

BAH-00661949 IP5-00176525
Baby SHRISTI ROY
26-06-2013 13 Y 0 M 23 D (F)
Dr. PILLARISETTI NAVEEN SARADHI

Fe not done

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SURGERY DETAILS

Date : 22/7/26
Patient Name: Baby Shruti Roy Date of Birth: 26-06-2013 Age: 13y
Gender: F Ward : P-OT UHID No.: 0126525
Date of Surgery: 22/7/26 ☐ OT-1 ☐ OT-2 ☒ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2
Name of the Surgery : LYMPH NODE BIOPSY

Time in : 3:15 PM

Time Out : 4:15 PM

	NAME	AMOUNT
1. Surgeon	<u>Dr. Habeel</u>	
2. Anaesthetist		
3. Assistant Surgeon		
4. OT Technician	<u>Aman</u>	
5. Circulating Nurse	<u>Archana</u>	
6. Assistant Nurse	<u>Sam</u>	

Special Equipment: ☐ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others

[Signature]
Signature of the Surgeon

[Signature]
Signature of Circulating Nurse

Order No: 09716932

Order by: [Signature]

BAH-00661949

5447

1340m230
331kg

Lymph Node Biopsy

CONSUMABLES OF OT

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Circulating staff : Technician : Date : Time :

Anaesthesia Disposables		Qty		Surgical Disposables		Qty		Disposables (Baby Side)		Qty	
Issued	Used	Issued	Used	Issued	Used	Issued	Used	Issued	Used	Issued	Used
ET tube	5, 2, 5, 5	14	—	Major Pack	Drape	1	1	Inj Vit.K			
LMA	2 1/2, 3	14	01	Sutures	Many 3-0	2		Cord Clamp			
ECG leads: A/P/N	5	03		u-o 5-0	(9915)	24	24	Suction Catheter			
HME filter: A/P/N	1	01		2338 2366		14	14	Feeding Tube			
Syringes: 10 cc	10	900						Vaccum Suction Set			
05 cc	10	90		Gloves	6, 6 1/2 (9) (9)	24	24	Surgical Gloves			
02 cc	10	05		PA, 3, 6 1/2 (2) (2)		14	14	Gauze Pack			
01 cc	3	—						Syringe 1ml / 2ml			
Cautery plate: A/P/N	1	01		Surgical blade	11 (15)	24	24	Surgical Blade # 20			
IV set	1	01		NG tube				Koochies (S)			
RL	1	01		Cautery pencil		1	1	NS 500ml	1	1	
NS (10ml / 100ml) / 500ml / 1000ml	44	01		Koochies				Transax	1	1	
minispiice	1	01		Ointments				10 cc, 5 cc, 2 cc	24	24	
vaccumist	1	—		Suction Catheter							
Fentanyl	1	01		Cap, Mask		515	10/10				
Morphine				Gauze Pack	(2) R	8	3				
Ketamine				Mop Pack		1	1				
Propofol	5	02		Steristrip							
Rocuronium	1	—		Underpad		1	2				
Glycopyrolate	1	—		Draw sheet		1	0				
Myopyrolate	1	—		Abgel							
Ondansetron	1	—		Foleys catheter							
Pencan 25g/ Spinal Needle (22)	1	—		Urobag							
Bupivacaine 0.25%	1	—		Chest Drainage Catheter				midazolam	1	—	
Bupivacaine 0.25% (Heavy)				Romodrain bag				NA (22, 24)	14	—	
Antibiotics				Bandage				O.P (112)	14	—	
up cm	1	01		Tegaderm				Nasal prong	1	—	
Suppositories				Ioban				chlor (P)		—	
Anamol: 80mg / 250mg / 170 mg				Double J Stent				Dexmed (100mg)		—	
Supridol: 100mg				Vaccum Suction set		1	—	Socetpmoline	24	—	
Justin (12.5 mg / 25mg) 100mg	14	—		Plastic Bed Sheet		1	—	stopcock	2	—	
Tab. Misoprost: 200mg				Betadine Solution		1	—				
3way 10x100cm	14	—		Microshield		1	—				
Glove all game	14	—		Cotton Balls		1	—				
Transera toera	24	—		Latex Gloves		10	20				
O2 mask (P)	1	—		Ramdione Scrub		1	—				
IV cannula (22, 24)	14	—		Saral		1	—				

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 9716837

Ordered by : [Signature]

Doc. No. : RQH / FRM / GENERAL / 125

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176525 Admit Date : 17-Jul-2026 Admit Time : 02:58 PM UHID : BAH-00661949

Patient Details :

Patient Name : Baby SHRISTI ROY Age : 13 Y 0 M 19 D
Guardian : Mr SAMAR ROY DOB : 28-06-2013
Gender : Female Religion :
Occupation : Martial Status : Single
Address (H) : H NO 1/113, WARD NO 12, SATHANAMI Phone No : 9406469588/ 6265876955
BHAVAN CHOWK, BADEBACHELI (M), E-mail : NOMAIL@GMAIL.COM
DAKSHIN BASTAR DANTEWADA - 494553
Banjara Hills Hyderabad Telangana INDIA
500034

Admission Details :

Bed Type : SEMI PRIVATE Bed No : SPVT 334 Ward Name : 3F-ZONE C
Room No : SPVT 334 Admission Type : First Visit

Contact Details :

Name : Mr SAMAR ROY Relationship : Father
Contact Address : H NO 1/113, WARD NO 12, SATHANAMI Phone No : 9406469588
BHAVAN CHOWK, BADEBACHELI (M),
DAKSHIN BASTAR DANTEWADA - 494553
Banjara Hills Hyderabad Telangana INDIA
500034

Signature

Doctor Details :

Doctor Name : Dr. PILLARISETTI NAVEEN SARADHI Specialisation : PULMONOLOGY
Referral Doctor : Self Phone No :
Co-Consultant : Dr. SHRUTI KOTAPALLI

Payment Details :

Deposit Amount : 0.00
Payment Mode : Cash Payor Name : NMDC LIMITED



ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No : _____ Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
17/7/26	4:15 pm	ER	334	Anneel
22/7/26	1:30 pm	334	OT	Shilpa
22/7/26	6:40 pm	OT	334	Thyagaraj/Akhil

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	DR. Rao Babababu	18/7/26	9709095	Shilpa
2	DR. Abhishek	18/7/26	9709228	Shilpa
3	DR. Sushma	18/7/26	9710473	Shilpa
4	DR. Leena priyambada	18/7/26	9710459	Shilpa
5	Dr. Chandrakesh (tele)	20/7/26		
6	Dr. Priyambada leena	21/7/26	9714059	Shilpa
7	Dr. Sushma Reddy	21/7/26	9714314	Shilpa
8	DR. Mainak	21/7/26	9714961	Shilpa
9				
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
17/07	CRP, CRP, ESR, LFT, RFT S/E, ANA IF, RF ACE, CXR (PA view) X-ray Erect abdomen USG chest & abdomen CVB	71768. 35654	T. snare T. snare
18/7	Genxpest MTB/PCR/Tuberculosis	72015/72237	Stk
18/7	CSF Culture/CSF Analysis	72243/72239	Stk
18/7	Thyroid Antibodies/PANCA/CANCA	72283	Stk
18/7	Thyroid antibodies (Thyroglobulin)	72283	Stk
18/7	TFT / RBS 8pm (65mg/dl)	72283/72286	Stk
18/7	10pm (128mg/dl) / 6am (84mg/dl)	72285/72287	Stk
19/7/26	RBS 150mg/dl - 1pm	26072456	Stk
19/7/26	RBS 131mg/dl @ 30pm	26072480	Stk
20/7/26	RBS (2am - 143) (6am - 113mg/dl)	26072617	Stk
20/7/26	RBS (12pm - 192)	26072730	Stk
20/7	USG Neck	036250	Stk

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
17/07	iv placement	1	707865	T. Smith
18/07	Lumbar puncture -	2 (1)	9709820	[Signature]
	conscience sedation			

ANY OTHER INFORMATION

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.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



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PEDIATRIC IN-PATIENT MEDICAL RECORD

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Dr. PILLARISETTI NAVEEN SARADHI



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

Pediatric Multiorgan History & Physical Examination

Name : Shristi Roy Age/Sex 13y/F

Information given by: Samar Roy Relationship Father

Chief Presenting Complaints & Duration (Chronologically)

1 mo fever headache since 1 month
vomiting since 1 month

History of present illness :

It was apparently asymptomatic 2 months back
Then she developed swelling in cervical region
not increasing in size even upon increase in size associated
with fever. No headache since 1 month.
associated with vomiting headache. Unilateral
lt side temporal supraorbital - parietal region
associated with nausea, vomiting 2-3 episodes
decreased with medication

H/o. Not gaining weight 1 month

H/o not taking food since 1 month

no H/o fever

no H/o cough

no H/o Abdominal pain

H/o cervical lymph node biopsy done 15/6/26



Pediatric Multiorgan History & Physical Examination

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

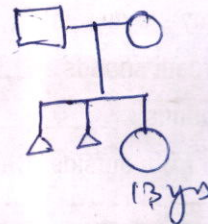
No Kalo TB on treatment 15/6/26

No H/o contact with TB

Birth & Neonatal History:

S/+^{Pre}term / NUD / F₃ | B-wt → 600gm

~~H/o~~ NICU (toplex) admission for 20 days



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Appropriate for age

Immunization History :

Completely Immunized



History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): 148cm (Centile _____)

Weight (kgs)) 33kg (Centile _____)

On Examination :

Temperature : 97.1°F Pulse Rate : 86/min B.P. 120/63 (77) SPO2 100% RA

Resp. rate and type of breathing : 22/min Abdomino thoracic

Rash NO

Lymphadenopathy _____

Oedema : NO

Allergies (if any): NO

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : Bilateral

Any addles sounds : Btl crepts & rh

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : 2 aus - clear

Any murmur : _____

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

Per Abdomen :

Inspection 2 soft, non tender

Palpation : 2

Ausculation : - Bowel sounds

Spine : _____ External Genitalia : _____

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

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Paediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : 3/12

Motor System:

Nutriton : 3

Tone: 3 Power 3

Co-ordinator : 3

Posture : 3

Involuntary Movements : 3

Reflexes : 3/0

DTR

Superficials: 3/0

Plantars 3

Sensory System : 3/0

Bladder / Bowel : 3/0

Clinical Summary & Diagnostic:

TB lymphadenitis

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Scandyl Injection

Desired goals of the treatment : haemodynamic stability

Planned Labs:

- CBP, CRP, ESR
- ESR
- LFT
- RFT
- Serum Electrolytes
- ANA IF, RF, ACE levels
- L.C.E.
- Chest X Ray PA view
- Fundo. ~~with~~ ad
- X-ray Erect abdomen
- Sputum GeneXpert TB
- USG - chest -
- US abdomen -

Planned Management

- Fundoscopy
- IV fluids
- Mj. Augmentin
- Mj. Zenler
- Mj. Pantop.

N/B Anus
 12/7/26

N/B Anus
 12/7/26

Signature of the Doctor: Dr Ramya

Name of the Doctor: Dr Ramya

Date & Time: 12/7/26

Signature of the Consultant: Dr. Pillariseti Naveen Saradhi

Name of the Consultant: Dr. Pillariseti Naveen Saradhi

Date & Time: 17/7/26

PILLARISETTI NAVEEN SARADHI
 Registration No: 38883



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	2			
5	In-patient Medical record	1			
6	Doctors progress sheets	8			
7	Nursing plan of care and handover sheets	8			
8	Consultation sheet	7			
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	1			
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)	1			
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list	1			
26	Surgical safety checklist	1			
27	Operation Theatre notes	1			
28	Nurses clinical Presentation				
29	TPR & BP chart	7			
30	Intake and Out take chart (fluid chart)	3			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	3			
38	Braden Q Scale				
39	Bed side check list				
40	PICU bed formula Dilution feeds	10			
41	Gastro monitoring chart				
42	Rch ED doctors note	1			
43	BP Monitoring chart				
44	RBS monitoring chart				
Total No. of Pages		65			

23/7/20



ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	↑ W/o cervical L.N. swelling x 2 months back in May 2026.	May 2026
	- No headache, vomiting chills since June 13, 2026. ↓ admitted in Apollo Vithakapatnam	
	② Cervical L.N. Biopsy done microscopy → multiple granulomas of central caseous type of necrosis	- No abortions - child was a triplet → other children did not survive.
	HPE:- Necrotising granulomatous lymphadenitis	- Preterm triplet / 600gms W/o NICU admission for 15 days.
	CSF:- analysis:- - WBC - 2 cells (100% lymphocytes) - AFB not seen - Biofire meningitis - Neg. - Cx - no growth. ↓ started on ART on 16/6/2026. ESR - 70.	- No recurrent fever till 5 yrs of age.
	USG Abdo - Subcentimetric L.N. at umbilical & right lumbar. - MRI brain - Normal	cervical L.N. noted in May 2026 → • went to Apollo Central, Bachehi → enlarged L.N. → ? lymph node abscess • Thyroid → heterogeneous echotexture - ? chronic thyroiditis



