

BAH-00557742 IP5-00176072
Baby DHARAMSOTH AISHWARYA
03-03-2018 8 Y 4 M 4 D (F)
Dr. SIRISHA RANI



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ACTIVITY RECORD FOR BILLING

Name : Aishwarya

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
7/7/26	2:30 pm	ER	ICU	poofa

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Phani Bhargava	7/7/26	96996219	Appu
2				
3				
4				
5				
6				
7				
8				
9				
10				

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
09/07	IV placement	1	91776	T. Sanyal
7/7/26	N/A	0	91777	Appu
8/7/26	Bone marrow Aspirations	1	26068254	
	Biopsy			

ANY OTHER INFORMATION

ultra sound small parts - ①

USG Abdomen and neck - ①

Date :

Time :

Prepared By : swanthi

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor

swanthi

ADMISSION SHEET

Registration Details :



Admission No : IR5-00176072 Admit Date : 07-Jul-2026 Admit Time : 01:14 PM UHID : BAH-00557742

Patient Details :

Patient Name	: Baby DHARAMSOTH AISHWARYA	Age	: 8 Y 4 M 4 D
Guardian	: Mrs DHARAMSOTH SAGAR	DOB	: 03-03-2018
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: PLOT NO 08, MALLIKARJUNA COLONY BANDLAGUDA JAGIR Hyderabad Telangana INDIA 500086	Phone No	: 9652070968/ 9381411344
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type	: GENERAL WARD	Bed No	: GW121 (C)	Ward Name	: 1F-GENERAL WARD I
Room No	: GW121 (C)	Admission Type	: First Visit		

Contact Details :

Name	: Mrs DHARAMSOTH SAGAR	Relationship	: Father
Contact Address	: PLOT NO 08, MALLIKARJUNA COLONY BANDLAGUDA JAGIR Hyderabad Telangana INDIA 500086	Phone No	: 9652070968 / 9652070968

D. Ramadevi
Signature

Doctor Details :

Doctor Name	: Dr. SIRISHA RANI	Specialisation	: HEMATO ONCOLOGY
Referral Doctor	: SELF	Phone No	:
Co-Consultant	: Dr. NALLA ANURAAG REDDY		

Payment Details :

Payment Mode	: Cash	Deposit Amount	: 0.00
		Payor Name	: NIVA BUPA HEALTH INSURANCE COMPANY LTD



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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

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UHID ID: _____



Department: _____

Consultant: _____

Perinatal Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Fever : 3 weeks

Decreased oral intake : 2 days

History of present illness :

from 3 weeks.

Fever, moderate-high grade, associated with chills, 101-102°F, Responding with paracetamol.

2-3 times in a day.

H/o vomit in the beginning / now subsided.

H/o Swelling of right elbow H/o pain from 3 weeks of age

H/o Decreased oral intake. H/o nappies ⊕

No H/o weight loss, No H/o contact of TB.

H/o H/o.

21/6/26 29/6/26 2/7/26

Hb - 13.5 13 14.3

TC - 23200 25300 30400

N 73 80 73

L 20

PC - 592 8-69 10 Lath.

22/6/26 - WGA and - (N) MW - 86

Weilferix - ⊖, ESR - 80, PPT ⊕, CFT, PPT - Negative (24/6/26).

Stool.

Stool - no growth.

Widal - ⊖

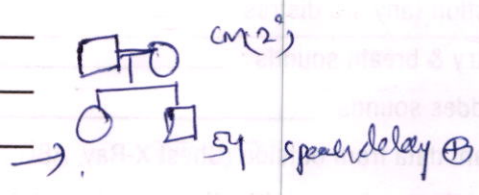
Mg ⊖, 1 W.B. ⊕



Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

uses No new stay. → 

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Normal for age -

Immunization History :

Immunized upto age . (Gart)



Paediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Albendazole

Desired goals of the treatment:

Haemodynamic stability.

Planned Labs:

LDH, CPK, CRP, TFT, S-Creatinine.
 ANA Profile, Blood U/L
 Mantoux
 Gastric aspirate for Gene Expert
 AFB.

1 Extra EDTA, 2 Extra Heparin.
 20 EUTO

Use of HEP Joints
 Temp

Planned Management

10 amedidols
 11 am. Gaviscon
 - NPO Continue.
 - Wt loss
 - BMA - sos.
 - Naproxen
 - Lateral BD
 - paracetamol

Signature of the Doctor:

N. P. R.

Name of the Doctor:

N. P. R.

Date & Time:

07/7/20

Signature of the Consultant:

Name of the Consultant:

Date & Time:

DR. SANDHYA VADDADE
 Registration No: 71634

DR. SIRISHA RANI
 Registration No: 40525



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>CL/B Dr. Sandhyamam</u>	
<u>9/3/20</u> <u>3:00pm</u>	Dis: PUB + Emulation.	
	<u>O/S</u>	
	Child Alert & Active	
	Vitals stable.	<u>Plan</u>
	CM: G11A	<u>2D Echo Now</u>
	M: BLA/EP	
	RA: Left	
	CM: NPO.	- trace Blood report.
		- plan for BMA-Tlm.
		+ Biopsy.
		- NPO from 4:00 AM.
		! TVF from NPO.
		- send gastric aspirate for
		Gene & pat
		ATB.
		- Check Ombour apru 4:30pm.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B Resident.	
5/5/22 8:20 AM	Dhs: Pro + Evulsion.	
	No fever spikes. Admission.	
	Slide - 10:00pm	No new issues.
NPO	Liquid: 2 AM,	<u>O/E</u>
	Child Alert & Active	
	Vital stable.	
	CX: Clear	
	PA: BLAC	<u>Plan</u>
	P/A: Left	
	CNS: APP	- BMA + Biopsy
		Today
		- NPO.
		- Trace BLU & ANA
		Gastrocym for postle -
		ASTB & Gene Express
		- Check monitor after
		4hrs.
		- monitor vitals
		- Temp (ax).

[Signature]
 R. Anand
 73451 EPM

[Signature]

Date & Time	Progress Notes	Doctor's Order
8/7/20 12:00 PM	<u>Procedure note.</u> BMA + Biopsy. Consent taken. Under strict aseptic precautions procedure was done. Short sedation given. Smear prepared. Samples taken. No clo bleeding. Hemostasis achieved. Post procedure → tolerated well. Hemodynamically stable. Dr. Prachant.	→ Send samples BMA + Biopsy

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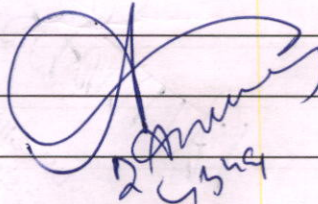
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/07/18 4pm	CI s/B Resident SSI - PVO Evaluation No Fever spikes O/E child Alert & Active	Plan → To trace ANA Profile → To check Mantoux after 48 hrs
	CVS RS P/A (2)	→ To trace BMA & BM Biopsy reports
	Blood culture till now no growth.	→ monitor vitals → Inform @
		Dr. T. Parani
8/8/18 4:30pm	fever spikes - both	Plan 1. Whole body PET scan T/m with out sedation 2. To send Brucella IgM now in same sample 3. Trace gastric aspirate for AFB 4. Stop DNS 5. Start NS IV fluid from 1pm
		Share

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 03-03-2018 8 Y 4 M 6 D (F)
 Dr. SIRISHA RANI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/2/21 9:00 AM	CL/B Resident puo 1 simulation. 1 face spike @ 10:00 AM (100.2°F) No new issues. O/E Abd (-ve) Gastric Aspiration for line output (-ve) ANAPURIC (-ve)	plan - Trace Gastric Aspiration for AB. - Trace Bnucal gm report. - monitor - Infection - Time BMA report.
	chck Abus Active. Vital stable. CX: 1/1/2 (A) M: BLAC (A) PA: 6ft CNS: NAD.	
	 2/5/21	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/07 upm	Evening Rounds Plan	
	osis PVO & Evaluation →	
	1 Fever spike in morning.	→ To trace Gastric Aspirate AFB by morning
	ole child Alert active	for Brucella Serology by today 10pm
	C/S R/S P/S	→ Chest Xray AP & Lateral
		→ Ultrasound Neck & US of abdomen & 2 quadrants swee
		→ Ophthalmologist opinion
	<i>[Signature]</i> Dr. Anurag	<i>[Signature]</i> Dr. Pawan
		<i>[Signature]</i> DR. SIRISHA RANI Registration No: 40525

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/03	morning Rounds	
8 AM	puo & Evaluation.	plan
	1 Fever spike in Night	→ To trace Gastric Aspiration AFB
	are child Alert & Active.	→ USG Neck
COS / RP / PIA	(2)	→ USA Abdomen & inguinal Axilla Screening / region Screening 18 days
	Brucella serology report Verbal - Negative	→ Ophthalmology opinion Today
	AFB report by 12 PM	→ R/w for USA joint - knee joint & Rt Elbow joint.
	No Joint Pains in Rt upper limb @ Elbow joint	
	in Rt Lower limb @ knee joint	
	Unable to extend both upper limbs.	
	COS	
	DR. SIRISHA RANI Registration No: 40525	→ Xray chest Lat view
		→ If no lymph nodes
		→ Start steroids
		→ Rheumatology opinion.
		→ Discharge by tomorrow.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/20 5:30 pm	No fever noisy	(P) → Prednisone 40 mg po stat today → 10 mg TID from TID X 1 week → Ct suppurative abs of TIA if well Rt CBP ESR, RBS } today 15/7
		DR. SANDHYA VADDADI Registration No: 71664
11/7 11 am	slb rhinorrhea Δ SOJIA no fever colic	(P) O/C today → Tab Omnicef 10mg TID X 1 week → Ct suppurative abs (larynx / alveoli) nasopharynx / trachea → Rpt CBP / RBS @ 16/7 RBS Q RLV monitor
		DR. SIRISHA RANI Registration No: 40525

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CROSS CONSULTATION FORM

Doctor Name : Date : 7/07/16 Time : 10:30

Diagnosis :

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 :

fever x 3 wks
~~1 month~~

single joint rt. elbow involvement

ECHO

MVP
NO MR

MV Annulus 24mm

② coronaries
GRUF

Adv

1. ESR / ASO titre.

Consultant :

BHARUVA

Name : Signature : [Signature] Date & Time : 7/07/16

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RESULT SHEET

Date	7/2/26				
Time	3pm				
Hb	13.4				
PCV	42.7				
RBC	4.89				
WBC	23.62				
N/L	77.2/16.1				
Platelets	616				
CRP	33.				
ESR		23			
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine	0.4				
ALP					
SGPT					
SGOT					
T.Bill/Conj	0.6-0.2 conjund.				
T.Protein	8.2-10.4				
S.Albumin	4.3				
S.Globulin	3.9				
A/G Ratio	3.9				
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L	LDH 236.				

