

ADMISSION SHEET

Registration Details :



Admission No : IP5-00173935

Admit Date : 17-May-2026

Admit Time : 01:48 PM UHID : LBH-00120584

Patient Details :

Patient Name : Baby Of KUNTLA SUJITHA (KUKUNURU LALITH
VEER REDDY)

Age : 0 Y 9 M 2 D

Guardian : Mr KUKUNURU UGENDER REDDY

DOB : 15-08-2025 06:01 PM

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : H NO 1-59, KANACHANPALLY (V),
ADDAGUDUR (M), Mothcore Nalgonda
Telangana INDIA 508277

Phone No : 9676785376/ 9959520552

E-mail : UGENDERENGLISH08@GMAIL.COM

Admission Details :

Bed Type : SEMI PRIVATE

Bed No : SPVT 101

Ward Name : 1F-VIBGYOR

Room No : SPVT 101

Admission Type : First Visit

Contact Details :

Name : Mr KUKUNURU UGENDER REDDY

Relationship : Father

Contact Address : H NO 1-59, KANACHANPALLY (V),
ADDAGUDUR (M), Mothcore Nalgonda
Telangana INDIA 508277

Phone No : 9676785376 / 9959520552

Signature

Doctor Details :

Doctor Name : Dr. VIJAYANAND JAMALPURI

Specialisation : GENERAL PEDIATRICS

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :


Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

ACTIVITY RECORD FOR BILLING

Name : _____
 UHID No. : _____ IP No. : _____
 Date of Admission: _____ Time : _____ Date of Discharge : 20/5/26 Time: 10 AM
 Room / Bed No : 101 Ward : SPVT Suggested Billable bed type : _____

LBH-00120584 IP5-00173935
 Baby Of KUNTLA SUJITHA (
 15-08-2025 0 Y 0 M 2 D (M)
 Dr. VIJAYANAND JAMALPURI


WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr:- poushy mam	18/05/26	9614726	<u>Shariq</u>
2				
3				
4				
5		<u>DCC</u>		
6				
7				
8				
9				
10				



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

LBH-00120584 IP5-00173788

Baby Of KUNTLA SUJITHA (

15-08-2025 0 Y 8 M 28 D (M)

Dr. VIJAYANAND JAMALPURI

UHID ID: _____



Department: _____

Consultant: _____

Pediatric Multiorgan History & Physical Examination

Name : Baby of Kuntla Sujitha Age/Sex _____

Information given by: Mother Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

c/o Fever - 3 days
Vomiting - 2 days
Poor oral Intake
dull activity

History of present illness :

As per informant, child apparently well then had

1) Fever - 3 days
moderate grade
not of chills
relieved with medication

2) vomiting - 2 days
3-4 episodes
non-projectile, non bilious, yellowish in colour

a/w poor oral intake & dull activity.

no H/o cold / cough

Had Hirschsprung disease - Endorectal pull through was done.

& stricturoplasty - fol stenosis done.

LBH-00120584 IP5-00173788
Baby Of KUNTLA SUJITHA (
15-08-2025 0 Y 8 M 28 D (M)
Dr. VIJAYANAND JAMALPURI

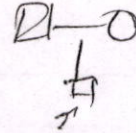


Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Ⓜ perinatal transition.



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information :]-middle

Developmental History :

Attained appropriate for age

Immunization History :

Immunised till date



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____
Weight (kgs)) 6.3 kg (Centile _____)

On Examination :

Temperature : 102.8°F Pulse Rate : 148/min B.P. 90/68 SPO2 98% @ RA

Resp. rate and type of breathing : 28/min
regular

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____ (N)

Air entry & breath sounds : _____ BAE (+)

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____ (N)

Heart Sounds : _____ S₁, S₂ Heard

Any murmur : _____

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

Per Abdomen :

Inspection _____ (N)

Palpation : _____ soft, non tender

Ausculation : _____

Spine : _____ (N) External Genitalia : _____ (N)

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



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: To prevent complications

Desired goals of the treatment: For Hemodynamic stability

Planned Labs:

Blood c/s

CUE, Urine c/s

USG Abdomen

CBP / Done in
CRP / OPD

*N.B
Planned*

Planned Management

1) IV ceftriaxone

2) IV esomeprazole

3) IV Ondansetron

DR. VIJAYANAND JAMALPURI
Registration No: 40526

Signature of the Doctor: J.V.

Name of the Doctor: Jayashri

Date & Time: 13/5/26

Signature of the Consultant: [Signature]

Name of the Consultant: Dr. Vijayanand J.

Date & Time: 13/5/26 @ 9:30



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Alert/Active

Cranial Nerves : _____

Motor System:

Nutrition : Good

Tone: (2) Power 5/5

Co-ordinator : _____

Posture : _____

Involuntary Movements : Nil

Reflexes :

DTR

(1)

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : Regular

Clinical Summary & Diagnostic:

Acute Febrile Illness w/ UTI

- some dehydration



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It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

BH-00120584 IP5-00173935
Baby Of KUNTLA SUJITHA (M)
5-08-2025 0 Y 9 M 5 D
Dr. VIJAYANAND JAMALPURI



Patient Name:

Baby of Kuntla Sujitha

UHID ID:

LBH-00120584

Department:

Paed.

Consultant:

Dr Vijayanand Jamalpuri



Pediatric Multiorgan History & Physical Examination

Name : B/o Kuntla Sujitha Age/Sex 8m / male

Information given by: _____ Relationship Mother

Chief Presenting Complaints & Duration (Chronologically)

40 fever x 3 days
Vomiting x 2 days
Poor oral intake
dull activity

History of present illness :

As per informant, child was
apparently well then developed.

