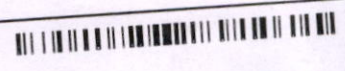




Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad
,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : <https://rainbowhospitals.in>

ADMISSION SHEET



Registration Details :

Admission No : IP5-00175831

Admit Date : 01-Jul-2026

Admit Time : 03:25 PM UHID : BAH-00660352

Patient Details :

Patient Name : Master BAKKA BHAVYANSH
Guardian : Mr BAKKA RAJU
Gender : Male
Occupation :
Address (H) : H NO 2-122/1, GOLLAWADA,
RAMACHANDRAPURAM, Mallampalli
Telangana INDIA 506349

Age : 4 Y 0 M 16 D
DOB : 15-06-2022
Religion :
Marital Status : Single
Phone No : 9676159357/ 9701564060
E-mail : NA@GMAIL.COM

Admission Details :

Room Type : SEMI PRIVATE
Room No : SPVT 110

Bed No : SPVT 110

Ward Name : 1F-VIBGYOR

Admission Type : First Visit

Contact Details :

Name : Mr BAKKA RAJU
Contact Address : H NO 2-122/1, GOLLAWADA,
RAMACHANDRAPURAM, Mallampalli Telangana
INDIA 506349

Relationship : Father
Phone No : 9676159357 / 9701564060

Signature

Doctor Details :

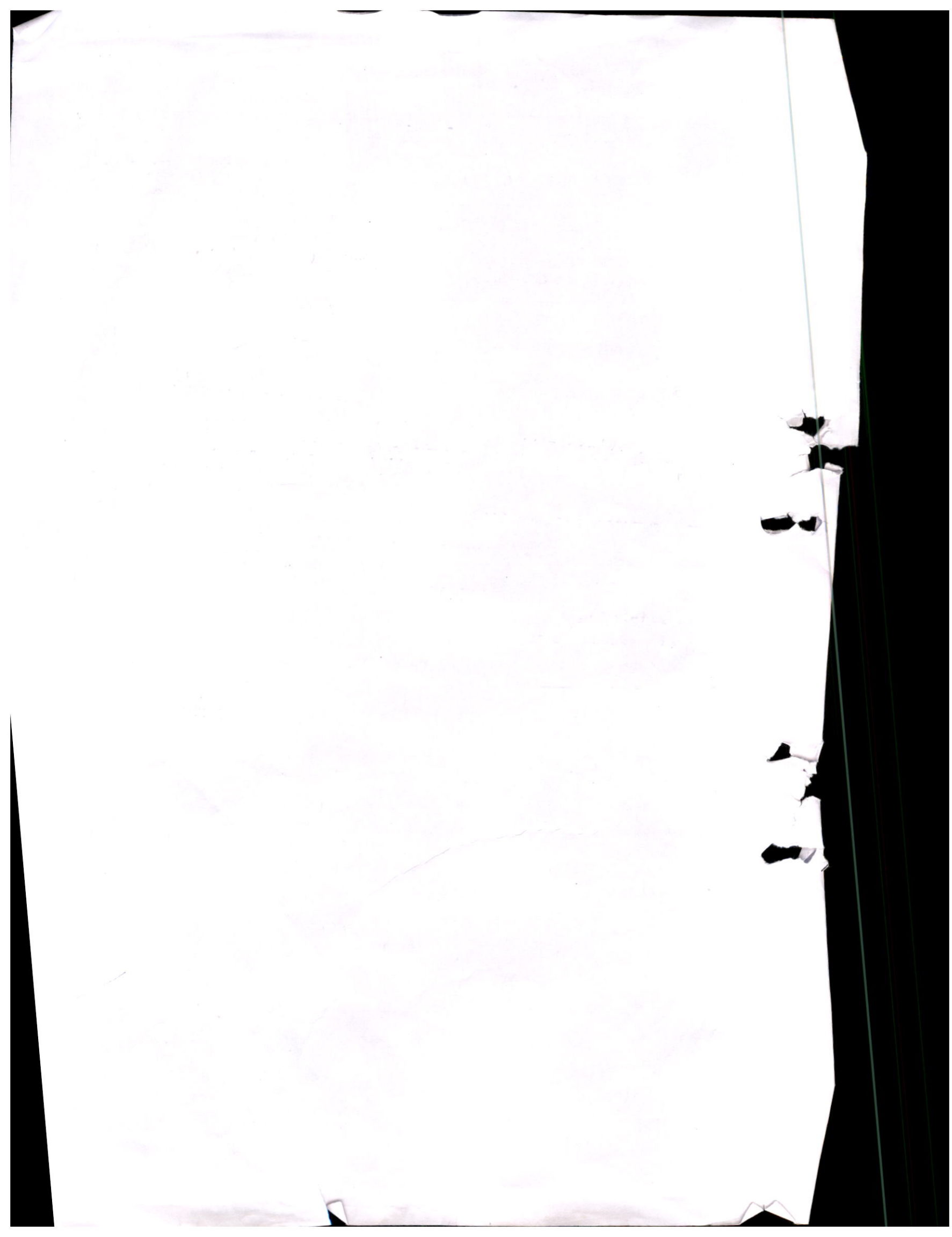
Doctor Name : Dr. ANUPAMA Y
Referral Doctor : Self
Consultant :