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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: ER

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	Syp- Ibuprofen plus	10ml	PO	8H	07/11/20	☐ C ☐ DC
2	Syp- Tardion forte	5ml	PO	12H	7/11/20 2pm	☐ C ☐ DC
3	Syp. sucralf.	7.5ml	PO	8H	7/11/20	☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: N. Perumal

Date & Time: 07/11/20, 1pm

Nurse Name & Signature: Susmita

Date & Time: 7/11/20 @ 1:26 pm

Patient Sticker

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Sheet

REGULAR PRESCRIPTIONS

Weight

Ward

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

VERIFIED BY : Name Signature

DRUG CHART

Date of Admission: 8/7/26 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG : <u>Paracetamol</u>				Date Time	<u>8/7/26</u> <u>9:40am</u> <u>Paracetamol</u> <u>Sublingual</u>
Dose <u>300mg</u>	Route <u>IV</u>	Frequency <u>SOS</u>	Start Date <u>07/7</u>		
Doctor's Signature <u>N. Prasad</u>		Valid Period <u>48H</u>	Pharm.		
Additional Instructions: <u>1st Temp 29.9°F</u> <u>max 6th hourly.</u>					

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

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



REGULAR PRESCRIPTIONS

Weight: 19.5kg. Ward:

DRUG : <u>inj. PANTOPRAZOLE</u>				Date Time																	
Dose	Route	Frequency	Start Date																		
20mg	IV	24H	07/7																		
Name & Signature of the Doctor Starting the Drugs: <u>N. Prathaban</u>																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG : <u>inj. ONDANSERON</u>				Date Time																	
Dose	Route	Frequency	Start Date																		
4mg	IV	8H	07/7																		
Name & Signature of the Doctor Starting the Drugs: <u>N. Prathaban</u>																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG : <u>Tab. Naproxen</u>				Date Time																	
Dose	Route	Frequency	Start Date																		
200mg	PO	12 times	7/2/2																		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Prathaban</u>																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG : <u>Tab. PANTOPRAZOLE</u>				Date Time																	
Dose	Route	Frequency	Start Date																		
20mg	PO	once daily	2/2/2																		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Prathaban</u>																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
8/12/20	12:30 PM	Inj. Ketamine	20mg.	IV	R	Dr. R
8/12/20	12:30 PM	Inj. midazolam	1mg.	IV	R	Dr. R
10/12/20	6:15 PM	Tab OMNACORTIL	40mg	P/O	R	Dr. R



I.V. FLUIDS CHART

Weight. 19.5kg Ward.

[illegible]

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

SCHOOL AGE (5-12 years)

Children's Observation &
Early Warning Scoring Chart

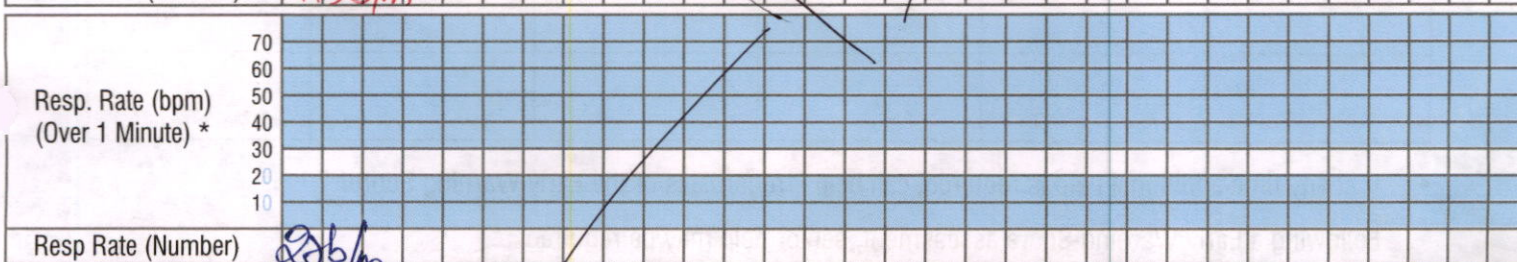
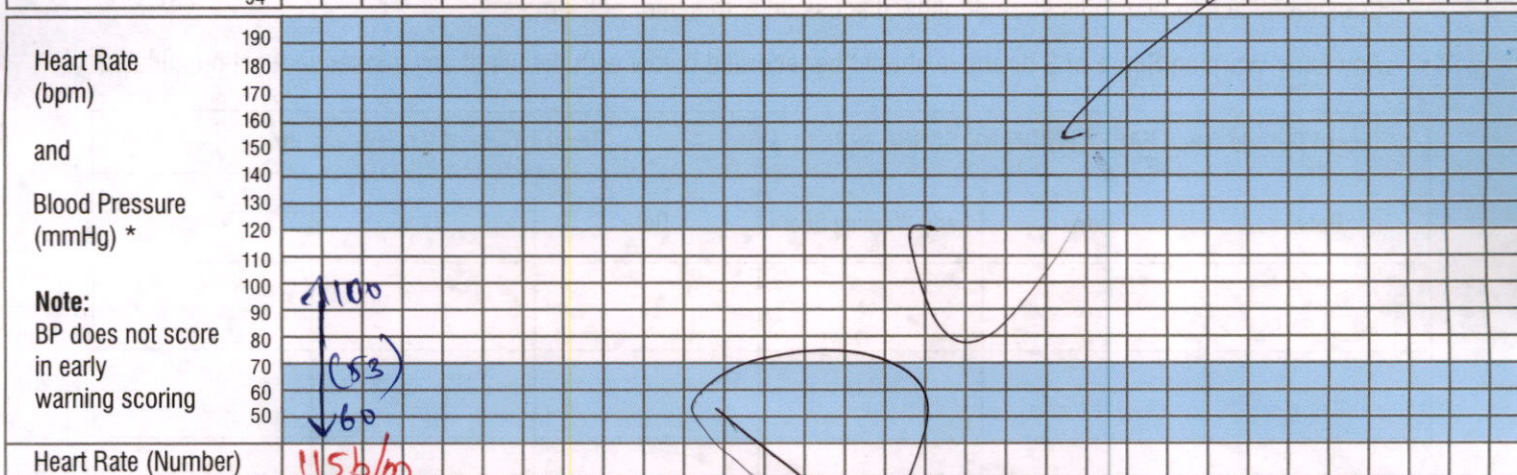
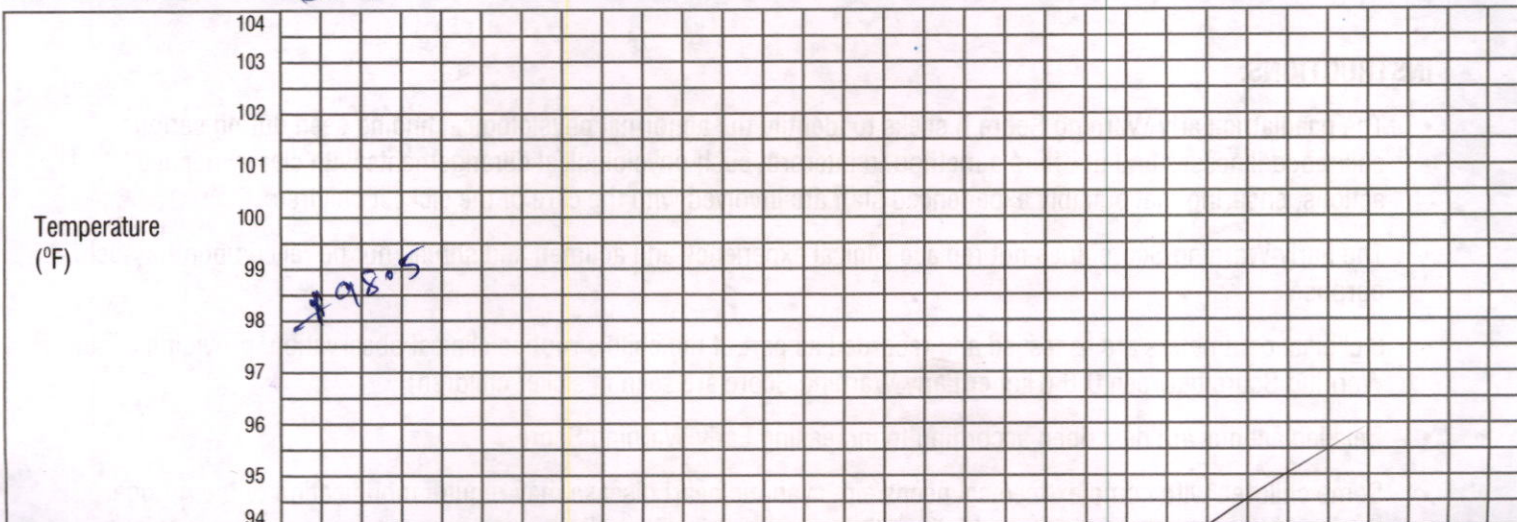
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/03/2018 Time: 11:30 AM

Doctor / Nurse / Family Concern? Gm



Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%) 100%

Conscious Level Normal
Altered

GCS * 15/18

TOTAL SCORE

Number of shaded boxes 0

Pain Score 0

Observer's Initials Gm

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
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BAH-00557742
 Baby DHARAMSOTH AISHWARYA
 03-03-2018 8 Y 4 M 7 D (F)



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

SCHOOL AGE (5-12 years)

Children's Observation &
 Early Warning Scoring Chart

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 20/11/2018 Time: 10pm

Doctor / Nurse / Family Concern?

