication	
4pm	provide comfort	5pm	provided comfort	
6pm	ensure safety	7pm	provided side rails	
8:30pm	maintain I/O chart	8pm	maintained I/O chart	

Re-Assessment: patient is stable.

Special Notes:

DI

Rhuvana

Date & Time: 1/2/20 @ 8pm

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIK
 11-02-2022 4 Y 4 M 19 D (F)
 Dr. SIRISHA RANI



16

NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 30/6/26

Assessment: patient heaving weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the patient general condition	9pm	Assessed the patient general condition	patient feels better.
10pm	monitored vitals	10:15pm	monitored vitals	
12am	maintains personal hygiene	1am	maintained personal hygiene	
3am	Ensure safety	3am	provided side rails	
4am	administer medications	5am	Administered medications	
6am	maintains I/O chart	7am	maintained I/O chart	

Re-Assessment: patient is stable

Special Notes:

Nurse Signature: pooja

Nurse Name: pooja

Date & Time: 1/7/26 @ 8am



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 30/6/24

Assessment:

Patient having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8:40 AM	Assess the patient general condition	9:10 AM	Assessed the patient general condition	pt was good
10:30 AM	monitor the vital and care	11:20 AM	monitored the vital and care	
11:55 AM	provide ensure safety	12 PM	provided side rail	
1:38 PM	provide chemotherapy	2:31 PM	provided chemotherapy ATG	
4 PM	provide personal hygiene	3 PM	3rd hr hair	
5 PM	provide side rail	4:10 PM	provided personal hygiene	
6 PM	monitor the I/O chart	5:52 PM	monitored the I/O chart	
6:45 PM	provide patient & family education	7 PM	provide patient & family education	

Re-Assessment:

patient was stable

Special Notes:

continue chemotherapy and care

Nurse Signature: Manjiv

Nurse Name: Manjiv

Date & Time: 30/6/24 @ 8 PM

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWIK
11-02-2022 4 Y 4 M 16 D (F)
Dr. SIRISHA RANI



NURSING CARE RECORD


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


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 29/6/20

Assessment: patient is having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	*Assess the general condition.	8:30pm	*Assessed the general condition.	Patient is comfortable
10pm	*Monitored and note vitals.	10:30pm	*Monitored and noted vitals.	
12Am	*Provide comfortable position.	12:30Am	*Provided comfortable position.	
2Am	*Provide supportive care.	2:30Am	*Provided supportive care.	
4Am	*Ensure safety.	4:30Am	*Provided pillows & side rails.	
6Am	*Educate parents.	6:30Am	*Provided health education re. personal hygiene.	
7Am	*Administer medications as per order.	7:30Am	*Administered medications.	

Re-Assessment: Patient is comfortable

Special Notes: CBP, LFT, Creat done

Nurse Signature: 

Nurse Name: Ajeen

Date & Time: 30/6 @ 8Am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date:

Assessment: patient having weakness

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 patient's general condition	9 Am	Assessed the patient's general condition	
10 Am	check vitals	11 Am	checked vitals	patient feels better
1 pm	provide side rails	2 pm	provided side rails	
3 pm	Maintain S/O chart	4 pm	Maintained S/O chart	
5 pm	Maintain personal hygiene	6 pm	Maintained personal hygiene	
7 pm	Administer medication	8 pm	Administered medication	

Re-Assessment: Re-assessment was with hourly

Special Notes: NA

Nurse Signature:

Nurse Name: Goyattor

Date & Time: 29/6/20 @ 8 pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 28/6/26

Assessment: Patient having Hypertension

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	To Assess the baby condition	9PM	Assessed the baby condition	Patient feel better
10PM	To monitor vitals and Record	11PM	Monitored vitals and Recorded	
12am	To maintain fluid balance	1am	Maintained fluid balance	
2am	To Ensure safety	3am	Provided supportive care	
4am	To maintain Hygiene	5am	Medication given as per doctor's order	
6AM	Administer medication as per doctor's order	7am	Maintain Ilo chanting	

Re-Assessment: Re-assessment done

Special Notes:

Nurse Signature:

Nurse Name: Moumita

Date & Time: 29/6/26 8AM



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 28/6/26

Assessment: Patient having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the patient General condition.	8:30am	→ Assessed the patient General condition	Patient feel Better.
12pm	→ Maintain fluid balance	12:30pm	→ Maintained personal hygiene	
2pm	→ Maintain personal hygiene	2:30pm	→ Provided side rail	
3pm	→ Ensure Safety	3:30pm	→ Given medications as order	
6pm	→ Administer medication as order	7:30pm	→ Monitored	
7pm	→ Monitor I/O chart			

Re-Assessment: Patient is active

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Sanjita

Date & Time: 28/6 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 27/6/26

Assessment: The Patient having Weakness

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
10pm	Monitor Vitals	11pm	Monitored Vitals	Pt felt better
12am	Administer medication as per doctor advice	1am	Administered medication as per doctor advice	
4am	Provide Hydration.	5am	Provided Hydration	
5am	Provide Supportive Care	6am	Provided Supportive Care	
6am	Provide Psychological Support	7am	Provided Psychological Support	

Re-Assessment: Pt felt better

Special Notes:

Nurse Signature: [Signature] Nurse Name: Pooja Date & Time: 28/6/26 8am.

BAH-00648830
Baby GARIGANTI RITHWIK
11-02-2022 4 Y 4 M 15 D (F)
Dr. SIRISHA RANI

NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 27/6/2026

Assessment: Patient having weaness

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	2pm	Assessed the patient Condition	Patient is comfortable.
3pm	Relieve pain	3pm	Given medication	
4pm	Ensure safety	4pm	provide side rails	
5pm	Monitor vitals.	5pm	checked vitals.	
6pm	Maintain I/O Chart.	6pm	passed urine.	
7pm	Maintain personal hygiene.	7pm	Maintaining personal hygiene	
8pm	Maintain Fluid Balance.	8pm	continue I/V fluids	

Re-Assessment: Re-Assessment 15 Hourly.

Special Notes: NA.

Nurse Signature: D. Dhanu

Nurse Name: Priyanka

Date & Time: 27/6/2026 at 8pm



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 27/6/26

Assessment: patient having weakness

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 patient general condition	9 AM	Assessed the patient general condition	patient feels better
10 AM	check vitals	10:30	checked vitals	
11 AM	provide side rail	11:30	provided side rail	
12 PM	Monitor P/O chart	12:30	Monitored P/O chart	
1 PM	Administer medication	2 PM	Administered medication	

Re-Assessment: NA

Special Notes: NA

Nurse Signature:

Nurse Name: Gayathri

Date & Time: 27/6/26 @

8

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 26/6/26

Assessment: disturbed sleeping pattern related 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 General condition of the baby & provide comfort	8pm	Assessed General condition of the baby & provided comfort	Baby has Comfort
8:10 PM	Monitor vital signs	8:10 PM	Monitored vital signs	
11 PM	Administer Medications as per chart	11 PM	Administered Medications as per chart	
2 AM	to maintain personal hygiene	2 AM	Maintained personal hygiene	
4 AM	to ensure safety	4 AM	provided Side rails	
6 AM	Maintain 1/6 chart	6 AM	Maintained 1/6 chart	

Re-Assessment: Baby feels better

Special Notes: nil

Nurse Signature: [Signature]

Nurse Name: Rajanman

Date & Time: 24/6/26 @ 8 AM



NURSING CARE RECORD



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 28/6/20

Assessment: Patient having weakness

- Goals
- ☒ Maintain Airway and Oxygenation
☒ Maintain Personal Hygiene
☒ Identify Potential Complications

☐ Relieve Pain & Discomfort
☐ Prevent Infection
☐ Any Others. Specify.....

☒ Maintain Fluid Balance
☐ Meet Elimination Needs

☐ Improve Activity Tolerance
☒ Ensure Safety

☒ Maintain Good Nutritional Status
☐ Early Ambulation Reduce Anxiety

☐ Maintain Skin Integrity
☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess general condition of Patient	2:30pm	Assessed general condition of Patient	Patient feels better
3pm	Monitor vital signs.	3:30pm	monitored vital signs	
4pm	Maintain hygiene	4:30pm	Maintained hygiene	
5pm	Ensure safety	5:30pm	Ensure safety	
6pm	Maintain fluid balance	6:30pm	Maintained fluid balance	
7pm	Maintain I/O chart	7:30pm	Maintained I/O chart	

Re-Assessment: Patient feels better

Special Notes:

Nurse Signature: [Signature] Nurse Name: Gayathri Date & Time: 28/6/20



6

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 26/6/20

Assessment: patient hearing weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the patient general condition	8:30am	Assessed the patient general condition	patient is now improved.
9am	monitor vitals	9:30am	monitored vitals	
10am	maintain personal hygiene	10:20am	maintained personal hygiene	
11am	ensure safety	11:30am	provided side rails	
12pm	maintain fluid balance	12:20am	maintained fluid balance	
1pm	maintain I/v chart	2pm	maintained I/v chart	

Re-Assessment: patient feels better.

Special Notes:

Nurse Signature: pooja

Nurse Name: pooja

Date & Time: 26/6/20 @ 2pm

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIK
 11-02-2022 4 Y 4 M 14 D (F)
 Dr. SIRISHA RANI



(5)
NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 25/6/26

Assessment: Patient having dull Activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8PM	To Assess the baby condition	9PM	Assessed the baby condition	Patient feels better
10PM	To Monitor vitals and Record	11PM	Monitored vitals and Recorded	
12am	To maintain fluid balance	1am	Maintained fluid balance	
2am	To Ensure safety	3am	Provided supportive care	
4am	To maintain Hygiene	5am	Medication given as per doctor's order	
6AM	Administer medication as per doctor's order	7am	Maintain Ilo charting	

Re-Assessment: Re-assessment done

Special Notes:

Nurse Signature:

Nurse Name: Moumita

Date & Time: 28/6/26 8AM

4

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 25/06/24

Assessment: Patient having weakness

- 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 pt general condition	3pm	→ Assessed the pt general condition	→ Pt is conscious and oriented
4pm	→ monitor vital sign	4:30	→ monitoring vital sign	→ vital normal
5pm	→ Maintain NPO status	5:30	→ NPO broken, water given	→ No vomiting
6pm	→ Provide psychological support	6:30	→ provided psychological support	
7pm	→ Plan shift to the ward	8pm	→ Pt shifted to the ward as per doctor advice	

Re-Assessment: NA

Special Notes: NA

Nurse Signature: [Signature]

Nurse Name: Goyathri

Date & Time: 25/6/24 @ 8pm

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 25/6/20

Assessment: patient having weakness

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 patient general condition.	8:20 AM	Assessed the patient general condition	
9 AM	monitor vitals	9:15 AM	monitored vitals	
10 AM	maintain personal hygiene	10:30 AM	Maintained personal hygiene	patient is now active
11 AM	ensure safety needs	11:30 AM	provided side rails	
12 PM	prevent infection.	1 PM	to explained prevent infection	

Re-Assessment: patient feels better.

Special Notes: Gyaneshwari

Nurse Signature: pooja

Nurse Name: pooja

Date & Time: 25/6/20 @ 1 PM



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 24/6/26

Assessment: Patient Having weakness

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	to Assess the baby condition	9PM	Assessed the baby condition	
10PM	to monitor vitals and Record	11PM	monitored vitals and Recorded	
12am	to maintain fluid balance	1am	Maintained fluid balance	Patient feel better
2am	to maintain personal Hygiene	3am	provided supportive care	
4am	to Ensure safety	5am	Medication given as per doctor's order	
6AM	Administer medication as per doctor's order	7am	Maintain Ilo chanting	

Re-Assessment: Re-assessment done

Special Notes:

Nurse Signature:

Nurse Name: Moumita

Date & Time: 25/6/26 8AM



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 24/6/26

Assessment: The patient nursing needs

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
3:30pm	To check the vitals	4pm	To check the vitals	The patient is stable
3:40pm	Maintain 210 club	5pm	Maintain 210 club	
4:5pm	Maintain 210 fluid	5:30pm	Maintain 210 fluid	
4:15pm	Administer medicine	6:30pm	Administer medicine	
4:30pm	Record all complaints	7pm	Record all complaints	

Re-Assessment: The patient is stable

Special Notes: NA

Nurse Signature: [Signature]

Nurse Name: Anjali

Date & Time: 24/6/26 4:30pm

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIKA
 11-02-2022 4 Y 4 M 13 D (F)
 Dr. SIRISHA RANI



1

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. S.R. Department: Onco Date of Admission: 24/6/26

