

ADMISSION SHEET


Registration Details :

Admission No : IP5-00176001 Admit Date : 06-Jul-2026 Admit Time : 01:37 AM UHID : BAH-00323970

Patient Details :

Patient Name	: Baby ILHAM ZUBEDI	Age	: 10 Y 1 M 18 D
Guardian	: SHAIK SAFWAM ZUBEDI	DOB	: 18-05-2016
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H.NO.3-3-123,MADINA MASJID Osmangunj Mahabubnagar Telangana INDIA 110005	Phone No	: 8142275770/ 7981865945
		E-mail	: safwan.91221@gmail.com

Admission Details :

Bed Type : PRIVATE ROOM Bed No : PVT 337 Ward Name : 3F-ZONE B
 Room No : PVT 337 Admission Type : First Visit

Contact Details :

Name	: SHAIK SAFWAM ZUBEDI	Relationship	: Father
Contact Address	: H.NO.3-3-123,MADINA MASJID Osmangunj Mahabubnagar Telangana INDIA 110005	Phone No	: 8142275770 / 7981865945



Signature

Doctor Details :

Doctor Name	: Dr. VENKATA LAKSHMI A	Specialisation	: GENERAL PEDIATRICS
Referral Doctor	: Self	Phone No	:
Co-Consultant	:		

Payment Details :

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

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

Date of Admission: _____

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

BAH-00323970 IP5-00176001
Baby ILHAM ZUBEDI
18-05-2018 10 Y 1 M 18 D (F)
Dr. VENKATA LAKSHMI A



Consultant: _____ Dept : _____

of Discharge : _____ Time: _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/7/26	2 PM	CR	337	[Signature]

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Stayaprasad	8/7/26	9693015	[Signature]
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

[illegible]

Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor



PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00323970 IP5-00176001
Baby ILHAM ZUBEDI
18-05-2018 10 Y 1 M 18 D (F)
Dr. VENKATA LAKSHMIA



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name: Ilham Age/Sex 10 Y / M

Information given by: _____ Relationship Mother

Chief Presenting Complaints & Duration (Chronologically)

Fever, cough, cold x 3 days
SOB x 1 day.

History of present illness :

C/O fever, cough, cold x 3 days



- Moderate-high grade.
- 2-3 spikes/day
- Partially relieved on antipyretics

C/O cough, cold x 1 day.

C/O Fast breathing associated with retractions x 1 day.

H/O recent travel ⊕

H/O similar illness in other family members ⊕

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Dr. VENKATA LAKSHMIA



Pediatric History & Physical Examination

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

H/O Recurrent UTI (+)

Birth & Neonatal History:

Not significant

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

} Lower middle class

Developmental History :

Achieved as per age

Immunization History :

As per age.



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 2.6 kg (Centile _____)

On Examination :

Temperature : 99°f Pulse Rate : 112 bpm B.P. 100/64 mmHg 94-100 RA

Resp. rate and type of breathing : 46 br/min, SCR ⊕ / IR ⊕

Rash _____

Lymphadenopathy _____ } ⊕

Oedema : _____

Allergies (if any): NK DA

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____ } B/L A/E, B/L wheeze ⊕

Any addles sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : _____ } S1 S2 ⊕

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : _____

Ausculation : _____ } Soft, Nondistended

Spine : _____ External Genitalia : _____

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

DEFICIENCY CHECK LIST OF CASE SHEET

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

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves :

Motor System:

Nutriton :

Tone: Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR

Plantars

Superficials:

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

WALRE



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Respiratory failure

Desired goals of the treatment : Hemodynamic stability

Planned Labs:

CBP
CRP, Blood c/s
5 viral Panel
CUE
CXR - PA view - done
in op basis

*Noted by
Lachry*

Planned Management

- IVE - DNS 1/2 maintenance
- INS. AUGMENTIN
- INS. ESOMEPRAZOLE
- INS. Hydrocortisone
- NEB. Levodrin q 3 hourly
- NEB. Budecort BD
- Syp. HESTAFREE
- SOS Low flow if
SpO₂ < 92%
- Vital monitoring & SpO₂
Charting q 2 hourly
- Head end elevation
- Wt ↑ in RD
- True viral Panel &
antivirals

*Noted
by
a*

Signature of the Doctor: Nalini

Name of the Doctor: Dr. Nandani

Date & Time: 06/07/2026, 10:40AM

Signature of the Consultant: _____

Name of the Consultant: _____

Date & Time: _____

DR. VENKATALAKSHMI A
Registration No: 50115



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26. 3 AM.	Seen by Resident. Asin - WARRI.	
	child asleep, afebrile hemodynamically stable. RS - BAE ⊕, less. B/L diffuse wheeze ⊕ = minimal crepts. RR - 35/min = subcostal, intercostal, supra- clavicular retraction (mild). SPO ₂ 96% + RA	Plan 1. Trace labs 2. Continue medication as charted. 3. Monitor RR, SPO ₂ & vitals Q3 Hrsly. inform SOS if SPO ₂ < 92%. 4. W/f RD. 5. Send CUE
6/7/26	Seen by Dr Venkatalakshmi	\$ Sainthi
	afebrile. fast breathing ⊕ poor sleep ✓ O/E : alert tachypnea ⊕ RR - 50/min SPO ₂ - 97% (RA) chest : B/L wheeze ⊕	Adv: - Change nebulisations Levolin 6hly Duolin 6hly. Budecort 12hly. Add Ambrodil plus. SPO ₂ monitoring - Trace adenovirus & CUE



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7 4:30pm	C/S/B Dr. Venkatalakshmi	
	afebrile	<u>Adv.</u>
	no distress	- Trace adenovirus
		- w/f fever spikes
		- monitor saturation
	O/E: child alert	- To if any RD,
	stable vitals	chest: wheeze inform SPS
	chest: wheeze	
	⊕ B/c.	
	no retractions	→ To evaluate
	tachypnea better	glucosuria further
		ok while
	CUE shows 3+ glucosuria	noted by sterile 607532
	4+ uric acid	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7 9:20am	C/S/B Resident A: NAURI	
	- afebrile	Adv:
	- sleep disturbed	1) Send urine for culture / sensitivity
	O/E: alert	2) R urine dipstick for glu / ketones
	dull	3) Continue
	vitals stable	IV Augmentin D ₂
	SpO ₂ - 100% ↓ RA	Syp Ambrodil plus
	RR - 28/min	Neb Levoflox / 6hly
	R/S: no retractions	Duoalin 16hly
	BAE ⊕, B/L reduced	Budecort 12hly
	B/L wheeze ⊕	IV Hydrocortisone
	CVS: NAD	
	abdomen soft	
		DR. VENKATALAKSHMI A Registration No: 50115
		Achile
		- Send spot urine for UA / Calcium / Creatinine
		- USG abdomen now