Temperature
 (F)

104
103
102
101
100
99
98
97
96
95
94

97.4 F
 98.3
 97.9 F

Heart Rate
 (bpm)

and

Blood Pressure
 (mmHg) *

Note:
 BP does not score
 in early
 warning scoring

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

82
 (56)
 43
 111b/m
 100
 (51)
 60
 115b/m

Heart Rate (Number)

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

70
60
50
40
30
20
10

Resp Rate (Number)

26b/m 26b/m

Resp Mod/ Severe
 Distress None / Mild

Receiving O₂(l/min)
 O₂Saturations (%)

100% 100%

Conscious Level
 Normal Altered

GCS *

15/15 15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0 0
 Qy Qy

ACTIONS

NB: Scores 3 should be
 recorded overleaf

- Score 1 : Continue normal observation by staff nurse
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* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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BAH-00557742 IP5-00176072
 Baby DHARAMSOTH AISHWARYA (F)
 03-03-2018 8 Y 4 M 7 D
 Dr. SIRISHA RANI

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

SCHOOL AGE (5-12 years)

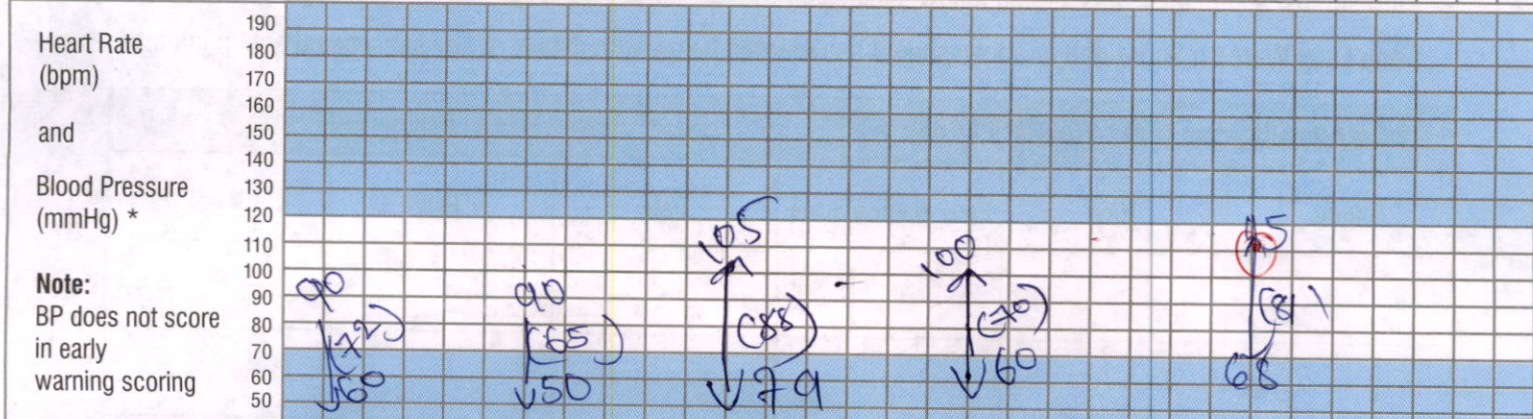
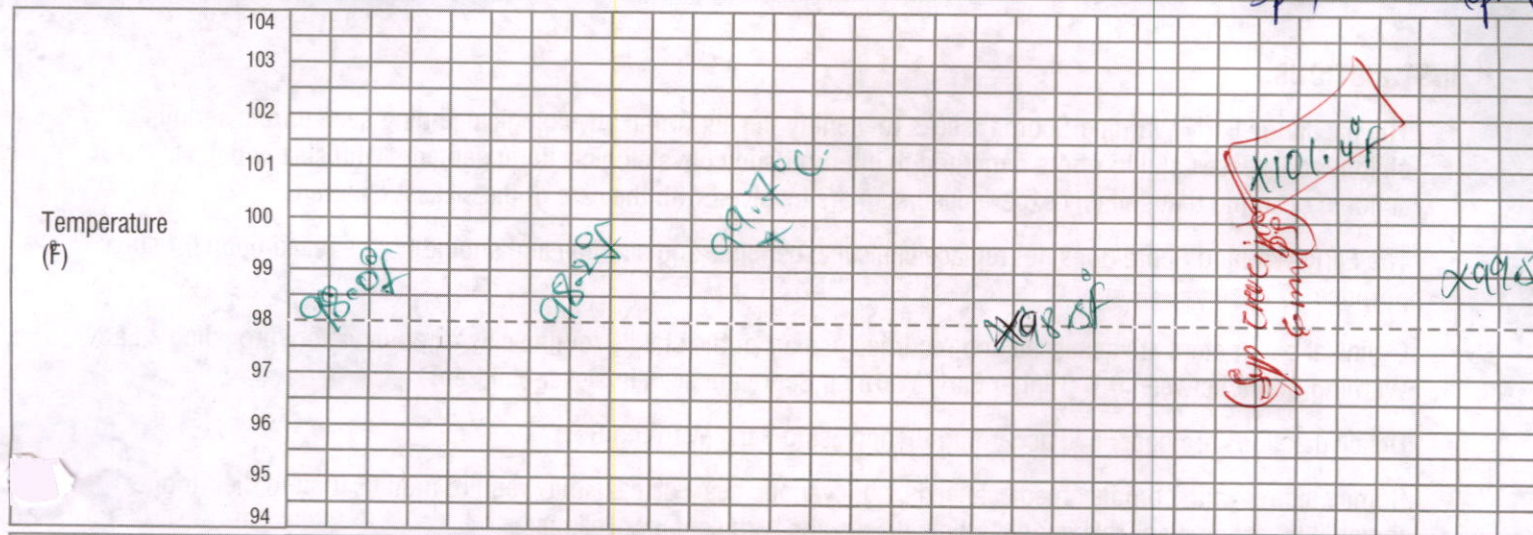
Children's Observation &
 Early Warning Scoring Chart

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

BirthRight®
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/3/25 Time: 8AM 6AM 10AM 2PM 5PM 6PM
 Doctor / Nurse / Family Concern?



Heart Rate (Number)

Time	Heart Rate (Number)
8AM	120
6AM	116
10AM	109
2PM	111
5PM	110

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

Time	p. Rate (bpm)
8AM	28
6AM	28
10AM	28
2PM	28
5PM	28

Resp Rate (Number)

Time	Resp Rate (Number)
8AM	28
6AM	28
10AM	28
2PM	28
5PM	28

Resp Mod/ Severe Distress None / Mild

Time	Resp Mod/ Severe Distress
8AM	None
6AM	None
10AM	None
2PM	None
5PM	None

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

Time	Receiving O ₂ (l/min)	O ₂ Saturations (%)
8AM	0	99
6AM	0	99
10AM	0	100
2PM	0	99
5PM	0	100

Conscious Level Normal / Altered

Time	Conscious Level
8AM	Normal
6AM	Normal
10AM	Normal
2PM	Normal
5PM	Normal

GCS *

Time	GCS
8AM	15/15
6AM	15/15
10AM	15/15
2PM	15/15
5PM	15/15

TOTAL SCORE

Time	TOTAL SCORE
8AM	1
6AM	1
10AM	1
2PM	1
5PM	1

Number of shaded boxes

Time	Number of shaded boxes
8AM	0
6AM	0
10AM	0
2PM	0
5PM	0

Pain Score

Time	Pain Score
8AM	0
6AM	0
10AM	0
2PM	0
5PM	0

Observer's Initials

Time	Observer's Initials
8AM	SR
6AM	SR
10AM	SR
2PM	SR
5PM	SR

ACTIONS

NB: Scores 3 should be recorded overleaf

Score	Action
Score 1	: Continue normal observation by staff nurse
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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SCHOOL AGE (5-12 years)