SITUATION		Diagnosis: <u>MPB-Type-I</u>						Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify: _____	
BACKGROUND	Area	ER 2:30 PM	Onco 2pm-4pm	Onco 8AM	Onco 5pm-7pm	OT 2pm	Onco 4pm-6pm		
	Shift Time								
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>nil</u>	<u>PA</u>	<u>NA</u>	<u>nil</u>	<u>NA</u>	<u>PA</u>		
	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
ASSESSMENT	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	<u>98°F</u>	<u>98.1°F</u>	<u>98.4°F</u>	<u>97.8°F</u>	<u>98°F</u>	<u>98.1°F</u>	
		Res:	<u>28b/m</u>	<u>28b/m</u>	<u>25b/m</u>	<u>23b/m</u>	<u>25b/m</u>	<u>25b/m</u>	
		SpO ₂ :	<u>99%</u>	<u>99b/m</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>	<u>100%</u>	
		Pulse:	<u>110b/m</u>	<u>100b/m</u>	<u>105b/m</u>	<u>103b/m</u>	<u>89b/m</u>	<u>89b/m</u>	
		BP:	<u>98/52</u>	<u>98/56</u>	<u>100/60</u>	<u>100/60</u>	<u>90/60</u>	<u>90/60</u>	
		Fall Risk Score:	<u>13</u>	<u>13</u>	<u>13</u>	<u>13</u>	<u>13</u>	<u>13</u>	
		Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	
Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>		
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
	Others Specify:	<u>nil</u>	<u>nil</u>	<u>NA</u>	<u>nil</u>	<u>NA</u>	<u>PA</u>		
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
	Other Special Orders / Medications:	<u>nil</u>	<u>nil</u>	<u>NA</u>	<u>nil</u>	<u>NA</u>	<u>NA</u>		
Post Operative Procedure Special Orders:		<u>nil</u>	<u>nil</u>	<u>NA</u>	<u>nil</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :		<u>Manoj</u>	<u>Gayatri</u>	<u>Manjita</u>	<u>Darsh</u>	<u>Anmol</u>	<u>Gayatri</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>24/6</u>	<u>24/6</u>	<u>25/6</u>	<u>25/6</u>	<u>25/6</u>	<u>25/6</u>		
Time:		<u>2:30 PM</u>	<u>8pm</u>	<u>8AM</u>	<u>4pm</u>	<u>8pm</u>	<u>8pm</u>		
Taken Over By Name :		<u>Gayatri</u>	<u>[Signature]</u>	<u>ch. pooja</u>	<u>[Signature]</u>	<u>Gayatri</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>24/6</u>	<u>24/6</u>	<u>25/6</u>	<u>25/6</u>	<u>25/6</u>	<u>25/6</u>		

BAH-00648830
Baby GARIGANTI RITHWIKA
11-02-2022
Dr. SIRISHA RANI
IP5-00175554
4 Y 4 M 14 D (F)

2

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Pt. Sirisha Rani Department: Oncology Date of Admission:

SITUATION	Diagnosis: <u>CPS - Type - 1</u>		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time	<u>onco 8AM</u>	<u>onco 2pm</u>	<u>onco 4-8pm</u>	<u>onco 8pm-12AM</u>	<u>onco 12AM-8pm</u>	
	Medical Condition: (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.5°F</u>	<u>98.9°F</u>	<u>98.4°F</u>	<u>98.1°F</u>	<u>98.4°F</u>	<u>98.8°F</u>
		Res:	<u>25b/m</u>	<u>26b/m</u>	<u>26b/m</u>	<u>26b/m</u>	<u>26b/m</u>	<u>26b/m</u>
		SpO ₂ :	<u>100%</u>	<u>99%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>99%</u>
		Pulse:	<u>101b/m</u>	<u>101b/m</u>	<u>101b/m</u>	<u>103b/m</u>	<u>103b/m</u>	<u>103b/m</u>
		BP:	<u>90/60</u>	<u>90/60</u>	<u>90/60</u>	<u>91/63</u>	<u>91/63</u>	<u>91/63</u>
Fall Risk Score:	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>10</u>		
Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>		
Recommendations	Safety Needs:		<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:			<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Maamita</u>	<u>poorja</u>	<u>Gayatri</u>	<u>Rajamini</u>	<u>Gayatri</u>	<u>Pr...</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>26/6</u>	<u>26/6</u>	<u>26/6</u>	<u>27/6</u>	<u>27/6</u>	<u>27/6</u>	
Time:		<u>8AM</u>	<u>2pm</u>	<u>4pm</u>	<u>8pm</u>	<u>2am</u>	<u>8am</u>	
Taken Over By Name :		<u>ch. poorja</u>	<u>Gayatri</u>	<u>Rajamini</u>	<u>Gayatri</u>	<u>Pr...</u>	<u>Pr...</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>26/6</u>	<u>27/6</u>	<u>27/6</u>	<u>27/6</u>	<u>27/6</u>	<u>27/6</u>	



3

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. SIRISHA RANI Department: HEMATO-ONCOLOGY Date of Admission: 24/6/2022

SITUATION	Diagnosis: <u>MPS - Type - 1</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	Area	Shift Time	onco 8am	onc 8am-3pm	onco 8AM	onc 8PM	onco 8PM-3AM	onco 3AM-8PM
BACKGROUND	Medical Condition (Any special condition to be noted):		NA	NA	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: 98.6	98.6	98.4	98.4	98.6	98.3
	Res:		20b/m	20b/m	20b/m	20b/m	20b/m	20b/m
	SpO ₂ :		100%	100%	100%	100%	100%	99%
	Pulse:		110b/m	112b/m	101b/m	101b/m	101b/m	103b/m
	BP:		98/60	98/59/62	100/60	100/60	103/63/60	98/53
	Fall Risk Score:		10	10	10	10	10	10
Recommendations	Pain Score:		0	0	0	0	0	0
	Safety Needs:		side rails	side rails	side rails	side rails	side rails	side rails
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		NA	NA	NA	NA	NA	NA
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Other Special Orders / Medications:		NA	NA	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Bojy	Swathie	Moumita	Gowtham	Aam m	Lavinia	
Signature :		Bojy	Swathie	Moumita	Gowtham	Aam m	Lavinia	
Date:		28/6	28/6	29/6	29/6	30/6	30/6	
Time:		8am	8pm	8AM	8pm	8AM	8PM	
Taken Over By Name :		Chunelle	Dip	Gowtham	Sudhakar	Nave	Sonam	
Signature :		Chunelle	Dip	Gowtham	Sudhakar	Nave	Sonam	
Date:		28/6	28/6	29/6	29/6	30/6	30/6	
Time:		8am	8pm	8AM	8PM	8AM	8PM	



4

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sirisha Rani Department: Oncology Date of Admission: 24/6

SITUATION		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify: <u>NA</u>						
BACKGROUND	Area	<u>once 8AM</u>	<u>once 8AM-2PM</u>	<u>once 8AM</u>	<u>once 2PM-2PM</u>	<u>once 8M</u>	<u>once 8PM-8PM</u>	
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.5F</u>	<u>98.4F</u>	<u>98.5F</u>	<u>98.4F</u>	<u>98.2F</u>	<u>98.5F</u>
		Res:	<u>26b/m</u>	<u>25b/m</u>	<u>25b/m</u>	<u>26b/m</u>	<u>26b/m</u>	<u>26b/m</u>
		SpO ₂ :	<u>99.1</u>	<u>100.1</u>	<u>99.1</u>	<u>99.1</u>	<u>100.1</u>	<u>100.1</u>
		Pulse:	<u>101b/m</u>	<u>102b/m</u>	<u>101b/m</u>	<u>102b/m</u>	<u>112b/m</u>	<u>112b/m</u>
		BP:	<u>98/61</u>	<u>100/62</u>	<u>98/62</u>	<u>99/62</u>	<u>101/66</u>	<u>99/63(20)</u>
	Fall Risk Score:	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	
Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>		
Recommendations	Safety Needs:	<u>side rails</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>side rails</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>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Pooja</u>	<u>Bhavana</u>	<u>Pooja</u>	<u>Gayathri</u>	<u>Blau</u>	<u>Arum</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>1/7</u>	<u>1/7</u>	<u>2/7</u>	<u>2/7</u>	<u>2/7</u>	<u>3/7/26</u>	
Time:		<u>8AM</u>	<u>8PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8PM</u>	<u>8AM</u>	
Taken Over By Name :		<u>Bhavana</u>	<u>Arum</u>	<u>Gayathri</u>	<u>Blau</u>	<u>Arum</u>	<u>Blau</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>1/7/26</u>	<u>1/7</u>	<u>2/7</u>	<u>2/7/26</u>	<u>2/7/26</u>	<u>3/7/26</u>	
Time:		<u>8AM</u>	<u>8PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8PM</u>	<u>8AM</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sirisha Department: Oncology Date of Admission: 24/6/20

SITUATION	Diagnosis: <u>ALL - Bcr-2</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify: <u>NA</u>				
BACKGROUND	Area	Shift Time	<u>ONCO 8-2pm</u>	<u>ONCO 2pm-8pm</u>	<u>ONCO 8pm-4am</u>	<u>Oncology 8-2pm</u>	<u>oncology 8pm-4am</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:						
	Temp:	<u>98.2°f</u>	<u>98°f</u>	<u>98.6°f</u>	<u>98.1°f</u>	<u>98°f</u>	<u>98°f</u>
	Res:	<u>24</u>	<u>20b/m</u>	<u>24b/m</u>	<u>24b/m</u>	<u>24b/m</u>	<u>22b/m</u>
	SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>98%</u>	<u>98%</u>	<u>98%</u>
	Pulse:	<u>124</u>	<u>120b/m</u>	<u>110b/m</u>	<u>110b/m</u>	<u>110b/m</u>	<u>112b/m</u>
	BP:	<u>100/60</u>	<u>100/60</u>	<u>96/57(73)</u>	<u>100/60</u>	<u>96/60</u>	<u>90/60</u>
Fall Risk Score:		<u>0</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	
Pain Score:		<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	
Recommendations	Safety Needs:		<u>Side rails</u>	<u>Side rails</u>	<u>Side rails</u>	<u>Side rails</u>	<u>Side rails</u>
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Devi</u>	<u>Pooja</u>	<u>Sonam</u>	<u>Sonuya</u>	<u>Priyanka</u>	<u>Garvi</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>3/2/20</u>	<u>3/2</u>	<u>4/7</u>	<u>4/7</u>	<u>4/7</u>	<u>5/2</u>
Time:		<u>2pm</u>	<u>8pm</u>	<u>8AM</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>
Taken Over By Name :		<u>Pooja</u>	<u>[Signature]</u>	<u>Sonuya</u>	<u>Priyanka</u>	<u>[Signature]</u>	<u>Moumita</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>3/2</u>	<u>3/7</u>	<u>4/7</u>	<u>4/7</u>	<u>4/7</u>	<u>5/7</u>
Time:		<u>2pm</u>	<u>8pm</u>	<u>@8:05 am</u>	<u>2pm</u>	<u>8pm</u>	<u>8AM</u>



6

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. SIRISHA Department: Oncology Date of Admission: 24/6/26

SITUATION		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify: <u>NA</u>						
BACKGROUND	Area							
	Shift Time	<u>onco 8PM</u>	<u>onco 8AM</u>	<u>onco DAY</u>	<u>onco 8AM</u>	<u>onco DAY</u>	<u>onco 8AM</u>	
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	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>98.5°F</u>	<u>98.5°F</u>	<u>98.4°F</u>	<u>98.5°F</u>	<u>98.3°F</u>	<u>98.3°F</u>
		Res:	<u>25b/m</u>	<u>24b/m</u>	<u>25b/m</u>	<u>25b/m</u>	<u>26b/m</u>	<u>26b/m</u>
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>	<u>100%</u>
		Pulse:	<u>105</u>	<u>110b/m</u>	<u>105</u>	<u>106b/m</u>	<u>105b/m</u>	<u>112b/m</u>
		BP:	<u>100/70</u>	<u>96/54</u>	<u>110/70</u>	<u>90/61</u>	<u>100/60</u>	<u>100/60</u>
	Fall Risk Score:	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	
	Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	
Recommendations	Safety Needs:	<u>side rails</u>	<u>side rails</u>	<u>side rails</u>	<u>side rails</u>	<u>side rails</u>	<u>side rails</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>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Moumita</u>	<u>Sapam</u>	<u>Moumita</u>	<u>Pooja</u>	<u>Moumita</u>	<u>NA</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>5/7</u>	<u>5/7</u>	<u>6/7</u>	<u>7/7</u>	<u>7/7</u>	<u>8/7/20</u>	
Time:		<u>8PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8AM</u>	
Taken Over By Name :		<u>Shweta</u>	<u>Moumita</u>	<u>Shweta</u>	<u>Moumita</u>	<u>Shweta</u>	<u>Shweta</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>5/7</u>	<u>6/7</u>	<u>6/7</u>	<u>7/7</u>	<u>7/7/20</u>	<u>8/7/20</u>	
Time:		<u>8PM</u>	<u>8AM</u>	<u>8AM</u>	<u>8AM</u>	<u>8AM</u>	<u>8AM</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. SIRISHA RANI Department: ONCOLOGY Date of Admission: 21/6/20