Date & Time	Progress Notes	Doctor's Order
4/8 3pm	<u>U/S/B Resident</u> A: WALRI UTI - afebrile - cough & sputum - not collected urine sample - passed stools - good o/i - feeling better O/E: alert / afebrile chest: RR - 24/min R/S: B/L A/E (+) wheezes & crackles (just nebulised) abdomen: soft	<u>Adv.</u> 1) Send urine - clean catch sample for culture/sensitivity - urine for UA (Urinalysis) Calcium creatinine - urine dipstick for glucose/ketones 2) Continue current medications 3) Plan (D) f/m Ashile Noted by Satya



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7 8:30am	WARI UTI / crystalluria <u>Glucosuria</u>	<u>Adv:</u>
mine dipstick 3+ glucose neg ketones neg	no fever cough (+) slop ✓	1) (D) today 2) Check & sugars
RBS-	no c/o itching burning micturition	Shihle
	O/E: child alert 4hrs post neb: comfortable. RR - 20/min SpO ₂ - 99% (RA) R/s: BAE (+) used. wheeze (+) B/L. abdomen soft	
8/7 10am	Seen by <u>Dr Venkatalakshmi</u>	<u>Adv</u>
	R/v after 3d.	- Send HbA1c - Dr. Satyaprasad consultation - (D) today

IP5-00176001

18-05-2016 10 Y 1 M 19 D (F)

Dr. VENKATA LAKSHMI A



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



CROSS CONSULTATION FORM

Doctor Name: Dr. Satyaprasad Alham Zubedi Date: 8/7/2026 Time: 10:30 am

Diagnosis: WALRI | Recurrent UTI, crystalluria, cystitis, glycosuria.

Hospital: RCH - B

Type of Referral :

☐ Emergency

☐ Urgent

☒ Non Urgent

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

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

Recurrent UTI
crystalluria
glycosuria

Signature: _____

Findings and Recommendations:

10 8/2 F child. with h/o recurrent episode of cystitis (E.coli) - 2022, c/o hematuria - 5th episode now.
- no VUR - (June 2023)
- not on prophylaxis
prev. CUE - calcium oxalate crystals (Dec 2024) - started on Citralpha.
- discontinued by parents 4 mon ago
- diet eating fruits. (Brazil nuts)

present CUE: 3+ glucose. no protein/kB.
nitrite positive; leukocyte neg.
PC - 3-4 bacteria present
RBC - 2-3.
4+ mic acid crystals

Consultant :

Name: Dr. Satyaprasad Signature: _____ Date & Time: 8/7/26

spot urine UA : creat. - 1.05
Ca : creat - 0.24

USG - (N) kidneys.
Bladder wall thickening (4mm)

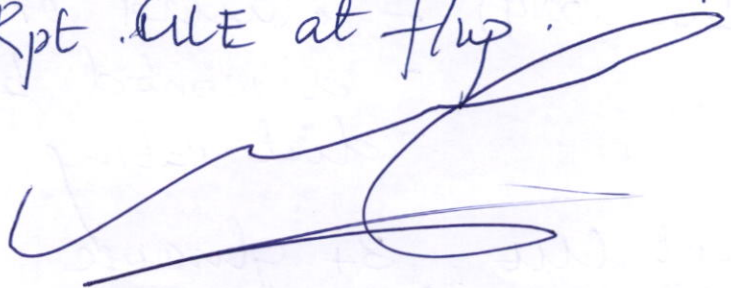
Adv:

1) HbA_{1c}
lab RBS
RP₂
S. Calcium.

2) Restart Syp. Citralka.
5ml - 0 - 5ml

dit in 1/4 glass. till further

3) R/v in OPD & reports.
Rpt. GUE at flup.



DR. V V R SATYA PRASAD
Registration No: 43599

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 Dr. VENKATA LAKSHMI A



Patient

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RESULT SHEET

Date	6/7/26				
Time	2 Am.				
Hb	13.2				
PCV	41				
RBC	4.87				
WBC	10.6K.				
N/L	65/21.				
Platelets	3.1L				
CRP	11				
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

BAH-00323970 IP5-00176001
Baby ILHAM ZUBEDI
18-06-2018 10 Y 1 M 18 D (F)
Dr. VENKATA LAKSHMIA



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MEDICATION RECONCILIATION FORM

Drug Allergies: ☒ Not known any Drug Allergies

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

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

Shifting From: ICU Shifted to: Ward

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Nalaka, Dr. Nandan

Date & Time: 06/07/2026, 11:45 AM

Nurse Name & Signature: Lachel @

Date & Time: 6/7/26 @ 2AM



DRUG CHART

Date of Admission: 06/07/2026 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 : SYP. CROCEIN-DS				Date Time
Dose	Route	Frequency	Start Date	
8ml	PO	SOS	06/07	
Doctor's Signature		Valid Period	Pharm.	
Dr. Nandan				
Additional Instructions: 240mg/15ml				
If temp > 100°F, minimum 6 hrs gap between 2 doses				

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:				

Signature

VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 26 Kg Ward.

VERIFIED

VERIFIED

VERIFIED

DRUG : INJ. AUGMENTIN				Date Time	6/7	11/8/2
Dose	Route	Frequency	Start Date			
780mg	IV	TID	06/07			
Name & Signature of the Doctor Starting the Drugs:				 		
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						
DRUG : INJ. ESOMEPRAZOLE				Date Time	6/7	11/8/2
Dose	Route	Frequency	Start Date			
25mg	IV	OD	06/07/26			
Name & Signature of the Doctor Starting the Drugs:				 		
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						
DRUG : INJ. HYDROCORTISONE				Date Time	6/7	11/8/2
Dose	Route	Frequency	Start Date			
60mg	IV	TID	06/07/26			
Name & Signature of the Doctor Starting the Drugs:				 		
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						
DRUG : NEB. DEVOLIN				Date Time		
Dose	Route	Frequency	Start Date			
1.2mg	NEB	q 3 hourly	06/07/26			
Name & Signature of the Doctor Starting the Drugs:				 		
Additional Instructions:				 		
Daily Doctor's Endorsement by a Sign						

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Sheet No:

REGULAR PRESCRIPTIONS

Weight 26kg

Ward

DRUG : NEB. BUDEKORT				Date Time
Dose 0.5mg	Route NEB	Frequency BD	Start Dt. 06/07/26	10pm
Name & Signature of the Doctor Starting the Drugs: Dr. Nandan				STOP
Additional Instructions:				10pm
Daily Doctor's Endorsement by a Sign				
DRUG : SYP. HISTAFREE				Date Time 6/7
Dose 5ml	Route PO	Frequency BD	Start Dt. 06/07/26	10am
Name & Signature of the Doctor Starting the Drugs: Dr. Nandan				STOP
Additional Instructions:				10pm
Daily Doctor's Endorsement by a Sign				
DRUG : SYP AMBRODOL				Date Time 6/7
Dose 7.5ml	Route PO	Frequency BID	Start Dt. 06/07/26	11pm
Name & Signature of the Doctor Starting the Drugs: Dr. Nandan				11pm
Additional Instructions:				12pm
Daily Doctor's Endorsement by a Sign				
DRUG : Neb LEVOLIN				Date Time 6/7
Dose 1.25mg	Route Neb	Frequency q6h	Start Dt. 06/07/26	3am
Name & Signature of the Doctor Starting the Drugs: Dr. Nandan				3am
Additional Instructions:				3pm
Daily Doctor's Endorsement by a Sign				



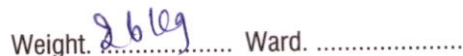
Sheet No:

REGULAR PRESCRIPTIONS

Weight 2.1kg

Ward

DRUG : Neb DUOLIN				Date Time	6/7	7/12
Dose	Route	Frequency	Start Dt.			
1 resp	Neb	q8h	6/7	6am	X	
Name & Signature of the Doctor Starting the Drugs:						
				12pm		
Additional Instructions:				6pm		
				12am		
Daily Doctor's Endorsement by a Sign						
DRUG : Neb BUDECORT				Date Time	6/7	7/12
Dose	Route	Frequency	Start Dt.			
0.5mg	Neb	BID	6/7	10am	X	
Name & Signature of the Doctor Starting the Drugs:						
				10pm		
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						
DRUG : Neb DUOLIN				Date Time	7/7	8/7
Dose	Route	Frequency	Start Dt.			
1 resp	Neb	q8h	7/7	4am		
Name & Signature of the Doctor Starting the Drugs:						
				12pm		
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						
DRUG : Neb BUDECORT + LEVOLIN				Date Time	7/7	8/7
Dose	Route	Frequency	Start Dt.			
Neb	q8h	7/7	8am	X		
Name & Signature of the Doctor Starting the Drugs:						
				4pm		
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						



DRUG :

VARIABLE DOSE

DRUG :

RouteStart DateName & Signature of the Doctor

Additional Instructions:

Weight. 26..... Ward.

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NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
6/7/26	00.00	Duolin 12pm	9690266	Annamma
6/7/26	01.00	Levolin 3pm	9690359	Shirish
6/7/26	02.00	Duolin 6pm	9690604	Shirish.
	03.00	Levolin - 9pm	Kalyani	9691199 (5) 9692188 9692580
	04.00	Budecort - 10pm	Kalyani	
7/7/26	05.00	Duolin - 12am, 6am	Kalyani	
	06.00	Levolin - 3am	Kalyani	
7/7/26	07.00	Levolin - 9am	Annamma	
7/7	08.00	Duoline. 12pm	Shirish	
7/7	09.00	Duolin 8pm	Shirish	
8/7	10.00	Budecort + Levolin	Shirish	
8/7	11.00	Duolin		
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			



EMERGENCY ROOM TRIAGE FORM

Patient's Name : ILHAM ZUBEDI Age : 10y Gender: ☐ Male ☒ Female
Date : 5/7/26 Time of Arrival : 11:45pm Triage Completion Time : 11:47pm
Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): NA ☐ Not known any drug Allergies
Source of Information : ☒ Parents ☐ Others (Specify) NA
Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

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

Initial Vital Signs: Temp: 98.5F PR: 120bpm BP: 116/61 RR: 18bpm SpO₂: 95-98% RA

Chief Complaints: Fever x 2-3 days. cold, cough x 2.5 days.

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Communicable Disease Triage Screening

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

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

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

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☐ No

If yes, State Location:

- Are your parents / close contacts at home healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☐ No

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

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

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

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

Name of Triage Nurse : Ramadevi

Date & Time : 5/7/26 at 11:47pm

Signature of Triage Nurse : Ramadevi

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 5/2/26 Time of arrival : 11:47pm
 Chief Complaints: Fever x 2-3 days, cold, cough x 4-5 days, PNOB RBS: 26 mg/dL
 Height : NA Weight : 26 kg BMI : NA Head Circumference (<2 years) : NA
 Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: NA
 If yes, identify : NA
 Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☒ Wong Baker
☐ Character : NA ☐ Location : NA ☐ Frequency : NA ☐ Duration : NA

RISK FOR FALL:

- ☐ If patient is < 6 years
 tick below fall risk intervention directly
☒ If Patient is > 6 years
 Assess the below parameters

History of Falling: within past 3 months

☐ Yes ☒ No

Ambulatory Aids:

- Wheelchair
- Uses furniture for support

☐ Yes ☒ No
☐ Yes ☒ No

Gait/Transferring:

- Bedrest / immobile
- Weak
- Impaired

☐ Yes ☒ No
☐ Yes ☒ No
☐ Yes ☒ No

Mental Status: Forgets limitations

☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

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

Social History: Lives With : parents

Siblings in household ☐ Yes ☒ No (if yes How Many?) : NA

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

Time of Initial assessment completed by ER Nurse : 12 AM

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

Time	Nursing Notes
7:30 pm	Syp. Ibuprofen plu given.
7:40 pm	Budecort nebulization given
8:00 pm	x iv placement done
	x sample sent
	x shifted to ward.