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	CT chest plain :-	
	- Fibrotic opacity at posterior seg. of right upper lobe	
	- tree in bud appearance	
	CT Abdo :- few subcentimeter LN adjacent to right ileocecal region hepatomegaly & mild edematous gall bladder	
	2D Echo - (N)	
	↓	
	Discharged on 23rd June on ATT was doing well x 1 week	
	↓	
	Now again headache & vomiting since July 1	
	Photophobia (+)	
	Afebrile	
	HR: 86/min	
	RR: 22/min	
	BP: 127/65 mmHg	
	Spo ₂ : 100%	
	chest: str crepts (+)	
	CVS: S ₁ S ₂ (+)	
	P/A: mild knee (+)	
	CNS: conscious.	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/7/26 2pm	Dr. Naveen Saradhi child headache & Vomiting Vitals stable Chest: B/L crepts (+) CNS: S₁S₂ (+) HA: Doughy abdomen. CNS: conscious No signs of meningeal irritation	Admit in ward. ① USG Abdomen ② USG Chest ③ Fundoscopy - (omission Ophthalmology consultation) ④ CBP, CRP, ESR, LFT, RFT, Serum electrolytes, ANA - IF, RF, ACE levels. Chest XRay; Sputum Genexpert TB Abdomen XRay Erect. ✓ CUE ⑤ maintenance fluids - 1/2 ⑥ Neurology opinion post admission. ⑦ Inj Augmentin ⑧ Inj Ondem ⑨ Inj Pantoprazole ⑩ Akarit-4 x 3 tablet OD x continue ⑪ T. Benadon
	15 x 30 H R Z E 300 950 1050 600 Handwritten signature Child on (continually) Handwritten signature	Alert H R Z E 75 150 400 275



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7/2013 9:00am	48/B Dr. Naveen Saradhi TB lymphadenitis. No fever. headache (+) 5 episodes of vomiting No fever. Bp: 118/64 mmHg Chest: B/c crepts (+) CVE: S/S₂ (+) P/A: doughy abdomen RBS - 79 CVE: B/c pupils 2mm reaching No signs of meningeal irritation Awaited — ANA - IF, RF, ACE, CVE	Adv:- 1) Inj Augmentin → 2 2) Inj ondrem - TID 3) Inj Paracetamol - TID 4) Inj Pantop 5) T. Akurit - 4 6) T. Benadon. 7) Continue iv fluids. 8) Gynac consultation 9) Neurology consultation 10) Nebulise with 3% NS → - Sputum collection for Genexpert TB 11) Dr. Sushma maam consultation 12) ↑ iv fluid Dns - maintenance + 20% extra 13) Dr. Leena Priyambada maam consultation 14) Send TFT, anti TPO, anti thyroglobulin antibodies, C-ANCA, p-ANCA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/7/26 9:45 AM	Thanks for referral This is a case of 13yr old.	C/O/w - Dr. Rao Balakrishna (Gynecologist)
18/7/26 3:30 PM	<u>CLS/B Pulmo team</u> Afebrile Vitals stable SpO ₂ - 99% (RA) Ophthalmology consultation ↓ Fundus normal	<u>Adv</u> - Shift to PICU for lumbar puncture ↓ Send CSF for - - CSF analysis GeneXpert CS - CS + AFB stain - comprehensive TB panel. - MRI brain + contrast at 6 PM today.

Date & Time	Progress Notes	Doctor's Order
18/7/26 5pm	clerk Pulmo team. S/P lumbar puncture ↓ Sedation No fever. No vomiting. Headache (+) Chest: clear. No meningeal signs Spulm GeneXpert - Neg. Awaited: ANA-IF RF, ACE; Spulm GeneXpert:	Adv: - Send TFT, anti TPO, anti thyroglobulin antibodies, CANCA, PANCA - MRI brain with contrast at 6pm. - Send CSF analysis, culture AFB, comprehensive TB panel. - Continue Cane t/t

Date & Time	Progress Notes	Doctor's Order
		procedure performed. by Tyoti
	Procedure Notes	& sedation given by Dr. Sukanya
10/2/26 5:30 pm	under all aseptic precautions, with informed consent, it was done at L3-L4 space. CSF was collected sedation - inj Ketamine Whole procedure remains uneventful	
		<u>AW.</u>
	Post procedure Notes HR - 74/min SpO ₂ - 95-96% on R room Air BP - 110/64 mmHg RR - <u>24/min</u>	send for CSF analysis as per pulmo team
		<u>Tyoti</u>
18/2/26 9:30 pm		<u>R:</u> • Inj Dene 4mg Q6H • GRBS & BP monitoring Q6H • Rest C7 etc. Dr. Ravi

Date & Time	Progress Notes	Doctor's Order
7/26 0am	US/B Dr Naveen Saradhi 40 TB lymphadenitis	Adv
	Afebrile vitals stable SpO₂ - 98% (RA) Chest - B/L VBS, B/L AE + CVS - NAD P/A - soft, non-tender Headache & photophobia reduced No further vomiting since last night	- Augmentin D3 - stop - Pantop / Ondem / Nexdom / P - ATT 1 Benadon - Dena DI - Trace ANA-IF, RF RF, TFT, c-ANCA, p-ANCA, anti-T CSF reports - IV ceftriaxone - Send CSF for biofire panel (same sample) / P

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/23	C&P Dr. Shanti Kotapalli	
9:00 am	Δ: TB lymphadenitis.	
		Adv:
	No fever	- Inj. Ceftriaxone - D ₂ .
	No vomiting / headache	- Inj. Dexa - D ₂ .
	Oral intake improved.	- ATT / Benadon.
	SPO ₂ : 98% R.A.	- Pantop / Ondem / Maxdom / PCM
	Chest: Sp. AE(+)	TID TID TID
	CVS: S ₁ S ₂ (+)	
	P/A: Soft, non tender.	
	CNS:- conscious,	
	active.	
	Awaited: ANA IF / RF /	
	TPP / anti TPO / anti TG	
	ABS / CANCA / PANCA /	
	CSF reports.	
		↓
		- Dr Chandrika Bhat
		consultations

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26 9:00am	C/S/B Dr. Shreeth Kotapalli C/O TB lymphadenitis + TBM. Afebrile No headache No vomiting SpO ₂ : 100% chest: AEBT CUE: GSS (+) P/A: Soft CNS: Active	Adv :- - Inj Ceftriaxone - D ₃ - [Inj Dexa - D ₂] → Stop - ATB / Benadon - Pantop / Ondem / (Maxdom) TID BD stop - Inj PCM (TID) { ½ maintenance iv fluids } stop → Dr. Leena Priyambada consultation → Paed Surgery consultation (to consider excision biopsy for cervical L.N). → Eye screen for choroid tubercles at 11:30 am. - Next week PDA panel, DHR → Start on Prednisolone
	Awaited - CANCA/ PANCA / CSF cts / TB cts.	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26 5:30pm	cf&B Dr. Shreethi Kotapalli No fever No vomiting / headache vitale stable SpO ₂ :- 98% R.A. chest - clear.	Adv :- - L.N. Biopsy under sedation tomorrow - PAC - NPO & iv fluids according to slot - Rest ct. same. Noted by Sreetha 21/7/26 @ 6pm
22/7/26 9:00am	cf&B Dr. Shreethi Kotapalli Δ: TB lymphadenitis + TB meningitis No fever / headache No vomiting vitale stable SpO ₂ : 98% R.A. chest: B/L AE (+) cvs: S/S (+) P/A: soft cns: Alert.	Adv: - Inj Ceftriaxone - Dy - ATN / Benadon - Prednisolone - Pantop - Ondem TID / PCM 800s - L.N. Biopsy at 2:00pm - PAC - Keep NPO - Continue iv fluids - DHR / PID - 2 on next prick



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 5pm	CLSB Pulmo team S/P L.N. excision biopsy No fever Vitals stable SpO₂: 100% Chest: clear.	Adv:- - Can be allowed full oral feeds when awake. - DHR / PID - 2 on next prick. - Rest continue same - Trace L.N. Biopsy reports, CSF C/S.
23/7/26 9:00am	CLSB Dr. Shanti Kobapalli Δ: TB lymphadenitis + TB meningitis No fever No headache/vomiting Vitals stable SpO₂: 98% R.A Chest - clear ENS - SpS₂ (+) P/A soft ENS: active.	Adv: - Inj Ceftriaxone - DS - ATT / Benadon. - Prednisolone - Pantop. - Next prick PID-2 / DHR. ✓ Discharge:- ① LFT, CBP after 2 weeks ② Trace L.N. Biopsy reports, CSF TB culture ③ ATT / Benadon / Prednisolone



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Baby SHRISTI ROY
28-06-2013 13 Y 0 M 24 D (F)
Dr. PILLARISETTI NAVEEN SARADHI



ti Roy



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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
23/7/26. 10:05 AM	C/S/B POD - (1)	Dr. Maliha
	No fever spikes Vitals stable	<u>Adv</u>
	L/E - dressing intact no soakage	1) Full feeds.
		Maliha 23/7/26 10:05 AM

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



Shristi Roy

CROSS CONSULTATION FORM

Doctor Name : LEENA PRIYAMBADA Date : 21/7/26 Time : 11Am

Diagnosis : TB lymphadenitis

Hospital :

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:

TB with TBM.
(L)

Signature: _____

Findings and Recommendations :

4/6/26 19/7/26 (off medications for >20 days) .
TSH 32.6 2.93] @
T₄ 10.4]
T₃ 80.8 (↑)
Thy AB . TPO ++ SIS (<26) .
T₈ -ve .

Imp: Autoimmune ~~thy~~ THYROIDITIS
, EUTHYROID .

Plan : . No need for thyroid medications .
✓ . Rpt after 2 weeks .
- TSH/T₄/T₃
- free T₄

Consultant :

Name : LEENA PRIYAMBADA Signature : Leena Date & Time : 21/7/26
11 Am

CROSS CONSULTATION FORM

Doctor Name : Dr. Mainak Date : 21/7/26 Time : 5pm

Diagnosis : T.B Lymphadenitis

Hospital :

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:

Signature:

Findings and Recommendations :

C/S/B Dr. Mainak

o/e - (R) upper jugulothoracic
LN palpable.

- (L) axillary LN palpable

Advice

- Plan for LN biopsy tomorrow
sedation

- PAE

- Financial clearance.

Consultant :

Name : Dr. Mainak Signature : [Signature] Date & Time : 21/7/26 5pm



CROSS CONSULTATION FORM

Doctor Name : Dr. Rao Balakrishna Date : 18/7/2026 Time : 9:45 Am

Diagnosis : TB lymphadenitis

Hospital :

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:

Ovarian hemagic cyst

Signature:

Findings and Recommendations :

18yr old Shristi Roy kelo TB lymphadenitis.

scan s/o: Left ovary - hemagic cyst - 25 x 21 mm

H/o hematuria

H/o vomiting

Therapy for referral.

No H/o pain in abdomen.

LMP - 20/6/2026.

Gc: fair

No pallor

B.P - 118/64

No abdominal pain.

P.R - 70

Temp 98°F

SpO₂ - 100% on RA

M/H: regular,

P/A: Soft, BS (+)

LMP: 20/6/2026, 4-7 days

normal flow, no pain, no clots

P/V: NAB

& 1). Repeat USG abdomen after next menstrual cycle.

or early if pain in abdomen.

Consultant :

Name : Dr. Rao Balakrishna Signature : [Signature] Date & Time : 18/7/2026



CROSS CONSULTATION FORM

Doctor Name : Dr. Sushma Reddy Date : 18/7/26 Time : 2 PM

Diagnosis : TR lymphoma

Hospital :

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:

Sus
Signature:

Findings and Recommendations :

Thank for refer

Ve Afe

ole

Also, we

follow up

normal findings

ph
in opd on flu

Consultant :

Name : Sushma Reddy Signature : Sus Date & Time : 18/7/26 2 PM



CROSS CONSULTATION FORM

Doctor Name : DR. Abhishek R. Jain Date : 18/7/26 Time : 10 AM

Diagnosis : T.B Lymphadenitis

Hospital :

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:

Signature:

Findings and Recommendations :

Thanks for Referral

18/7/26
10 pm
c/o headache
vomiting] : 1 month

History Noted

H/o photophobia (+) ; phonophobia (+)

c/o (L) hemicranial headache (+)

No H/o visual disturbances (+)

O/E:

Child conscious, E4V5M6
EOM-full

No ophthalmoplegia

No cranial nerve deficits

Vitals - stable

No Focal Neurological deficits

Adv

1) MRI - Brain C
contrast

2) Fundus examination

3) LP- CSF Analysis, + VEP
Gene Xpert, AFB,
C/S. Comprehensive TB pa

Consultant :

Name : Dr. Abhishek R. Jain Signature : Dr. Abhishek R. Jain Date & Time :



SHRISTI ROY

CROSS CONSULTATION FORM

Doctor Name : DR. Leena priyambada Date : 18/7/26 Time : 4pm

Diagnosis : T.B lymphadenitis

Hospital :

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:

Signature:

Findings and Recommendations :

History reviewed, examined.
Headache / vomiting / wt loss 7kg - ? TB.
- no goiter, Menarche 2 yrs back (now stable)
- Trace TFT / Thy A6 reports
 ↓ ANA

AC - 5.7

RR - 70, 106.

shall TN.

4/6/26

TS4 - 32.6.

dp.