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	BACKGROUND	Area	Shift Time	ONCO 8AM-2PM	ONCO 2PM-8PM	ONCO 8PM-2AM	ONCO 2AM-8AM	ONCO 8AM-2PM
	Medical Condition (Any special condition to be noted):		NA	N.A	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:	98.8°F	98.5°F	98.5°F	98.5°F	98.5°F	98.5°F
		Res:	25/10/4	26/10/4	26/10/4	24/10/4	25/10/4	25/10/4
		SpO ₂ :	100%	100%	100%	99%	100%	100%
		Pulse:	115/b/m	110/b/m	110/b/m	100/b/m	100/b/m	100/b/m
		BP:	106/61	106/63/20	106/63/20	90/60	100/60	94/57/10
	Fall Risk Score:	11	11	11	10	10	10	
	Pain Score:	0	0	0	0	0	0	
Recommendations	Safety Needs:		Side rails	Side rails	Side rails	Side rails	Side rails	Side rails
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		NA	NA	NA	NA	NA	NA
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		NA	N.A	NA	NA	NA	NA
Post Operative Procedure Special Orders:			NA	N.A	NA	NA	NA	NA
Handed Over By Name:			Rajanna	Arum	Rajanna	Gargi	Shel	Syren
Signature:			[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:			9/7	9/7	9/7	10/7	10/7	10/7
Time:			8PM	8PM	8PM	8AM	8AM	8PM
Taken Over By Name:			Sushan	Rajanna	Gargi	Sushan	Sonam	Arum
Signature:			[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:			8/7	9/7	9/7	10/7	10/7	10/7
Time:			8PM	8AM	2PM	8PM	8AM	8PM



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Srinivas Department: Oncology Date of Admission: 24/6/20

SITUATION	Diagnosis: <u>D Mps: Type - I</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify: <u>NA</u>					
BACKGROUND	Area	<u>onco</u>	<u>onco</u>	<u>onco</u>	<u>onco</u>	<u>onco</u>	<u>onco</u>	
	Shift Time	<u>8pm</u>	<u>AM</u>	<u>PM</u>	<u>8pm</u>	<u>DAY</u>	<u>PM</u>	
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NR</u>	<u>NR</u>	<u>NR</u>	<u>NA</u>	<u>NA</u>	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.0</u>	<u>98.8</u>	<u>98.4</u>	<u>98.5</u>	<u>98.5</u>	<u>98.4</u>
		Res:	<u>24b/m</u>	<u>24b/m</u>	<u>24</u>	<u>24b/m</u>	<u>28b/m</u>	<u>28b/m</u>
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>
		Pulse:	<u>113b/m</u>	<u>112</u>	<u>104b/m</u>	<u>110b/m</u>	<u>108b/m</u>	<u>108b/m</u>
		BP:	<u>93/68 (12)</u>	<u>90/65</u>	<u>93/64</u>	<u>100/65</u>	<u>100/60</u>	<u>100/60</u>
	Fall Risk Score:	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	
	Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	
	Recommendations	Safety Needs:	<u>side rails</u>	<u>side rails</u>	<u>NR</u>	<u>side rails</u>	<u>side rails</u>	<u>side rails</u>
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Others Specify:		<u>NA</u>	<u>NR</u>	<u>NA</u>	<u>NR</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>NR</u>	<u>NA</u>	<u>NR</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NR</u>	<u>NR</u>	<u>NR</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Anur M</u>	<u>Shel</u>	<u>Shel</u>	<u>Shel</u>	<u>Moumita</u>	<u>Goya</u>	
Signature :		<u>Anur M</u>	<u>Shel</u>	<u>Shel</u>	<u>Shel</u>	<u>Moumita</u>	<u>Goya</u>	
Date:		<u>10/7</u>	<u>11/7</u>	<u>11/7</u>	<u>12/7</u>	<u>12/7</u>	<u>13/7</u>	
Time:		<u>8pm</u>	<u>8AM</u>	<u>8pm</u>	<u>8AM</u>	<u>8PM</u>	<u>8AM</u>	
Taken Over By Name :		<u>Subham</u>	<u>Ping</u>	<u>Subham</u>	<u>Moumita</u>	<u>Goya</u>	<u>Moumita</u>	
Signature :		<u>Subham</u>	<u>Ping</u>	<u>Subham</u>	<u>Moumita</u>	<u>Goya</u>	<u>Moumita</u>	
Date:		<u>10/7</u>	<u>11/7</u>	<u>11/7</u>	<u>12/7</u>	<u>12/7</u>	<u>13/7</u>	
Time:		<u>8pm</u>	<u>8pm</u>	<u>8PM</u>	<u>8AM</u>	<u>8pm</u>	<u>8AM</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sirisha Department: ONCOLOGY Date of Admission: 24/6/22

SITUATION	Diagnosis:	<u>DMPs: TYPE - I</u>						
	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify: <u>NA</u>							
BACKGROUND	Area	<u>ONCO</u>	<u>ONCO</u>	<u>ONCO</u>	<u>ONCO</u>	<u>ONCO</u>	<u>ONCO</u>	
	Shift Time	<u>Day</u>	<u>8p</u>	<u>Day</u>	<u>8p-8am</u>	<u>8am-8pm</u>	<u>8pm-8am</u>	
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>No</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.5°F</u>	<u>98.2°F</u>	<u>98.4°F</u>	<u>98°F</u>	<u>98.2°F</u>	<u>98°F</u>
		Res:	<u>25b/m</u>	<u>24b</u>	<u>25b/m</u>	<u>24b/m</u>	<u>24b/m</u>	<u>24b/m</u>
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>
		Pulse:	<u>100b/m</u>	<u>112b</u>	<u>118b/m</u>	<u>118b/m</u>	<u>124b/m</u>	<u>118b/m</u>
		BP:	<u>100/60</u>	<u>100/60</u>	<u>100/60</u>	<u>100/60</u>	<u>110/60</u>	<u>100/60</u>
	Fall Risk Score:	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	
	Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	
	Recommendations	Safety Needs:	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Siderails</u>	<u>Siderails</u>
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Others Specify:		<u>NA</u>	<u>No</u>	<u>NA</u>	<u>No</u>	<u>Nil</u>	<u>NA</u>	
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Moumita</u>	<u>Blue</u>	<u>Moumita</u>	<u>Blue</u>	<u>Sumita</u>	<u>Arun</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>13/7</u>	<u>14/7</u>	<u>14/7</u>	<u>15/7</u>	<u>15/7</u>	<u>16/7</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>8pm</u>	<u>8am</u>	<u>8pm</u>	<u>8am</u>	
Taken Over By Name :		<u>Blue</u>	<u>Moumita</u>	<u>Blue</u>	<u>Sumita</u>	<u>Blue</u>	<u>Arun</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>13/7</u>	<u>14/7</u>	<u>14/7</u>	<u>15/7</u>	<u>15/7</u>	<u>16/7</u>	
Time:		<u>8am</u>	<u>8am</u>	<u>8pm</u>	<u>8am</u>	<u>8pm</u>	<u>8am</u>	



NG SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. SIRISHA Department: Oncology Date of Admission: 24/2

SITUATION	Diagnosis: <u>ASX DMPL</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
BACKGROUND	Area	<u>Once 2PM</u>	<u>Once 3PM</u>	<u>Once 8AM</u>	<u>Once 2PM</u>	<u>Once 8PM</u>	<u>Once 8AM</u>
	Shift Time						
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:						
	Temp:	<u>98.6°</u>	<u>98.6°</u>	<u>98.6°</u>	<u>98.6°</u>	<u>98.6°</u>	<u>98.6°</u>
	Res:	<u>26b/m</u>	<u>26b/m</u>	<u>28b/m</u>	<u>28b/m</u>	<u>25b/m</u>	<u>28b/m</u>
	SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>
	Pulse:	<u>120b/m</u>	<u>120b/m</u>	<u>112b/m</u>	<u>120b/m</u>	<u>110b/m</u>	<u>112b/m</u>
	BP:	<u>100/60</u>	<u>100/60</u>	<u>98/59/62</u>	<u>90/60</u>	<u>100/60/50</u>	<u>98/59/62</u>
	Fall Risk Score:	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>
	Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Recommendations	Safety Needs:	<u>side rail</u>	<u>side rail</u>	<u>side rail</u>	<u>side rail</u>	<u>side rail</u>	<u>side rail</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>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Handed Over By Name :		<u>Rajam</u>	<u>Gaya</u>	<u>Savitree</u>	<u>Gari</u>	<u>Sonam</u>	<u>Savitree</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>12/7</u>	<u>16/7</u>	<u>17/7</u>	<u>17/7</u>	<u>17/7</u>	<u>18/7</u>
Time:		<u>2PM</u>	<u>8PM</u>	<u>8AM</u>	<u>2PM</u>	<u>8PM</u>	<u>8AM</u>
Taken Over By Name :		<u>Gaya</u>	<u>Nash</u>	<u>Gari</u>	<u>Sonam</u>	<u>Nash</u>	<u>Sumit</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>16/7</u>	<u>16/7</u>	<u>17/7</u>	<u>17/7</u>	<u>17/7</u>	<u>18/7</u>
Time:		<u>2PM</u>	<u>8PM</u>	<u>8PM</u>	<u>2PM</u>	<u>8PM</u>	<u>8AM</u>



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sirisha Rani Department: Oncology Date of Admission:

SITUATION		Diagnosis: <u>mbs-type-I</u>					
		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
BACKGROUND	Area	<u>BMT</u> <u>8AM-8PM</u>	<u>Onc</u> <u>8am</u>	<u>Onc</u> <u>9AM</u>	<u>Onc</u> <u>PM</u>	<u>Onc</u> <u>8am</u>	<u>Onc</u> <u>PM</u>
	Shift Time						
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Vital Signs:	Temp: <u>98.2°F</u> Res: <u>24b/m</u> SpO ₂ : <u>100%</u> Pulse: <u>118b/m</u> BP: <u>102/61</u> Fall Risk Score: <u>10</u> Pain Score: <u>0</u>	Temp: <u>98.6°F</u> Res: <u>28b/m</u> SpO ₂ : <u>100%</u> Pulse: <u>112b/m</u> BP: <u>108/62</u> Fall Risk Score: <u>10</u> Pain Score: <u>0</u>	Temp: <u>98.8°F</u> Res: <u>26b/m</u> SpO ₂ : <u>100%</u> Pulse: <u>112b/m</u> BP: <u>100/61</u> Fall Risk Score: <u>10</u> Pain Score: <u>0</u>	Temp: <u>98.8°F</u> Res: <u>20b/m</u> SpO ₂ : <u>100%</u> Pulse: <u>112b/m</u> BP: <u>100/61</u> Fall Risk Score: <u>10</u> Pain Score: <u>0</u>	Temp: <u>98.6°F</u> Res: <u>28b/m</u> SpO ₂ : <u>100%</u> Pulse: <u>112b/m</u> BP: <u>100/60</u> Fall Risk Score: <u>10</u> Pain Score: <u>0</u>	Temp: <u>98.6°F</u> Res: <u>28b/m</u> SpO ₂ : <u>100%</u> Pulse: <u>112b/m</u> BP: <u>100/60</u> Fall Risk Score: <u>10</u> Pain Score: <u>0</u>
RECOMMENDATIONS	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
	Safety Needs:	<u>Side rails</u>	<u>Side rails</u>	<u>Side rails</u>	<u>Side rails</u>	<u>Side rails</u>	<u>Side rails</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>
Other Special Orders / Medications:	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Handed Over By Name :		<u>Savitri</u>	<u>Savitri</u>	<u>Rajamoni</u>	<u>Gaya</u>	<u>Savitri</u>	<u>Gaya</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>18/7</u>	<u>18/7</u>	<u>19/7</u>	<u>19/7</u>	<u>20/7</u>	<u>20/7</u>
Time:		<u>8AM</u>	<u>8am</u>	<u>2PM</u>	<u>8PM</u>	<u>8am</u>	<u>2PM</u>
Taken Over By Name :		<u>Nashup</u>	<u>Rajamoni</u>	<u>Gaya</u>	<u>Nashup</u>	<u>Gaya</u>	<u>Pooja</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>18/7</u>	<u>19/7</u>	<u>19/7</u>	<u>19/7</u>	<u>20/7</u>	<u>20/7</u>
Time:		<u>8PM</u>	<u>8AM</u>	<u>2PM</u>	<u>8PM</u>	<u>8AM</u>	<u>2PM</u>



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sirisha Rani Department: Oncology Date of Admission: 20/6/20

SITUATION	Diagnosis: <u>MDS - Type I</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
BACKGROUND	Area	Shift Time	<u>ONCO 8pm</u>	<u>ONCO 8am</u>			
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>			
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp: <u>98.4</u>	<u>98.6</u>				
	Res:	<u>20b/m</u>	<u>20b/m</u>				
	SpO ₂ :	<u>99%</u>	<u>100%</u>				
	Pulse:	<u>112b/m</u>	<u>108b/m</u>				
	BP:	<u>100/71</u>	<u>92/59/62</u>				
	Fall Risk Score:	<u>10</u>	<u>10</u>				
Recommendations	Pain Score:	<u>0</u>	<u>0</u>				
	Safety Needs:	<u>side rails</u>	<u>side rails</u>				
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	<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>				
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>				
Handed Over By Name :		<u>Pooja</u>	<u>Savitro</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>20/6</u>	<u>21/7</u>				
Time:		<u>8pm</u>	<u>8am</u>				
Taken Over By Name :		<u>Marhup</u>					
Signature :		<u>[Signature]</u>					
Date:		<u>20/7</u>					
Time:		<u>8pm</u>					



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 3:30pm Mode of Arrival: with Parents Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: nil

Body Weight: 10.29 Kg

Height: 10.29 cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
nil	nil	nil

Family History: healthy family

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

If yes please list: _____

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

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

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

Observations: Weight: 10.29kg Length: _____ Head Circumference (< 2 years): _____

Temp.: 98.4 HR: 100/min RR: 24/min BP: 100/60/61

Pain Score: 0 Specify Site: Side of back (Follow Pain Assessment Sheet & Document) -

Fall Risk Assessment: ☐ Yes ☒ No Score: 4 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

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

Character of Pain: NA Location: NA Frequency: NA Duration: NA

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

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWIKA
11-02-2022 4 Y 5 M 7 D (F)
Dr. SIRISHA RANI



P88

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 18/07/26 Time: 3:15 pm.