Samples collected by: / Mr. Lofkel
 Samples sent by :

Time: / @ 11:40 pm.
 Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
5/7/26	LEVOLIN x 3	Neb	0.63 mg 1.2 mg	\$	ayd
12:00 AM 5/7/26	BUDECORT	Neb	0.5 mg	\$	J
12:35 AM 5/7/26	Suj HYDROCORTISONE	IV	100 mg	\$	Ramekay
12:45 AM 5/7/26	Suj PANTOPRAZOLE	IV	30 mg	\$	Ramekay

Condition of patient at time of shift - out :	Details of Shift - out
HR: 105 bpm BP: 116/58/60 CFT: 22 sec RR: 22 bpm SPO ₂ : 98% RA GCS: 15/15 Temperature: 98.5 F Pain Score: 0/10 Repeat RBS (if applicable): NA	Shift - out from ER to: 337 Time of Shift - out: 2 AM Handover given to: Dinya (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

iv placement done

Name of the Nurse : Mr. Rachel Signature of the Nurse : [Signature]

Date & Time : 6/7/26 @ 2:00 AM

BAH-00323970 IP5-00176001
Baby ILHAM ZUBEDI
18-05-2016 10 Y 1 M 18 D (F)
Dr. VENKATA LAKSHMI A



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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 2:50 PM Mode of Arrival: Working Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Body Weight: Kg

..... Height: cm

..... NER

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

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

Family History:

..... NA

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

is 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: 26 Length: 0 Head Circumference (< 2 years): 0

Temp.: 97.2°F HR: 100 bpm RR: 24 bpm BP: 100/72

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

Fall Risk Assessment: ☐ Yes ☐ No Score: 10/10 (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: 0/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker

Character of Pain 0 Location NA Frequency 0 Duration 0

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

Inform consultant for positive criteria

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

Inform consultant for positive criteria

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

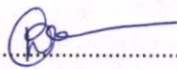
If Yes Consultant Notified: Dr. Venkata Lakshmi (Date/Time): 6/7/26 @ 8:30 PM

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

Social History: Lives With Family

Siblings in household ☐ Yes ☒ No (if yes How Many?)All Information Obtained From ☐ Patient ☒ Mother ☒ Father ☒ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach : ☒ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump : ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ No

Information given to Mother

Nurse Signature: 

Nurse Name: Priya

Date: 5/7/26 @ 2:50 PM

Time: 2:50 PM



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
06/07/26 26 12:50AM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	WALRI	Hemodynamic stability	IV medication	Nick	☒ Nursing ☐ Others:
6/7/26 1AM	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fast breathing cough	H. stability	VIP nebs.	@	☐ Medical ☐ Others:
6/7/26 9am	☐ Medical ☐ Nursing ☒ Others: dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	WALRI	Normal high protein diet	RDA E - 1650 Kcal/d P - 29g/d	Niketh	☐ 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: Hindi Patient / Learner Literacy: ☒ Read ☒ Write ☒ Speak Willingness to Learn: ☒ Yes ☐ No Healthcare Literacy: ☒ Yes ☐ No

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
8/2/24	1 AM	2	Treatment and care plan	M	1	0	1	1	NA	Q
6/8/26	9 am	9	Normal high protein diet	M	1	0	1	2	—	Nithin

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-00323970
 Baby ILHAM ZUBEDI
 18-05-2018 10 Y 1 M 18 D (F)
 Dr. VENKATA LAKSHMI A

IP5-00176001

oc. No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years) Children's Observation & Early Warning Scoring Chart

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BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

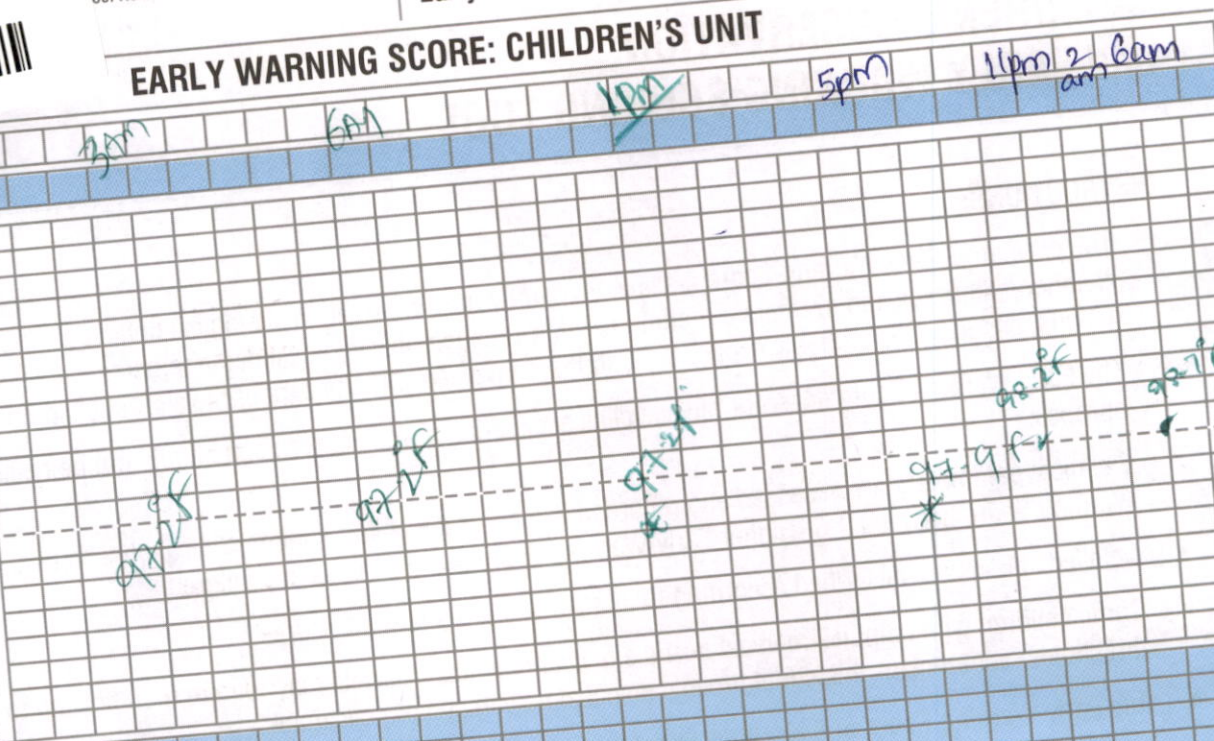
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 18/05/2018 Time: 3:30 PM

Doctor / Nurse / Family Concern?