Consultant :

Name : Leena Priyambada Signature : Lp Date & Time : 18/7/26
4pm

BAH-00661949 IP5-00176525
 Baby SHRISTI ROY
 28-06-2013 13 Y 0 M 19 D (F)
 Dr. PILLARISETTI NAVEEN SARADHI



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RESULT SHEET

Date	17/7/26				
Time					
Hb	10.7				
PCV	35.2				
RBC	4.51				
WBC	4.91				
N/L	196				
Platelets	166/27				
CRP	13				
ESR	60				
PCT					
RBS					
Na	137				
K	4.2				
Cl	102				
Ca/Mg					
Phosphate					
Urea	30				
Creatinine	0.4				
ALP					
SGPT					
SGOT					
T.Bill/Conj	0.3/0.2				
T.Protein	8.4				
S.Albumin	4.6				
S.Globulin	3.8				
A/G Ratio	1.2				
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar	46/45				
Cells	12				
N/L	0/100%				

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones	++++					
CUE - PUS Cells	3-4					
CUE - RBC Cells	1-2					
CUE						
Epithelial cells	20-25					
nuclei threads	+					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
- TSH	2.93 (N)		Anti Tg	-27 (<64)		
- T4	10.39 (N)		Anti TPO	-515 (<26)		
- T3	80.77 (N)					
Sputum Genexpert TB	- Neg.					
CSF biofire	- Neg.					
CSF Genexpert TB	- Not detected					

ANA - 1:160 (Immunoblot - Neg)
ACE - 42.2 (12-68) , RF - 566 (<12)

Culture and Sensitivities :

CANCA] (N)
PANCA]

C&Fcs - NG

Radiology :

USG :

USG chest → (N) , USG Abdo → small left ovarian
hemorrhagic cyst

X-Ray :

ECHO :

CT :

MRI

Brain (P+C) - tentorial pachymeningitis with
subcentimetric nodular focus - focal tuberculoma
pachymeningitis
tuberculoma

Others (ECG, Contrast Studies etc.,) :

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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	TAB - FORECOX 450mg [TAB. ETHAMBUTOL 800mg TAB ISONIAZID 300mg TAB PYRAZINAMIDE 750mg RIFAMPICIN 450mg]	1Tab	PO	OD (BBF)	16/7/26	☒ C ☐ DC
2						☐ C ☐ DC
3	TAB BENADON b	40 mg 1Tab	PO	OD	17/7/26	☒ C ☐ DC
4	TAB LIVOPEN	152mg 1.5mg 1Tab	PO	OD	17/7/26	☒ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Ramya R

Time: 17/7/26

Name & Signature: Anneel

: 17/7/26 4:15 PM



DISCIPLINARY PATIENT EDUCATION RECORD



Part - I.

Patient's / Learner Language: Tamil

Patient / Learner Literacy: ☐ Read ☐ Write ☒ Speak

Willingness to Learn: ☒ Yes ☐ No

Healthcare Literacy: ☐ Yes ☐ No

Identified Education Needs:

1. Diagnosis
2. Treatment and Care Plan
3. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights
13. Risk / Safety
14. Activity / Exercise
15. Social & Rehabilitation Needs
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		
17/7	4pm	10	Low Risk Education	mother	1	own	1	1	no	Aal
17/7/20	4:15pm	9	NORMAL diet	father	1	0	1	1	-	San

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
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify) _____

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:

1. None
2. Obtain translator
3. Reassurance & Support
4. Teach Family / Others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify _____

Understanding:

1. Verbalizes Understanding
2. Demonstrates Understanding
3. Needs Review



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 17/7/13 Time of arrival: 12:31 pm

Chief Complaints: Headache & 1 monthy vomiting & mny v abd RBS: 72 mg/dl

Height: 1.48m Weight: 33kg BMI: — Head Circumference (<2 years) —

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

If yes, identify no

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

☐ Character no ☐ Location no ☐ Frequency no ☐ Duration no

RISK FOR FALL:

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

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

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

Social History: Lives With family

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

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

Time of Initial assessment completed by ER Nurse: 12:40 pm

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

Time	Nursing Notes
	Dr. Seen the pt and said the pt's
	vitals are recorded
	→ IV placement done
	→ Sample collected and sent to lab
	→ X-Ray done
	→ X-Ray Report need to be collected from Radiology.
	→ Shifted to ward

Samples collected by:

Am. Reficul

Time:

Time:

3:15

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
	Paracetamol	PO			
17/11/20	Wj - Paracetamol	W	450mg	N.P.M. Shawal	
17/11/20	Wj - ONDANSERON	W	4mg	N.P.M. Shawal	
17/11/20	Wj - PANTOPRAZOLE	W	40mg	N.P.M. Shawal	

Condition of patient at time of shift - out :	Details of Shift - out
HR: 116b/min BP: 101/61 CFT: 6u	Shift - out from ER to: 334
RR: 24b/min SPO ₂ : 99%	Time of Shift - out: 4:15 PM
GCS: 15/15 Temperature: 98.1 F	Handover given to: Sybil
Pain Score: 0/10	(Nurse's Name)
Repeat RBS (if applicable): Not	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

IV placement

Name of the Nurse: Annab

Signature of the Nurse: [Signature]

Date & Time: 17/11/20 4:15 PM



REGULAR PRESCRIPTIONS

Weight. 33 kg Ward.

VERIFIED

VERIFIED

VERIFIED

VERIFIED

DRUG : INJ AUGMENTIN				Date Time	17/7/26	18/7/26	19/7/26			
Dose 1g	Route IV	Frequency 8hrly	Start Date 17/7/26	18/7/26 19/7/26 20/7/26 21/7/26 22/7/26 18/7/26 19/7/26 20/7/26 21/7/26 22/7/26						
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Ramya</i>				18/7/26 19/7/26 20/7/26 21/7/26 22/7/26						
Additional Instructions:				18/7/26 19/7/26 20/7/26 21/7/26 22/7/26						
Daily Doctor's Endorsement by a Sign										
DRUG : INJ ONDANSETRON				Date Time	17/7/26	18/7/26	19/7/26	20/7/26	21/7/26	22/7/26
Dose 4mg	Route IV	Frequency 8hrly	Start Date 17/7/26	18/7/26 19/7/26 20/7/26 21/7/26 22/7/26						
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Ramya</i>				18/7/26 19/7/26 20/7/26 21/7/26 22/7/26						
Additional Instructions:				18/7/26 19/7/26 20/7/26 21/7/26 22/7/26						
Daily Doctor's Endorsement by a Sign										
DRUG : INJ PANTOPRAZOLE				Date Time	18/7/26	19/7/26	20/7/26	21/7/26	22/7/26	23/7/26
Dose 40mg	Route IV	Frequency 2hrly	Start Date 17/7/26	18/7/26 19/7/26 20/7/26 21/7/26 22/7/26 23/7/26						
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Ramya</i>				18/7/26 19/7/26 20/7/26 21/7/26 22/7/26 23/7/26						
Additional Instructions:				18/7/26 19/7/26 20/7/26 21/7/26 22/7/26 23/7/26						
Daily Doctor's Endorsement by a Sign										
DRUG : 7. AKURIT-4				Date Time	17/7/26	18/7/26	19/7/26	20/7/26	21/7/26	22/7/26
Dose 3tablets	Route Oral	Frequency OD	Start Date 17/7/26	18/7/26 19/7/26 20/7/26 21/7/26 22/7/26						
Name & Signature of the Doctor Starting the Drugs: <i>[Signature]</i>				18/7/26 19/7/26 20/7/26 21/7/26 22/7/26						
Additional Instructions: <i>Empty stomach in morning</i>				18/7/26 19/7/26 20/7/26 21/7/26 22/7/26						
Daily Doctor's Endorsement by a Sign										

BAH-00661949 IP5-00176525
 Baby SHRISTI ROY
 28-06-2013 13 Y 0 M 20 D (F)
 Dr. PILLARISETTI NAVEEN SARADHI

Weight. 33kg Ward. 3

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
18/7/26	9:00am	3% NC NEB.	1 respule stat	NEB	[Signature]	NUT given
18/7/26	8:15	INJ ONDEM	6mg	IV	[Signature]	[Signature]
22/7/26	2:10pm	INJ CEFZOLIN	1.6g	IV	Malik	Aku
24/7/26	4:30	INJ PARACETAMOL	450mg	IV	[Signature]	Aku



I.V. FLUIDS CHART

Weight: 3.3 kg Ward:

Signature
VERIFIED BY : Name

Date	Time	Composition of I.V. Fluid (If infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
16/7/26		IVF DNS	IV	40 ml/hr	Do Lane		16/7		
17/7/26	6:30 AM	IVF DNS	IV	60 ml/hr	Sh	18/7	18/7		
18/7/26	9:00 am	IV FLUID - DNS	iv	75 ml/hr	Dr	18/7	18/7		
20/7/26	9:00 am	iv FLUID - DNS full maintenance	iv	60 ml/hr	Dr	20/7	20/7		
20/7/26	5 pm	DNS (2/3 maintenance)	iv	40	Dr	20/7	20/7		
20/7/26	6 pm	DNS (1/2 maint)	iv	30	Dr	21/7	21/7		
20/7/26	6 pm	→ (according DNS to NPO) (1/2 maintenance)	iv	30	Dr	22/7	22/7		

Ward 510

VERIFIED BY: Name

Sheet No:

REGULAR PRESCRIPTIONS

Weight 2350g

Ward 300

DRUG : INJ CEFTRIAXONE				Date Time
Dose	Route	Frequency	Start Dt.	
1.6gm	IV	BD	19/7	19/7 20/7 21/7 22/7 23/7
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : T. NABDOM (250mg + 10mg)				Date Time
Dose	Route	Frequency	Start Dt.	
1 tab	Oral	BD	20/7	20/7 21/7
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : INJ DEXAMETHASONE				Date Time
Dose	Route	Frequency	Start Dt.	
6.5mg	IV	TID	20/7	20/7 21/7
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : T. PREDNISOLONE (20)				Date Time
Dose	Route	Frequency	Start Dt.	
1 tablet	Oral	TID	21/7	21/7 22/7 23/7
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

VERIFIED

VERIFIED Signature

VERIFIED BY : Name



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 4:30 PM Mode of Arrival: Bed Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction NKDA Body Weight: Kg

Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission

Family History:

Is 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: Length: Head Circumference (< 2 years):

Temp.: 98.2°F HR: 28 RR: 19 BP: 110/68

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

Fall Risk Assessment: ☒ Yes ☐ No Score: 0 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 0) (Document in the Braden Q Assessment Sheet)

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

Character of Pain NA Location NA Frequency NA Duration NA

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-00661949 IP5-00176525
 Baby SHRISTI ROY
 28-06-2013 13 Y 0 M 19 D (F)
 Dr. PILLARISSETTI NAVEEN SARADHI



RCHBH/ FRM / CLINICAL / 127

TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

Rainbow®
 Children's
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time: 10 PM	2 AM	6 AM	8 AM		
Doctor / Nurse / Family Concern?						
Temperature (°F)	104					
	103					
	102					
	101					
	100					
	99					
	98	97.8	97.0	96.3		
	97					
	96					
	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					
	117	116	111	118		
	(76)	(22)	(68)	(27)		
	64	60	56	60		
	Heart Rate (Number)	95b/m	106b/m	78b/m	70b/m	
	Resp. Rate (bpm) (Over 1 Minute)	70				
60						
50						
40						
30						
20						
10						
Resp Rate (Number)		24b/m	22b/m	24b/m	28b/m	
Resp Distress		Mod/ Severe				
		None / Mild	N	N	N	N
Receiving O ₂ (l/min)						
	O ₂ Saturations (%)	99%	100%	98%	98%	
Conscious Level	Normal	N	N	N	N	
	Altered					
GCS *		15/15	15/15	15/15	15/15	
TOTAL SCORE						
Number of shaded boxes	0	1	1	1		
Pain Score	8	9	9	9		
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.

BAH-00661949 IP5-00176525
 Baby SHRISTI ROY
 28-06-2013 13 Y O M 19 D (F)
 Dr. PILLARISETTI NAVEEN SARADHI

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	10 Am	2 PM	7 PM	10 PM	2 AM	6 AM	
Doctor / Nurse / Family Concern?								
Temperature (°F)	104							
	103							
	102							
	101							
	100							
	99							
	98							
	97							
	96							
	95							
94								
Heart Rate (m) 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							
	40							
	30							
	20							
	10							
	0							
Heart Rate (Number)		70b/m	69b/m	96	80b/m	74b/m	86b/m	
Resp. Rate (bpm) (Over 1 Minute)	70							
	60							
	50							
	40							
	30							
	20							
	10							
	0							
	Resp Rate (Number)		28b/m	30	35	24b/m	24b/m	22b/m
	Mod/ Severe Distress None / Mild							
Receiving O ₂ (l/min) O ₂ Saturations (%)								
Conscious Level Normal Altered								
GCS *								
TOTAL SCORE								
Number of shaded boxes								
Pain Score								
Observer's Initials								

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

BAH-00661949 IP5-00176525

Baby SHRISTI ROY

28-06-2013 13 Y 0 M 20 D (F)

Dr. PILLARISETTI NAVEEN SARADHI



Doc. No. : RCHBH/ FRM / CLINICAL / 127

TEENAGE (12 + years)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	10	2	6	10	2	6
Doctor / Nurse / Family Concern?		Am	pm	pm	pm	am	am
Temperature (°F)	104						
	103						
	102						
	101						
	100						
	99						
	98	97.9°F	98.0°F	97.8°F	96.0°F	97.2°F	97.6°F
	97	*	*	*	*	*	*
	96						
	94						
Heart Rate (bpm)	190						
	180						
and	170						
	160						
Blood Pressure (mmHg) *	150						
	140						
Note: BP does not score in early warning scoring	130						
	120						
	110	108	100	110	122	104	111
	100	(80)	(80)	(80)	(72)	(72)	(72)
	90						
	80						
	70						
	60						
	50						
	Heart Rate (Number)		102b/m	72b/m	71b/m	83b/m	90b/m
Resp. Rate (bpm) (Over 1 Minute)	70						
	60						
Resp Rate (Number)	50						
	40						
	30						
	20						
	10						
	22b/m	22b/m	22b/m	22b/m	24b/m	22b/m	
	Respiratory Distress						
	Mod/ Severe						
	None / Mild						
	Receiving O ₂ (l/min)						
O ₂ Saturations (%)	99%	100%	99%	100%	98%	98%	
Conscious Level							
Normal							
Altered							
GCS *	1/5	1/5	1/5	15/15	15/15	15/15	
TOTAL SCORE							
Number of shaded boxes	1	1	1	1	1	1	
Pain Score	2	2	2	2	2	2	
Observer's Initials	S	S	S	S	S	S	