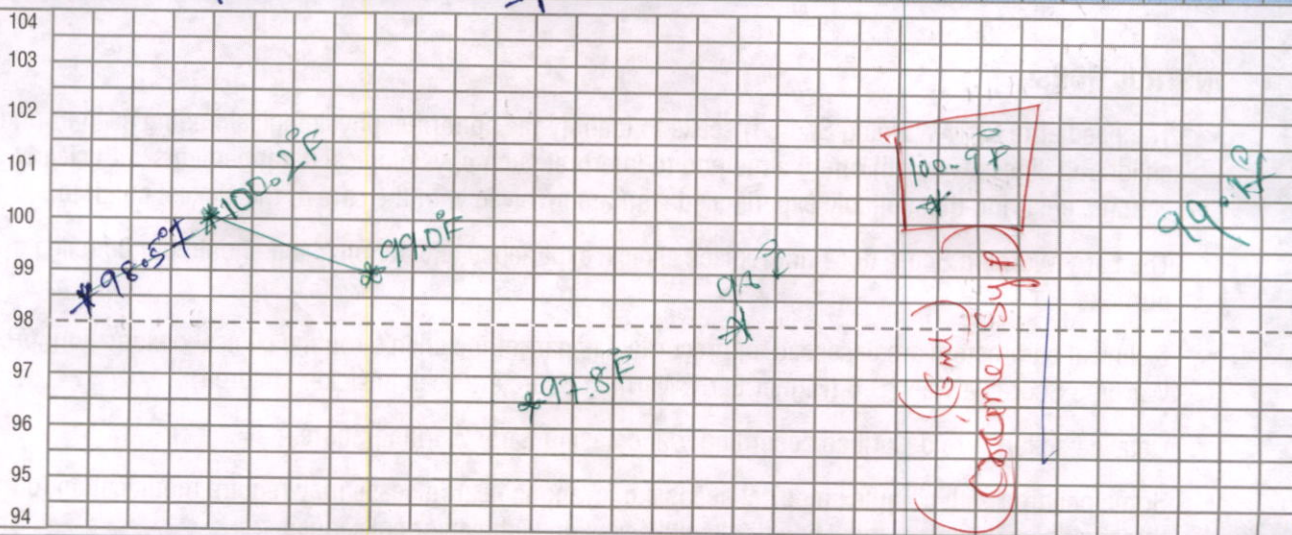
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9/2/20 Time: 6pm

Doctor / Nurse / Family Concern? Cam 10am 11am 1pm 6pm 7:46pm 10pm

Temperature
(F)

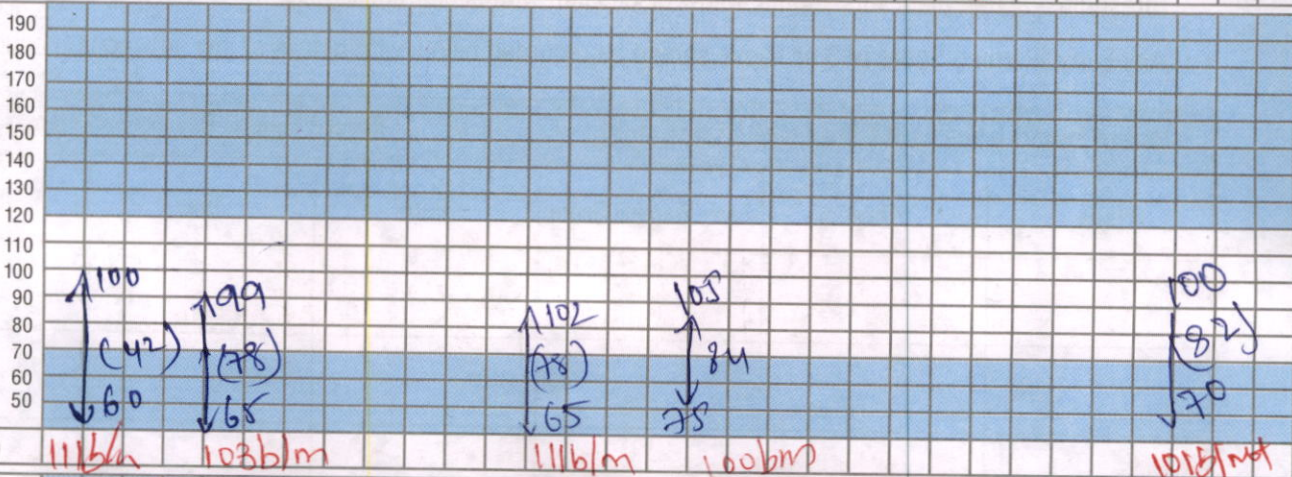


Heart Rate
(bpm)

and

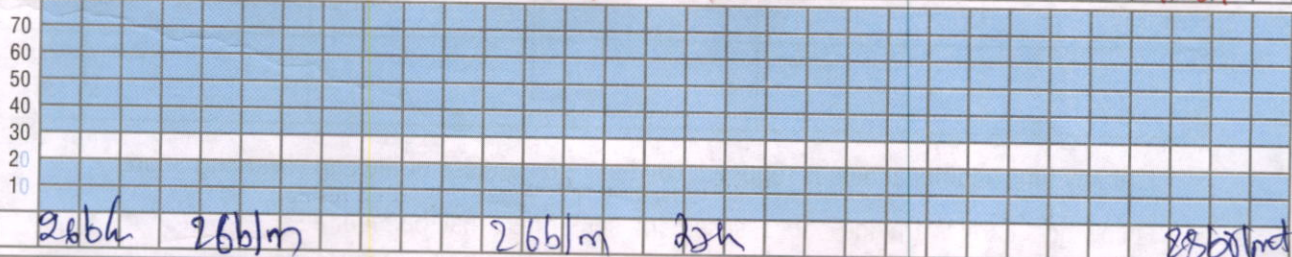
Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring



Heart Rate (Number)

sp. Rate (bpm)
over 1 Minute *



Resp Mod/ Severe
Distress None / Mild

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

Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

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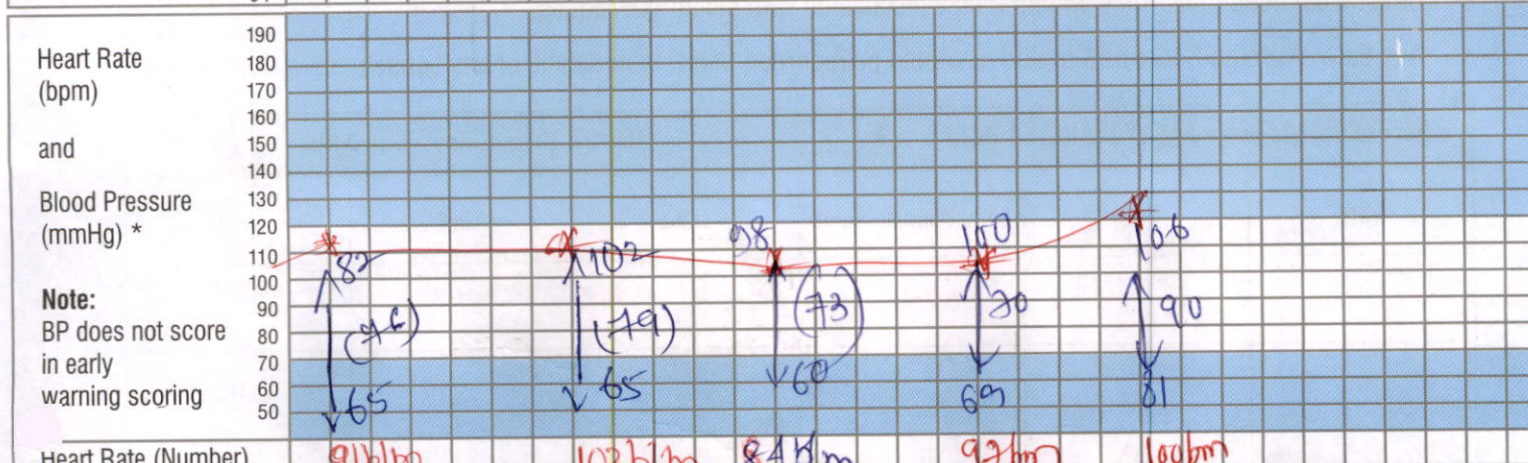
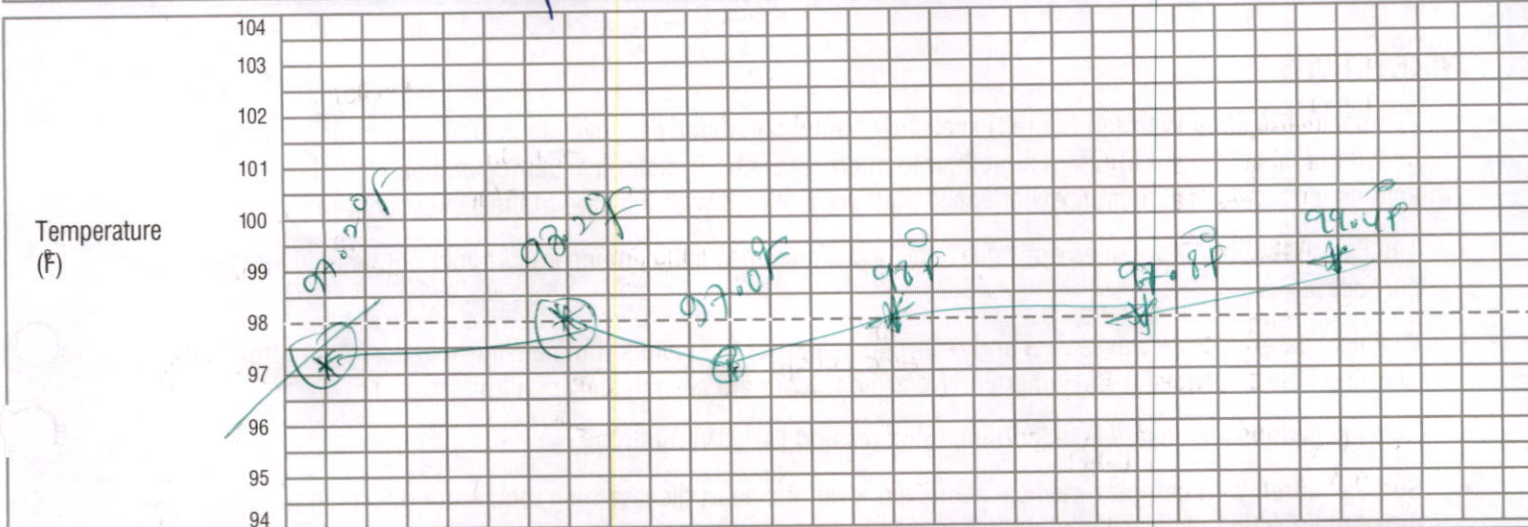


SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 2/7/20 Time: 5:30pm 6pm 10PM 2am 6am 7:15am
Doctor / Nurse / Family Concern? 5:30pm 6pm 10PM 2am 6am 7:15am



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

Time	Resp. Rate (bpm)
5:30pm	25
6pm	25
10PM	26
2am	28
6am	27

Resp Distress	Mod/ Severe	None / Mild

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

Conscious Level	Normal	Altered

GCS *
15/15
15/15
15/15
15/15
15/15

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

ACTIONS

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FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign, Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :					Total Output :						
7/7	02:00 pm			40ml							0	7/7
	03:00 pm	1		40ml							0	7/7
	04:00 pm	1		40ml							0	7/7
	05:00 pm	1		40ml							0	7/7
	06:00 pm	1		40ml							0	7/7
	07:00 pm	1		40ml							0	7/7
	Total Intake :					Total Output :						
8/8	08:00 pm	1		40ml							0	8/8
	09:00 pm	1		40ml							0	8/8
	10:00 pm	1		40ml							0	8/8
	11:00 pm	1		40ml							0	8/8
	12:00 am	1		40ml							0	8/8
	01:00 am	1		40ml							0	8/8
	Total Intake :					Total Output :						
8/8	02:00 am	1		40ml							0	8/8
	03:00 am	1		40ml							0	8/8
	04:00 am	1		60ml							0	8/8
	05:00 am	1		60ml							0	8/8
	06:00 am	1		60ml							0	8/8
	07:00 am	1		60ml							0	8/8
	Total Intake :					Total Output :						
Total 24 hrs. Intake					Total 24 hrs. Output							



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.

		Intake				Output					IV Site Thrombo-phlebitis Score					
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		Sign. Nurse				
8/7			Mouth	I.V	N.G	/	☒	☐	☐	☒	0	{R}				
	08:00 am	DMS		60ml									☒	☐	☒	0
	09:00 am		NPO	60ml									☒	☐	☒	0
	10:00 am			-	/										☒	0
	11:00 am			-											☒	0
	12:00 pm			-											☒	0
01:00 pm		-				☒	0									
Total Intake :			Total Output :													

Total Intake :				Total Output :					
8/7	02:00 pm	↑ DMS		60ml	/	/	/	0	{shape
	03:00 pm		60ml	0					
	04:00 pm		-						
	05:00 pm	60ml	0	{shape					
	06:00 pm	60ml				0			
	07:00 pm	60ml	6	{shape					

Total Intake :					Total Output :				
8/7	08:00 pm	1	Ric		1			0	Ch
	09:00 pm							0	
	10:00 pm	NO					✓	0	Chenel
	11:00 pm	GVF			29			0	
	12:00 am				1			0	Chenel
	01:00 am	ns	Gom				✓	0	

Total Intake :				Total Output :			
9/7	02:00 am	1	60ml	1	0	Chend	
	03:00 am	1	60ml	1	0		
	04:00 am	1.5	60ml	2P	0	Chend	
	05:00 am	1	60ml	1	0		
	06:00 am	1	60ml	1	0	Chend	
	07:00 am	1	60ml	1	0		

Total 24 hrs. Intake

Total 24 hrs. Output

BAH-00557742 IP5-00176072
 Baby DHARAMSOTH AISHWARYA
 03-03-2018 8 Y 4 M 6 D (F)
 Dr. SIRISHA RANI



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Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
9/7	08:00 am		NPO	-		/			/		0	Re	
	09:00 am			-		/				✓	0		
	10:00 am	NO		60ml		/	✓				0		
	11:00 am		Obsa water	-		/				✓	0		
	12:00 pm	NO		-		/					0		
	01:00 pm	NO IVF		-		/					0		
Total Intake :						Total Output :							
9/7	02:00 pm			-		/			/		0	Re	
	03:00 pm			-		/				✓	0		
	04:00 pm	NO		-		/	✓				0		
	05:00 pm	NO IVF		-		/					0		
	06:00 pm			-		/				✓	0		
	07:00 pm			-		/				✓	0		
Total Intake :						Total Output :							
9/7	08:00 pm			-		/			/		0	Rana	
	09:00 pm			-		/					0		
	10:00 pm	NO	TDIY			/	✓			✓	0		
	11:00 pm	NO IVF				/					0		
	12:00 am			-		/					0		
	01:00 am			-		/					0		
Total Intake :						Total Output :							
9/7	02:00 am			-		/			/		0	Rana	
	03:00 am			-		/				✓	0		
	04:00 am	NO	water			/	✓				0		
	05:00 am	NO IVF				/					0		
	06:00 am			-		/				✓	0		
	07:00 am			-		/				✓	0		
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							



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.

		Intake				Output					IV Site	Sign.
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo- phlebitis Score	Nurse
			Mouth	I.V	N.G							
10/7	08:00 am	NO NP Stomach		/							entire Branched Syringe	Syringe
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
10/8	02:00 pm										NO cannula	Syringe
	03:00 pm											
	04:00 pm	NO FW Free DS										
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
10/9	08:00 pm										NO cannula	Clear
	09:00 pm											
	10:00 pm	no FW Free										
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
11/2	02:00 am										NO cannula	Clear
	03:00 am											
	04:00 am	NO FW Free										
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						

BAH-00557742 IP5-00176072
 Baby DHARAMSOTH AISHWARYA
 03-03-2018 8 Y 4 M 4 D (F)
 Dr. SIRISHA RANI

NURSING CARE RECORD

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

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 Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 7/7/26

Assessment: baby having

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
2:50pm	→ Assess the Baby General Condition, monitor vitals & Record	2:50pm	→ Assessed the Baby General Condition, monitored vitals & Recorded	By Anus dose pt condition is improved
3pm	→ provide comfortable position	3:30pm	→ provided comfortable position	
4pm	→ continue w fluid intake	4:30pm	→ continued w fluid intake	
5pm	→ plan to do 2 Echo today	6pm	→ planned to do 2 Echo today	
7pm	→ Administer medication as per doctor order	8pm	→ Administered medication as per doctor order	

Re-Assessment:

Special Notes: (Bowel movement Tomorrow) Npo as per doctor order

Nurse Signature: [Signature] Nurse Name: Aparanjitha (021266) Date & Time: 7/7/26 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 7/7/26

Assessment: fever, Nausea

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 for general health condition	8pm	Assessed the pt's general health condition condition	
10pm	Plan to check vitals	10pm	checked vitals signs	
12am	Maintain I/O chart	12am	Maintained I/O chart	
2am	Continue IVF 40ml/hr	2am	Maintaining fluid balanced	
4am	Plan for Bone marrow t/m	4am	plan for bone marrow t/m	
6am	Provide medicine as per drug chart	6am	Provided medicine as per drug chart	
8am	pt NPO t/m from 4am t/m	8am	Now pt NPO from 4am	After providing all these care now pt stable

Re-Assessment: assess for fever spike

Special Notes: Bone marrow t/m (NPO from 4am)

Nurse Signature:

Nurse Name: Priyanka

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

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 8/7/26

Assessment: Baby having fever

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
10 am	→ Assess the baby general condition. & monitor the vital sign.	10:30 am	→ Assessed the baby general condition. & monitor vital sign.	By Done all the procedure Baby condition is improved.
11 am	→ Give Inj: PCM	11:30 am	→ Given Inj & PCM	
12 pm	→ Administered the medication as per doctor order	→ Administered the medication as per doctor order		
12:30 pm	→ provide the comfortable position	12 pm	→ provided the comfortable position	
1 pm	→ Maintain the IV fluids	1:30 pm	→ maintained the IV fluids	

Re-Assessment: Monitor the vital

Special Notes: BMT Done Today.