Temperature
 (F)

104
103
102
101
100
99
98
97
96
95
94



Heart Rate
 (bpm)

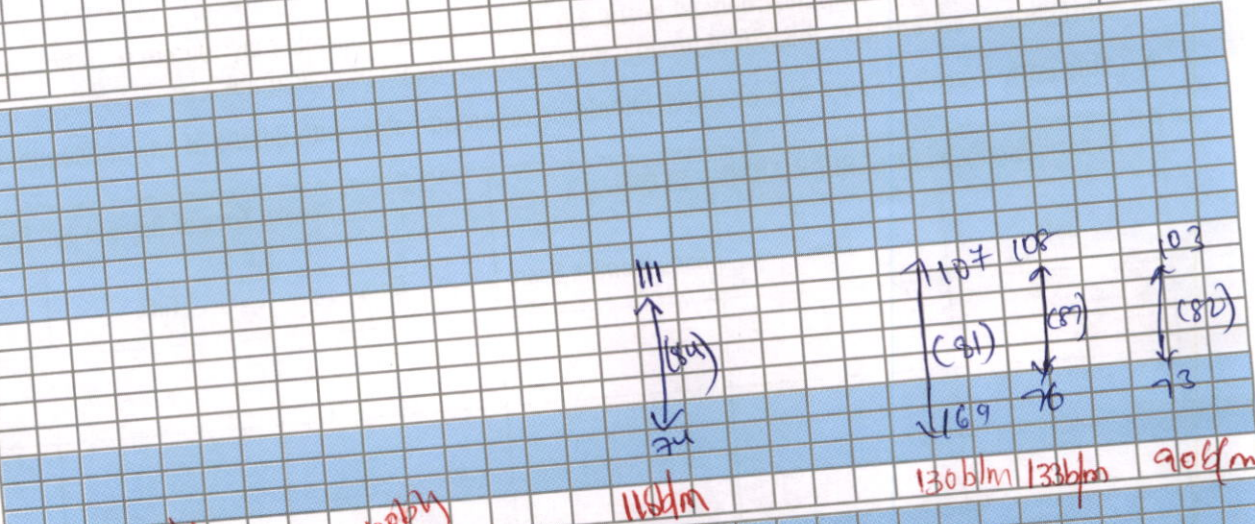
and

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)

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

70
60
50
40
30
20
10



Resp Rate (Number)

Resp Distress
 Mod/ Severe
 None / Mild

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

Conscious Level
 Normal
 Altered

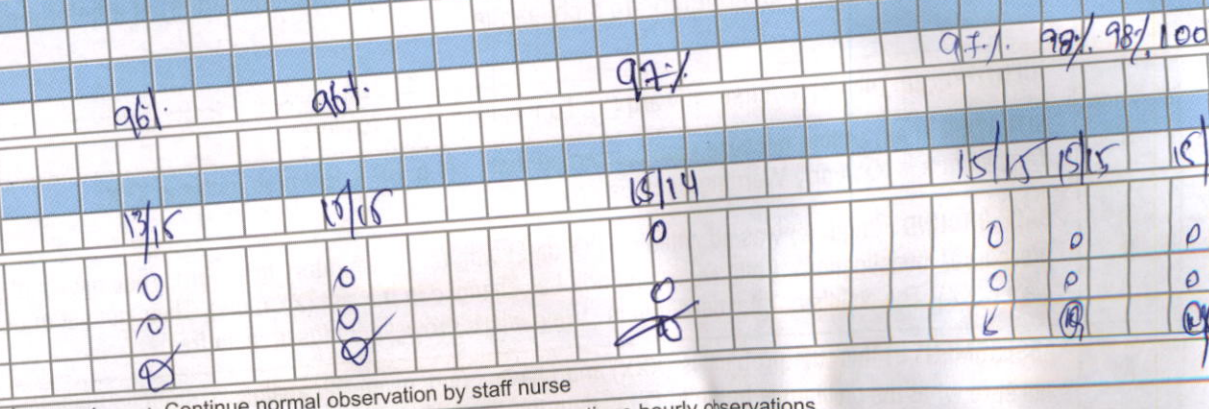
GCS *

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.
	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-00323970 IP5-00176001
 Baby ILHAM ZUBEDI 10 Y 1 M 18 D (F)
 18-05-2016 Dr. VENKATA LAKSHMI A

No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)
 Children's Observation &
 Early Warning Scoring Chart

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 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 11Am 5PM 10PM 6AM

Doctor / Nurse / Family Concern?

Temperature
 (F)

104
103
102
101
100
99
98
97
96
95
94

98.2 98.5 98.5 98.1

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

105/60 121/60 107/60 110/65

Heart Rate (Number)

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

70
60
50
40
30
20
10

29/1m 29/1m 28/1m

Resp Rate (Number)

Resp Mod/ Severe
 Distress None / Mild

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

99% 98% 98%

Conscious Level Normal
 Altered

15/15 15/15 15/15

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0 0 0
 0 0 0
 0 0 0

ACTIONS

NB: Scores 3 should be
 recorded overleaf

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- 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.
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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
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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)

Patient S

BAH-00323970 IP5-00176001
 Baby ILHAM ZUBEDI
 18-06-2016 10 Y 1 M 18 D (F)
 Dr. VENKATA LAKSHMIA



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FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output						IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	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			35 ml							6		
	03:00 am			35 ml							0		
	04:00 am			35 ml							0		
	05:00 am			35 ml							0		
	06:00 am			35 ml							0		
	07:00 am										0		
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							



FLUID CHART

Sheet No. : 6/7/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am			35ml			1					0	Amma
	09:00 am	D		-						✓	0	0	
	10:00 am	NR		-			NP				0	0	
	11:00 am			35ml			1				0	0	
	12:00 pm			35ml			1				0	0	
	01:00 pm			35ml			1				0	0	
Total Intake :						Total Output : m-o-u-1							
	02:00 pm			35ml			1				0	0	Shish
	03:00 pm			35ml			1			✓	0	0	
	04:00 pm	DNS		35ml			NP				0	0	
	05:00 pm			35ml			1			✓	0	0	
	06:00 pm			35ml			1				0	0	
	07:00 pm			-							0	0	
Total Intake :						Total Output : m-o-u-2							
	08:00 pm			35ml							0	0	Shish
	09:00 pm			35ml							0	0	
	10:00 pm		Rice	-							0	0	
	11:00 pm	DNS		-			✓		✓	0	0	0	
	12:00 am			-						0	0	0	
	01:00 am			35ml							0	0	
Total Intake :						Total Output :							
	02:00 am			35ml			1				0	0	Shish
	03:00 am			35ml			1				0	0	
	04:00 am			35ml			NP			✓	0	0	
	05:00 am	DNS		35ml			1				0	0	
	06:00 am			35ml			1				0	0	
	07:00 am			35ml			1				0	0	
Total Intake :						Total Output :							
Total 24 hrs. Intake			IV=630ml			Total 24 hrs. Output			m=1, u=5				



FLUID CHART

Sheet No. :