① Fever x 3 days
moderate grade, not also chills
relieved with medication.

② Vomiting : 2 days
3-4 episodes
non projectile, non bilious
yellowish in colour.
also poor oral intake & dull activity

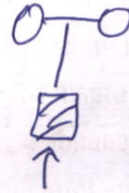
no H/O cold/cough

paediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Normal Perinatal and Antepartum transition



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : } middle

Developmental History :

attained appropriate for age

Immunization History :

immunized till date

(P.T.O.)

Reflexes :

DTR

+++

Plantars

elicited

Superficials: +++

Sensory System :

Intact + (N)

Bladder / Bowel :

regular, adequate

Clinical

Patient S#

IPS-00173935

LBH-00120584

Baby Of KUNTALA SUJITHA (

15-08-2025

0 Y 9 M 2 D
Dr. VIJAYANAND JAMALPURI



History & Physical Examination

Anthropometry :

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

Weight (kgs)) 6.3 kg (Centile _____)

On Examination :

Temperature : 102.5°F Pulse Rate : 148/min B.P. 90/68 SPO2 98% @ RA

Resp. rate and type of breathing : 28/min
regular

Rash _____

Lymphadenopathy _____

Oedema : _____ some dehydration

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : Normal

Air entry & breath sounds : BAE ⊕

Any added sounds : _____

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

Cardiovascular

IPS-00173935

LBH-00120584

Baby Of KUNTALA SUJITHA (

15-08-2025

0 Y 9 M 2 D
Dr. VIJAYANAND JAMALPURI



Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

To prevent sepsis

Desired goals of the treatment: _____

Resolution

Planned Labs:

CBP
CRP } 6am

Planned Management

- ① IV Ceftriaxone Metrogyl
(METRONIDAZOLE)
- ② INS MEROPENEM
- ③ INS ESMO PRAZOLE
- ④ QUADRACEL UA

Signature of the Consultant: _____

DR. VIJAYANAND JAMALPURI

Registration No: 40526

LBH-00120584 IP5-00173935
 Baby Of KUNTLA SUJITHA (M)
 15-08-2025 0 Y 9 M 2 D
 Dr. VIJAYANAND JAMALPURI

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/5/26		
5:40pm	CS/B Resident	
	Δ: AFIA UTI	Plan ① Inj MERO PENAM
	child is stable doing well taking oral feeds milk formula	② Inj METROGYL ③ MESMOPIRAZOLE
	90ml & 4 times/day not passed stools	④ QUADRAGEL LA
	OLE child is hemodynamically stable	Soheil cDr. Soheil
	CVS: S, S (F) RS: BAE (F), air entry (F) PA: firm, some distention (F) ENT: clear	T/M CBP } CRP } @ 6am

LBH-00120584 IP5-00173935
 Baby Of KUNTLA SUJITHA (M)
 15-08-2025 0 Y 9 M 2 D
 Dr. VIJAYANAND JAMALPURI

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/5	CSIB Resident	
8:00am	Δ: AFI+UTI	<u>Plan</u>
	child is afebrile doing well taking formula feed ≈ 85-90 ml / 4 times	① <u>Cont</u> MEROPENAM
	Stools - wash done evening	② INJ METROGYL
	abd. girth - 39cm	③ INJ ESMOPRAZOLE
	started oral Nestum rice	④ <u>OBADRAGEL</u> 4A
	O/E: child is asleep	<u>Sohib</u>
	CVS: S1S2 ⊕	<u>CA. Sohib</u>
	PIA: soft	
	RS: BAE ⊕, airway clear	
	EWT: clear	
18/5	Seen by <u>Dr. Vijayanand</u>	
9:30am		
		<u>Plan</u>
		• <u>Cont</u> Antibiotics
		• <u>Engaging Surgical Review</u> (Nabeel)
		DR. VIJAYANAND JAMALPURI Registration No. 40626

LBH-00120584 IP5-00173935
 Baby Of KUNTLA SUJITHA (0 Y 9 M 2 D)
 15-08-2025
 Dr. VIJAYANAND JAMALPURI (M)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/5/26 9:35 AM	afebrile Vitals stable	<u>C/S/B Dr. Harish</u> <u>Adw</u>
	P/A - distended. did not pass stool	1) Feeds as per pediatrician's advice. 2) Plan - Colostomy tomorrow
18/5/26 14:45hr	No fever spikes. Remo by Dr. Harish Sir noted. Dr. Harish Sir NOT FOR COLOSTOMY at present.	plan ① continue IV antibiotics. ② Encourage oral intake. ③ START SOLIDS.