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

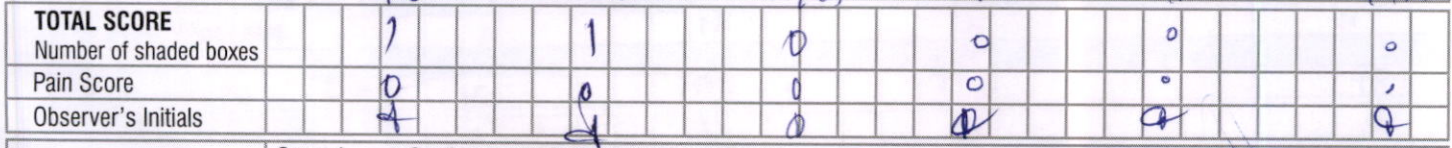
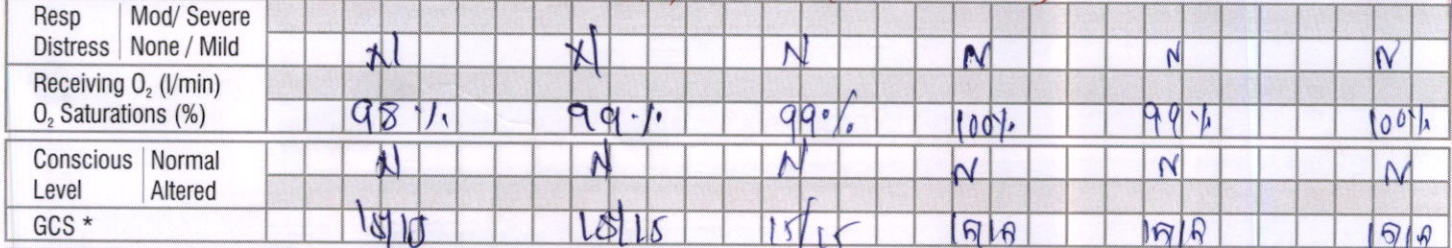
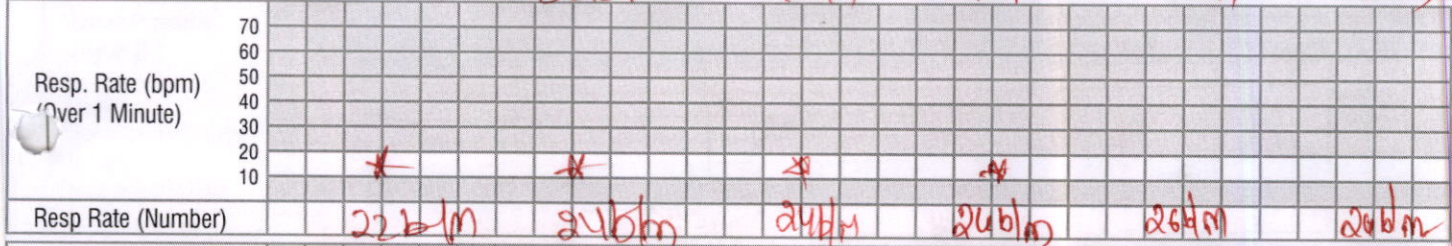
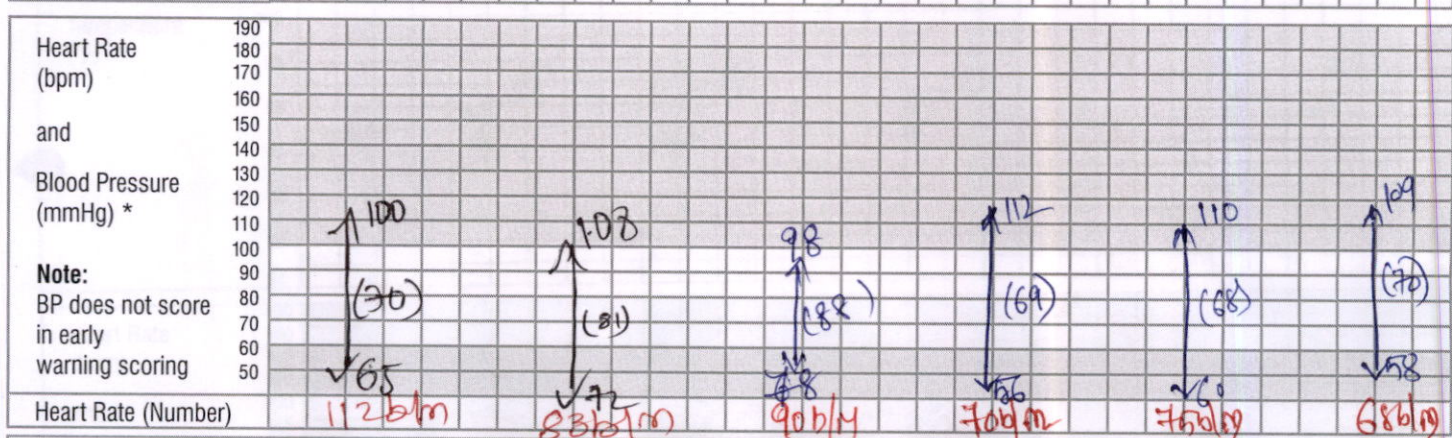
Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

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.

Date : 20/11/26	Time: 10 AM	2 PM	6 PM	10	2	6
Doctor / Nurse / Family Concern?				PM	AM	AM



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.

NB: Scores 3 should be recorded overleaf

- 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.

Patient Sticker



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)

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	10	2	6	7	10	2	6
Doctor / Nurse / Family Concern?		AM	PM	PM	PM	PM	AM	AM
Temperature (°F)		98.0	98.0	98.0	98.0	98.0	98.0	98.0
Heart Rate (bpm)		88bpm	89	88bpm	88bpm	92bpm	100bpm	106bpm
Blood Pressure (mmHg) *		101/71	114/78	101/60	108/61	100/63	114/65	
Resp. Rate (bpm)		28bpm	30bpm	28bpm	21bpm	19bpm	20bpm	
Receiving O ₂ (l/min)		99%	100%	99%	98%	99%	100%	
O ₂ Saturations (%)		99%	100%	99%	98%	99%	100%	
Conscious Level		Aw	Aw	Aw	Aw	Aw	Aw	
GCS *		15/15	15/15	15/15	15/15	15/15	15/15	
TOTAL SCORE		1	1	0	0	0	0	
Number of shaded boxes		1	1	0	0	0	0	
Pain Score		0	0	0	0	0	0	
Observer's Initials		S	S	S	S	S	S	
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.



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am			60ml							0	Shil
	09:00 am	D water		60ml					✓		0	Shil
	10:00 am	N water		60ml			NP				0	Shil
	11:00 am	S water		75ml							0	Shil
	12:00 pm			75ml							0	Shil
	01:00 pm										0	
Total Intake :			Taken			Total Output :					M-0	
	02:00 pm			75ml							0	Shil
	03:00 pm	NP		75ml					✓		0	Shil
	04:00 pm	P		75ml			NP				0	Shil
	05:00 pm	O							✓		0	Shil
	06:00 pm								✓		0	Shil
	07:00 pm										0	
Total Intake :			Taken			Total Output :					M-2 U-2	
	08:00 pm	water		75ml					✓		0	Shil
	09:00 pm	D		75ml							0	Shil
	10:00 pm	N		75ml			NP				0	Shil
	11:00 pm	S		75ml					✓		0	Shil
	12:00 am			75ml							0	Shil
	01:00 am			75ml							0	Shil
Total Intake :			Taken			Total Output :					M-0 U-0	
	02:00 am			75ml							0	Shil
	03:00 am	D		75ml							0	Shil
	04:00 am	N		75ml			NP				0	Shil
	05:00 am	S		75ml					✓		0	Shil
	06:00 am			75ml							0	Shil
	07:00 am			75ml							0	Shil
Total Intake :			Taken			Total Output :					M-0 U-1	
Total 24 hrs. Intake			Taken			Total 24 hrs. Output					M-0 U-5V-2	

FLUID CHART

Sheet No. :

19/6/26

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.

		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								
19/6/26	08:00 am			75ml						✓	0	Shily	
	09:00 am	D water		75ml			✓				0	Shily	
	10:00 am			75ml							0	Shily	
	11:00 am	N water		75ml						✓	0	Shily	
	12:00 pm	S water		75ml						✓	0	Shily	
	01:00 pm			-							0	Shily	
Total Intake : Taken					Total Output : U-2 M-1								
19/6/26	02:00 pm			-							0	Shily	
	03:00 pm	D water		-			✓				0	Shily	
	04:00 pm			75ml						✓	0	Shily	
	05:00 pm	N water		75ml			NP				0	Shily	
	06:00 pm	S water		75ml							0	Shily	
	07:00 pm			75ml							0	Shily	
Total Intake : Taken					Total Output : U-1 M-0								
	08:00 pm			75ml							0	Shily	
	09:00 pm	D water		75ml			✓				0	Shily	
	10:00 pm			75ml							0	Shily	
	11:00 pm	N		75ml			NP			✓	0	Shily	
	12:00 am	S		75ml							0	Shily	
	01:00 am			75ml							0	Shily	
Total Intake : Taken					Total Output : M-0 U-1								
	02:00 am			75ml							0	Shily	
	03:00 am	D water		75ml			✓				0	Shily	
	04:00 am			75ml							0	Shily	
	05:00 am	N		75ml			NP				0	Shily	
	06:00 am	S		75ml						✓	0	Shily	
	07:00 am			75ml							0	Shily	
Total Intake : Taken					Total Output : M-0 U-1								
Total 24 hrs. Intake		Taken											
Total 24 hrs. Output		M-1 U-5											



FLUID CHART

Sheet No. :

20/7/26

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.

		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								
20/7/26	08:00 am	D		75ml						✓	0	Admission	
	09:00 am		Water	75ml			✓				0		
	10:00 am	N		75ml							0		
	11:00 am		Water	75ml						✓	0		
	12:00 pm	S		75ml			✓				0		
	01:00 pm			75ml						✓	0		
Total Intake : Taken						Total Output : U-3 M-2							
20/7	02:00 pm									✓	0	Lamp	
	03:00 pm		Water				✓				0		
	04:00 pm						NP			✓	0		
	05:00 pm		Water								0		
	06:00 pm	DNS		30ml							0		
	07:00 pm	DNS		30ml						✓	0		
Total Intake : Taken						Total Output : M-0 U-3							
20/7	08:00 pm						✓				0	Pig	
	09:00 pm	D	Water	30ml						✓	0		
	10:00 pm			30ml			NP				0		
	11:00 pm	N		30ml							0		
	12:00 am	S	Water	30ml							0		
	01:00 am			30ml							0		
Total Intake :						Total Output : U=1 M=0							
21/7	02:00 am			30ml			✓				0	Pig	
	03:00 am	D	Water	30ml							0		
	04:00 am	N		30ml							0		
	05:00 am	S		30ml							0		
	06:00 am		Water	30ml							0		
	07:00 am			30ml			✓			✓	0		
Total Intake :						Total Output : U=1 M=1							

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

Total 24 hrs. Output	U=8 M=3
----------------------	---------

FLUID CHART

Sheet No. :

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

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
21/7	08:00 am			30ml							0	Soul
	09:00 am	D	water	30ml			✓			✓	0	
	10:00 am			30ml							0	
	11:00 am	N		30ml							0	
	12:00 pm	S	water	-						✓	0	
	01:00 pm			-							0	
Total Intake :						Total Output : M - 1 U - 2						
21/7	02:00 pm			30ml							0	Soul
	03:00 pm	D	water	30ml						✓	0	
	04:00 pm			30ml			✓				0	
	05:00 pm	N	water	30ml						✓	0	
	06:00 pm	S		30ml						✓	0	
	07:00 pm			30ml						✓	0	
Total Intake : Taken						Total Output : M - 1 U - 4						
21/7	08:00 pm										0	Pugs
	09:00 pm		water								0	
	10:00 pm										0	
	11:00 pm										0	
	12:00 am		water							✓	0	
	01:00 am										0	
Total Intake : Taken						Total Output : U = 1 M = 0						
22/7	02:00 am									✓		Pugs
	03:00 am		water									
	04:00 am											
	05:00 am											
	06:00 am		water									
	07:00 am									✓		
Total Intake : Taken						Total Output : U = 2 M = 0						
Total 24 hrs. Intake		Taken										
Total 24 hrs. Output		U = 9 M = 2										

FLUID CHART

Sheet No. :

22/7

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

		Intake				Output					IV Site	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	N.G							
	08:00 am										0	Shi
	09:00 am	D	30ml								0	Shi
	10:00 am	N	30ml							✓	0	Shi
	11:00 am	N	30ml				✓				0	Shi
	12:00 pm	N	30ml								0	Shi
	01:00 pm										0	Shi
Total Intake : <u>100ml</u>						Total Output : <u>U-1 M-1</u>						
	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										02	
	09:00 pm	H2O									03	
	10:00 pm										0	math
	11:00 pm	H2O									0	
	12:00 am										0	math
	01:00 am										0	
Total Intake :						Total Output : <u>M-0 U-1</u>						
	02:00 am											
	03:00 am	H2O										math
	04:00 am											
	05:00 am	H2O										math
	06:00 am											
	07:00 am											
Total Intake :						Total Output : <u>M-0 U-1</u>						
Total 24 hrs. Intake		<u>100ml</u>										
Total 24 hrs. Output		<u>M-1 U-3</u>										

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 17/7/26

Assessment: Baby is with TB & Severe 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 general Condition of baby.	8:10pm	Assessed the general Condition of baby.	Baby is stable and well doing.
10pm	plan to reduce Cough.	10:10pm	plan to reduced Cough.	
12am	maintain personal hygiene.	12:10am	maintained personal hygiene.	
2am	plan to send Genexpect.	2:10am	planned send Genexpect	
4am	plan to trace CUE.	4:10am	Traced CUE.	
6am	Relieve head ache	6:10am	Relieved head ache	
8am	Ensure Safety.	8:10am	Ensured safety	

Re-Assessment: Reduce Severe Cough

Special Notes: Relieve head ache

Nurse Signature: Suettha Nurse Name: Suettha Date & Time: 18/7/26 @ 8am.