7/7/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am	g		35ml							0	
	09:00 am	H ₂ O		35ml			✓		✓		0	
	10:00 am	DM Food		35ml							0	Riawana
	11:00 am			35ml							0	
	12:00 pm	H ₂ O		35-							0	
	01:00 pm			-							0	
Total Intake :						Total Output : M-1 0 7						
	02:00 pm			35ml							0	
	03:00 pm	H ₂ O		35ml					✓		0	
	04:00 pm	DM		35ml			NP				0	Satyra
	05:00 pm	H ₂ O		35ml							0	
	06:00 pm			-							0	
	07:00 pm	H ₂ O		-					✓		0	
Total Intake :						Total Output : M-0 0 2						
	08:00 pm			35ml							0	Satya
	09:00 pm			35ml							0	
	10:00 pm	DM Food		35ml			NP		✓		0	Sri
	11:00 pm			-							0	
	12:00 am	H ₂ O		35ml					✓		0	
	01:00 am			35ml							0	
Total Intake :						Total Output : M-0 0 2						
	02:00 am			35ml					✓		0	
	03:00 am			35ml							0	
	04:00 am	DM H ₂ O		35ml			NP		✓		0	skishu
	05:00 am			35ml					✓		0	
	06:00 am			-							0	
	07:00 am			-					✓		0	
Total Intake :						Total Output : M-0 0 3						
Total 24 hrs. Intake			Perf: 630ml			Total 24 hrs. Output			M-1 0 8			

BAH-00323970 IP5-00176001
 Baby ILHAM ZUBEDI
 18-05-2018 10 Y 1 M 19 D (F)
 Dr. VENKATA LAKSHMIA

FLUID CHART

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 Hospital
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Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
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														
	09:00 am														
	10:00 am														
	11:00 am														
	12:00 pm														
	01:00 pm														
Total Intake :						Total Output :									
	02:00 pm														
	03:00 pm														
	04:00 pm														
	05:00 pm														
	06:00 pm														
	07:00 pm														
Total Intake :						Total Output :									
	08:00 pm														
	09:00 pm														
	10:00 pm														
	11:00 pm														
	12:00 am														
	01:00 am														
Total Intake :						Total Output :									
	02:00 am														
	03:00 am														
	04:00 am														
	05:00 am														
	06:00 am														
	07:00 am														
Total Intake :						Total Output :									
Total 24 hrs. Intake						Total 24 hrs. Output									

BAH-00323970 IP5-00176001
 Baby ILHAM ZUBEDI
 18-05-2016 10 Y 1 M 18 D (F)
 Dr. VENKATA LAKSHMI A



NURSING CARE RECORD

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BirthRight™
 BY RAINBOW HOSPITALS
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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 05/7/26

Assessment: patient having cough

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
3Am	⇒ Assess the patient General condition	3:16 Am	⇒ Assessed the patient General condition	patient is stable
4Am	⇒ Assess the patient vitals signs	4:20 Am	⇒ Assessed the patient vitals signs	
5Am	⇒ To encourage oral intake	5:10 Am	⇒ maintained I/O chart	
8Am	⇒ To nebulization I/O chart	8:10 Am	⇒ Encouraged oral intake	
	⇒ ensure safety		⇒ ensure safety	

Re-Assessment: patient is Good

Special Notes: Nebulization

Nurse Signature: @Devi

Nurse Name: Deepa

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

BAH-00323970 IP5-00176001
 Baby ILHAM ZUBEDI
 18-05-2016 10 Y 1 M 18 D (F)
 Dr. VENKATA LAKSHMI A



NURSING CARE RECORD

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BirthRight
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Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 6/7/26

Assessment: patient having cough.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the Baby General condition	8:30 am	Assessed the Baby General condition on bed	⇒ patient is stable.
9am	to monitor vitals	9:30 am	monitored Baby patient vitals	
10am	to monitor I/O chart	10:30 am	monitored Baby I/O chart	
11am	to provide comfortable position	11:30 am	provided patient comfortable position	
12pm	to plan nebulization	12:30 PM	given nebulization	
1 pm	to plan Administered medication	1:30 PM	Administered medication	

Re-Assessment: Re-assessment done given Baby comfortable position.

Special Notes:

Nurse Signature: Annamma

Nurse Name: Annamma

Date & Time: 6/7/26 2pm

BAH-00323970 IP5-00176001
 Baby ILHAM ZUBEDI
 18-05-2016 10 Y 1 M 18 D (F)
 Dr. VENKATA LAKSHMI A



NURSING CARE RECORD

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Date: 6/7/26

Assessment: ☒ Afternoon ☐ Night

patient having cough

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	2:05pm	Assessed the patient. General condition	Patient was stable.
3pm	Monitor the vitals.	3:05pm	Monitored the vitals.	
4pm	Maintain I/O chart.	4:05pm	Maintained I/O chart.	
5pm	Provide comfortable position to patient.	5:05pm	provided comfortable position to patient	
6pm	plan to give nebulization.	6:05pm	nebulization done.	
7pm	To Administer medication.	7:05pm	Administer medication.	

Re-Assessment: Provided comfortable position Patient was stable.

Special Notes: nebulization done and continue.
 continue IV fluids.

Nurse Signature:  Nurse Name: Shinish Date & Time: 6/7/26 8pm

RAH-00323070

IP5-00176001

Baby ILHAM ZUBEDI

18-05-2016 10 Y 1 M 18 D (F)

Dr. VENKATA LAKSHMI A



NURSING CARE RECORD

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BirthRight
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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6/7/26

Assessment: Cough, cold

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 general condition of the patient	8:20 pm	→ Assessed the general condition of the patient	Patient is stable also fever spikes
11pm	→ To monitor vital signs	11:15 pm	→ Monitored vitals and documented	
1am	→ To give nebulizations	6:30 am	→ Given nebulizations	
3am	→ To maintain fluid balance	3:10 am	→ Maintained DRs fluid balance	
5am	→ To provide safety.	5:25 am	→ Provided safety	
7am	→ To administer medicines.	7:18 am	→ Administered medicines	

Re-Assessment:

Cold + Cough settled, after given nebulization

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Kalyani

Date & Time: 7/20/26

BAH-00323970 IP5-00176001
 Baby ILHAM ZUBEDI
 18-05-2018 10 Y 1 M 18 D (F)
 Dr. VENKATA LAKSHMI A



NURSING CARE RECORD

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BirthRight
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 Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 2/2/26

Assessment: patient having cough

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 pt condition	8.10am	patient is stable / active	pt stable
10am	monitor vital	10.10am	vitals stable	
12pm	monitor I/O chart	12.20pm	monitored I/O chart documented	
2pm	to administer medication	2.10pm	administered medication	
4pm	to encourage orally	4.10pm	oral intake good	
6pm	to encourage ambulatory	6.10pm	well ambulatory	