Dr. Malika Malika
 18/5/26
 9:35 AM

DR. VIJAYANAND JAMALPURI
 Registration No: 40526

LBH-00120584
 Baby Of KUNTLA SUJITHA (M)
 15-08-2025 0 Y 9 M 2 D
 Dr. VIJAYANAND JAMALPURI

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Counselling Notes</u>	
13/5 4pm	<p>48/2 Resident AFI</p> <p>No fever Abd-distension (+) Dist Passed small quantity of stools after detactⁿ.</p> <p>Taking Oral Nestum Rice Child alert Hemodynamically stable</p>	<p>Plan</p> <ul style="list-style-type: none"> o No colostomy o Cont. Rectal wash o Cont. IV Antibiotics o start Solids o Syp Enty & Colax <p><u>Ayudman</u></p>
15/05/26 9:20hr	<p>? Enterocolitis</p> <ul style="list-style-type: none"> • No fever Spikes • Stools - ^{Stool} taking • Bowel - ✓ • URINE - ✓ 	<p>plan</p> <ol style="list-style-type: none"> ①. Encourage oral intake ②. D/w Gastro team ③. If unable to eat <p>↓</p> <p>oral Elixime x5d & Metronidazole x5d</p> <p>DR. VIJAYANAND JAMALPURI Registration No: 40524</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/5/26 4:30pm	E/S/B Resident	
	No fever spikes	<u>Plan</u>
	taking solid cereals - Once	continue as <u>charted</u>
	milk - 4 times ~ 120ml	
	passed stools → 6 times e out diatcher	
	no fresh complaint	
	<u>Oral</u> Vitab I table	<u>Solu</u> <u>Cor Solu</u>
19/5/26	_____	
18h	_____	plan
—	• Taking ad solids well	①. Continue
	• Bowel - ✓	ORAL Antibiotics
	• NO fever	

(Signature)
 DR. VIJAYANAND JAMALPURI
 Registration No: 40526

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/05/20		plan
9 AM		
—	NO Fever Spikes	①. Discharge
	No vomiting	②. Continue & complete Slay course of
	Bowel - ✓ No loose motions	Cefixime Methonidazole
	Urine - ✓	③. R/V @ hospital 3 weeks
	Activity - better	④. Video consultation in 5 days (i.e. Monday)
	Oral intake - Better	⑤. continue 2 Lactulose & Sodium Picosulphate
		⑥. Continue Lantidol DT or
		@ Home for 5 days
		⑦. Simultaneous Total comfortable feed.
		⑧. Restart
		encounter / I/F/D exp
		DR. VIJAYANAND JAMALPURI Registration No: 40526

LBH-00120584 IP5-00173935
 Baby Of KUNTLA SUJITHA (
 15-08-2025 0 Y 9 M 3 D (M)
 Dr. VIJAYANAND JAMALPURI



CROSS CONSULTATION FORM

Doctor Name : Dr. MNV Panshya Sai Date : 18/5/26 Time :

Diagnosis :

Hospital : <u>Rel</u>	Type of Referral : <input type="checkbox"/> Emergency <input type="checkbox"/> Urgent <input checked="" type="checkbox"/> Non Urgent
Referred for : <input checked="" type="checkbox"/> Opinion <input type="checkbox"/> Co-Management <input type="checkbox"/> Transfer of care	

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

Rationale of using oral stimulant laxatives

Signature: [Signature]

Findings and Recommendations :

wt 6.3kg

~~abd~~
 short segment HD
 s/p. full through
 Dilates @ home 7 → 14.
 concerns of Abd distension.
 ↓ stooling.
 ↓
 Post sphincteroplasty,
 intervals ~~stooling~~
 ↓
 Re concerns of Abd distension.
 ↓ stooling.

Used enema once. BD x 10 days
 XSm apo.
 No oral laxatives.
 Rectal wash given yesterday,
 Dilated yet \bar{c} 15 (Hegarty)
 → passed stools
 No blood.

USA Abd on 13/5
 s/p. gaseous distension of
 bowel loop noted \bar{c} dilated loop
 in pelvis → ? dit anastomotic
 narrowing.

→

Consultant :
 Name : Dr. Panshya Sai Signature : [Signature] Date & Time : 18/5/26

(a) 11/26

use d/w Dr. Harsh Sir \rightarrow ^{anatomical} no narrowing when done dilation.

Plan
 \leftarrow

① Vegetable puree } can mix with Uggu/Hestum. \rightarrow s. d. H. S. / s. / feed.
Apple puree } (Rice + dal).
(Other fruit purees) can be attempted. 3-4 times / day
can start.

② ~~can use Aftamit pepti (to gradually)~~

③ change feed to Similac total comfort
to qty of milk / day

④

SYP Emty	5ml	H.S.	} to cont HII further advice.
SYP Gelax	5ml	H.S.	

⑤ R/V x 2 wks.

⑥ cont Rectal dilation.
and Rectal washes
as usual.

Sharma

LBH-00120584 IP5-00173935
 Baby Of KUNTLA SUJITHA ((M)
 15-08-2025 0 Y 9 M 2 D
 Dr. VIJAYANAND JAMALPURI



RESULT SHEET

Date	18/5			
Time				
Hb	10.7			
PCV	34.2			
RBC	4.5			
WBC	20.57			
N/L	11.7/79			
Platelets	5.07l			
CRP	29			
ESR				
PCT				
RBS				
Na				
K				
Cl				
Ca/Mg				
Phosphate				
Urea				
Creatinine				
ALP				
SGPT				
SGOT				
T.Bil/Conj				
T.Protein				
S.Albumin				
S.Globulin				
A/G Ratio				
Uric Acid				
S.Amylase				
Sr.Lipase				
Blood Lactate				
S.Cholesterol				
PT/INR				
APTT				
CSF Protein / Sugar				
Cells				
N/L				

LBH-00120584
 Baby Of KUNTLA SUJITHA (M)
 15-08-2025 0 Y 9 M 2 D
 Dr. VIJAYANAND JAMALPURI



IPS-00173935



Sheet No:

REGULAR PRESCRIPTIONS

Weight 6.36 Ward

DRUG : <u>Syp Retent P/O</u>				Date Time																		
Dose	Route	Frequency	Start Dt.																			
<u>2 ml</u>	<u>P/O</u>	<u>BID</u>	<u>1715</u>																			
Name & Signature of the Doctor Starting the Drugs: <u>Soheh</u>																						
Additional Instructions: <u>X</u>																						
Daily Doctor's Endorsement by a Sign																						