BAH-00661949 IP5-00176525
 Baby SHRISTI ROY
 28-06-2013 13 Y 0 M 20 D (F)
 Dr. PILLARISETTI NAVEEN SARADHI



NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 18/7/20

Assessment: pt having vomitings

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 pt general condition & vitals	8 AM	→ Assessed the pt general condition & vitals	
10 AM	→ Maintain fluid balance	10 AM	→ Maintained fluid balance	Good safety
12 PM	→ Relieve pain & Discomfort	12 PM	→ Relieved pain & Discomfort	
	→ plan to do VEP		→ VEP done	
	→ plan to do fundus examination		→ plan to do fundus examination	
1 PM		1 PM		

Re-Assessment:

Special Notes: MRI today at 6 PM, VEP, fundus examination

Nurse Signature: Shilpa Nurse Name: Shilpa Date & Time: 18/7/20 @ 8 PM

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 18/7/26

Assessment: Patient having vomiting

- 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 general condition monitor vitals	2pm	Assessed general condition monitored vitals	Baby is stable
4pm	Administer medication	4pm	Administered medication	
5pm	LP to be done Ensure safety	5pm	LP done Ensured safety	
6pm	MRI to be done	6pm	MRI done	
7pm	maintain flow chart	7pm	maintained flow chart	

Re-Assessment: done

Special Notes: int

Nurse Signature: [Signature] Nurse Name: [Signature] Date & Time: 18/7/26 @ 8pm

BAH-00661949
Baby SHRISTI ROY
28-06-2013 13 Y 0 M 20 D (F)
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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 18/7/26

Assessment: Baby is with Cephalgia.

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 baby.	8:10pm	Assessed the general condition of baby.	Baby is stable and well doing.
10pm	monitor GRBS & BP 6th baby	10:10pm	GRBS & BP 6th baby recorded	
12am	and records. Plan to add new medicine.	12:10am	Medicine added to drug chart	
2Am	plan to send samples and	2:10am	samples to trace ad	
4am	need to trace.	4:10am	search	
6am	Baby is with Emeris.	6:10am	Baby Emeris is ongoing.	
8am	ensure safety.	8:10am	Ensure Safety	

Re-Assessment: Baby Cephalgia is relieved.

Special Notes: Trace all samples / w/f Vomitting.

Nurse Signature: [Signature]

Nurse Name: Suethe

Date & Time: 19/7/26 @ 8am



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 19/7/26

Assessment:

Observation

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 general condition	8Am	→ Assessed the pt general condition	
10Am	→ Maintain fluid balance	11Am	→ Maintained fluid balance	
12pm	→ Relieve pain & Discomfort	12pm	→ Relieved pain & Discomfort	
3pm	→ vitals and GRBS Monitor 6th hrly	2pm 3pm	→ vitals & GRBS Monitored 6th hrly	
5pm	→ Administer sedation as per chart	5pm	→ Administered medication as per chart	
7pm		7pm		

Re-Assessment:

NA

Special Notes:

NA

Nurse Signature: Shilpa

Nurse Name: Shilpa

Date & Time: 19/7/26 @ 8pm

BAH-00661949
Baby SHRISTI ROY
28-06-2013 13 Y 0 M 21 D (F)
Dr. PILLARISETTI NAVEEN SARADHI

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 19/7/26

Assessment: Baby is for observation

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 baby.	8:10pm	Assessed the general Condition of baby.	Baby is stable and well doing. no headache.
10pm	plan to trace all Samples.	10:10pm	Traced all Samples which are got.	
12am	Relieve pain & discomfort.	12:10am	Relieved pain & discomfort.	
2am	maintain fluid balance of pt.	2:10am	Relieved pain & discomfort.	
4am	Maintain Personal Hygiene.	4:10am	maintained fluid balance of pt.	
6am	Improve activity tolerance.	6:10am	Improved activity tolerance.	
8am	Ensure safety of baby.	8:10am	Ensured safety of baby.	

Re-Assessment:

Baby doing good
Special Notes: Trace all Samples.

Nurse Signature: Sneetha

Nurse Name: Sneetha

Date & Time: 20/7/26 @ 8am

BAH-00661949 IP5-00176525
 Baby SHRISTI ROY
 28-08-2013 13 Y 0 M 21 D (F)
 Dr. PILLARISETTI NAVEEN SARADHI

NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 20/7/26

Assessment: Baby under observation

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	Assess the general condition of Baby	8:15 AM	Assessed the general condition.	Baby is stable
10 AM	Maintain fluid balance	10:10 AM	Maintain fluid balance	
12 AM	Monitor vital signs & Record	12:10 AM	Monitor vital signs & Record	
1 PM	Ensure safety	1:05 PM	Ensure safety	
2 PM	Administer medication as per drug chart	2:10 PM	Administer medications as per drug chart	

Re-Assessment: Reassessment done

Special Notes: N/A

Nurse Signature: Ashwini Nurse Name: Ashwini Date & Time: 20/7/26 @ Ashwini 2 PM

BAH-00661949
Baby SHRISTI ROY
26-06-2013 13 Y 0 M 22 D (F)
Dr. PILLARISETTI NAVEEN SARADHI

NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 20/7

Assessment: Baby is under observation

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 baby condition	2:10 PM	* Assessed the baby condition.	
4 PM	* vitals checked & documented * I/O chart maintained	4:15 PM	* vitals checked & documented * I/O chart maintained	
6 PM	* Administer the medications as per chart	6:10 PM	* Administered the medications.	
8 PM	* Ensure safety.	8 PM	* Ensured safety	Baby is stable now.

Re-Assessment: Baby is comfortable now.

Special Notes: NNT prick PID 2 panel, DHR, Dr. Kenu Priyambada review thm

Nurse Signature: [Signature] Nurse Name: [Signature] Date & Time: 20/7 @ 8 PM

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/07/2013 6 PM

Assessment: Baby having neck pain and 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
8 PM	→ Assess the general condition of the patient and checked vitals.	8:00 PM	→ assessed the general condition of the baby and checked vitals.	Baby is stable
10 PM	→ Giving medication as advised.	10:00 PM	→ Given medication as advised.	
12 AM	→ Continue IV fluid 30ml/hr.	12:00 AM	→ Continued IV fluid 30ml/hr.	
4 AM	→ Maintaining good nutritional status.	4:00 AM	→ maintained good nutritional status.	
6 AM	→ maintaining personal hygiene.	6:00 AM	→ maintained personal hygiene.	
8 AM	→ Ensure safety.	8:00 AM	→ ensured safety.	

Re-Assessment:

Special Notes:

Read surgery consultation 6 AM

Nurse Signature:

Pijs

Nurse Name:

Pijs

Date & Time:

21/07/2013 6 AM

BAH-00661949
Baby SHRISTI ROY
28-08-2013
Dr. PILLARISSETTI NAVEEN SARADHI
13 Y 0 M 22 D (F)
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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 21/2

Assessment: Baby is under observation

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	* Assess the general condition of Baby.	8:10AM	* Assessed the baby condition.	Baby is stable now.
10AM	* Monitor vital signs	10:15AM	* vitals checked & documented	
12 PM	* Maintain I/O chart	12:10PM	* Dr. Geena Priyambada Consultation done.	
	* Administer the medications.		* Optometry consultation done.	
2PM	* Ensure safety.	2PM	* Administered the medication as per chart	

Re-Assessment: Baby is stable now.

Special Notes: take all reports.

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 21/2 @ 2PM

BAH-00661949
Baby SHRISTI ROY
28-06-2013 13 Y 0 M 22 D (F)
Dr. PILLARISETTI NAVEEN SARADHI

NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 21/7/26

Assessment:

Baby Is with TB under observation.

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
9pm	Assess the general Condition of baby.	2:10pm	Assessed the general Condition of baby.	Baby Is stable and well doing. Headache relieved.
4pm	Relieve pain & discomfort. plan to do sample in next prick.	4:10pm	Relieved pain & discomfort. Samples to do next prick as advice.	
6pm	plan to do biopsy and Consultation of Surgeon.	6:10pm	To do biopsy and Consultation of Surgeon.	
8pm	plan to start medicine. Ensure Safety.	8:10pm	Ensured Safety.	

Re-Assessment:

Evaluation going on:

Special Notes:

Next prick to do PD-2 panel & DTR.
Tm 2pm slot booked for LN procedure

Nurse Signature:

Suretha

Nurse Name:

Suretha

Date & Time:

21/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/12/2013

Assessment: Baby having neck pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8PM	→ Assess the general condition of the patient and check vital.	8:10AM	→ assessed the general condition of the patient and checked vital.	patient is stable
10PM	→ Giving medication as advised.	10:40PM	→ Given medication as advised.	
12AM	→ Maintaining good nutritional status.	12:00AM	→ Maintained good nutritional status.	
4AM	→ Maintaining personal hygiene.	4:40AM	→ Maintained personal hygiene.	
6AM	→ ensuring urine output.	6:40AM	→ ensured urine output.	
8AM	→ Ensure safety.	8:40AM	→ Ensured safety.	

Re-Assessment: Patient under observation

Special Notes: Lymph nodes biopsy tm 2/12

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 20/12/2013

BAH-00661949 IP5-00176525
 Baby SHRUTI ROY
 28-06-2013 13 Y 0 M 23 D (F)
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NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 21/7/26

Assessment: Baby is in NPO

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 pt general condition	8AM	→ Assessed the pt general condition	Ensur safety
10AM	→ Maintain fluid balance	10AM	→ Maintained fluid balance	
12pm	→ plan to do choiced. L.N Biopsy under sedation	12 ¹⁰ pm	→ Choiced L.N Biopsy at 2pm	
4pm	→ PAC should be done	4:10pm	→ PAC should be done	
6pm	→ plan to keep in NPO	6:10pm	→ Baby is NPO	
8pm		8pm	→ Administer medication as per chart	

Re-Assessment:

Special Notes: Lymphnode biopsy @ 2pm

Nurse Signature: *Atul*

Nurse Name: *Shilpa*

Date & Time: 21/7/26 @ 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 22/7/26

Assessment: Wf pain & Discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
10PM →	Assess the general condition	10PM →	Activity good	Continue Same
12AM →	Wf due activity	12AM →	baby was comfortable sleeping	
2AM →	Plan for Medication	2AM →	oral medication - continue	
4AM →	Administer medication	4AM →	ing. ceftriaxone continue as per order	
6AM →	Plan for safety	6AM →	side effects	

Re-Assessment: NPO break med oral started

Special Notes: Reports home to have

Nurse Signature: M

Nurse Name: Martha

Date & Time: 23/7/26 @ 8am



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Naveen Department: Pulmo Date of Admission: 17/7/12

SITUATION	Diagnosis: <u>TB lymphadenopathy</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
BACKGROUND	Area	<u>TP</u>	<u>3rd floor</u>	<u>3rd floor</u>	<u>3rd floor</u>	<u>3rd floor</u>	
	Shift Time	<u>4:10</u>	<u>2pm-4pm</u>	<u>2pm-4pm</u>	<u>2pm-4pm</u>	<u>2pm-4pm</u>	
	Medical Condition (Any special condition to be noted):	<u>no</u>	<u>no</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>98.1°</u>	<u>98.1°</u>	<u>98.2°</u>	<u>98.0</u>	<u>98.1°</u>
		Res:	<u>22b/m</u>	<u>22b/m</u>	<u>20b/m</u>	<u>28</u>	<u>20b/m</u>
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>99</u>	<u>100%</u>
		Pulse:	<u>101b/m</u>	<u>102b/m</u>	<u>102b/m</u>	<u>110</u>	<u>110b/m</u>
		BP:	<u>101/66</u>	<u>116/67</u>	<u>117/70</u>	<u>118/64</u>	<u>116/68</u>
		Fall Risk Score:	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>
	Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	
	Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Others Specify:		<u>no</u>	<u>no</u>	<u>NO</u>	<u>NA</u>	<u>NA</u>	
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:		<u>no</u>	<u>no</u>	<u>Trace all report</u>	<u>yes</u>	<u>GRBS & BP 6-4 daily</u>	
Post Operative Procedure Special Orders:		<u>no</u>	<u>no</u>	<u>no</u>	<u>no</u>	<u>NA</u>	
Handed Over By Name :		<u>Anneeb</u>	<u>Syony</u>	<u>Sueetha</u>	<u>Syony</u>	<u>Sueetha</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>17/7</u>	<u>17/7/26</u>	<u>18/7/26</u>	<u>18/7</u>	<u>19/7</u>	
Time:		<u>4:10</u>	<u>@ 8pm</u>	<u>@ 8pm</u>	<u>@ 8pm</u>	<u>@ 8pm</u>	
Taken Over By Name :		<u>Syony</u>	<u>Sueetha</u>	<u>Syony</u>	<u>Sueetha</u>	<u>Syony</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>17/7</u>	<u>17/7/26</u>	<u>18/7</u>	<u>18/7</u>	<u>19/7</u>	
Time:		<u>@ 8pm</u>	<u>@ 8pm</u>	<u>@ 8pm</u>	<u>@ 8pm</u>	<u>@ 8 AM</u>	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR Naveen Department: 3rd floor Date of Admission: 17/7/26