Blood Group of the Patient: B (+ve) Blood Group on the Blood Bag: B (+ve)

Blood Bank Issue No: Date of Collection: Date of Expiry:

Date & Time of Starting Transfusion: 18/07 @ 3:15 pm. Planned duration of Transfusion: 4 hours

Check for Correct Unit: ☒ Correct Patient: ☒

Blood products cross checked by: Nurse 1: Susmita. Nurse 2: Anuradha.

Before starting transfusion vitals: Temp: 98.3°F HR: 124b/m RR: 24b/m BP: 103/48 SpO₂: 100%.

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
18/07	15 Min	122b/m	98.2°F	106/48	100%	Nil	Nil	Nil	Nil
	15 Min	123b/m	98.3°F	103/51	99%	Nil	Nil	Nil	Nil
	30 Min	119b/m	98°F	104/56	100%	Nil	Nil	Nil	Nil
	30 Min	124b/m	98.5°F	106/61	98%	Nil	Nil	Nil	Nil
	30 Min	113b/m	98.4°F	102/52	98%	Nil	Nil	Nil	Nil
	1 Hr	125b/m	98.3°F	104/55	100%	Nil	Nil	Nil	Nil
	1 Hr	120b/m	98.6°F	103/58	99%	Nil	Nil	Nil	Nil

Comments: No fast breathing, No rashes, no complaints.

Name of the Incharge-Nurse: Anuradha. Name of the Nurse: Susmita.

Signature of the Incharge-Nurse: [Signature] Signature of the Nurse: [Signature]

Date & Time: 18/07/26 @ 2:30 pm. Date & Time: 18/07/26 @ 7:30 pm

1656

BIACH&RI
BLOOD BANK

OPERATOR

DATE

18/7/26

Hospital Blo

25 Gy INDICATOR

IRRADIATED

103/1,2,3,4 &

Banjara Hills, Hyderabad, Telangana State

Lic.No. 46/HD/TS/2018/BB/G

LEUCO REDUCED BLOOD CELLS I.P200 ml. Prepared from Whole human blood collected in 49 ml. of C.P.D.A.
ution.**B****Rh Positive**HIV I & II/ HBsAG/ HCV - Non
reactive

VDRL - Non reactive

MP - Negative

NAT(HIV I & II/ HBsAG/ HCV)- Non
reactive

Unit No.: BAH26-01656

Blood Group: B Rh Positive

Collection Date: 11/Jul/2026

Expiry Date: 22/Aug/2026

1) Administer Without Warming. 2) Shake Gently Before Use. 3) Do Not

Add Ar

Issue Label / CrossMatching Report

Group

With F

There i

Approp

Antibo

Patient : Baby GARIGANTI RITHWIK

Patient's Blood Group : B Rh Positive

Hosp/Dr : Rainbow Childrens Hospital, DR. SIRISHA RANI

UHID No. : BAH-00648830 Wd-Bed No. :

Product : LR-PRBC

Blood Group : B Rh Positive

Unit No. : BAH26-01656

XMatching Report: Compatible

X-matched by: Premalatha

Issue Dt : 18/Jul/2026

Colln. Dt : 11/Jul/2026

Exp. Dt : 22/Aug/2026

Issued By : MONOJ

**Rainbow Hospital Blood Centre, Rainbow Childrens
Hospital**D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road
No.2, Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWIK
11-02-2022 4 Y 5 M 7 D (F)
Dr. SIRISHA RANI



rainbow
children's
hospital
It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CONSENT FOR BLOOD TRANSFUSION

Name: Gariganti Rithwika Age: 4 years Gender: Male ☐ Female ☒
UHID.No : BAH-00648830 Date: 18/7/26

Type of Blood Product: ☐ Fresh Frozen Plasma ☒ Packed Red Blood Cells ☐ Random Donor Platelets
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood
☐ Albumin ☐ Red Blood Cell ☐ Others

I, Kavitha hereby give my consent for whole blood transfusion or blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immuno-deficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in the "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that none

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during the present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Signature: Kavitha
Name: Kavitha
Date & Time: 18/07 @ 2:45pm

Doctor (Who is talking the consent)

Signature: Ce-12
Name: Dr. Vishwaje
Date & Time: 18/7/26 at 2:45pm

Witness

Signature: Kavitha
Name: Kavitha
Date & Time: 18/7 @ 2:45pm

రక్త మార్పిడి కొరకు అంగీకార పత్రము

రోగి పేరు: వయస్సు: లింగము ☐ పురుషుడు ☐ స్త్రీ

UHID. సంఖ్య: తేదీ:

రక్త ఉత్పత్తి రకాలు:

- | | | |
|---|---|---|
| ☐ తాజా ఘనీభవించిన ప్లాస్మా | ☐ ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు | ☐ Random Donor Platelets |
| ☐ క్రయోప్రెసిపిటేట్ | ☐ ఒకే ధాత ఫ్లేటిలెట్స్ | ☐ Whole Blood |
| ☐ మొత్తం రక్తం | ☐ ఎర్ర రక్త కణం | ☐ ఇతరులు..... |

నేను ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడిస్, హైపటైటిస్ బి సర్వేస్ యాంటిజన్, హైపటైటిస్ యాంటిబడిస్, మలేరియా మరియు సిఫ్లిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణీత కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలెత్తవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు

పైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి చికిత్స చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. చికిత్స చేస్తున్న సమయంలో అన్ని రకముల రక్తమార్పిడులకు (మొత్తం రక్తం / లేదా రక్త ఉత్పత్తులు ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ప్లెష్ ప్రోజెన్ ప్లాస్మా, క్రయోప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకం

పేరు

పేరు

తేదీ మరియు సమయము

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు



CONSENT FOR BLOOD TRANSFUSION

1819

Name: Gariganti Rithwika Age: 4yrs Gender: Male ☐ Female ☒
UHID.No: 648830 Date: 8/2/20

Type of Blood Product: ☐ Fresh Frozen Plasma ☐ Packed Red Blood Cells ☐ Random Donor Platelets
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood
☐ Albumin ☐ Red Blood Cell ☒ Others 1819

I Kavitha hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immunodeficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

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

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Doctor (Who is talking the consent)

Signature: Kavitha Signature: A
Name: Kavitha Name: Swarni
Date & Time: 8/2/20 3pm Date & Time: 8/2/20 3pm

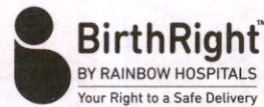
Witness

Signature: Kavitha
Name: Kavitha
Date & Time: 8/2/20 3pm

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWIKA
11-02-2022 4 Y 4 M 23 D (F)
Dr. SIRISHA RANI



PRBC
200ml



BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 4/7/26 Time: 9 PM

Blood Group of the Patient: B+ve Blood Group on the Blood Bag: B+ve

Blood Bank Issue No: NTRH26-07109 Date of Collection: 26/6/26 Date of Expiry: 4/8/26

Date & Time of Starting Transfusion: 4/7 @ 9 PM Planned duration of Transfusion: 4 hrs

Check for Correct Unit: ☒ Correct Patient: ☒

Blood products cross checked by: Nurse 1: Sonam Nurse 2: Anuselha

Before starting transfusion vitals: Temp: 98°F HR: 112 b/m RR: 24 b/m BP: 98/60 SpO₂: 99%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
4/7	15 Min	100	98°F	90/60	99	NA	NA	NA	NA
4/7	15 Min	98	98°F	92/58	99	NA	NA	NA	NA
4/7	30 Min	110	98°F	90/62	99	NA	NA	NA	NA
4/7	30 Min	112	98°F	94/60	99	NA	NA	NA	NA
4/7	30 Min	114	98°F	90/60	99	NA	NA	NA	NA
4/7	1 Hr	112	98°F	90/60	100	NA	NA	NA	NA
4/7	1 Hr	100	98°F	90/54	99	NA	NA	NA	NA

Comments: No any reaction.

Name of the Incharge-Nurse: Anu

Name of the Nurse: Sonam

Signature of the Incharge-Nurse: A

Signature of the Nurse: S

Date & Time: 4/7, 9 PM

Date & Time: 4/7, 9 PM

NTR Memorial Trust Blood Centre, Hyderabad
NTR Bhavan, Road No.2, Banjara Hills Hyderabad – 500034
Ph.No. 04048577888, Lic.No. 01/HD/AP/2008/BB/R

PACKED RED BLOOD CELLS IP -ALIQUOT-A

Qty. 200 ml derived from 350 ± 35 ml of whole human blood mixed with 49ml of CPD with 78ml SAGM solution. Storage & Transport temp. is 2° C to 6° C

 Rh Positive	Syphilis HIV I & II HBsAg Anti HCV MP - Negative Donor Type: Voluntary
	Blood Group : B Pos Collection Date : 26/Jun/2026 Expiry Date : 07/Aug/2026
NTRH26-07109	

1. Keep continuously temperature 2-6° c. 2) Administers with not warming. 3) Disposable transfusion sets with filter shall be used in administration Equipment. 4) Appropriate cross matched blood without a typical antibody in Recipient shall be used 5) evidence of de WHB IP will be Practitioner. 7) in one hour of i matching repor grou

rad-sure™
irradiation indicator
OPERATOR  DATE: **4/7/26**
25 Gy INDICATOR
LOT 040312GX25
IRRADIATED

Issue Label / CM label

Patient : RITHVIKA .	
Patient's Blood Group: B Pos	
Hosp/Dr : RAINBOW CHILDRENS	
It Hosp Reg No.: 19821	Wd-Bed No:
Product : PRC Aliquot-A	Issue No.: IM26-4661
Blood Group : B Pos	Issue Dt : 04/Jul/2026
Bag Sr.No.: NTRH26-07109	Colln. Dt : 26/Jun/2026
XM Report: Compatible	Exp. Dt : 07/Aug/2026
NTR Memorial Trust Blood Centre, Hyderabad NTR Bhavan, Road No.2, Banjara Hills Hyderabad – 500034 Lic. No. 01/HD/AP/2008/BB/R	

CONSENT FOR BLOOD TRANSFUSION

BAH-00648830 IPS-00175554
Baby GARIGANTI RITHWIKA
11-02-2022 4 Y 4 M 23 D (F)
Dr. SIRISHA RANI



Name: Age: 4/ Gender: Male ☐ Female ☒

UHID.No : Date: 4/2

Type of Blood Product:

☐ Fresh Frozen Plasma	☒ Packed Red Blood Cells	☐ Random Donor Platelets
☐ Cryoprecipitate	☐ Single Donor Platelet	☐ Whole Blood
☐ Albumin	☐ Red Blood Cell	☐ Others

I Kavitha hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immunodeficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

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

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Signature: Kavitha

Name: Kavitha

Date & Time: 4/2 @ 9pm

Doctor (Who is talking the consent)

Signature: Dr. Prashant

Name: Dr. Prashant

Date & Time: 4/2/2022 at 9pm

Witness

Signature: Kavitha

Name: Kavitha

Date & Time: 4/2 @ 9pm



CONSENT FOR CHEMOTHERAPY

Patient Name : Gariganti Rithwikha Age : 4 yrs Gender : Male ☐ Female ☒
UHID No : 649830 Department : Oncology Date : 26/6/26
Type of Chemotherapy : IV

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

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

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

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

Patient Attendant :

Signature : Kavitha
Name : Kavitha
Relationship with Patient : Mother
Date & Time : 26/6/26 @ 3:45pm

Witness :

Signature : Kavitha
Name : Kavitha
Date & Time : 26/6/26 @ 3:45pm

Doctor (who is taking the consent):

Signature : [Signature]
Name : Nishitha
Date & Time : 26/6/26 @ 3:45pm

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWIK
11-02-2022 4 Y 4 M 14 D (F)
Dr. SIRISHA RANI



Name: Rithwik Age: 4y4m Sex: F UHID No: _____
Date: 25/6/26 Time: 2pm Proposed Operation: Grothong line
Diagnosis: Mucopolysaccharidosis type I for Stem cell Transplant
B.P / CRT: 98/65 H.R: 101 Weight: 10.2kg ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:				
Hgb: <u>10.9</u>	Glucose: <u>100</u>	Protein: _____	HIV: _____	X-Ray: _____
PCV: <u>37.6</u>	Urea: _____	Alb: _____	HBS Ag: _____	ECG: <u>LVH (+) mild MR</u>
WBC: <u>3-34</u>	Creat: _____	Total Bill: _____	HCV: _____	2D Echo: _____
Plate: <u>3-34</u>	Na: _____	Dir. Bill: _____	Blood group: _____	Stress/Angio: _____
PT: _____	K: _____	LDH: _____	T3: _____	Other: _____
PTT: _____	Ca++: _____	Alk phos: _____	T4: _____	
INR: _____	Mg++: _____	Amylase: _____	TSH: _____	
Cl-: _____	SGOT/SGPT: _____			