DRUG : <u>Syp EMTY</u>				Date Time	<u>18/5/2025</u>																	
Dose	Route	Frequency	Start Dt.																			
<u>5ml</u>	<u>P/O</u>	<u>use once daily</u>	<u>18/5</u>																			
Name & Signature of the Doctor Starting the Drugs: <u>Ayushman</u>																						
Additional Instructions: <u>10 Amibon pm Sachin Amim Sam</u>																						
Daily Doctor's Endorsement by a Sign																						

DRUG : <u>Syp COLAX</u>				Date Time	<u>18/5/2025</u>																	
Dose	Route	Frequency	Start Dt.																			
<u>5ml</u>	<u>P/O</u>	<u>use once daily</u>	<u>18/5</u>																			
Name & Signature of the Doctor Starting the Drugs: <u>Ayushman</u>																						
Additional Instructions: <u>10 Amibon pm Sachin Amim Sam</u>																						
Doctor's Endorsement by a Sign																						

DRUG : <u>SYP METRONIDAZOLE</u>				Date Time	<u>19/5/2025</u>																	
Route	Frequency	Start Dt.																				
<u>P/O</u>	<u>BID</u>	<u>19/5</u>																				
Name & Signature of the Doctor Starting the Drugs: <u>Soheh</u>																						
Additional Instructions: <u>7.5mg/kg (200mg)</u>																						
Doctor's Endorsement by a Sign																						

VERIFIED

LBH-00120584 IP5-00173935
 Baby Of KUNTLA SUJITHA (M)
 15-08-2025 0 Y 9 M 2 D
 Dr. VIJAYANAND JAMALPURI



She **REGULAR PRESCRIPTIONS** Weight Ward

DRUG : SYP LEFIXIME				Date Time																			
Dose	Route	Frequency	Start Dt.																				
3ml	PO	BID	1915																				
Name & Signature of the Doctor Starting the Drugs:				<p>Soheeb</p> <p>6AM IV. Drip</p>																			
Additional Instructions:				<p>zipmax</p> <p>5ml = 50mg</p> <p>6pm Puff</p>																			
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

Signature

Name

LBH-00120584 IP5-00173935

Baby Of KUNTLA SUJITHA (15-08-2025 0 Y 9 M 5 D (M)