Nurse Signature: V. Ravina

Nurse Name: V. Ravina (Gosia)

Date & Time: 8/7/26 @ 2pm

BAH-00557742 IP5-00176072
Baby DHARAMSOTH AISHWARYA
03-03-2018 8 Y 4 M 6 D (F)
Dr. SIRISHA RANI



NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 08/9/26

Assessment: Baby having pain at Bone marrow site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the baby General condition	2pm	→ Assessed the baby general condition	By doing the all procedure's the baby condition is improved
3pm		3pm		
4pm	→ provide comfort position	4pm	→ provided comfortable position	
5pm	→ monitor the vitals & recorded it	5pm	→ monitored the vitals & recorded it	
6pm	→ administered the all drugs as per doctor order	6pm	→ administered the all drugs as per doctor order	
7pm	→ ensure the safety	7pm	→ ensured the safety side rails	
8pm		8pm		

Re-Assessment:

Re-assessment is done

Special Notes:

Nurse Signature:

[Signature]

Nurse Name:

Shailaja (65563)

Date & Time:

8/9/26 (8pm)



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/7/24

Assessment: pt having dull activity

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the pt General Condition	8:10pm	→ Assessed the pt General Condition	pt is stable
10pm	→ Check the Vital signs	10:10pm	→ Checked the Vital signs	
12am	→ plan for Administration medication	12:10am	→ providing medication as per doctor Order	
2am	→ plan for I/O Chart	2:10am	→ Strictly I/O Chart	
6am	→ plan for Comfortable position	6:10am	→ providing Comfortable position	

Re-Assessment: Re-Assessment Every 4th hrly

Special Notes: -

Nurse Signature:

Nurse Name: Chondan

Date & Time: 9/7/24 @ 8am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Baby having fever

Date: 9/7/26

Assessment:

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

Time	Plan of Care	Time	Implementation	Evaluation
8:30 am	→ Assess the baby general condition & monitor the vital sign.	10:30 am	→ Maintained the I/O chart	By now all the procedure baby condition is improved.
11:30 am	→ Administer the medication	11:30 am	→ Administered the medication as per doctor order	
12:30 pm	→ provide the comfortable position	12:30 pm	→ provided the comfortable position	
1 pm	→ Maintaining I/O PCM	1:30 pm	→ Given I/O PCM	

Re-Assessment:

Monitor vital

Special Notes:

Nurse Signature: V. Ravina

Nurse Name: V. Ravina (607729)

Date & Time: 9/7/26 @ 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/7/26

Assessment: Baby having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the general condition of the patient	2:30 pm	Assessed the general condition of the patient	Baby condition is good
3pm	monitored the vitals signs	3:30 m	monitored the vitals signs	
4pm	maintain I/O chart	4:30 m	maintained I/O chart	
5pm	Administer medication as per as chart	5:30 m	Administered medication as per as chart	
6pm	ensure the patient safety	6m	ensured the patient safety	

Re-Assessment: Re-Assessment

Special Notes:

Nurse Signature:

Nurse Name: Nitika

Date & Time: 9/7/26 @ 3pm

BAH-00557742 IP5-00176072
Baby DHARAMSOTH AISHWARYA
03-03-2018 8 Y 4 M 6 D (F)
Dr. SIRISHA RANI



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/7/2026

Assessment: Baby is having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	⇒ Assess the general condition of the baby	8:10am	⇒ Assessed the general condition of the baby	The baby condition is Improving slowly
10pm	⇒ monitor vital signs	10:10 Am	⇒ monitored vital signs	
12Am	⇒ provide comfortable bed and position	12:10Am	⇒ provided comfortable bed and position	
4Am	⇒ Administer medication as per doctor order	4:10Am	⇒ Administer medication as per doctor order	
6Am	⇒ Educate personal hygiene	6:10 Am	⇒ Educated personal hygiene	

Re-Assessment:

Baby is feeling discomfortable

Special Notes:

Nurse Signature: Rama

Nurse Name: Rama

Date & Time: 10/7/2026 8Am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 10/7

Assessment: Baby having discomfort

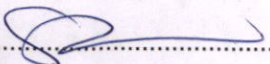
Goals

- ☒ 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
9am	→ Assess the baby general condition	9:10am	→ Assessed the baby general condition	baby condition is normal
10am	→ monitor the vital's	10:10am	→ monitored the vital's	
11am	→ provide comfortable position	11:10am	→ provided comfortable position	
12pm	→ Administer medication as per doctor orders	12:10pm	→ Administered medication as per doctor orders	

Re-Assessment:

Special Notes:

Nurse Signature: 

Nurse Name: SPS81e

Date & Time: 10/7 @ 2pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 10/17/20

Assessment: Baby having poor oral Intake

Goals

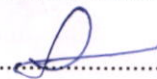
- ☐ Maintain Airway and Oxygenation
- ☐ Relieve Pain & Discomfort
- ☐ Maintain Fluid Balance
- ☐ Improve Activity Tolerance
- ☐ Maintain Good Nutritional Status
- ☐ Maintain Skin Integrity
- ☐ Maintain Personal Hygiene
- ☐ Prevent Infection
- ☐ Meet Elimination Needs
- ☐ Ensure Safety
- ☐ Early Ambulation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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	1. Assess the general condition of the child	2:5 pm	1. Assessed the general condition of the child	By done all the procedure baby condition is Improved
3	2. provide comfortable position	4pm	2. provided comfortable position.	
5p	3. maintain good nutritional food	5:30 p	3. maintained good nutritional food	
6pm	4. maintain I & O chart	6:30 p	4. maintained I & O chart	
8:30 pm	5. Administer medication as per doctor order	8pm	5. Administered medication as per doctor order	

Re-Assessment:

Special Notes:

11m DIC

Nurse Signature: 

Nurse Name: Swarna

Date & Time: 10/17/20 8:00 pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/7/21

Assessment: Baby having low activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the pt General Condition	8:10pm	→ Assessed the pt General Condition	pt is stable
10pm	→ monitor the vital signs	10:10pm	→ Checked the vital signs	
12am	→ plan for administration medication	12:10am	→ providing medication as per doctor order	
2am	→ plan for I/O Chart	2:10am	→ strictly I/O Chart	
4am	→ plan for Comfortable Position	4:10am	→ providing Comfortable position	

Re-Assessment: Re-Assessment every 4th hrly

Special Notes:

Nurse Signature:

Nurse Name: Chandana

Date & Time: 11/7/21 2:08am

BAH-00557742 IP5-00176072
Baby DHARAMSOTH AISHWARYA
03-03-2018 8 Y 4 M 7 D (F)
Dr. SIRISHA RANI



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. Sirisha Rani Department: Gynecology Date of Admission: 7/7/26

SITUATION	Diagnosis: <u>Fever</u>	Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	Area						
BACKGROUND	Shift Time	<u>ER 2:30 pm</u>	<u>1st floor 8pm-8am</u>	<u>1st floor 8pm-8am</u>	<u>1st floor 8pm-8am</u>	<u>1st floor 8pm-8am</u>	<u>1st floor 8pm-8am</u>
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>Fever</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp: <u>98.2°F</u>	Temp: <u>98.5°F</u>	Temp: <u>98.2°F</u>	Temp: <u>98.2°F</u>	Temp: <u>98.0</u>	Temp: <u>98.3°F</u>
	Res:	<u>28 bpm</u>	<u>26 bpm</u>	<u>25 bpm</u>	<u>26 bpm</u>	<u>26 bpm</u>	<u>26 bpm</u>
	SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>
	Pulse:	<u>105 bpm</u>	<u>110 bpm</u>	<u>95 bpm</u>	<u>117 bpm</u>	<u>112 bpm</u>	<u>111 bpm</u>
	BP:	<u>101/61</u>	<u>82/65</u>	<u>101/63</u>	<u>102/62</u>	<u>103/70</u>	<u>101/60</u>
	Fall Risk Score:	<u>9</u>	<u>9</u>	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>
Recommendations	Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>
	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>side rails</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NO</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NO</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NO</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Handed Over By Name :		<u>Susmita</u>	<u>Aparna</u>	<u>Priyanka</u>	<u>Ravina</u>	<u>Shalaja</u>	<u>Chandana</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>7/7/26</u>	<u>7/7</u>	<u>8/7</u>	<u>8/7</u>	<u>8/7</u>	<u>9/7/26</u>
Time:		<u>2:30 pm</u>	<u>8pm</u>	<u>8am</u>	<u>8pm</u>	<u>1pm</u>	<u>2pm</u>
Taken Over By Name :		<u>Aparna</u>	<u>Priyanka</u>	<u>Ravina</u>	<u>Shalaja</u>	<u>Chandana</u>	<u>Ravina</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>7/7/26</u>	<u>7/7/26</u>	<u>8/7</u>	<u>8/7</u>	<u>8/7/26</u>	<u>9/7</u>
Time:		<u>2:30 pm</u>	<u>8pm</u>	<u>@ 8am</u>	<u>7pm</u>	<u>@ 8pm</u>	<u>@ 8am</u>



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sirisha Rani Department: Date of Admission: 7/7/26

SITUATION		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:						
BACKGROUND	Area	1st Floor Santo 2m	1st Floor 2pm-8p	1st Floor 8pm-10pm	1st Floor 10pm-2pm	1st Floor 2pm-8p	1st Floor 8pm-10pm	
	Shift Time							
ASSESSMENT	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	NA	NA	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ASSESSMENT	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	98.1°F	97.7	98.2°F	98.5°F	96.3	98.3°F
		Res:	26b/m	22m	28b/m	25b/m	20	26b/m
		SpO ₂ :	100%	99%	99%	99%	100	99%
		Pulse:	126b/m	120m	120b/m	107b/m	110	116b/m
		BP:	102/62	100/64	100/70	107/70	100/54	98/60
	Fall Risk Score:	10	10	11	11	11	11	
	Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10	
Recommendations	Safety Needs:	yes	yes	yes	yes	yes	yes	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NA	NA	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Ravi	Nitika	Rama	Ravi	Swarna	Chandam	
Signature :								
Date:		9/7	9/7	10/7/26	10/7	10/7	11/7	
Time:		2pm	8pm	8am	2pm	8pm	2pm	
Taken Over By Name :		Nitika	Rama	Sirisha	Swarna	Chandam	Sirisha	
Signature :								
Date:		9/7	9/7/26	10/7	10/7	10/7/26	11/7	
Time:		2pm	8pm	8am	2pm	8pm	8pm	



THE HUMPTY DUMPTY SCALE

7/7 8/7 9/7 10/7 11/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	2	2	2
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	1
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1	1	1
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	1
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
TOTAL			9	9	9	9	9