Allergies: _____

Medical History: CVS: Kidney Failure's Syndrome
RESP: _____ Diabetes: _____
CNS: _____
Renal: _____
Hepatic / GE: _____ Physical Activity: OK
Others: FT / NVD / CIAB ; UE - Mild Dup Delay (+) Language del
Past Anaesthetic History: 2 Umb Hernia Repair (Open) GA ; UE
Physical Exam: Bossing Forehead, Nasal bridge flat ; Neck webbing
Airway: MP 1 2 3 4 ? Mouth Opening: (N) Mentohyoid Distance: (N) Neck: Ext Teeth: Caries (+)
Lungs: NAD Restricted Upper jaw incisors & canines missing
Heart: Pansyst Murrer (+)
CNS: _____
Pregnant: ☐ Yes ☐ No ☒ NA Venous Access Site: 22G Spine Exam for regional: (N)
Anaesthetic Plan: ☐ MAC ☐ REGIONAL ☐ GA-ETT ☒ LMA
Peri-Operative Plan Explained to the Patient: ☒ Yes ☐ No

CURRENT MEDICATIONS	DOSAGE

- Pre-Operative Instructions:**
- DVT Prophylaxis:
 - NIL ORAL $\rightarrow$ Water / ORS 2 Hours
 $\rightarrow$ Others 6 Hours
 - Informed Consent: ☐ Standard ☒ High Risk
 - Post Operative Pain Management: ☒ Discussed with Patient
 - Other Instructions: bring Echo report ECG

Signature: [Signature] Name: Dr. Sumit



ANAESTHESIA CHART



Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☒ No	Fasting Status: <u>confirmed</u>
Physical Status: ☒ Patient Identified ☒ Consent Present ☒ Chart Reviewed	

H.R: <u>120/min</u>	B.P / CRT: <u>90/50mmHg</u>	SpO ₂ : <u>100%</u>	R.R: <u>20/min</u>	Last Feed: <u>6 hrs</u>
Pre-OP Diagnosis:		Operation: <u>Cerebrovascular line placement</u>		Date: <u>25/6/20</u>
Surgeon: <u>Dr. Shilpa / Dr. Ayesha</u>		Anaesthesiologist: <u>Dr. BT/Dr. SD</u>		Technician: <u>P. S. Shankar</u>

TIME: <u>3:30</u> to <u>4:30</u> N ₂ O / AIR 10, LPM HALO / ISO / SEVO Drugs: <u>MIDAZOLAM 0.5mg</u> <u>FENTANYL 20mcg</u> <u>PROPOFOL 20 + 20 + 20</u> FIO ₂ / SaO ₂ : <u>100 / 100</u> ET CO ₂ : <u>36</u> ECG: <u>SR SN SR</u> Temperature Urine Output Fluids Blood B.P V Systolic A Diastolic X Mean • Heart Rate Tourniquet on Time Tourniquet off Time Throat Pack In Throat Pack Out	Antibiotic Suppository Blood Loss NOTES
--	--

LAB Values	ABG
	GRBS
	Others

☒ Equipment Checked and Functional ☒ BP ☐ Cuff Site: ☐ Art Site: ☒ EKG Lead ☒ Temp Site ☒ FIO ₂ Monitor ☒ Agent Monitor ☒ Pulse Oximeter ☒ Capnograph ☒ Ventilator ☐ Nerve Stimulator Position: <u>Supine</u> ☒ Pressure Points Checked Eye Care: ☒ Oint ☐ Tape ☐ Padding ☐ Awake	Temp: ☒ HME ☐ Fluid Warmer ☐ Cling Film ☐ OH Warmer ☒ Hugger's ☐ Cotton Wool ☐ Other Times: Anaes Start: <u>3:30pm</u> OP Start: OP End: Leave OR: <u>4:30pm</u> Anaesthesia: ☒ GA ☐ Monitored Anaesthesia Care ☐ Regional Line (Size & Location) ☐ CVP: ☐ ART: ☒ IV: <u>22G D.U.</u> ☐ IV: ☐ IV:	Induction ☒ IV ☒ Inhal ☐ Pre O ₂ ☐ RSI ☐ Others ☐ Mask ☒ SGA <u>#1.5 AMBU</u> ☐ Airway ☐ Oral ☐ Nasal <u>WAL</u> ETT# at cm ☐ Oral ☐ Nasal ☐ Cuff ☐ Tracheostomy ☐ Topical ☐ Drug: ☐ Awake ☐ Direct Vision ☐ Video Laryngoscopy ☐ Stylette / Bougie ☐ Fiberoptic Blade # Attempts: Difficulty Why? ☐ Bilat = BS ☐ Semi-Closed Circle ☒ Closed Circle ☐ Other	Regional: Extremity ☐ Spinal ☐ Epidural ☐ Caudal Others: Position: Site: Needle Size: Depth: Parasthesia ☐ Yes ☐ No Catheter at skin cm Drug Name & Conc: Bolus: Infusion: Block Level: Comments: Transportation to ☒ PACU ☐ ICU ☐ Other Relaxant Reversed ☐ Yes ☐ No ☐ NA Name of the Doctor: <u>Dr. Prabhu</u> Signature of the Doctor:
--	---	--	---



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Amos Time Received : 04:30pm Time Discharged :

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site: <u>① hand</u> ☐ O ₂ Mask ☐ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway
		Vomiting: ☐ Yes ☒ No Drug: NG Tube: ☐ Yes ☒ No Drain: ☐ Yes ☒ No Urinary Catheter: ☐ Yes ☒ No Chest Tube: ☐ Yes ☒ No Nil Oral ☐ Yes ☒ No IV Fluids: Oral Feeds: <u>water</u>

POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES			OUT	SCORING INTERPRETATION
			30	60	90		
Able to move 4 extremities voluntary or on command	= 2	1	2				A Minimum Total Score of 8 is Required for Discharge
Able to move 2 extremities voluntary or on command	= 1						
Able to move 0 extremities voluntary or on command	= 0						
Able to deep breathe & cough freely	= 2	2	2				Exceptions to this, are to be explained in the space below by the Discharging Physician:
Dyspnea or limited breathing	= 1						
Apneic	= 0						
BP $\pm$ 20 of Pre Anaesthetic level	= 2	2	2				
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1						
BP $\pm$ 50 of Pre Anaesthetic level	= 0						
Fully awake	= 2	2	2				
Arousable on calling	= 1						
Not responding	= 0						
Pink	= 2	2	2				
Pale, dusky, blotchy, jaundiced, other	= 1						
Cyanotic	= 0						
TOTAL		9	10				

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
25/06/26	0710		NA	<u>[Signature]</u>

Pain Tool Used: ☐ N PASS ☒ FLACC ☐ Wong Baker ☐ NPS

Anaesthesiologist Name : Dr. Akhila K

Anaesthesiologist Signature: [Signature]

Date & Time: 25/6/26 @ 5pm

PACU Nurse Name : Shravan

PACU Nurse Signature: [Signature]

Date & Time: 25/6/26 @ 5pm

Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): 1351

Date & Time: 25/6/26 @ 5pm

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWIKA
11-02-2022 4 Y 4 M 14 D (F)
Dr. SIRISHA RANI



EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

CSE /Spinal /Epidural Position : Space : Technique (LOR/LOS)

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

[illegible]

Delivery Details : Time : APGAR: SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :



INFORMED CONSENT FOR SURGERY / PROCEDURE

Authorization By: ☐ Patient ☒ Patient Attendant

I, the undersigned do hereby agree to undergo the following surgery(s), Procedure(s) on patient / myself at Rainbow Children's Hospital. (Avoid technical terms and leave no blank space)

1. Growth chart line placement
2. _____

I acknowledge the following:

- I have been made aware of the benefits and reasons of the surgery / procedure as indicated by the clinical observations and / or diagnostics performed.
- The benefits and risks of this surgery / procedure have been explained to me. I have also been told about the alternatives available for this surgery / procedure including the advantages and disadvantages of the alternatives.

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
<u>Long term chemo therapy</u>	<u>Hickman's line</u>

3. As with any procedure, I am aware that risks such as blood loss, infection, cardiac arrest, anesthetic allergic reactions, paralysis, Deep Vein thrombosis (DVT), Pulmonary thromboembolism (PTE) etc may arise necessitating attention. Therefore, in addition to consenting to the performance of the above-mentioned surgery/procedure(s), I also consent and authorize the rendering of such other care and treatment as patient/my surgeon or his / her designee reasonably believes necessary should one or more of these and or other unforeseeable events occur.

Apart from the listed above, I have also been explained about the possible complications of the surgery / procedure are as follows:

- a. Hematoma, Infection
Bleeding

- I authorize Dr. Amudha / Shilpa and his / her team to perform the procedural sedation upon the patient / myself.
- I recognize that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: Kavitha

Name: Kavitha

Relationship with patient: Mother

Date & Time: 25/6/26 @ 2pm

Witness:

Signature: [Signature]

Name: Amudha

Date & Time: 25/6/26 @ 2pm

Doctor (who is taking consent):

Signature: [Signature] Name: Dr Shilpa

Date: 25/6/26 Time: 2:06pm

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్బో చిల్డ్రన్ హాస్పిటల్లో చేయబడబోయే క్రింది శస్త్రచికిత్స(లు) / ప్రాసీజర్(లు) చేయడానికి అంగీకరిస్తున్నాను. (టెక్నికల్ పదాలు వాడవద్దు మరియు ఖాళీ స్థలం వదిలివేయకండి)

1

2

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

- క్లినికల్ పరిశీలనలు మరియు/లేదా చేసిన పరీక్షల ఆధారంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
- ఈ శస్త్రచికిత్స / ప్రాసీజర్ కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి.
ఈ శస్త్రచికిత్స / ప్రాసీజర్ కు ఉన్న ప్రత్యామ్నాయాల గురించి, వాటి ప్రయోజనాలు మరియు సవ్యాలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

- ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్ లాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్టీషియా వల్ల అలెర్జిక్, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు.
అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్ నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినపుడు, రోగి/నా కోసం అవసరమని వైద్యుడు భావించే ఇతర చికిత్సలను చేయడానికి కూడా నేను అనుమతిస్తున్నాను.

అదనంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ వల్ల సంభవించగల ఇతర సమస్యలు కూడా నాకు వివరించబడ్డాయి:

a.	
b.	

- డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్ ను చేయడానికి నేను అనుమతిస్తున్నాను.
- వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
- పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భావ సమాధానం ఇచ్చారు.
ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో, స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Si Pa
Asst. Surgeon :
Anaesthetist : Dr. Tejaswini
Scrub Nurse : Bola

Patient Name : Baba Rathiokha Age : 7y Gender : F
UHID No. BAH-00648830 Surgery Name : Gyroscopic Laparoscopic Placement
Date : 25/06/22 In-time : 03:30pm Out-time : 04:30pm

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWIKHA
11-02-2022 4 Y 4 M 14 D (F)
Dr. SIRISHA RANI

Before Induction of Anaesthesia ➤ ➤

SIGN IN	Time: <u>2:09pm</u>
Patient Has Confirmed	
Identity	☒ Yes ☐ No
Site	☐ Yes ☒ No
Procedure	☐ Yes ☐ No
Consent	☐ Yes ☐ No
Site Marked	☒ Yes ☐ No ☐ NA
Anaesthesia Safety Check Completed	☐ Yes ☒ No
Pulse Oximeter on Patient & Functioning	☐ Yes ☐ No
Does Patient have a:	
Known Allergy?	☐ Yes ☒ No
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available	☒ Yes ☐ No
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☒ No ☐ NA
Blood Units Reserved	☐ Yes ☒ No ☐ NA
Has Antibiotic Prophylaxis been given within the last 60 minutes?	
	☐ Yes ☒ No ☐ NA
Signature : <u>[Signature]</u>	
Name : <u>Dr. Bola</u>	

Before Skin Incision ➤ ➤

TIME OUT	Time: <u>02:59pm</u>
Confirm all team members have introduced themselves by Name and Role ☒ Yes ☐ No	
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm	
Correct Patient (Check ID Band)	☒ Yes ☐ No
Correct Site	☒ Yes ☐ No
Correct Procedure	☒ Yes ☐ No
Anticipated Critical Events	
Surgeon Reviews:	
What are the Critical or Unexpected Steps, Operative Duration, <u>Ant</u> Anticipated Blood Loss? ☐ Yes ☐ No ☐ NA	
Anaesthesia Team Reviews:	
Are There Any Patient-specific Concerns? ☐ Yes ☐ No ☐ NA	
Nursing Team Reviews:	
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☒ Yes ☐ No ☐ NA	
Is Essential Imaging Displayed? ☐ Yes ☐ No ☒ NA	
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☒ Yes ☐ No	
Signature : <u>[Signature]</u>	
Name : <u>Surgeon</u>	

Before Patient Leaves Operating Room

SIGN OUT	Time: <u>04:25pm</u>
Nurse Verbally Confirms with the Team:	
The Name of the Procedure Recorded	☒ Yes ☐ No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☒ Yes ☐ No ☐ NA
The Specimen is Labelled (including patient name)	☐ Yes ☒ No ☐ NA
Whether there are any Equipment Problems to be addressed	☐ Yes ☒ No ☐ NA
To Surgeon, Anaesthetist and Nurse:	
What are the key concerns for recovery and management of this patient? ☐ Yes ☒ No	
Signature : <u>Dr. Tejaswini</u>	
Name : <u>[Signature]</u>	



BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 25/06/20

Department : OT Duration of Procedure : 1hr

Name of Surgeon : Dr. Swalpa Date of Admission : 25/06/20

Bundle Care Criteria : (Tick (✓) if done)

		Staff Signature
1.	Antibiotic given prior to surgery ? ☐ Yes ☐ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☐ Yes ☐ No Name of the Antibiotic : _____	Swalpa
2.	Hair Removal ☐ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : _____ Skin preparation done (cleanse surgical area with antiseptic agent)? ☒ Yes ☐ No	Swalpa
3.	Patient's body temperature immediately post operation (Recovery Room) _____ °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : _____ Date & Time of antibiotic administration : _____ Date & Time procedure started : 25/06/20 @ 02:00 PM	Swalpa

- Ensure form is filled in completely by assigned staff whenever patient had surgery
- If any bundle care criteria has not been observed or unmet, assigned staff must inform infection control nurse for management
- All forms (Bundle care and when required SSI form) are completed properly
- Forms must always be kept in Infection Control folder in respective department

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWKA
11-02-2022 4 Y 4 M 14 D (F)
Dr. SIRISHA RANI



Groshong® NXT ClearVue™ Catheter

REF 7655405
LOT REKR3116
2028-07-31

(01)00801741035272
(17)280731
(10)REKR3116



DAVID

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

OPERATION THEATER NOTES

Patient's Name : BABY GARIGANTI RITHWKA Age : 4Y Gender : ☐ Male ☒ Female

UHID No.: BAH-00648830 Weight : Height :

Surgeon :		Asst. Surgeon :	
Anesthetist :	OT Nurse:		OT Technician:
Pre-Operative Diagnosis:			
Surgical Procedure : <u>Groshong's line insertion for chemotherapy</u>			
Indications for Surgery : <u>Leukodysplasia → for Bone marrow transplant.</u>			
Date : <u>25/6/26</u>	Start Time : <u>03:00pm</u>		End Time : <u>04:25pm</u>
Pre Operative Preparations: <u>Inguinal area sterilised & Betadine</u> <u>sterile drapes applied.</u>			
Post Operative Diagnosis: <u>Groshong's line inserted & Leukodysplasia</u>			
Peri-Operative Complications: <u>nil</u>			
Operation Notes: <u>ultrasonically guided. AFR. Groshong line - needle</u> <u>in Rt. Basilic vein. Guide wire passed confirmed</u> <u>& C-arm - entering into the Rt. Atrium. Then</u> <u>dilator & sheath inserted over the guide wire.</u> <u>Groshong line inserted through the sheath.</u> <u>wire inside the line and sheath removed.</u> <u>position of tip of line confirmed & C-arm.</u> <u>and fixed in the arm & sterile</u> <u>drapings.</u>			



POST-SURGICAL CARE PLAN FORM

Procedure Done: Grossman's line insertion

Post-Surgical Diagnosis: line insert & myopharyngeal atresia

Post-Operative Monitoring Parameters /Frequency:

ECG, NIBP, pulse oxymetry

Wound Care:

sterile precautions while handling the line

Drain /Special Lines/Catheters:

Grossman's line

Special Patient Positioning and Requirements:

Supine

Nutritional Instructions:

nil

When to Start Mobilization:

2hrs

Special Referrals:

nil

The new order for all required medications documented in the doctor order/medication sheet:

☐ Yes ☒ No

Any Other Post-Operative Care Needed including Required Follow Up

sterile handling of line

Treating Surgeon
(Signature & Stamp)

Dr Sirisha

Date: 25/6/20 Time: 4:33pm

Note: Plan of care will be readjusted if necessary.



CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: G-nouchoangi line placement

Anaesthesiologist: Shilpa Surgeon: Dr. Sundhara

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk(s): The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders
☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease
☐ Others Difficult airway.

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☐ Regional Anaesthesia ☒ General Anaesthesia ☐ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: Kavitha

Name: Kavitha

Relationship with patient: Mother

Date & Time: 25/6/26 @ 2pm

Witness:

Signature: Anusuya

Name: Anusuya

Date & Time: 25/6/26 @ 2pm

Doctor (who is taking consent):

Signature: Dr. Shilpa Name: Dr. Shilpa

Date: 25/6/26 Time: 2pm

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మాకరక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్థావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

రిజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై లిస్ట్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ రిజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనెస్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, రిజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

St. Theresa's Hospital Blood Cen

(A unit of Vidya Sadhana Educational Society)
SanathNagar, Opp. Erragadda Rythu Bazar,
Hyderabad-18, Ph.No: 2380 2255, 2381 2288.
Lic No. 12/HD/AP/2010/BB/CC

SINGLE DONOR PLATELETS (USP)

Patients Name : **Blo. Rithwika**

Age / Sex : **4y/F**

Hospital : **R. C. H**

Date : **10/07/26**

BLOOD GROUP : **'B'**

Bag No. : **257**

Date of Collection : **10/07/26**

Expiry Date : **15/07/26**

Volume : **150 ml**

Tech. Sign

Zany

HIV I & II

HBsAg

HCV

VDRL

MP

NEG

1) Do not store, transfuse immediately. 2) Check blood group on the label & recipient's Group before transfusion. 3) Do not warm. 4) Do not add any other medicine to the Blood Component. 5) Confirm the absence of deterioration like discoloration. 6) Use a Fresh, Clean, Sterile and appropriate set to Transfuse. 7) Store at 20°C to 24°C or room temp. 8) Transfuse under medical supervision without prescription.

DATE: **10/7/26**

OPERATOR: **[Signature]**

rad-sure™

Irradiation Indicator

25 Gy INDICATOR

Lot 040312GX25

IRRADIATED

2029-02-11



SDP-

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 10/7/26 Time: 2pm

Blood Group of the Patient: B+ve Blood Group on the Blood Bag: B+ve

Blood Bank Issue No: 257 Date of Collection: 10/7/26 Date of Expiry: 15/7/26

Date & Time of Starting Transfusion: 10/7/26 @ 2pm Planned duration of Transfusion: 30 mins

Check for Correct Unit: ☒ Correct Patient: ☒

Blood products cross checked by: Nurse 1: Mr. Sorem Nurse 2: Mr. Senthil

Before starting transfusion vitals: Temp: 98°F HR: 113b/min RR: 24b/min BP: 93/68(20) SpO₂: 100%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
10/7/26	2:15pm 15 Min	118b/min	98°F	93/68 (20)	100%	N/A	N/A	N/A	N/A
	2:30pm 15 Min	116b/min	98.3°F	93/70 (60)	100%	N/A	N/A	N/A	N/A
	30 Min								
	30 Min								
	30 Min								
	1 Hr								
	1 Hr								

Comments: No any issues

Name of the Incharge-Nurse: Anuradh

Name of the Nurse: Anuradh

Signature of the Incharge-Nurse: [Signature]

Signature of the Nurse: [Signature]

Date & Time: 10/7/26 @ 2:30pm

Date & Time: 10/7/26 @ 3pm

రక్త మార్పిడి కొరకు అంగీకార పత్రము

రోగి పేరు: వయస్సు: లింగము ☐ పురుషుడు ☐ స్త్రీ
UHID. సంఖ్య: తేదీ:

రక్త ఉత్పత్తి రకాలు:

- | | | |
|---|---|--|
| ☐ తాజా ఘనీభవించిన ప్లాస్మా | ☐ ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు | ☒ Random Donor Platelets |
| ☐ క్రయో ప్రెసిపిటేట్ | ☐ ఒకే ధాత ఫ్లేటిలెట్స్ | ☐ Whole Blood |
| ☐ మొత్తం రక్తం | ☐ ఎర్ర రక్త కణం | ☐ ఇతరులు..... |

నేను ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. ధాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడిస్, హైపటైటిస్ జి సర్వైస్ యాంటిజన్, హైపటైటిస్ యాంటిబడిస్, మలేరియా మరియు సిప్లిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణయ కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలెత్తవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు

పైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి చికిత్స చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. చికిత్స చేస్తున్న సమయంలో అన్ని రకముల రక్తమార్పిడులకు (మొత్తం రక్తం / లేదా రక్త ఉత్పత్తులు ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ప్లెష్ ప్రోజెన్ ప్లాస్మా, క్రయో ప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకం

పేరు

పేరు

తేదీ మరియు సమయము

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

CONSENT FOR BLOOD TRANSFUSION

Name: RITHWIK Age: 4yrs Gender: Male ☐ Female ☒
UHID.No : BAH-00648830 Date: 10/7/26

Type of Blood Product: ☐ Fresh Frozen Plasma ☐ Packed Red Blood Cells ☐ Random Donor Platelets
☐ Cryoprecipitate ☒ Single Donor Platelet ☐ Whole Blood
☐ Albumin ☐ Red Blood Cell ☐ Others

I, Kavitha hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immuno-deficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

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

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Doctor (Who is talking the consent)

Signature: Kavitha Signature: T. Parvathi

Name: Kavitha Name: T. Parvathi

Date & Time 10/7/26 @ 2:45 pm Date & Time 10/7/2023 at 2:45 pm

Witness

Signature: Anna M

Name: Anna M

Date & Time 10/7/26 @ 2:45 pm

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2,
Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

PLATELETAPHERESIS SDP-I

Qty. 125 ml. Prepared from Human Whole Blood by Apheresis using Cell
Separator (Qty. 250 ml - 20 ml.)

B

HIV I & II/ HBsAG/ HCV - Non
reactive
VDRL - Non reactive
MP - Negative

Donor Type: Replacement

Unit No.: BAH26-P0172
Blood Group: B Rh Positive
Collection Date: 16/Jul/2026
Expiry Date: 21/Jul/2026

1) Administer Without Warming. 2) Shake Gently Before Use. 3) Do Not
Add Any Medication. 4) check Blood Group on Label & Recipient's
Group and Name Before Administration. 5) Use Sterile Transfusion Set
With Filter. 6) Do Not Dispense Without Prescription. 7) Do Not Use if
There is Any Visible Evidence. 8) Store Between 2° C to 6° C 9)
Appropriate Compatible Cross Matched Blood Without Atypical
Antibodies in Recipient Should Be Used.

Issue Label / Cross Matching Report

Patient: Baby GARIGANTI RITHWIK
Patient's Blood Group: B Rh Positive
Hosp/Dr: Rainbow Childrens Hospital, DR. SIRISHA RANI
UHID No.: BAH-00648830 Wd-Bed No.:

Product: SDP-I
Blood Group: B Rh Positive
Unit No.: BAH26-P0172
Cross Matching Report: ABO Compatible
Cross matched by: MONOJ

Issue Dt: 16/Jul/2026
Colln. Dt: 16/Jul/2026
Exp. Dt: 21/Jul/2026
Issued By: MONOJ

Rainbow Hospital Blood Centre, Rainbow Childrens
Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road
No.2, Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

SDP

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 16/7/26 Time: 8pm

Blood Group of the Patient: B+ve Blood Group on the Blood Bag: B+ve

Blood Bank Issue No: BAH-00648830-20172 Date of Collection: 16/7/26 Date of Expiry: 21/7/26

Date & Time of Starting Transfusion: 16/7/26 Planned duration of Transfusion: 20min

Check for Correct Unit: ☒ Correct Patient: ☒

Blood products cross checked by: Nurse 1: Dharini Nurse 2: Divya

Before starting transfusion vitals: Temp: 98.0k HR: 106 RR: 23 BP: 98/60 SpO2: 92

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
16/7	15 Min	106	98.3k	98/60	99%	NA	NA	NA	NA
	15 Min	96	98.6k	100/60	100%	NA	NA	NA	NA
	30 Min								
	30 Min								
	30 Min								
	1 Hr								
	1 Hr								

Comments:

Nil

Name of the Incharge-Nurse: Santhia

Name of the Nurse: Dharini

Signature of the Incharge-Nurse: Santhia

Signature of the Nurse: Dharini

Date & Time: 16/7/26 8pm

Date & Time: 16/7/26 8pm

రక్త మార్పిడి కొరకు అంగీకార పత్రము

రోగి పేరు: వయస్సు: లింగము ☐ పురుషుడు ☐ స్త్రీ
UHID. సంఖ్య: తేదీ:

రక్త ఉత్పత్తి రకాలు:

☐ తాజా ఘనీభవించిన ప్లాస్మా	☐ ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు	☒ Random Donor Platelets
☐ క్రయోప్రెసిపిటేట్	☐ ఒకే ధాత ప్లేటిలెట్స్	☐ Whole Blood
☐ మొత్తం రక్తం	☐ ఎర్ర రక్త కణం	☐ ఇతరులు.....