Dr. V. JAYANAND JAMALPURI

ic. No. : RCHBH / FRM / CLINICAL / 124

INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

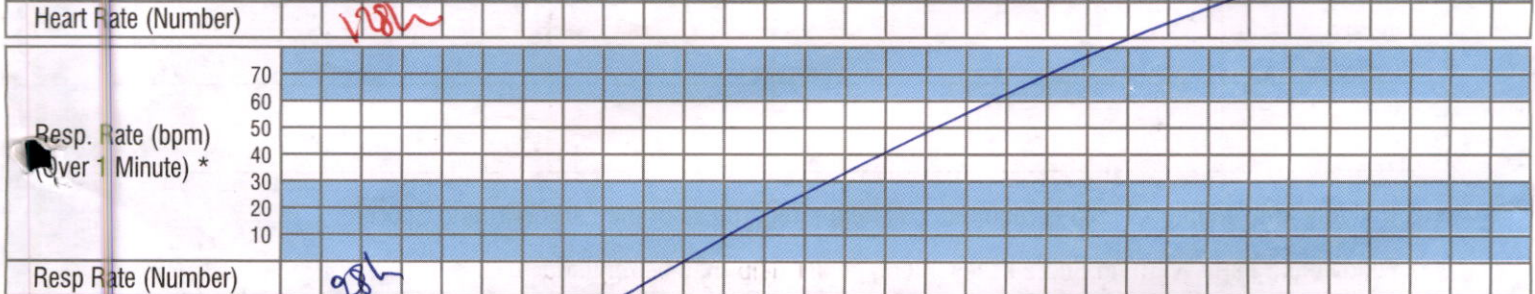
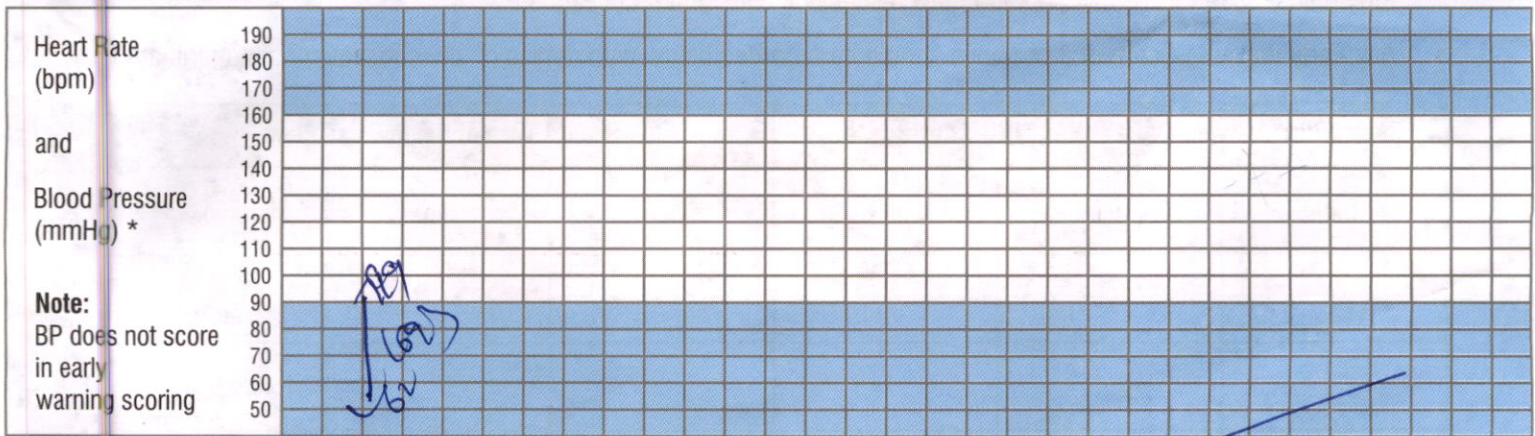
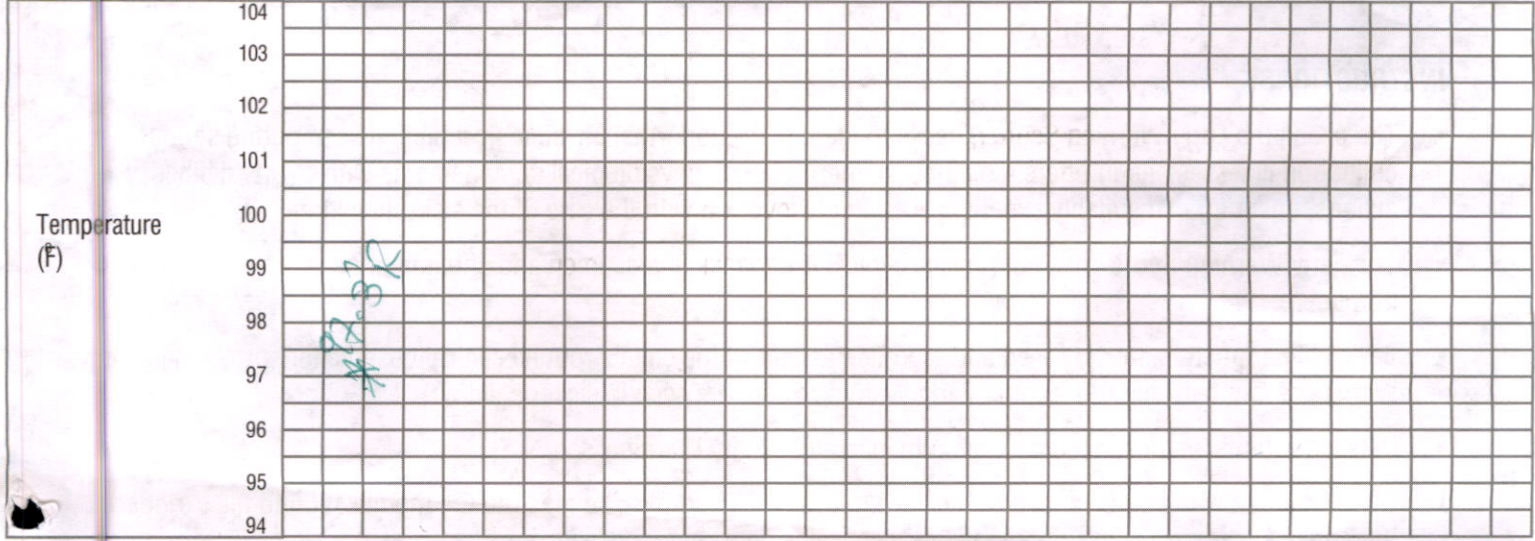
Pratiksha
Rainbow Children's Hospital
 It takes a lot to treat the little.

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 15/8 Time: _____

Doctor/Nurse/Family Concern? ba



Resp Rate (Number) 30

Resp Mod/ Severe Distress None / Mild

Receiving O₂(l/min) O₂Saturations (%) 98

Conscious Level Normal / Altered

GCS * 15/15

TOTAL SCORE

Number of shaded boxes 1

Pain Score 0

Observer's Initials g

- 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 incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