Intervention : -Fall Risk : Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

Bed in low position	Yes	Yes	Yes	Yes	Yes
Call device within reach	Yes	Yes	Yes	Yes	Yes
Wheels Locked	Yes	Yes	Yes	Yes	Yes
Room free of clutter	Yes	Yes	Yes	Yes	Yes
Adequate Lighting	Yes	Yes	Yes	Yes	Yes
Wheel Chair Support	NO	NO	NO	NO	NO
Other Intervention(s) Specify	NO	NO	NO	NO	NO
Nurse's Name :	Pooja	Prigya	Prigya	Rama	Rama
Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :	7/7	8/7	9/7	10/7	11/7
Time :	1pm	8am	6am	6am	6am

BAH-00557742
Baby DHARAMSOTH AISHWARYA
03-03-2018 8 Y 4 M 7 D (F)
Dr. SIRISHA RANI

BRADEN 'Q' SCALE

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

				Date : 11/2			
				Time : 6am			
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:tremitry position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4		
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4		
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		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4		
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		
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	
Docu. No. : RCHBH/FRM / CLINICAL / 119					Evaluator's Name	Q1	

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

BRADEN 'Q' SCALE

					Date :	7/2	8/2	9/2	10/2
					Time :	1pm	8am	6am	6am
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
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	poor's	Pr	Qy	Ramen

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
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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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/2/26	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chordana
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

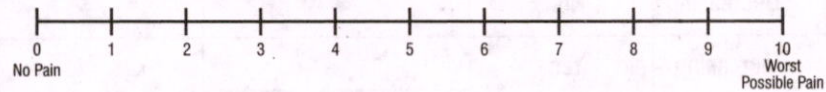
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

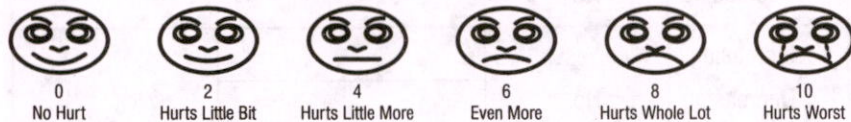
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
7/8/26	1pm	9/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	poofa
7/8/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Priganka
8/8/26	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Priganka
8/7	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chandana
8/7	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chandana
9/7	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chandana
9/7	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rawina
9/7	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rama
10/7	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rama
10/7	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chandana

Re-assessment Frequency:

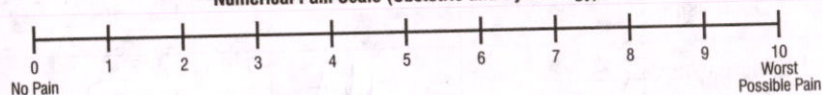
- Every eight hours for all hospitalized patients.
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 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

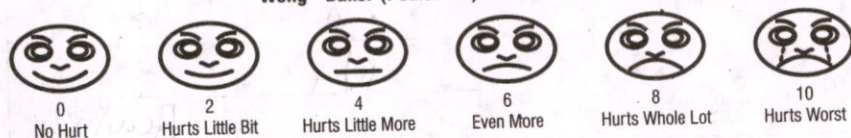
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Assessment Criteria	Sedation		Normal	Pain / Agitation	
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Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or 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





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									
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									
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	1									
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	1									
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	1									
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	1									
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 : Anishbar Name : Anishbar

Signature of Ward In Charge :

Signature : Neeraja Name : Neeraja

BAH-00557742
Baby DHARAMSOTH AISHWARYA
03-03-2018 8 Y 4 M 7 D
Dr. SIRISHA RANI (F)



CHECKLIST FOR THROMBOPHLEBITIS

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S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	7/7/20 DAY-1			8/7 DAY-2			9/7 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		
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			Cannula Removed
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				Appu P.B. (Signature)									

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 : (Signature) Name : Sourav

Signature of Ward In Charge :

Signature : (Signature) Name : Heeraja Devi



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Patient's / Learner Language: Telugu Patient / Learner Literacy: ☐ Read ☒ Write ☒ Speak Willingness to Learn: ☒ Yes ☐ No Healthcare Literacy: ☒ Yes ☐ No

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
7/7/26	1pm	7	Infection control measures	F	4	0	1	1	NA	Pooja
7/7/26	2:30 pm	9	Normal High protein diet	F	1	0	1	1	-	Monika

Part - III: CODES

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

BAH-00557742 IPS-00175072
 Baby DHARAMSOTH AISHWARYA
 03-03-2018 8 Y 4 M 4 D (F)
 Dr. SIRISHA RANI



MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
7/7/26 1125 PM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fever: 3 weeks	Hemodynamic Stability	NPO IV Fluids BMA 503	N-P [Signature]	☐ Nursing ☐ Others:
7/7/26 @ 8:26 PM	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fever	U - Stability	NPO IV Fluid	[Signature]	☐ Medical ☐ Others:
7/7/26 2:30 PM	☐ Medical ☐ Nursing ☒ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Pyrexia	Normal diet High protein diet	RDA E: 1550 kcal/d P: 27g/d	Monica	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

BAH-00557742
 Baby CHAKRANISOTH AISHWARYA
 05-05-2018 3 Y 4 M 6 D
 Dr. Srikanta Rani (F)

Moderate Sedation Flow-Sheet

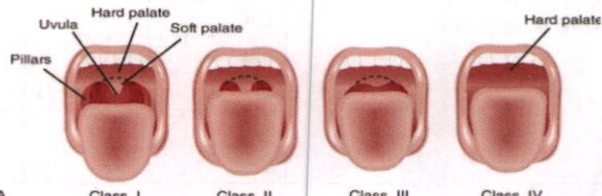
Immediate Pre-Sedation Assessment

B.P	PR	R.R	Temp	SPO ₂	Pain Score	Weight
83/60	120b/m	20b/m	99.2°	100%		19.5kg

Diagnosis: P40.1 Smelation.

Procedure: BMA + Biopsy.

Comorbidities:

☒ Risk, benefits & alternatives discussed; ☒ Patient understand & elects to proceed ☒ Consents for procedure and sedation signed and dated		AIRWAY EVALUATION Mouth: ☒ Normal ☐ Loose Teeth ☐ Small Mouth ☐ Protruding Incisors ☐ Receding Lower Jaw ☐ Dentures Neck: ☐ Normal ☒ Decreased ROM ☐ Thyromental Distance Less Than 6 cm ☐ Short Neck	
ASA Physical Status ☐ ASA PS 1: Healthy Patient ☒ ASA PS 2: Mild Systemic Disease, no functional limitations ☐ ASA PS 3: Severe Systemic Disease, functional limitations ☐ ASA PS 4: Severe Systemic Disease, constant threat to life ☐ ASA PS 5: Moribund Patient unlikely to survive 24 hrs. ☐ ASA PS 6: A declared braindead patient whose organs are being removed for donor purposes ☐ E: Emergency procedure GCS: E4 M6 V5			
☒ IV Site: Gauge:		Mallampati Class: ☐ I ☐ II ☐ III ☐ IV	
Sedation Plan: Short sedation.			
Allergies: (C)			

Monitoring of Patient Intra – Procedure

Procedure Monitoring

Heart Rate (HR), Respiratory Rate (RR), Oxygen Saturation (O₂ Sat) continuously monitored, and Level of Consciousness (LoC) to be monitored and recorded minimally every 15 minutes until 15 minutes after the last administration of any sedation, then every 30 minutes, then every 1 hour until stable. Respiratory status to be monitored continuously.

Level of Consciousness (LOC):

- ☒ A - Alert
- ☐ V - Verbally Responsive
- ☐ P - Painfully Responsive
- ☐ U - Unresponsive

TIME	BP	PR	RR	O ₂ Sat%	O ₂ Supplementation	Comments / Initials
Baseline	83/60 mmHg	126 bpm	20 B/min	100%	RA	

Signature:

BAH-00557742 IP5-00176072
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03-03-2018 8 Y 4 M 5 D (F)
Dr. SIRISHA RANI




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CONSENT FOR SPECIAL SEDATION

Patient Name: D. Aishwarya. Gender: ☐ Male ☒ Female

UHID No: 00557742 Department: _____ Date: 8/2/26

I Mrs. Ramadevi S/D/W/O _____

Here by give consent for procedure for my patient : _____

The doctors have explained to me in language known to me the details of sedation as follows:

- Type of Sedation : Short sedation.
- Possible complications from the procedure of sedation:
Intubation.

The doctors have explained to me about the benefits, risk, alternative of the procedure.

I have understood the matter mentioned above in language known to me and give consent for administering sedation for procedure.

Patient Attendant :

Signature : D. Ramadevi

Name : D. Ramadevi

Relationship with Patient: Mother

Date & Time : 8/2/26 @ 11:55 AM

Witness :

Signature : D. Ramadevi

Name : D. Ramadevi

Date & Time : 8/2/26 @ 11:55 AM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Prakash

Date & Time : 8/2/26

ప్రత్యేక మత్తు కోసం సమ్మతి

వయస్సు లింగం పు ☐ స్త్రీ ☐

రోగి పేరు : యు.పావ్.బి.డి. విభాగము

తేదీ

నేను కుమారుడు / కుమార్తె / భార్య

..... అను విధానంకై పూర్తి అంగీకారం తెలుపుతున్నాను.

వైద్యులు నాకు తెలిసిన భాషలో మత్తుమందు వివరాలను ఈ క్రింది విధంగా వివరించారు:

- సెడేషన్ రకం
- మత్తు ప్రక్రియ నుండి తలెత్తు సమస్యలు:

ప్రక్రియ యొక్క ప్రయోజనాలు, ప్రమాదం, ప్రత్యామ్నాయం గురించి వైద్యులు నాకు వివరించారు.