నేను ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడీస్, హైపటైటిస్ జి సర్వేస్ యాంటిజన్, హైపటైటిస్ యాంటిబడీస్, మలేరియా మరియు సిఫ్లిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణీత కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలెత్తవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు

పైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి చికిత్స చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. చికిత్స చేస్తున్న సమయంలో అన్ని రకముల రక్తమార్పిడులకు (మొత్తం రక్తం / లేదా రక్త ఉత్పత్తులు ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ప్లెప్ ప్రోజెన్ ప్లాస్మా, క్రయోప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను ధానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకం

పేరు

తేదీ మరియు సమయము



CONSENT FOR BLOOD TRANSFUSION



Name: G. Rithwika Age: 4y Gender: Male ☐ Female ☒
UHID.No : 648830 Date: 16/7

Type of Blood Product: ☐ Fresh Frozen Plasma ☐ Packed Red Blood Cells ☐ Random Donor Platelets
☐ Cryoprecipitate ☒ Single Donor Platelet ☐ Whole Blood
☐ Albumin ☐ Red Blood Cell ☐ Others

I Kavitha hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immuno-deficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

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

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient / Patient Relative / Guardian):

Signature: Kavitha

Name: Kavitha

Date & Time 16/7/2026 2pm

Doctor (Who is talking the consent)

Signature: Z

Name: T. Ravani

Date & Time 16/7/2026 6pm

Witness

Signature: Kavitha

Name: Kavitha

Date & Time 16/7/2026 2pm

Daily Notes:



135

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 24/6/26 Time: 2pm

Weight: 10.20kgs Centile: 5th

Height: 84cms Centile: 5th

Inference: underweight child

RDA: - Calories: 1350kcal/d Protein: 23g/d

Diet Recommendations: soft diet & High protein diet.

Re-Assessment: avoid spicy, chilled out side foods.

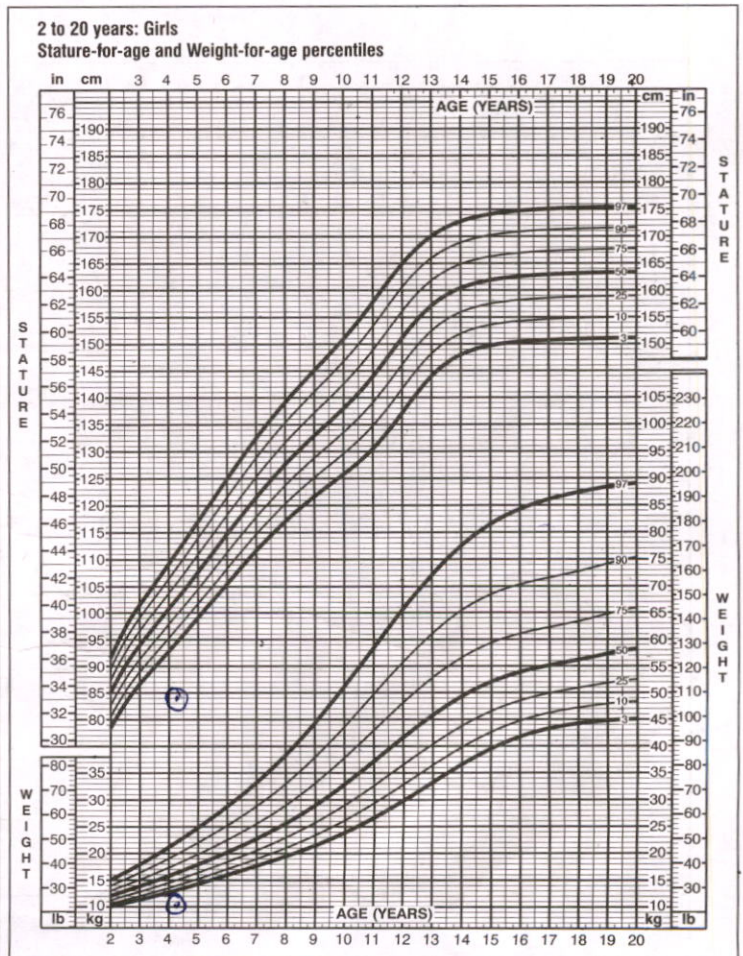
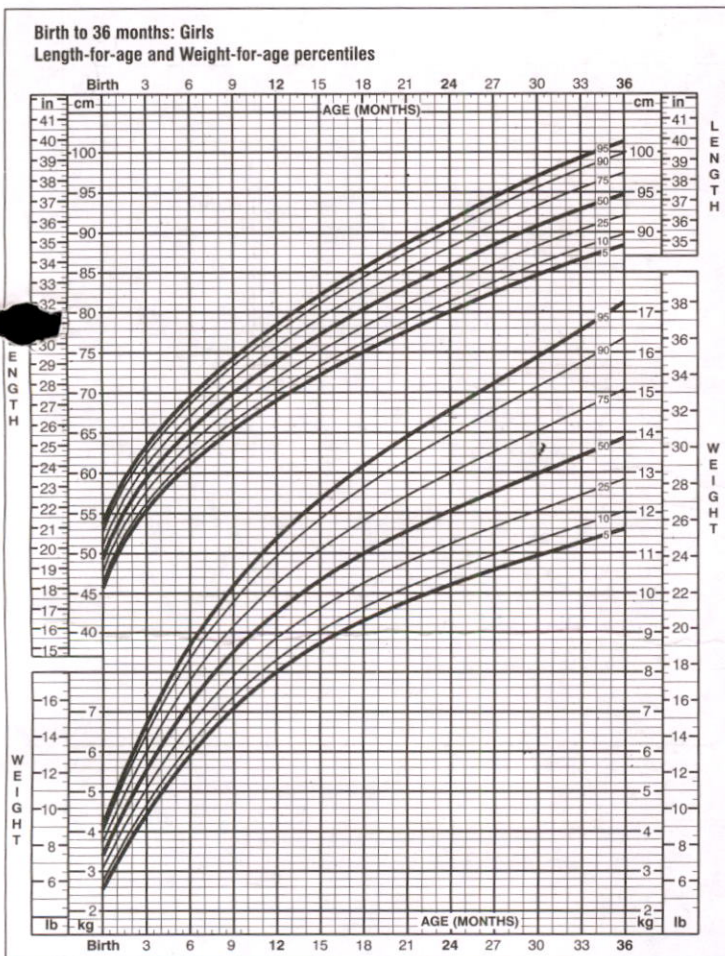
Food Allergies: NO Veg/Non-veg non-veg

Diagnosis: k/c/o mps types I

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (GIRLS)



Dietician's Name: [Signature]

Dietician's Signature: [Signature]

Docu. No. : RCHBH / FRM / CLINICAL / 161

(P.T.O.)

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										
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3										
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
Signature of the Nurse													

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :



CHECKLIST FOR THROMBOPHLEBITIS

24/8/26 25/8/26 26/06/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0	0	0	0	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		-	NA	NA	NA	NA	NA	NA	NA	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		-	NA	NA	NA	NA	NA	NA	NA	
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		-	NA	NA	NA	NA	NA	NA	NA	
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		-	NA	NA	NA	NA	NA	NA	NA	
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		-	NA	NA	NA	NA	NA	NA	NA	
Signature of the Nurse													

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

Signature of Shift In Charge :

Signature : Divyanshu Name : Divyanshu

Signature of Ward In Charge :

Signature : Sarika Name : Sarika



CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

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

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

Parameters	Date	Shift Time	29/6	30/6	30/6	1/7	1/7	2/7	2/7
			8AM	8AM-8PM	8AM-8PM	8AM	8PM	8AM	8AM-8PM
Can we remove Central Line today (Discuss in the clinical round)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Evidence of any inflammation at insertion site (Redness / Swelling (If yes inform the doctor))			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Blood at insertion site (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Any peeling of dressing? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Is dressing clean and dry? (If no inform the doctor)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Any leakage at insertion site? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Is there any obstruction to the infusion flow? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☒ Yes ☐ No
Dressing intact and labelled properly			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☒ No
Central line changed on									
Name of the Nurse			Moumida	Am m	Nandini	Pooja	Shrey	Pooja	Angadhar
Signature of the Nurse									



CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

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

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

Parameters	Date	Shift Time	3/7	3/7	3/7	4/7	4/7	4/7	4/7/26	5/7
			8am-8am	2m	8pm	8am	2m	8pm	8pm	8am
Can we remove Central Line today (Discuss in the clinical round)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Evidence of any inflammation at insertion site (Redness / Swelling (If yes inform the doctor))			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Blood at insertion site (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Any peeling of dressing? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Is dressing clean and dry? (If no inform the doctor)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Any leakage at insertion site? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☒ Yes ☒ No
Is there any obstruction to the infusion flow? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Dressing intact and labelled properly			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Central line changed on										
Name of the Nurse			Agam	Shrey	Pooja	Soumya	Soumya	Soumya	Dehith	
Signature of the Nurse										



3

CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

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

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

Parameters	Date	Shift Time	5/7 Sat-Sun Day	6/7 8am	6/7 Day	7/7 8am	7/7 Day	8/7 Night	8/7
Can we remove Central Line today (Discuss in the clinical round)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Evidence of any inflammation at insertion site (Redness / Swelling (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Blood at insertion site (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Any peeling of dressing? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Is dressing clean and dry? (If no inform the doctor)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Any leakage at insertion site? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Is there any obstruction to the infusion flow? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Dressing intact and labelled properly			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Central line changed on									
Name of the Nurse			Moumita	Sangam	Moumita	Pooja	Moumita	Bluel	Rajamoni
Signature of the Nurse									



CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

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

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

Parameters	Date	Shift Time	10/7 AM	10/7 2 PM	11/7 AM	11/7 PM	12/7 AM	12/7 Day	13/7 PM
Can we remove Central Line today (Discuss in the clinical round)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Evidence of any inflammation at insertion site (Redness / Swelling (If yes inform the doctor))			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Blood at insertion site (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Any peeling of dressing? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Is dressing clean and dry? (If no inform the doctor)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Any leakage at insertion site? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Is there any obstruction to the infusion flow? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Dressing intact and labelled properly			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Central line changed on									
Name of the Nurse			Shreya	Sonam	Shreya	Shreya	Shreya	Mamita	Goyas
Signature of the Nurse									

CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

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

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

Parameters	Date	Shift Time	13/7 Day	14/7 8am	14/7 Day	15/7 8pm - 8am	15/7 8pm	16/7 8am - 8am	16/7 8pm
Can we remove Central Line today (Discuss in the clinical round)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Evidence of any inflammation at insertion site (Redness / Swelling (If yes inform the doctor))			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Blood at insertion site (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Any peeling of dressing? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Is dressing clean and dry? (If no inform the doctor)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Any leakage at insertion site? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Is there any obstruction to the infusion flow? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Dressing intact and labelled properly			☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Central line changed on									
Name of the Nurse			Moumita	Shrushti	Moumita	Arin	Arin	Arin	Arin
Signature of the Nurse									



CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

Type of Line: ☐ PICC Line ☐ UAC ☐ UVC ☐ Other Cerebral line Date of Initial Line Insertion: Duration of Central Line: 3 month

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

Parameters	Date	Shift Time	11/2	12/2	13/2	18/2	19/2	19/2
			8am	2pm	8pm	8am	8pm	8am
Can we remove Central Line today (Discuss in the clinical round)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Evidence of any inflammation at insertion site (Redness / Swelling (If yes inform the doctor))			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Blood at insertion site (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Any peeling of dressing? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Is dressing clean and dry? (If no inform the doctor)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Any leakage at insertion site? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Is there any obstruction to the infusion flow? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Dressing intact and labelled properly			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Central line changed on								
Name of the Nurse			Savitri	Gargi Sonam	Savitri	Sumita	Savitri	Devi
Signature of the Nurse								

CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

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

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

Parameters	Date	Shift Time	20/2 8am	20/2 8-2pm	20/2 8pm				
Can we remove Central Line today (Discuss in the clinical round)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Evidence of any inflammation at insertion site (Redness / Swelling (If yes inform the doctor))			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Blood at insertion site (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any peeling of dressing? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is dressing clean and dry? (If no inform the doctor)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any leakage at insertion site? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there any obstruction to the infusion flow? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing intact and labelled properly			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Central line changed on									
Name of the Nurse			Savitri	Gayatri	Pooja				
Signature of the Nurse									

IP5-00175554
 Baby GARIGANTI RITHWIK
 11-02-2022 4 Y 4 M 13 D (F)
 Dr. SIRISHA RANI

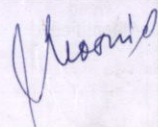


②

MULTI-DISCIPLINARY PLAN OF CARE FORM



Diagnosis:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
24/6	☒ Medical ☐ Nursing ☐ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	MRS - Type-I	1st Study	BMT.		☐ Nursing ☐ Others:
24/6/26	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	MRS - Type-I	1st Study	- BMT - IV placed - CBP.		☐ Medical ☐ Others:
24/6/26 2pm	☐ Medical ☐ Nursing ☒ Others: Dr. Sirisha Rani	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	MRS - Type I	Soft High protein diet	<u>RDA</u> E: 1350 kcal/d P: 23g/d		☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: Telugu Patient / Learner Literacy: ☐ Read ☐ Write ☒ Speak Willingness to Learn: ☒ Yes ☐ No Healthcare Literacy: ☒ Yes ☐ No

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
24/6	2pm	8	Procedures	F	1	0	1	1	nil	Neerab
25/6/26	2pm	9	Soft High protein diet	F	1	0	1	1	-	Monika
26/6	8AM	3	Pain management	F	1	0	1	1	nil	Pooja
27/6	12pm	7	Infection control measures	F	1	0	1	1	nil	G

Part - III: CODES

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



PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: Telugu Patient / Learner Literacy: ☐ Read ☒ Write ☐ Speak Willingness to Learn: ☒ Yes ☐ No Healthcare Literacy: ☒ Yes ☐ No

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
28/6	3pm	3	Pain Management	F	1	0	1	1	ad	[Signature]
29/6	10pm	4	Hand hygiene	M	1	0	1	1	my	[Signature]
30/6	12pm	2	Treatment and care plan	m	1	0	1	1	ad	[Signature]
2/7	10am	7	maintain personal hygien	m	1	0	1	1	ad	[Signature]

Part - III: CODES

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

IDENT / FAMILY EDUCATION RECORD

3

Part - I.