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known		If Yes Specify:		
BACKGROUND	Area							
	Shift Time	3rd floor 8PM-11PM	3rd floor 8PM-8AM	3rd floor 8AM-2PM	3rd floor 2PM-8PM	3rd floor 8PM-11PM	3rd floor 8AM-2PM	
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:	98.0F	96.0F	98.0F	98.1F	98.0F	97.5F
		Res:	22	20b/m	20b/m	22b/m	24b/m	26b/m
		SpO ₂ :	99%	100%	99%	99%	100%	100%
		Pulse:	78b/m	83b/m	89b/m	80b/m	65b/m	79b/m
		BP:	108/64	120/66	100/65	98/78	114/56	112/70
		Fall Risk Score:	10	10	10	10	10	10
Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10		
Recommendations	Safety Needs:	Yes	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	Trace all samples	NA	Trace all samples	Trace samples	Trace all reports	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Silpa	Suetha	Ashwini	Ramya	Priya	Ramya	
Signature :		Silpa	Suetha	Ashwini	Ramya	Priya	Ramya	
Date:		19/7/26	20/7/26	20/7/26	20/7	21/7	21/7	
Time:		@8pm	@8am	@2pm	@8pm	8AM	@2pm	
Taken Over By Name :		Suetha	Ashwini	Ramya	Priya	Ramya	Suetha	
Signature :		Suetha	Ashwini	Ramya	Priya	Ramya	Suetha	
Date:		19/7/26	20/7/26	20/7	21/7/26	21/7	21/7	
Time:		@8pm	@2pm	@2pm	8am	@8AM	@2pm	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Naveen Department: 3rd floor Date of Admission: 17/7/22

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:			
BACKGROUND	Area	Shift Time	3rd floor 8pm-8pm	3rd floor 8pm-8pm	3rd floor 8pm-8pm	3rd floor 8pm-8pm	
	Medical Condition (Any special condition to be noted):		NA	NA	NA	NA	
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:	97.8F	97.9F	98.0	97.9F	
	Res:	24b/m	26b/m	30	30		
	SpO ₂ :	99.1	99.1	99	98.5		
	Pulse:	70b/m	66b/m	87	82		
	BP:	114/74	102/53	101/71	100/61		
	Fall Risk Score:	10	10	10	10		
Pain Score:	0/10	0/10	0/10	0/10			
Recommendations	Safety Needs:		SPR	Side rails	SPR	Yes	
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No
	Others Specify:		NA	NA	NA	NA	
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No
	Other Special Orders / Medications:		PID-2 Pain relief	LV biopsy 2pm	LV biopsy 2pm	Reports Pending	
Post Operative Procedure Special Orders:			NA	NA	NA	NA	
Handed Over By Name :			Sandeep	Raj	Shilpa	Manthi	
Signature :			Sandeep	Raj	Shilpa	Manthi	
Date:			21/7/22	22/7	22/7	23/7	
Time:			@ 8pm	8pm	@ 8pm	@ 8am	
Taken Over By Name :			Raj	Shilpa	Manthi	S	
Signature :			Raj	Shilpa	Manthi	S	
Date:			21/7	22/7	22/7	23/7	
Time:			8pm	@ 8pm	@ 8pm	8	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

BAH-00661949 IP5-00176525
 Baby SHRISTI ROY
 28-06-2013 13 Y 0 M 19 D (F)
 Dr. PILLARISSETTI NAVEEN SARADHI

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
17/7	4pm	0/10	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NO NO	Annex
17/7/26	10pm	0/10	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	sk
18/7	2am	0/10	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	sk
18/7	6am	0/10	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	sk
18/7	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	sk
18/7	4pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	sk
18/7	7:45pm	1/10	head	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	inj. pcam given	sk
18/7	10pm	0/10	Headache	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	inj. Pan	sk
18/7	30 12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	sk
18/7	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	sk

Re-assessment Frequency:

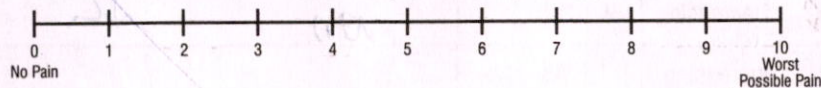
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

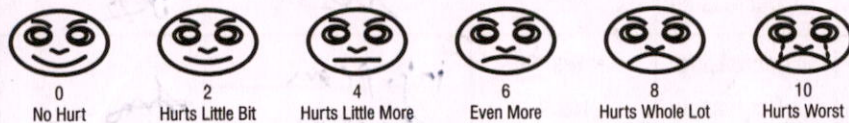
Numerical Pain Scale (Obstetric and Gynecology)



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
19/7/26	10am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Silly
19/7/26	4pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shies
19/7/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sweetly
20/7/26	2am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sweetly
20/7/26	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sweetly
20/7/26	8am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Asleep
20/7/26	10am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Asleep
20/7/26	2pm	1/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	2ml Paracetamol given	Awake
20/7/26	3pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Awake
20/7/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Asleep

Re-assessment Frequency:

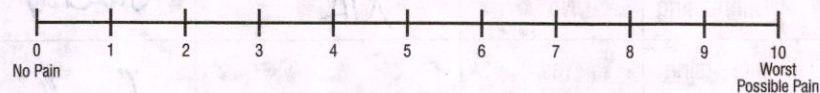
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

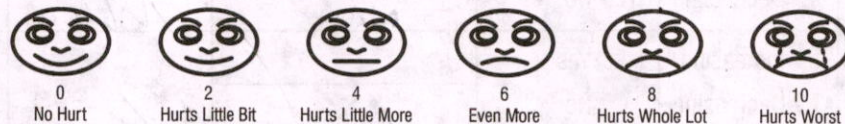
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



BAH-00661949
Baby SHRUTI ROY
28-06-2013
Dr. PILLARISETTI NAVEEN SARADHI (F)
13 Y 0 M 22 D
IP5-00176525

PAIN ASSESSMENT FORM

Date	Time	Score (10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/7/26	8-00 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Amaka Rys
21/7	10 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Samy
21/7	2 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sueetha
21/7	6 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sueetha
21/7	10 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Riya
22/7	2 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Riya
22/7	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Riya
22/7/26	12 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shal
22/7/26	6 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sh
22/7/26	10 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	manthe

Re-assessment Frequency:

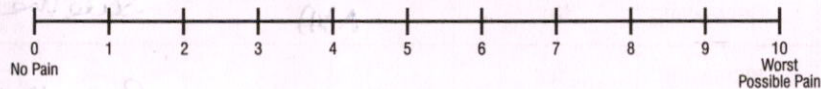
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	(0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				☐ 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:

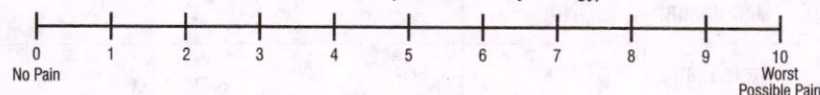
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

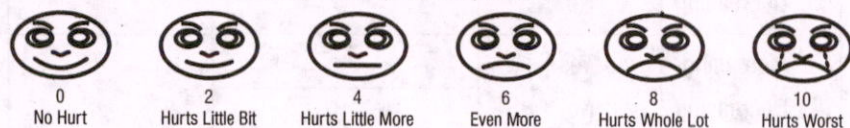
Numerical Pain Scale (Obstetric and Gynecology)



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-00861949
Baby SHRISTI ROY
28-06-2013 13 Y 0 M 19 D (F)
Dr. PILLARISETTI NAVEEN SARADHI



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 :	12/7	12/7	12/7	12/7
					Time :	9:10	8:45	8:15	8:17
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.	9	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.	9	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: Unresponsive 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.	9	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.	9	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."	9	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.	9	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.	9	4	4	4	
TOTAL SCORE					28	28	28	28	
Evaluator's Name					Adi	sk	sk	sk	

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
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BAH-00661949
Baby SHRISTI ROY
28-08-2013 13 Y 0 M 20 D (F)
Dr. PILLARISETTI NAVEEN SARADHI

IP5-00176525

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 :	18/2	18/2	29/2/24	20/12/20
					Time :	8:22	8:45	8:45-9:00	8:00-9:00
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or 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
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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.		4	4	4	4
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	28	28
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	shu	ls	sh	AD

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
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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 :	20/7	2017	21/7	21/7
					Time :	8 AM	10 AM	12 PM	2 PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:xtremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
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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.	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	
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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.	4	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	28	28
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Paul	Riya	Ravi	da

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
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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 :	28/6/2013	28/6/2013	28/6/2013
				Time :	8:00 AM	10:00 AM	10:00 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 e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4
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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.	4	4	4
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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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4
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				TOTAL SCORE	28	28	28
				Evaluator's Name	Riya	Heena	Master

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)
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BRADEN 'Q' SCALE

Patient ID

					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 extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.					
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Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.					
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."					
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.					
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.					
TOTAL SCORE									
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

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 17/6			DAY-2 18/6			DAY-3 19/6			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	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			-	-	-	-	-	-	-	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			-	-	-	-	-	-	-	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			-	-	-	-	-	-	-	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			-	-	-	-	-	-	-	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-	-	-	-	-	-	
Signature of the Nurse													

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 : Ananika Name : Ananika

Signature of Ward In Charge :

Signature : Supriya Name : Supriya



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	0	0		
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	1	-	-	-	-	-	1	Cannula changed	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	✓	-	-	-	-	-	-		
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	✓	-	-	✓	-	-	✓		
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	✓	✓	-	✓	✓	-	✓		
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	✓	-	-	✓	✓	-	✓		
Signature of the Nurse				 									

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

Signature of Shift In Charge :

Signature : Name :

Signature of Ward In Charge :

Signature : Name :

BAH-00661949 IP5-00176525

Baby SHRISTI ROY

28-06-2013 13 Y 0 M 24 D (F)

Dr. PILLARISSETTI NAVEEN SARADHI



CHECKLIST FOR THROMBOPHLEBITIS

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

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

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

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 of Ward In Charge :

Signature : Name :

Signature : Name :



THE HUMPTY DUMPTY SCALE

17/12/12 18/12/12 19/12/12

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					
	13 years old and above	1	4	4	4	4	4
Gender	Male	2					
	Female	1					
Diagnosis	Neurological Diagnosis	4	1	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					
	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	✓
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	X	No	X
Other Intervention(s) Specify	No	No	X	No	X
Nurse's Name :	Arun	Subh	Subh	Subh	Subh
Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :	17/12	18/12	18/12	18/12	19/12
Time :	4:15 PM	4:15 PM	4:15 PM	4:15 PM	4:15 PM



THE HUMPTY DUMPTY SCALE

19/7 20/7/20 21/7/20 22/7/20

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					
	13 years old and above	1	1	1	1	1	1
Gender	Male	2	1	1	1	1	1
	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			8	8	8	8	8

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	X	NA	X
Other Intervention(s) Specify	NO	NO	X	NA	X
Nurse's Name:	Sundee	Aditya	Devi	Piyush	Devi
Signature:	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:	19/7	20/7	20/7	20/7	21/7
Time:	8 PM	8 PM	8 PM	8 PM	8 PM

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					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
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					
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					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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					
TOTAL							

intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position						
Call device within reach						
Wheels Locked						
Room free of clutter						
Adequate Lighting						
Wheel Chair Support						
Other Intervention(s) Specify						
Nurse's Name :						
Signature :						
Date :						
Time :						

PRE - OPERATIVE CHECK LIST

Patient's Name : BABY SHRISTI ROY Age : 13 YRS Gender : ☐ M ☒ F
Blood Group : A POSITIVE UHID : BAH-00661949
Planned Surgery : LN BIOPSY Surgeon : DR. MAINAK DEB
Anesthetist : Date & Time of Operation : 22/7/2026 @ 2:00pm

Tick Appropriate Boxes, To be filled by Nurse Incharge / Senior Nurse :