Re-Assessment: re-assessed after 2 hrs pt stable

Special Notes: urine sample duu

Nurse Signature: Satya Nurse Name: Satya Date & Time: 2/2/26 @ 8pm

BAH-00323970

IPS-00176001

Baby ILHAM ZUBEDI

18-05-2016 10 Y 1 M 18 D (F)

Dr. VENKATA LAKSHMI A



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: 2/2/26

Assessment:

pt having cough

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 → vitals	8pm	→ Assessed the pt general condition	Growth Safety
10pm	→ Maintain fluid balance	2e 11pm	→ Maintained fluid balance	
1Am	→ w/f for fever spikes	10 1Am	→ w/f for fever spikes and RPS	
3Am	end RDS	20 3Am	→ Encourage orally	
5Am	→ Trace sample of urine	30 5Am	→ Trace sample for Urine	
7Am	→ Administer medication as per chart	40 7Am	→ Administered medication as per chart	

Re-Assessment:

Reduce cough

Special Notes:

Trace urine sample (urine dipstick) (glucose level was (1000.55+++)
(ketone was (neg

Nurse Signature: Subitha

Nurse Name: Subitha

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

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Venkat Lakshmi Department: General Paeds Date of Admission: 6/7/26

SITUATION		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:						
BACKGROUND	Area							
	Shift Time	1:10Am	3rd floor 2pm	3rd floor 8pm	3rd floor 8am	3rd floor 8:30Am	3rd floor 8pm to 8am	
BACKGROUND	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	Breast difficulty	NA	
	Diagnosis:	NALRI						
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:	98.3f	97.1f	-	98f	98.2f	98.0f
		Res:	22b/m	20b/m	-	20b/m	21b/m	20
		SpO ₂ :	99%	97%	-	98%	99%	99
		Pulse:	109b/m	115b/m	-	130b/m	105b/m	110
		BP:	108/65(30)	111/70(30)	-	108/76	107/75	110/76
		Fall Risk Score:	09	01	01	9	10	10
	Pain Score:	0	0	0/10	0	0	0	
	Recommendations	Safety Needs:	side rails	yes	yes	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 :		Lachet	Annanya	Shinsh	Kalyani	Lipo	Shirke	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		6/7/26	6/7/26	6/7/26	7/7	7/7/26	8/8/26	
Time:		12:30Am	2pm	8pm	8am	8pm	8am	
Taken Over By Name :		Annanya	Shinsh	Kalyani	Annanya	Shirke		
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]		
Date:		6/7/26	6/7/26	6/7	7/7/26	7/7/26		
Time:		8am	2pm	8pm	8am	8pm		



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/7/26	1 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Am
6/7/26	11 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Annamma
6/7/26	12 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Annamma
6/7/26	6 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Shin'sha
6/7	10 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Kalyani
7/7	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Kalyani
7/7/26	12 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Satya
7/7/26	6 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Satya
7/7/26	10 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Shrisha
8/7/26	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Shrisha

Re-assessment Frequency:

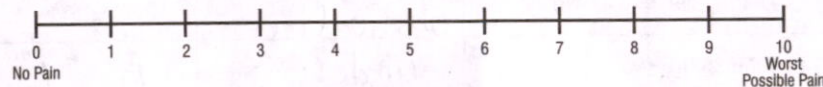
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

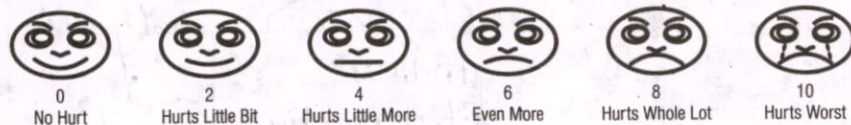
Numerical Pain Scale (Obstetric and Gynecology)



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

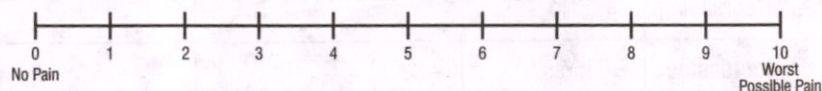
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
7/1/20	10 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	skin is b
8/7/20	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	skin is b
				☐ 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

Numerical Pain Scale (Obstetric and Gynecology)



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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

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Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
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Wong - Baker (Pediatrics) Above 7 Years



0
No Hurt

2
Hurts Little Bit

4
Hurts Little More

6
Even More

8
Hurts Whole Lot

10
Hurts Worst



BRADEN 'Q' SCALE

					Date :	6/1/20	7/7	8/7	
					Time :		6am	6a	
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:remity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	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		
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		
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		
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		
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		
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		
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk 14 Mild Risk : 15-18 Not at Risk: 19-23									
TOTAL SCORE					28	28	28		
Evaluator's Name					A. Kalpana				

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

Patient ID

BRADEN 'Q' SCALE

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
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BAH-00323970
Baby ILHAM ZUBEDI
18-05-2018 10 Y 1 M 18 D (F)
Dr. VENKATA LAKSHMI A

Patient S

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

8/20/2018 8/2

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	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	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		
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	✓		
Call device within reach	Yes	Yes	✓		
Wheels Locked	Yes	Yes	✓		
Room free of clutter	Yes	Yes	✓		
Adequate Lighting	Yes	Yes	✓		
Wheel Chair Support	NO	NO	NO		
Other Intervention(s) Specify	NO	NO	NO		
Nurse's Name :	Lakshmi	Shanthi	Shanti		
Signature :	[Signature]	[Signature]	[Signature]		
Date :	6/2	7/2/18	8/2		
Time :	1Am	8am	8am		

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0	0				cannula changes
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				Anna	Shirish	Kalyani	Ana	Saty	Shirish				

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 : Souhasini Name : Souhasini

Signature of Ward In Charge :

Signature : Anna Name : Anna

BAH-00323970 IP5-00176001
 Baby ILHAM ZUBEDI
 18-05-2016 10 Y 1 M 18 D (F)
 Dr. VENKATA LAKSHMI A



DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: As Per doctor order

2. Destination Post Discharge: ☒ Home
 Family Members Notified (Person Contacted)

☐ Transfer
 Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

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

Yes Assistance

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:
☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Nebulization

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: [Name]

Date and Time: 6/7/26 @ 3PM

BAH-00323970 IP5-00176001
 Baby ILHAM ZUBEDI
 18-05-2016 10 Y 1 M 18 D (F)
 Dr. VENKATA LAKSHMI A



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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Duo - 6/12/6,12
 Levolin, 3,9,3^o

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00	DUOLIN 1 resp.		
	01.00			
	02.00			
	03.00	LEVOLIN 1.25mg		
	04.00			
	05.00			
	06.00 am	DUOLIN 1 resp.		
	07.00 am	4		
	08.00			
	09.00 am	LEVOLIN 1.25mg.		
	10.00	BUDECORT 0.5mg.		
	11.00			
	12.00 pm	DUOLIN 1 resp.	Annamma	
	13.00			
	14.00			
	15.00	LEVOLIN 1.25mg.		
	16.00			
	17.00			
	18.00	DUOLIN 1 resp.		
	19.00			
	20.00			
	21.00	LEVOLIN 1.25mg		
	22.00	BUDECORT 0.5mg.		
	23.00			

Docu. No. : RCHBH/FRM/CLINICAL/170

Bed not ready

TRANSFER FORM

Patient Name & Unit No.		Date of Transfer	
From Unit		To Unit	
Reason for Transfer		Remarks	
Signature of Medical Officer		Signature of Nurse	
Date		Time	

This form is to be filled up by the Medical Officer of the unit to which the patient is transferred.