NB: Scores 3 should be recorded overleaf

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

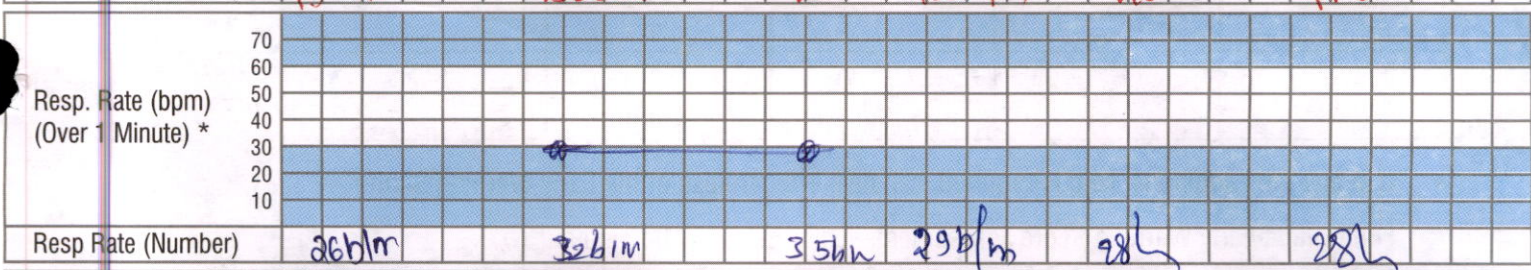
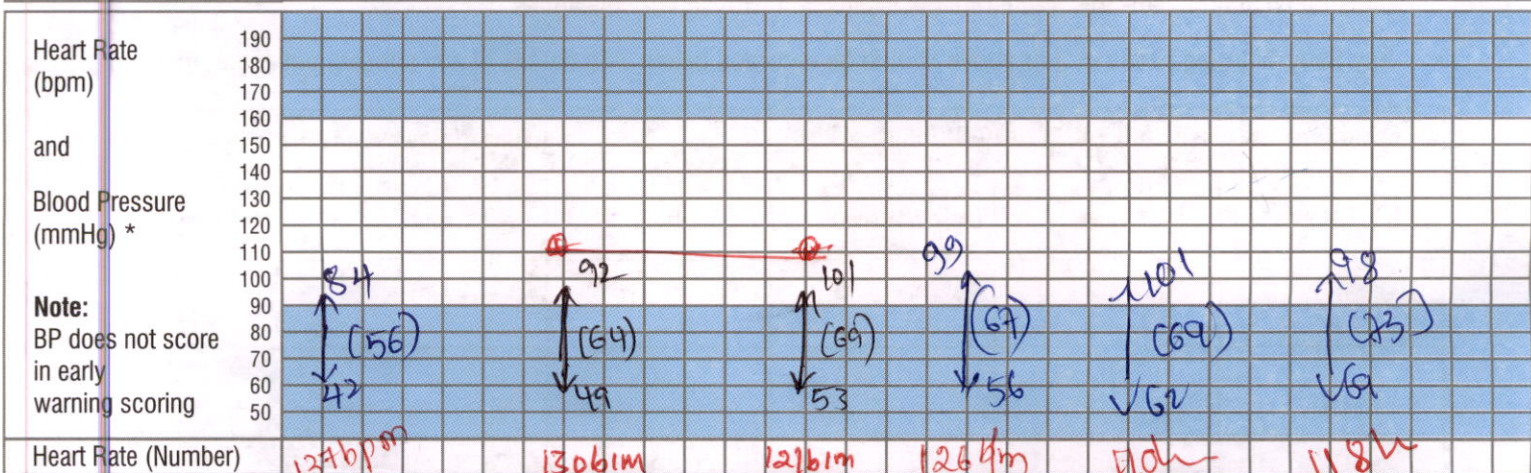
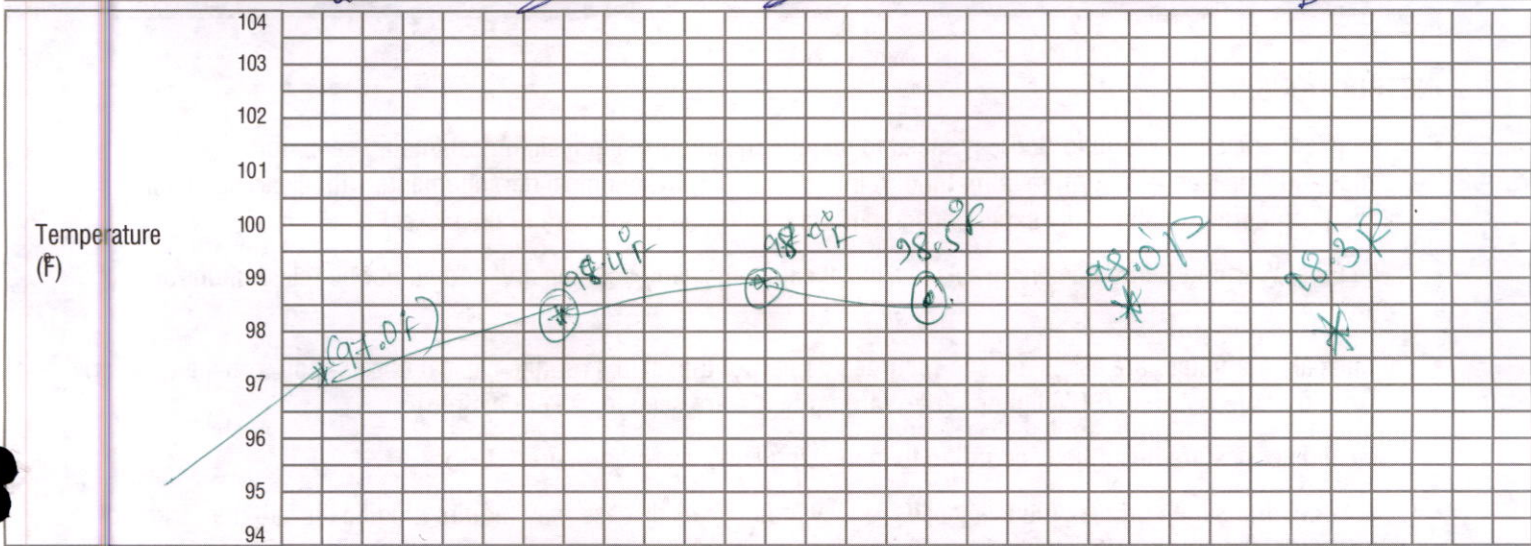


INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 19/5 Time: 6 AM

Doctor/Nurse/Family Concern? and 10 AM 1 PM 6 PM 10 PM 9 PM



Resp Mod/ Severe Distress	None / Mild
Receiving O ₂ (l/min)	
O ₂ Saturations (%)	99% 99% 100% 99% 99% 99%
Conscious Level	Normal / Altered
GCS *	15/15 15/15 15/15 15/15 15/15 15/15
TOTAL SCORE	
Number of shaded boxes	1 1 1 2 1 1
Pain Score	0 0 0 0 0 0
Observer's Initials	and and and and and and

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 incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