నేను పైన పేర్కొన్న విషయాన్ని నాకు తెలిసిన భాషలో అర్థం చేసుకున్నాను మరియు మత్తుమందు ఇవ్వడానికి సమ్మతిని ఇచ్చాను.

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకము

పేరు

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

తేదీ మరియు సమయము

సంతకము

పేరు



CONSENT FOR SPECIAL PROCEDURES

Patient Name : D. Aishwarya Gender: ☐ Male ☒ Female

UHID No : _____ Department : Haematology Date : _____

I Mrs. Ramadevi ^{MC} S/D/W/O _____

Here by give consent for procedure of : BMA + Biopsy

For my patient, Named : _____

The doctors have clearly explained to me that the procedure has following possible complications:

Pain, bleeding.

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: _____

Patient Attendant :

Signature : D. Ramadevi

Name : D. Ramadevi

Relationship with Patient: Mother

Date & Time : 8/3/26 @ 11:55AM

Witness :

Signature : D. Ramadevi

Name : D. Ramadevi

Date & Time : 8/3/26 @ 11:55AM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Sirisha Rani

Date & Time : 8/3/26

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00557742 IP5-00176072 Baby DHARAMSOTH AISHWARYA 03-03-2018 8 Y 4 M 5 D (F) Dr. SIRISHA RANI 		Date & Time of Admission 4/07/26 @ 1:14pm	Date & Time of Transfer Order 4/7/26
		Transfer Ordered by Dr. sirisha rani	Reason for Transfer BMA
From Unit 120c	To Unit onco	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Number of Imaging Films pen	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?	
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 Ravina		Name of Person Ordered Transfer Dr. sirisha Rani	
Patient & Clinical Records Received by : pooja			
Date & Time of Patient Received : 4/7/26 @ 1:14pm			

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

pt not willing for pet scan
D. Ramadevi;

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00557742 IP5-00176072 Baby DHARAMSOTH AISHWARYA 03-03-2018 8 Y 4 M 4 D (F) Dr. SIRISHA RANI 		Date & Time of Admission 7/7/26 @ 11:14 PM	Date & Time of Transfer Order 7/7/26 @ 2:30 PM
		Transfer Ordered by Dr. prathiba	Reason for Transfer Admission
From Unit ER	To Unit ward		Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File 19	Number of Imaging Films NA		Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what? op files
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 Dr. pouja		Name of Person Ordered Transfer Dr. prathiba	
Patient & Clinical Records Received by :			
Date & Time of Patient Received :			

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

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Baby DHARAMSOTH AISHWARYA
03-03-2018 8 Y 4 M 4 D (F)
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DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: As per doctor order

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status:

☐ Self Care

☒ Family Home Care

☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication

☒ Yes

☐ No

☐ Bathing

☒ Yes

☐ No

☐ Eating

☒ Yes

☐ No

☐ Walking

☒ Yes

☐ No

☐ Dressing

☒ Yes

☐ No

☐ Toileting

☒ Yes

☐ No

Explain to parents

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Personal Hygiene

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

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: Au

Nurse Name: Aparajitha

Date and Time: 7/7/26 @ 2pm

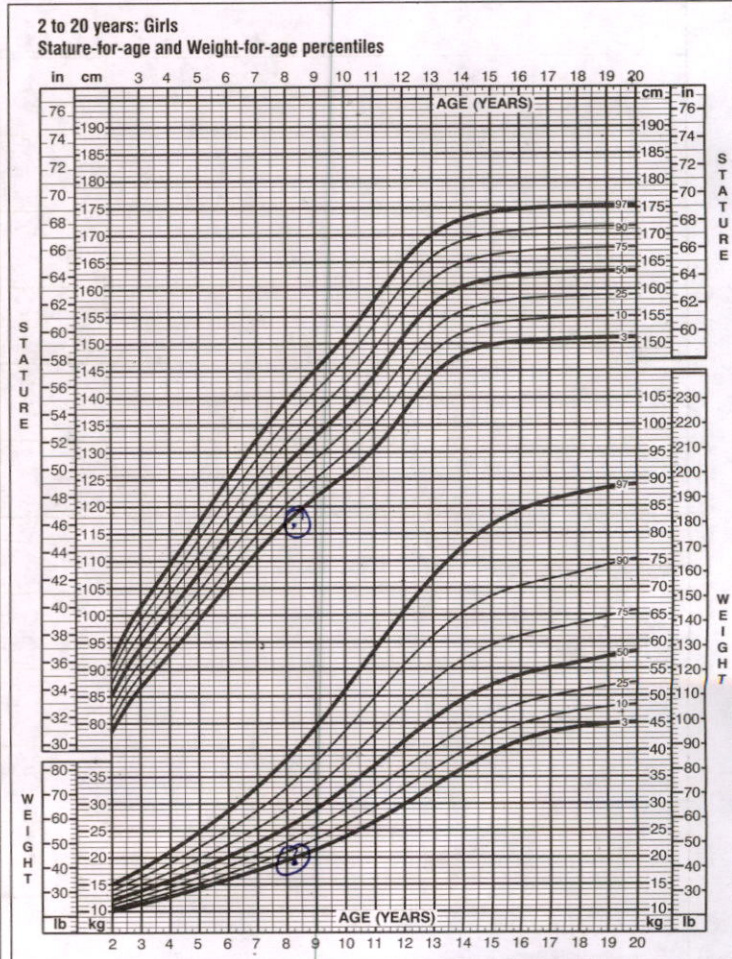
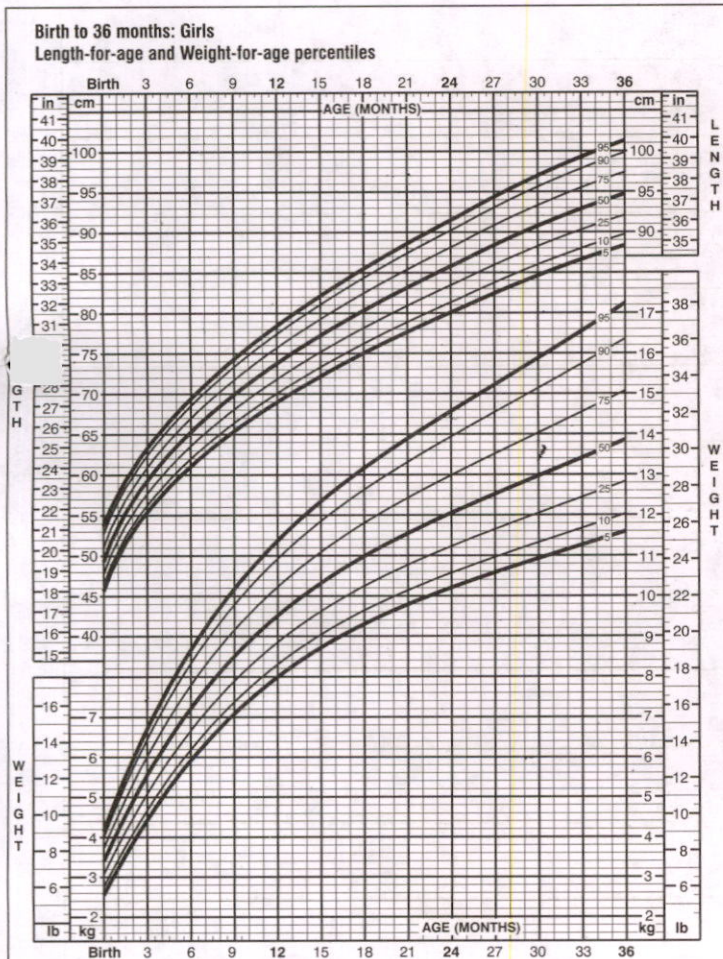


NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 7/7/26 Time: 2:30pm

Weight: 19.5 Kgs Centile: 55th
Height: 116 cm Centile: 55th
Inference: Underweight child
RDA: — Calories: 1550 Kcal/d Protein: 27g/d
Diet Recommendations: High protein Normal diet
Re-Assessment: Avoid spicy, chilled and outside foods
Food Allergies: NO Veg/Non-veg: neg
Diagnosis: Pyrexia funkunen Ocifla
Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral
Patient's Signature: D. Ramadevi

GROWTH CHART (GIRLS)



Dietician's Name: Mounica

Dietician's Signature: Mounica

Daily Notes:

~~2/3/22~~
jam

child is on NPO

Nibbles

BAH-00557742 IP5-00176072
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ACTIVITY RECORD FOR BILLING

Name : Aishwarya

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
7/7/26	2:30 pm	ER	12/E	poofa

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Phani Bhargava	7/7/26	96996219	Appu
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

INVESTIGATIONS			
Date	Investigations	Order No.	Signature
27/07	LDH, CRP, CRP, LFT, Sr. Creat ANA profile, Blood clt Mantoux (Lt fore Arm) very small joints	67968	Tsneal
07/07	USG small parts (RT elbow) ①	33718	Tsneal
7/7	2nd echo ①	33719	Appu
8/7	Gastric aspiration for AFB & Geneexpert	2677614	Amir
8/7	Burcella IgM	2509611	Rel
10/7	USG Abdomen - neck	250970	Rel
10/7	SIX-ray chest lateral	54817	Rel

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
09/07	IV placement	1	91776	T. Sanyal
7/7/26	N/A	0	91777	Appu
8/7/26	Bone marrow Aspirations	1	26068254	
	Biopsy	1		

ANY OTHER INFORMATION

ultra sound small parts - ①

USG Abdomen and neck - ①

Date :

Time :

Prepared By : S. Sanyal

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
S. Sanyal			