S.No.	INSTRUCTIONS	ER/Ward,Nurse			OT Nurse		
		Yes	No	NA	Yes	No	NA
1	Weight checked recorded ?	☒	☐	☐	☒	☐	☐
2	Is the patient fasting for over 6 hours Pre-Operatively ?	☒	☐	☐	☒	☐	☐
3	Check Pre-OP Investigations & Results (CBP, Blood Group, BT, CT, PT, APTT, Viral Screening, CXR etc) Available before starting the procedure	☐	☐	☒	☒	☐	☐
4	Enema given / Bowel Preparation	☒	☐	☐	☐	☒	☐
5	Remove all ornaments, earrings, toe rings, nose rings etc and implants, dentures	☒	☐	☐	☒	☐	☐
6	Sterile Gown Given	☒	☐	☐	☒	☐	☐
7	Is Blood arranged as required ?	☐	☐	☒	☐	☒	☐
8	If Blood has been ordered - is Blood bag ready ?	☐	☐	☒	☐	☒	☐
9	IV Cannula to be placed / IV fluids if Indicated	☒	☐	☐	☒	☐	☐
10	Pre Anesthetic consultation with anesthesiologist	☒	☐	☐	☒	☐	☐
11	Pre Medications Given ? (Sedatives / etc)	☒	☐	☐	☐	☒	☐
12	Skin Preparation	☒	☐	☐	☒	☐	☐
13	Site is marked	☒	☐	☐	☒	☐	☐
14	Surgery Consent / High Risk consent taken by surgeon? (Consent should be taken by the operating surgeon only)	☒	☐	☐	☒	☐	☐
15	Implants are available	☐	☐	☒	☐	☒	☐
16	Equipment is available	☒	☐	☐	☒	☐	☐
17	Antibiotic Prophylaxis is given within the last 60 minutes	☒	☐	☐	☐	☒	☐
18	Other (if any)	☐	☐	☒	☐	☒	☐

NOTE : if any of above is ticked "NO" Discuss with the registrar / consultant immediately

Billing Clearance Taken : ☐ Yes ☐ No

Billing Executive Name : OT Nurse Name : [Signature] ER/Ward Nurse Name : K. Suneetha

Billing Executive Signature : [Signature] Signature of OT Nurse : [Signature] Signature of ER/Ward Nurse : K. Suneetha

Date & Time : Date & Time : 22/7/26 Date & Time : 21/7/26 @ 2:00pm

NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

7889

Patient Name:	BABY. SHRISTI POY		Age:	13Y 0M 19D	Gender:	FEMALE	
UHID No:	BAH-00661949	IP No:	00176525	Date:	22/7/26	Time:	3:30pm
Diagnosis:	LYMPH NODE BIOPSY						
PRESCRIPTION DETAILS (Tick only one of the following)							
S.No	Drug Name	Dosage	Remarks				
1.	Inj. Fentanyl Citrate 100 mcg / 2 ml	100mcg	SOS				
2.	Fentanyl Citrate 25 mcg patch	-	-				
3.	Inj. Morphine 15 mg / ml	-	-				
Doctor Name:		DR. ANITA NEWKIRK		Doctor Registration No:			
Signature:		[Signature]		2019/04/2258			

NARCOTIC DISPENSING FORM APPENDIX 4 – FORM NO. 3E

(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: IP5- 00176525 Date: 22/7/26

Aadhaar No. of the Patient (Optional):

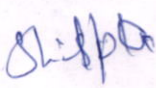
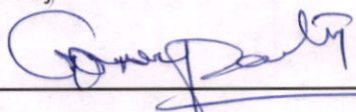
1.	Name :	BABY. SHRISTI POY		Remarks	
2.	Complete postal address (with contact number, if any)	H No 1/103, WARD NO 12, SATIYANAMI BHAVAN CHOWK,			
3.	Brief description of the illness	LN BIOPSY			
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	-			
5.	Details of essential Narcotic drug dispensed	FENTANYL			
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any	
22/7/26	FENTANYL	ONE	[Signature]	-	

Dispensed by (Name & ID No.): SANGRETHA 815095 Signature: [Signature]

Received by (Name & ID No.): KULSUM (01006) Signature: [Signature]

Time: 3:30pm

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00661949 IP5-00176525 Baby SHRISTI ROY 28-05-2013 13 Y 0 M 23 D (F) Dr. PILLARISETTI NAVEEN SARADHI 		Date & Time of Admission 17/7/26 @ 2:58pm	Date & Time of Transfer Order 22/7/26 @ 1:30pm
Transfer Ordered by DR. Samashree		Reason for Transfer for biopsy	
From Unit 334	To Unit 27	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 60	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what?	Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films 8 1			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	USG Report	1	
2.	MRI Report & Serology report	1	
3.	XRay	1	
4.	MRI FILMS	1	
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer DR. Sama Shree	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received : 23/07/26 @ 3:00pm			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00661949 IP5-00176525 Baby SHRISTI ROY 28-06-2013 13 Y 0 M 24 D (F) Dr. PILLARISETTI NAVEEN SARADHI 		Date & Time of Admission 17/7/26 @ 2:00pm	Date & Time of Transfer Order 22/7/26 @ 6:40pm
		Transfer Ordered by Dr. Shanthi	Reason for Transfer Post OP recovery
From Unit OT	To Unit 334	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 304	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If Yes, what?		Patient shifted with ID band: Yes ☒ No ☐ If No:
Number of Imaging Films			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Akhila		Name of Person Ordered Transfer Dr. Shanthi	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received : 22/7/26 @ 7:00pm			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

BAH-00661949
Baby SHRISTI ROY
28-08-2013
Dr. PILLARISETTI NAVEEN SARADHI
IP5-00176525
13 Y 0 M 23 D (F)
Barcode

INFORMED CONSENT FOR SURGERY / PROCEDURE

☒ Patient Attendant

I do hereby agree to undergo the following surgery(s), Procedure(s) on patient / myself at Rainbow Children's Hospital and I have read and understood the following technical terms and leave no blank space)

LYMPH NODE BIOPSY (RIGHT CERVICAL)

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)
For diagnostic purpose.	

3. As with any procedure, I am aware that risks such as blood loss, infection, diaphragmatic arrest, anesthetic allergic reactions, paralysis, Deep Vein thrombosis (DVT), Pulmonary thromboembolism (PTE) etc may necessitate attention. Therefore, in addition to consenting to the performance of the above-mentioned surgery/procedure, 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:

- Bleeding
- Infection

- I authorize Dr. Mainak Deb upon the patient / myself.
- I recognize that the practice of medicine is as much an art as a science and that the outcome of any medical procedure or can be made regarding the likelihood of success or outcome.
- I acknowledge that I fully understand the above information. I have given my consent is given by me in my full senses.

his / her team to perform the procedural sedation and therefore acknowledge that no guarantees have been made. I have been given the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I am

Patient / Patient Attendant:

Signature: [Signature]

Name: Mother

Relationship with patient: Mother

Date: 22/7/26 Time: 2:08

Signature: [Signature]
Date: 22/7/26 Time: 2:05pm

(01d) is taking consent):
[Signature] Name: Dr
(26)

శస్త్రచికిత్స / ప్రాసీజర్

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్బో చిల్డ్రెన్ హాస్పిటల్లో చేయబడబోయే క్రింది శస్త్రచికిత్స (ఒక అంగీకరిస్తున్నాను. (టెక్నికల్ పదాలు వాడవద్దు మరియు భాగస్థలం వదిలివేయకండి)

1. చేయడానికి

2.

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

1. క్లినికల్ పరిశీలనలు మరియు/లేదా చేసిన పరీక్ష ఆధారంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
2. ఈ శస్త్రచికిత్స / ప్రాసీజర్కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి. ఈ శస్త్రచికిత్స / ప్రాసీజర్కు ఉన్న ప్రత్యామ్నాయాల గురించి, వాటి ప్రయోజనాలు మరియు నష్టాలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

3. ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్లోగానూ, రక్తప్రాపం, క్షీణ, గుండె ఆగిపోవడం, అనస్థీషియా వల్ల అలెర్జి, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రాంబోఎంబోలిజం (E) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు. అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్కు నేను ఇచ్చే అతిపాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినప్పుడు, రోగి/నా కోసం అవసరమని వైద్యుడు భావించే చికిత్సలను చేయడానికి కూడా నేను అనుమతిస్తున్నాను.

అదనంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ వల్ల సంభవించే సమస్యలు కూడా నాకు వివరించబడ్డాయి:

a.

b. గాలిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స

1. 4. డాక్టర్ / ప్రాసీజర్ను చేయడానికి నేను అనుమతిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం

5. వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అనిపిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను. అడగడానికి అవకాశం ఇచ్చారు, మరియు అవస్థ నాకు అర్థమయ్యే భాష

6. పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. అడగడానికి అవకాశం ఇచ్చారు, మరియు అవస్థ నాకు అర్థమయ్యే భాష సమాధానం ఇచ్చారు. ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో, స్వచ్ఛమైన ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

తేదీ & సమయం:

పేరు:

(25)

UNICAL / 027

CKLIST

Surgeon : Dr. Nabeel
Asst. Surgeon :
Anaesthetist : Dr. Sushil
Scrub Nurse : Alan

Patient Name : Baby SHRISTI ROY
UHID No. : 28-06-2013
Date : 13 Y 0 M 23 D (F)
Dr. PILLARISETTI NAVEEN SARADHI

Gender : F
Lymph node
biopsy
Rainbow Children's Hospital
It takes a lot to treat the little.
BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Before Induction of Anaesthesia >>

SIGN IN Time: 2.50

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 : Dr. Nabeel

Name : Dr. Nabeel

Before Skin Incision >>

TIME OUT Time: 3.20

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, 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 : Alan

Name : Alan

Before Patient Leaves Operating Room

SIGN OUT Time: 4.10

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 : Dr. Nabeel

Name : DR. NABEEL

CLINICAL SAFETY CHECKLIST

Surgeon :
Asst. Surgeon :
Anaesthetist :
Scrub Nurse :

Patient Name : Age : Gender :
UHID No. : Surgery Name :
Date : In-time : Out-time :

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Birthing
BY RAINBOW HOSPITAL
Your Right to a Safe Birth

Before Induction of Anaesthesia ➤ ➤

SIGN IN		Time:.....
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 :		
Name :		

Before Skin Incision ➤ ➤

TIME OUT		Time:.....
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, 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 :		
Name :		

Before Patient Leaves Operating Room

SIGN OUT		Time:.....
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 :		
Name :		

BAH-00661949 IP5-00176525
 Baby SHRISTI ROY
 28-06-2013 13 Y 0 M 23 D (F)
 Dr. PILLARISETTI NAVEEN SARADHI



BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 28/6/2013

Department : P-09 Duration of Procedure : 1 hr

Name of Surgeon : Dr. Naveen Date of Admission :

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 : <u>800 mg cephalexin</u>	<u>[Signature]</u>
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	<u>[Signature]</u>
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 : <u>Dr. Naveen</u> Date & Time of antibiotic administration : <u>28/6/2013 @ 2:00 PM</u> Date & Time procedure started : <u>28/6/2013 @ 3:15 PM</u>	<u>[Signature]</u>

- 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

Right
Child
Hosp

LIST TO PREVENT
INFECTION (22)

CHILD CARE
MEDICAL

2. Review

BAH-00661949 IP5-00176525
 Baby SHRISTI ROY
 28-06-2013 13 Y 0 M 23 D (F)
 Dr. PILLARISETTI NAVEEN SARADHI



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OPERATION THEATER NOTES

Patient's Name: Baby Shruti Roy Age: 13y Gender: ☐ Male ☒ Female

UHID No.: BAH-00661949 Weight: Height:

Surgeon: Dr. Nabeel Asst. Surgeon: Dr. Maliha

Anesthetist: Dr. Aditi OT Nurse: Alam OT Technician: Kulsum

Pre-Operative Diagnosis: ?TB lymphadenitis

Surgical Procedure:

(RT) Cervical LN Biopsy.

Indications for Surgery:

?TB lymphadenitis

Date: 22/7/26 Start Time: 3:15 PM End Time: 4:15 PM

Pre Operative Preparations:

Post Operative Diagnosis: ?TB lymphadenitis

Peri-Operative Complications:

Operation Notes:

FINDINGS:-

1) Multiple discrete palpable lymph nodes in (RT) 2c lymph node station above previous scar

Procedure

- 1) Incision made to include previous scar
- 2) Incision deepened upto subcutaneous tissues
- 3) Findings noted.

Amount of Blood Loss: ~1ml

Blood Transfused (in ML) —

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications: —

1) HPE
TB Culture
Gene Xpert
AFB
C/s

} Comprehensive
TB
Panel

- 4) 3 lymph nodes dissected and sent for testing.
- 5) Hemostasis ensured
- 6) Wound sutured in layers.

Name of the Surgeon: Dr. Nabeel

Signature of the Surgeon: 

Date & Time: 22/7/26 4:34 pm

BAH-00661949

IPS-00176525

Baby SHRISTI ROY

28-06-2013

13 Y 0 M 23 D (F)

Dr. PILLARISETTI NAVEEN SARADHI



POST-SURGICAL CARE PLAN FORM

Procedure Done:

(RP) Cervical LN Biopsy

Post-Surgical Diagnosis:

? TB lymphadenitis

Post-Operative Monitoring Parameters /Frequency:

TPR every 15 minutes for first 1 hour

Wound Care:

Dressing

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

Full feeds once fully awake

When to Start Mobilization:

As early as possible

Special Referrals:

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

Treating Surgeon
(Signature & Stamp)

Date: 22/7/26 Time: 4:35 pm

Note: Plan of care will be readjusted if necessary.