NB: Scores 3 should be recorded overleaf

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

- If at any time additional help is required, call help – regardless of the Early Warning Score!
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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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INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 18/5	Time: 6 am	10 am	2 pm	6 pm	10 pm	12 am
Doctor/Nurse/Family Concern?						
Temperature (F)	104					
	103					
	102					
	101					
	100					
Heart Rate (bpm)	190					
	180					
	170					
	160					
	150					
Blood Pressure (mmHg) *	130					
	120					
	110					
	100					
	90					
Heart Rate (Number)	138 bpm	132 bpm	120 bpm	110 bpm		
	Resp Rate (bpm) (Over 1 Minute) *					
	70					
	60					
	50					
Resp Rate (Number)						
Resp 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	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 incharge and PICU /NICU fellow or PICU/NICU 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

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LBH-00120584 IP5-00173935
 Baby Of KUNTLA SUJITHA (
 15-08-2025 0 Y 9 M 2 D (M)
 Dr. VIJAYANAND JAMALPURI

Loc. No. : RCHBH / FRM / CLINICAL / 124

INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 15/8/25	Time: 6:30 AM	10 PM	9:30 AM
Doctor/Nurse/Family Concern?			
Temperature (F)	96.8	98.0	98.0
Heart Rate (bpm)	98	102	102
Blood Pressure (mmHg) *	109/62	100/60	98/50
Resp. Rate (bpm) (Over 1 Minute) *	28	28	28
Conscious Level	15/15	15/15	15/15
GCS *	15/15	15/15	15/15
TOTAL SCORE	1	1	1
Number of shaded boxes	0	0	0
Pain Score	0	0	0
Observer's Initials			

ACTIONS	Score 1 : Continue normal observation by staff nurse
	Score 2 : Shift in charge nurse to be informed and continue hourly observations
	Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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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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R	RECOMMENDATION: I need you to ... come to see the child in the next (XX mins) AND is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)

Patient Sticker

LBH-00120584 IP5-00173935
 Baby Of KUNTLA SUJITHA (M)
 15-08-2025 0 Y 9 M 2 D
 Dr. VIJAYANAND JAMALPURI



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm										0		Drugs
	03:00 pm										0		
	04:00 pm										0		
	05:00 pm	DS									0		Drugs
	06:00 pm										0		
	07:00 pm										0		Drugs
Total Intake :						Total Output :							
	08:00 pm										0		Drugs
	09:00 pm	↑									0		Drugs
	10:00 pm	NO MILK									0		Drugs
	11:00 pm	IVF									0		Drugs
	12:00 am										0		Drugs
	01:00 am	↓									0		Drugs
Total Intake :						Total Output :							
	02:00 am										0		Drugs
	03:00 am	↑									0		Drugs
	04:00 am	NO MILK									0		Drugs
	05:00 am	IVF									0		Drugs
	06:00 am										0		Drugs
	07:00 am	↓									0		Drugs
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

LBH-00120564 IP5-00173935
 Baby Of KUNTLA SUJITHA (0 Y 9 M 2 D (M)
 15-08-2025
 Dr. VIJAYANAND JAMALPURI



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			
18/08/26	08:00 am	↓	Milk	↓		↘	↓			0	shank		
	09:00 am		Milk	↓		↘	↓		✓	0	shank		
	10:00 am	NO I.V				↘	↓			0	shank		
	11:00 am	NO I.V				↘	↓			0	shank		
	12:00 pm					↘	↓		✓	0	shank		
	01:00 pm					↘	↓			0	shank		
Total Intake :						Total Output :							
18/08/26	02:00 pm	↓				↘	↓		✓	0	shank		
	03:00 pm		Milk			↘	↓			0	shank		
	04:00 pm	NO I.V				↘	↓			0	shank		
	05:00 pm	NO I.V				↘	↓		✓	0	shank		
	06:00 pm					↘	↓			0	shank		
	07:00 pm					↘	↓			0	shank		
Total Intake :						Total Output :							
18/8	08:00 pm	↑				↘	↓			0	shank		
	09:00 pm	↑	milk			↘	↓		✓	0	shank		
	10:00 pm	NO				↘	↓			0	shank		
	11:00 pm	I.V				↘	↓		✓	0	shank		
	12:00 am	↓	milk			↘	↓			0	shank		
	01:00 am	↓				↘	↓			0	shank		
Total Intake :						Total Output :							
19/8	02:00 am	↑				↘	↓			0	shank		
	03:00 am	↑				↘	↓		✓	0	shank		
	04:00 am	NO				↘	↓			0	shank		
	05:00 am	I.V				↘	↓		✓	0	shank		
	06:00 am	↓				↘	↓			0	shank		
	07:00 am	↓				↘	↓		✓	0	shank		
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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
19/5	08:00 am					/		/					
	09:00 am		milk			/	✓	/		✓		No cannula	Praveek
	10:00 am	No IVF				/		/					Praveek
	11:00 am		Nestle rice milk			/		/		✓			Praveek
	12:00 pm					/	✓	/					Praveek
	01:00 pm					/		/					
Total Intake :						Total Output :							
19/5	02:00 pm	↑				/		/					
	03:00 pm		milk			/	✓	/		✓			Praveek
	04:00 pm	No IVF				/		/					
	05:00 pm					/	✓	/		✓			
	06:00 pm					/		/					
	07:00 pm	↓				/	✓	/		✓			
Total Intake :						Total Output :							
19/5	08:00 pm					/		/					
	09:00 pm					/		/					Praveek
	10:00 pm	No IVF	milk			/		/					
	11:00 pm					/		/					
	12:00 am					/		/					
	01:00 am					/		/					
Total Intake :						Total Output :							
20/5	02:00 am					/		/					Praveek
	03:00 am		milk			/		/					
	04:00 am					/		/					
	05:00 am	No IVF				/		/					
	06:00 am	IVF	milk			/	✓	/					
	07:00 am					/		/					
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output