A separate form is to be filled up for each patient transferred.

Date of Transfer

Signature of Medical Officer

Signature of Nurse

Date

Time of Patient Received

If the patient is transferred to a unit other than the one to which he was originally transferred, the Medical Officer of the unit to which he is transferred must fill up this form.

337

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 6/7/28 Time: 9am

Weight: 26 kgs Centile: >5th

Height: 129 cms Centile: >5th

Inference: underweight child

RDA: - Calories: 1650 kcal/d Protein: 29g/d

Diet Recommendations: Normal high protein diet

Re-Assessment: Avoid spicy, chilled, outside foods

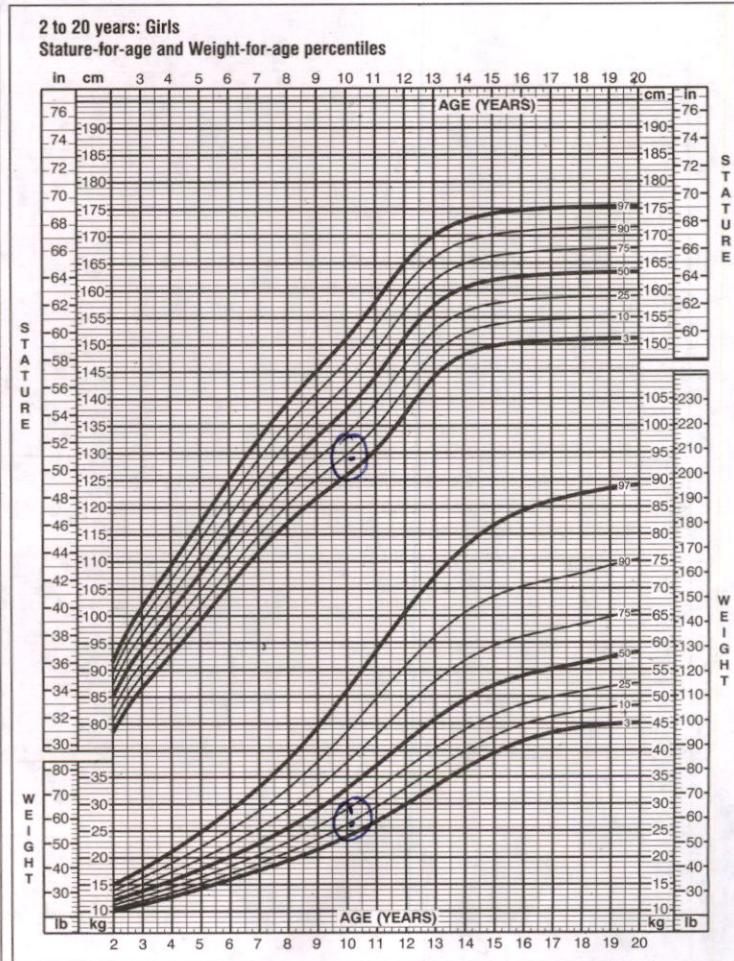
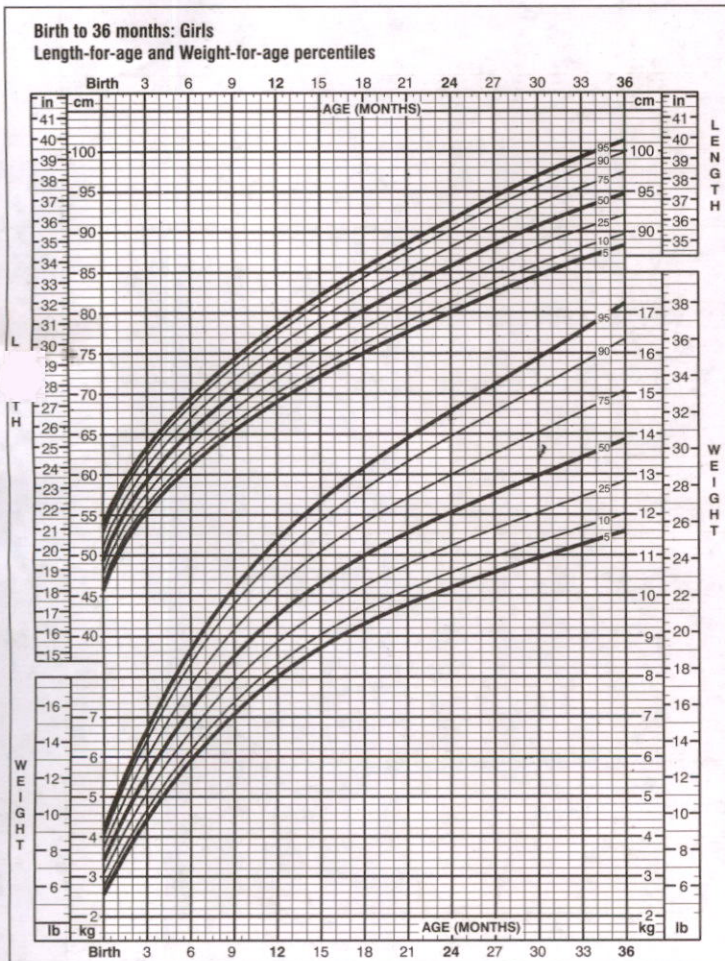
Food Allergies: No Veg/Non-veg Non-Veg

Diagnosis: WAKRI

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (GIRLS)



Dietician's Name Nikitha

Dietician's Signature [Signature]

Daily Notes:

7/7/26

child is stable, oral intake is good

11:25
am

continue Normal High protein diet

Saine

8/7/26

child is stable, oral intake is optimal

10am

continue Normal high protein diet

Saine