Patient's /

..... 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		
3/2	4pm	4	Hand hygiene	M	1	0	1	1	nil	\$
4/2	7am	7	Infection control by hand hygiene	M	1	0	1	1	N.A	Sant
5/2	8AM	3.	Pain Management	M	1	0	1	1	N.A	PS.
6/2	10AM	7	Infection control by Hand Hygiene	M	1	0	1	1	N.A	[Signature]

Part - III: CODES

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

Learning Barriers:

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

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

Mechanism/s to overcome barrier/s:

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

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

TIENT / FAMILY EDUCATION RECORD

4

Part - I.

Patient's 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		
7/7	10AM	7	Infection control by Hand Hygiene	M	1	0	1	1	NA	[Signature]
8/7	11AM	10	Fall risk Education	M	1	0	1	1	NA	[Signature]
9/7	7PM	3.	Pain Management	M	1	0	1	1	NA	[Signature]
10/7	11am	2	Hand hygiene	M	1	0	1	1	my	[Signature]

Part - III: CODES

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



PATIENT / FAMILY EDUCATION RECORD

21/02/2022

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		
12/7	10 AM	7	Infection control measure	M	1	0	1	1	MA	[Signature]
13/7	8 AM	7	Infection control by Hand Hygiene	M	1	0	1	1	MA	[Signature]
14/7	10 AM	7	Infection control measure	M	1	0	1	1	MA	[Signature]
15/7	10 AM	2-	Treatment and care plan	M	1	0	1	1	W/	Sumita

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						

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWKA
11-02-2022 4 Y 5 M 5 D (F)
Dr. SIRISHA RANI



PATIENT / FAMILY EDUCATION RECORD

..... 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		
17/2	1PM	3.	Pain Management	M	1	0	1	1	—	AS
18/2	10Am	2.	Treatment and care plan.	M	1	0	1	1	Nil	Bumta
19/2	6m	2	Infection control measure	M	1	0	1	1	Nil	G
20/2	1m	2	Infection control measure	M	1	0	1	1	Nil	G

Part - III: CODES

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

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 :	24/6	25/6	26/6	27/6
					Time :	2PM	8AM	8AM	
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.		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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
					TOTAL SCORE	28	28	28	28
					Evaluator's Name	Shree	MD	MD	Daya

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 :	28/6	28/6	28/6	1/7
					Time :	8:45	8 AM	8 AM	8 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4	
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of 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	
TOTAL SCORE					28	28	28	28	
Evaluator's Name					21	12	Arm	21	

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 :	2/7	3/7	4/7	5/7
					Time :	8 AM	8 AM	8 AM	8 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4	
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings 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					28	28	28	28	
Evaluator's Name					Dr. Sirisha Rani	Dr. Sirisha Rani	Dr. Sirisha Rani	Dr. Sirisha Rani	

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 :	6/2	7/2	8/2	9/2
					Time :	8:30 AM	8 AM	8 AM	8:30 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	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	
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
TOTAL SCORE					28	28	28	28	
Evaluator's Name									

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

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

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIK
 11-02-2022 4 Y 4 M 28 D (F)
 Dr. SIRISHA RANI



BRADEN 'Q' SCALE

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

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

		Date : 01/2/2022 Time : 8:05 AM			
Mobility	Immobile: Does not move 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
"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
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
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
FRICITION-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
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4
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
TOTAL SCORE					20
Evaluator's Name					[Signature]

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 :	4/2	15/2	16/2	17/2
					Time :	7	8am	8am	8am
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	
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of 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	
TOTAL SCORE					28	28	28	28	
Evaluator's Name					My	form	form	form	

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 :	18/2	19/2	20/2	21/2
					Time :	8am	8am	8am	8am
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 or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
					TOTAL SCORE	28	28	28	28
					Evaluator's Name	[Signature]	[Signature]	[Signature]	[Signature]

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

Patie



THE HUMPTY DUMPTY SCALE

24/6 25/6 26/6 27/6 28/6

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

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes	yes	yes	yes
Call device within reach	yes	yes	yes	yes	yes
Wheels Locked	yes	yes	yes	yes	yes
Room free of clutter	yes	yes	yes	yes	yes
Adequate Lighting	yes	yes	yes	yes	yes
Wheel Chair Support	no	no	no	no	no
Other Intervention(s) Specify	no	no	no	no	no
Nurse's Name :	Murugan	M	M	Raji	Raji
Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :	24/6	25/6	26/6	27/6	28/6
Time :	2M	8AM	8AM	8AM	8AM

2

THE HUMPTY DUMPTY SCALE

2016 2016 1/7 2/7 3/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					3/7
	3 to less than 7 years old	3	3	3	3	3	3
	7 to less than 13 years old	2					
	13 years old and above	1	1	1	1		
Gender	Male	2					
	Female	1		1	1	1	1
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	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	4				
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
Total			13	10	10	10	10

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	Yes	Yes	Yes	Yes	Yes
Call device within reach	Yes	Yes	Yes	Yes	Yes
Wheels Locked	Yes	Yes	Yes	Yes	Yes
Room free of clutter	Yes	Yes	Yes	Yes	Yes
Adequate lighting	Yes	Yes	Yes	Yes	Yes
Wheel chair support	NA	NO	NO	NO	NO
Other Intervention(s) Specify	NA	NO	NO	NO	NO
Nurse's Name:	Am	Am	Am	Am	Am
Signature:	Am	Am	Am	Am	Am
Date:	2016	30/6	1/7	2/7	3/7
Time:	8 AM	8 AM	8 AM	8 AM	8 AM

BAH-00648830 IP5-00175554
 Baby GARIGANTI RITHWIK
 11-02-2022 4 Y 4 M 21 D (F)
 Dr. SIRISHA RANI



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

4/25/24 6/7 2/7 8/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	7	8	3	3
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	1
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.)	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	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	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	1
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
TOTAL			10	10	10	10	10

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		yes	yes	yes	yes	yes
Call device within reach		yes	yes	yes	yes	yes
Wheels Locked		yes	yes	yes	yes	yes
Room free of clutter		yes	yes	yes	yes	yes
Adequate Lighting		yes	yes	yes	yes	yes
Wheel Chair Support		no	no	no	no	no
Other Intervention(s) Specify		no	no	no	no	no
Nurse's Name :		Sangam	Arin	Sangam	Pooja	Shruti
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :		4/7	5/7	6/7	7/7	8/7
Time :		8am	8am	8am	8am	8am



4

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	9/7	10/7	11/7	12/7	13/7
	3 to less than 7 years old	3	3	3	3	3	3
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	1
Diagnosis	Neurological Diagnosis	4		1	1	1	1
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	1	1	1
	History of Falls or Infant-Toddler Placed in Bed	4		1	1	1	1
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3		1	1	1	1
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
Total			10	10	10	10	10

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		Yes	Yes	Yes	Yes	Yes
Call device within reach		Yes	Yes	Yes	Yes	Yes
Wheels Locked		Yes	Yes	Yes	Yes	Yes
Room free of clutter		Yes	Yes	Yes	Yes	Yes
Adequate lighting		Yes	Yes	Yes	Yes	Yes
Wheel chair support		No	No	No	No	No
Other Intervention(s) Specify		No	No	No	No	No
Nurse's Name:		Am	Am	Am	Am	Am
Signature:		Am	Am	Am	Am	Am
Date:		9/7	10/7	11/7	12/7	13/7
Time:		8AM	8AM	8AM	8AM	8AM



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	7	3	3	3
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	1
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1	1	1
	History of Falls or Infant - Toddler Placed in Bed	4	1				
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1	1	1	1
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	1
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
TOTAL			9	9	9	9	9

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		Yes	Yes	No	Yes	Yes
Call device within reach		Yes	Yes	No	Yes	Yes
Wheels Locked		Yes	Yes	No	Yes	Yes
Room free of clutter		Yes	Yes	No	Yes	Yes
Adequate Lighting		Yes	Yes	No	Yes	Yes
Wheel Chair Support		No	No	No	No	No
Other Intervention(s) Specify		No	No	No	No	No
Nurse's Name :		Ravi	Alex	Ann	Sany	Sany
Signature :		Ravi	Alex	Ann	Sany	Sany
Date :		10/12	10/12	10/12	10/12	10/12
Time :		11	8am	8am	8am	8am



6

THE HUMPTY DUMPTY SCALE

19/2 20/2 21/2

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		
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1		
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1		
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	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					
	Outpatient Area	1	1	1	1		
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1		
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1		
TOTAL			9	9	9		

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		Yes	Yes	Yes		
Call device within reach		Yes	Yes	Yes		
Wheels Locked		Yes	Yes	Yes		
Room free of clutter		Yes	Yes	Yes		
Adequate Lighting		Yes	Yes	Yes		
Wheel Chair Support		No	No	No		
Other Intervention(s) Specify		No	No	No		
Nurse's Name :		Sany	Sany	Sany		
Signature :		[Signature]	[Signature]	[Signature]		
Date :		19/2	20/2	21/2		
Time :		8am	8am	8am		

BAH-00648830 IP5-00175554
Baby GARIGANTI RITHWIKA
11-02-2022 4 Y 4 M 14 D (F)
Dr. SIRISHA RANI



Groshong® NXT ClearVue™ Catheter
REF 7655405
LOT REKR3116
2026-07-31
(01)00801741035272
(17)280731
(10)REKR3116

Hosp...
It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CPFD

Fc not done

SURGERY DETAILS

Date : 25/6/26

Patient Name: Baby Rithwika Date of Birth: 11-02-2022 Age: 21 Y

Gender: Female Ward: P-OT UHID No: BAH-00648830

Date of Surgery: 25/6/26 ☐ OT-1 ☒ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery: Gracchani's line insertion

Time in : 03:30pm

Time Out : 04:30pm

	NAME	AMOUNT
1. Surgeon	Dr. Shilpa	
2. Anaesthetist	Dr. Sundhara	
3. Assistant Surgeon	Dr. Aysha	
4. OT Technician	Prabha	
5. Circulating Nurse	Srijata	
6. Assistant Nurse	Bobi	

Special Equipment: ☐ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator
☒ C-ARM 9674850 ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9674849

Order by: [Signature]



growth line
skema

CONSUMABLES OF OT

Circulating staff : Technician : prashant Date : 24/06/26 Time : 1:30pm

Anaesthesia Disposables		Qty		Surgical Disposables		Qty		Disposables (Baby Side)		Qty	
Issued	Used	Issued	Used	Issued	Used	Issued	Used	Issued	Used	Issued	Used
ET tube	4/11	1	1	Major Pack	3	3		Inj Vit.K			
LMA	1/1	1	1	Sutures	1	1		Cord Clamp			
ECG leads : A/P/N	5	3	3					Suction Catheter			
HME filter : A/P/N	1	1	1					Feeding Tube			
Syringes : 10 cc	10	5	5					Vaccum Suction Set			
05 cc	10	5	5	Gloves	24	24		Surgical Gloves			
02 cc	10	5	5					Gauze Pack			
01 cc	3	1	1					Syringe 1ml / 2ml			
Cautery plate : A/P/N	1	1	1	Surgical blade				Surgical Blade # 20			
IV set	1	1	1	NG tube				Koochies (S)			
RL	1	1	1	Cautery pencil							
NS : 10ml / 100ml / 500ml / 1000ml	4/1	1	1	Koochies							
minispike	1	1	1	Ointments							
vaccumset	1	1	1	Suction Catheter							
Fentanyl	1	1	1	Cap, Mask	8	2					
Morphine				Gauze Pack	1	1					
Ketamine				Mop Pack	1	1					
Propofol	5	2	2	Steristrip							
Rocuronium	1	1	1	Underpad	1	1					
Glycopyrolate	1	1	1	Draw sheet	1	0					
Myopyrolate	1/2	1	1	Abgel							
Ondansetron	1	1	1	Foleys catheter							
Pencan 25g/ Spinal Needle 22	1	1	1	Urobag							
Bupivacaine 0.25%	1	1	1	Chest Drainage Catheter							
Bupivacaine 0.25%(Heavy)				Romodrain bag							
Antibiotics				Bandage							
iv p cm	1	1	1	Tegaderm	3	2					
suppositories				Ioban							
Anamol : 80mg / 250mg / 170 mg				Double J Stent							
Supridol : 100mg				Vaccum Suction set							
Justin : 12.5 mg / 25mg / 100mg	1/1	1	1	Plastic Bed Sheet	1	1					
Tab. Misoprost : 200mg				Betadine Solution	1	1					
3way 10/100cm	1/1	1	1	Microshield	1	0					
Glove aut glove	4/1	1	1	Cotton Balls	1	1					
transera + dera	1/1	1	1	Latex Gloves	10	5					
o2 mask (P)	1	1	1	Ramdone Scrub							
iv cannula (24g)	1	1	1	Saral							

Surgeon : Anaesthesiologist : Nurse : OT Technician :

Order No. : Ordered by :