FLUID CHART

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			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

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

Total 24 hrs. Output	
-----------------------------	--



NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 18/5/26 Time: 9am

Weight: 6.3 kgs Centile: <5th

Height: 66 cm Centile: <5th

Inference: underweight child

RDA: - Calories: 98 kcal/kg/d Protein: 1.8g/kg/d

Diet Recommendations: Aptamil pepti (1:30ml) dilution

Re-Assessment: stage II weaning foods - HCF advised

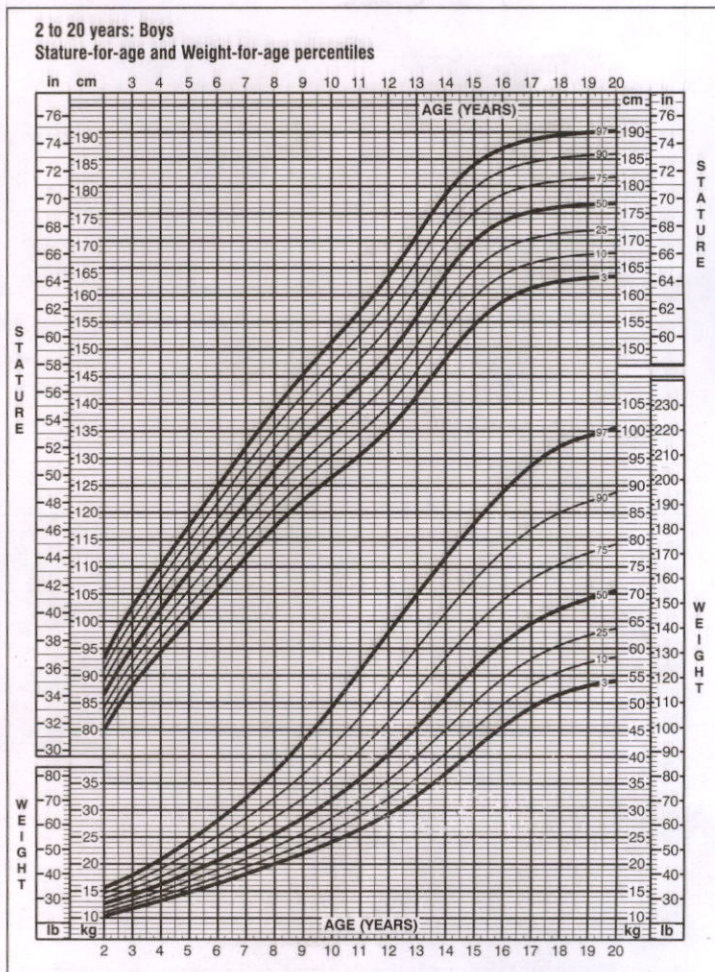
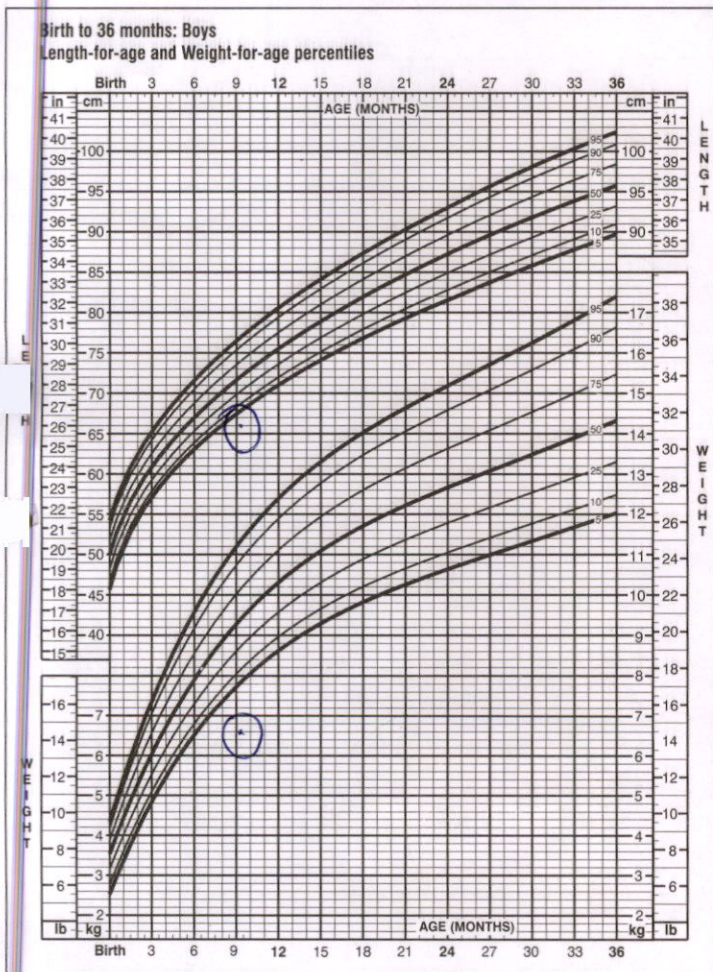
Food Allergies: NO Veg/Non-veg veg

Diagnosis: AFI + UTI

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: K. Sujitha

GROWTH CHART (BOYS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha

Daily Notes:

19/5/26
11:30 AM

child is stable. Encourage orally Nestum
Rice. 1 scoop to m of dilution. — Mounica.

20/5/26
8 AM

child is stable. Oral intake is fair
continue to stage II weaning foods Mitha