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: Baby Shristi Roy Age: 13y Sex: F UHID No: BCH-00661949
Date: 22/11/26 Time: 2:10 pm Proposed Operation: Cervical lymph node biopsy
Diagnosis: TB lymphadenitis
B.P / CRT: H.R: Weight: 33kg ASA Physical Status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 10.4 Glucose: Protein: 8.4 HIV: X-Ray:
PCV: 35.2 Urea: 30 Alb: 4.6 HBS Ag: ECG:
WBC: 4.91 Creat: 0.4 Total Bill: 0.3 HCV: 2D Echo:
Plate: 196000 Na: 137 Dir. Bill: 0.2 Blood group: Stress/Angio:
PT: K: 4.2 LDH: T3: 80.74 Other:
PTT: Ca++: Alk phos: T4: 10.39
INR: Mg++: Amylase: TSH: 2.93
CSF protein / Sugar - 46/45 Cl-: 102 SGOT/SGPT: Allergies: NKA
ONE - Ketona @@@@

Medical History: CVS: * NVD / Preterm / Triplet / 600gm /
RESP: Diabetes: Nil Thru NICV admission on
CNS: * Vaccinated upto date for 20 days.
Renal: * Milestones achieved as per age
Hepatic / GE: Physical Activity: Active
Others:
Past Anaesthetic History: H/o lymph node biopsy on @ side in June 2026 - sedation
Physical Exam: on ATT 1: June 2026
Airway: MP 1 2 3 4 Mouth Opening: > 3fb. Mentohyoid Distance: N Neck: N Teeth: All teeth intact
Lungs: BDE @, clear
Heart: 98 @
CNS: Grossly Intact
Pregnant: ☐ Yes ☐ No ☒ NA Venous Access Site: Spine Exam for regional:

Anaesthetic Plan: ☒ MAC ☐ REGIONAL ☐ GA-ETT ☐ LMA

Peri-Operative Plan Explained to the Patient: ☒ Yes ☐ No

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

- DVT Prophylaxis:
 - Water / ORS 2 Hours
 - Others 6 Hours
- NIL ORAL
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☒ Discussed with Patient
- Other Instructions:

- last meal 19:00 AM
- liquid 18:00 AM

Signature: [Signature] Name: Dr. K. S. Singh

Patient Sticker

ANAESTHESIA CHART

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Your Right to a Safe Delivery

Pre Induction Assessment:

Change in Patient Condition:

☐ Yes☒ No

Fasting Status:

Adequate

Physical Status:

☐ Patient Identified☐ Consent Present☐ Chart Reviewed

H.R:

74/min

B.P / CRT:

90/60

SpO₂:

100

R.R:

16

Last Feed:

26m

Pre-OP Diagnosis:

TB lymph node

Operation:

Lymph Node biopsy

Date:

22/01/21

Surgeon:

Dr. Adnan et al

Anaesthesiologist:

Dr. Anitha

Technician:

Kilsun

TIME

3:45

N₂O / AIR O₂ LPM

MAC 1.0

HALO / SO / BEVO

Drugs:

IV MIDAZOLAM 1mg

IV Fentanyl 100mcg

IV Propofol 100mg

IV PARACETAMOL 400mg

Antibiotic

Suppository

Blood Loss

NOTES

FIO₂ / SaO₂

100 100 100 100

ETCO₂

38 38 38 38

ECG

Temperature

Urine Output

Fluids

IV AL 330ml

B.P

V Systolic

A Diastolic

X Mean

• Heart Rate

Tourniquet on Time

Tourniquet off Time

Throat Pack In

Throat Pack Out

LAB Values

ABG

GRBS

Others

☐ Equipment Checked and Functional☒ BP☒ Cuff Site: R/L☐ Art Site:☒ EKG Lead 3 lead☐ Temp Site☐ FIO₂ Monitor☐ Agent Monitor☐ Pulse Oximeter☐ Capnograph☐ Ventilator☐ Nerve Stimulator

Position: Supine

☐ 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: 3:15

OP Start: 3:30

OP End: 4:00

Leave OR: 4:15

Anaesthesia:

☒ GA☐ Monitored Anaesthesia Care☐ Regional

Line (Size & Location)

☐ CVP:☐ ART:☒ IV:☐ IV:☐ IV:

Induction

☒ IV☐ Inhal☐ Pre O₂☐ RSI☐ Others☐ Mask☒ SGA 2 1/2☐ Airway☐ Oral☐ Nasal

ETT#

at

cm

☐ Oral☐ Nasal☐ Cuff☐ Tracheostomy☐ Topical☐ Drug: R☐ Awake☐ Direct Vision☐ Video Laryngoscopy☐ Stylette / Bougie☐ Fiberoptic

Blade#

Attempts:

Difficulty Why?

☐ Bilat = BS☐ Semi-Closed Circle☒ Closed Circle☐ Other

Regional:

Extremity

Specify:

☐ Spinal☐ Epidural☐ Caudal

Others:

Position:

Site:

Needle Size:

Depth:

Parasthesia

☐ Yes☐ No

Catheter at skip

cm

Drug Name & Conc:

Bolus:

Infusion:

Block Level:

Comments:

Transportation to

☒ PACU☐ ICU☐ Other

Relaxant Reversed

☐ Yes☐ No☐ NA

Name of the Doctor:

Dr. Adnan

Signature of the Doctor:

Dr. Adnan

Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ThijsTime Received : 4:20 pm

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	BLOOD PRESSURE PULSE RESP		IV Cannula Site : ☐ 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: <u>ins</u> Oral Feeds:

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES			OUT	SCORING INTERPRETATION
				30	60	90		
Able to move 4 extremities voluntary or on command	= 2	ACTIVITY	0	1	2		2	A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
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	RESPIRATION	2	2		2		
Dyspnea or limited breathing	= 1							
Apneic	= 0							
BP ± 20 of Pre Anaesthetic level	= 2	CIRCULATION	2	2		2		
BP ± 20-50 of Pre Anaesthetic level	= 1							
BP ± 50 of Pre Anaesthetic level	= 0							
Fully awake	= 2	CONSCIOUSNESS	0	1	2		2	
Arousable on calling	= 1							
Not responding	= 0							
Pink	= 2	COLOR	2	2		2		
Pale, dusky, blotchy, jaundiced, other	= 1							
Cyanotic	= 0							
TOTAL			6	8	10		10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
22/7	6:30 pm	1/10	✓	Thijs

Pain Tool Used: ☐ N PASS ☐ FLACC ☐ Wong Baker ☐ NPSAnaesthesiologist Name : Dr. SumAnaesthesiologist Signature: [Signature]Date & Time: 22/7/26 @ 6:37 pmPACU Nurse Name : ThijsPACU Nurse Signature: [Signature]Date & Time: 22/7/26 @ 6:37 pm

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): AlkhalDate & Time: 22/7/26 @ 4:20 pm

Patient Sticker

Department of Anaesthesiology

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)

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR	Comments
			Left	Right	BP	Pulse		

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 :

334

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 17/7/20 Time: 4:15pm

Weight: 33kg Centile: 75th

Height: 148cm Centile: 75th

Inference: Underweight child

RDA: - Calories: 1800kcal/d Protein: 31gm/d

Diet Recommendations: Normal diet

Re-Assessment: Avoid spicy, Chilled & outside foods

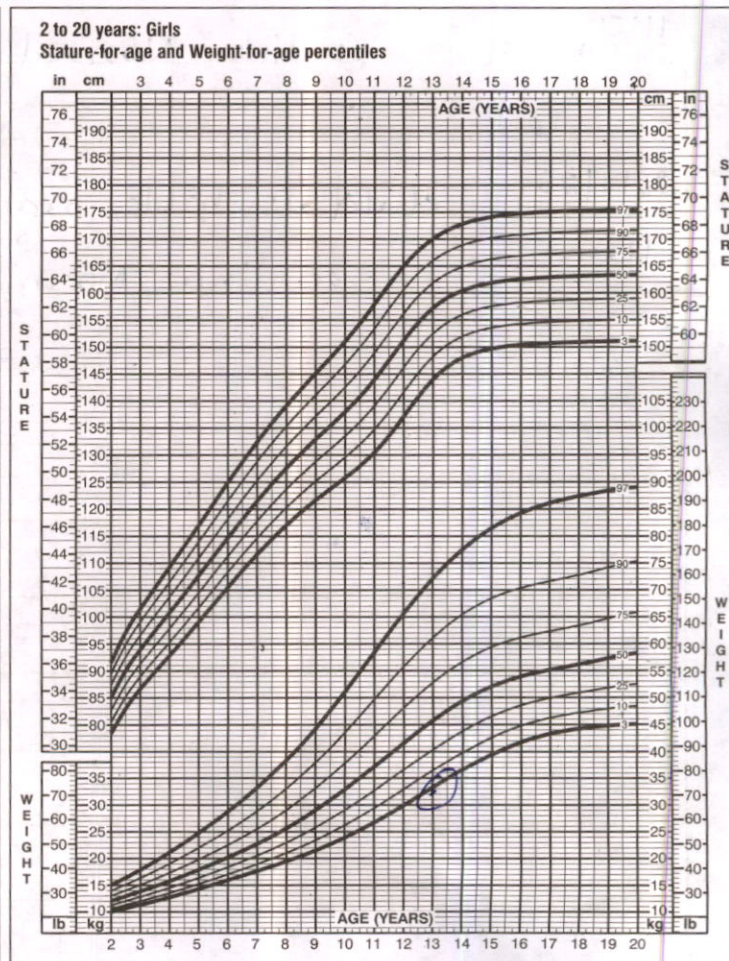
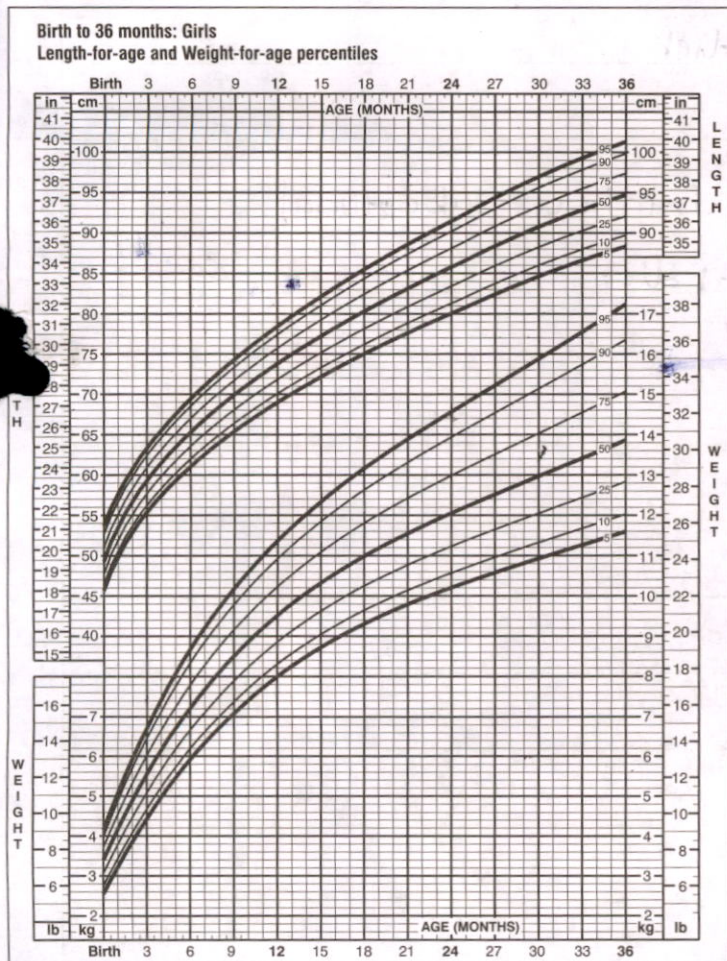
Food Allergies: NO Veg/Non-veg NON-veg

Diagnosis: hyperadentia

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (GIRLS)



Dietician's Name: Lalma

Dietician's Signature: [Signature]

Daily Notes:

18/7/26

child is stable, oral intake is optimal

10:50
am

continue Normal diet

Saving

19/7/26

child is stable, oral intake is better

11:10 am

continue Normal diet

Sai me

20/7/26

child is stable, oral intake is good

9:50 am

Continue Normal diet

Saini

21/7/26

child is stable, oral intake is fair

11:30
am

Continue Normal diet

same

২২/৭/২৬

child is stable, oral intake is suboptimal

I am

continue Normal diet

Saints



REQUEST FOR CREDIT FACILITY

To,
The Credit Billing,
Tenet Diagnostics,
Banjara Hills, Hyderabad.

Patient details:

BAH-00661949 IP5-00176525
Baby SHRISTI ROY
28-06-2013 13 Y 0 M 20 D (F)
Dr. PILLARISETTI NAVEEN SARADHI

Dear Sir/Madam,

We are sending the above mentioned patient for the diagnostic test MRI brain plain + contrast in your diagnostic center on credit basis. Request you to kindly do the needful. The bill will be settled by Rainbow Hospital, billing department as per the agreement. For any further queries, please contact the billing manager.

Order ID: 50009709280

Thanking you,
Department of Inpatient Billing

Coordinator:

Signature:

Name: Maimuna

Date & Time: 18/07/2026 @ 11:36am

Billing Executive:

Signature:

Name: ABDUL KADER

Date & Time: 18-07-2026/12:18pm

Mobile (Billing Manager): 9247505898

Billing Department
Rainbow Children's Medicare Ltd
Banjara Hills, Hvc

Manager on Duty (MOD):

Signature:

Name: M. R. Reddy

Date & Time: 18/07/2026 12:15pm

Mobile: 9676838787

Docu. No: RCH/ FRM/ GENERAL/ 663