Specialisation : GENERAL PEDIATRICS
Phone No :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00
Payor Name : STAR HEALTH AND ALLIED
INSURANCE CO LTD



BAH-00660352 IP5-00175831
Master BAKKA BHAVYANSH
15-06-2022 4 Y 0 M 16 D (M)
Dr. ANUPAMA Y



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ACTIVITY RECORD FOR BILLING

Name : _____

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
1.7.26.	5:30pm	ER	oneo	
4/7/26	12pm	(110)	OT	
4/07/26	12pm	OT	110	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Venkatesh Ram	01/07/26	2788	
2	Dr. Sankhosh	3/7/26	9686708	
3	Dr. Venkat Ram	06/9/26	9689690	
4	Dr. Sankhosh	6/7/26	9689763	
5	Dr. - Abhishek sir	06/7/26	9689826	
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

[illegible]

Date _____

Name of Equipment

Connecting Time

Disconnecting Time

Order No.

Signature

5/7

Infusion Pump

I AM

gef

9837 67

Ponyance

[illegible]

Date : 6/2/26

Time : 9:30 AM

Prepared By : *Sushr*

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor

Zushwa

svpt



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Anupama Y. Date : 01/7/20

Type of Admission: ☒ OPD ☐ ER ☐ Referral (if referral, Doctor's Name:

Start Time of Assessment:

Weight: 13.3 kg

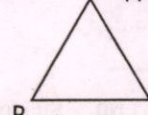
Allergic History:

Chief Complaints:

40 (septic arthritis)
High fever: 38.5°C
Swelling over left knee
behind knee
Restriction of left knee joint
movements

Pediatric Assessment Triangle

A Appearance - TICLS



B

C Circulation

Breathing

☐ ↑ WOB

☐ ↓ WOB

☒ Normal

☐ Gasping / Apnea

☒ Normal

☐ Abnormal

Pallor ☐

Cyanosis ☐

Mottling ☐

Bleeding ☐

Initial Physiological Status: ☒ Stable ☐ Unstable

Life Threatening ☐

Non Life Threatening ☐

Any urgent interventions needed: ☐ Yes ☒ No

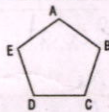
If Yes

Significant Past History:

Medication History:

Relevant Investigations:

Primary Assessment



Airway



☒ Open

☐ Maintainable

☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

Breathing



Rate: 24/min

SpO₂ on FiO₂ 98% E RA

Any urgent interventions needed: ☐ Yes ☐ No

If Yes

Rhythm:

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR

☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry:

Palpation Findings (If necessary)

Circulation

HR: 115/min

BP: 91/59 mmHg

Pulse Volume: ☐ Central ☐ Peripheral

If in Shock: ☐ Compensated ☐ Hypotensive

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

CFT ☐ Central ☐ Peripheral

Murmurs: ☐ Yes ☐ No

Liver Span:

ECG:

Any Signs of Heart Failure: ☐ Yes ☐ No

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

Disability

GCS: 15/15 AVPU:

Pupils: ☐ Responsive ☐ Non-Responsive

Size ☐ Right ☐ Left

Active Seizures: ☐ Yes ☐ No Sugars:

Signs of Neurological compromise

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

Exposure

Temp.: 97.1°F

Any Rash: ☐ Yes ☐ No

If yes describe the rash

Active bleed

Lacerations ☐ Abrasions ☐ bruises ☐

Describe:

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☒ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings:

Labs Planned: CBC CRP PT, APTT CXR 2D Echo Left knee XSC - by Dr. N. P. R.	Treatment Planned: Adjust in ward IV ceftriaxone IV Linezolid IV. Snopapain after 6hrs Exp. can in 10s. orthopedic consultation
---	---

Need for Oxygen: ☐ Yes ☒ No if yes Low Flow ☐ High Flow ☐ PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): Left knee epiphyseal fracture with lateral dislocation

Assessment done by

Name of the Doctor: N. P. R.

Signature: N. P. R.

Date & Time: 01/07/2028

Sr. Doctor on Duty (If necessary) 2nd year

Name of the Sr. Doctor:

Signature:

Date & Time:

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

BAH-00660352 IP5-00175831
Master BAKKA BHAVYANSH
15-06-2022 4 Y 0 M 18 D (M)
Dr. ANUPAMA Y



Patient Name: Bhavyansh
UHID ID: _____
Department: _____
Consultant: _____

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

(P.T.O.)

Immunization History :

appropriate for age

vaccinated till date

(P.T.O.)



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

No. self-medications and treatments



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 13.3 kg (Centile _____)

On Examination :

Temperature : 97.1 F Pulse Rate : 115/min B.P. 91/59/66 SP02 97% on room air

Resp. rate and type of breathing : 24/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : Bilateral air entry present

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S1, S2

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Soft

Auscultation : _____

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____

Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Septic arthritis
left sigmoid and transverse sinus thrombosis

Preventive aspects of the treatment: complications

Desired goals of the treatment : Resolution of symptoms

UBP, URP
PILADITT 18 NR
CNR
20 t/ho.
left knee jt. vlg-

- 1.) Inf. Ceftriaxone
line solid
- 2.) Inf. Enoxaparin after
reports
- 3.) For CCRW
- 4.) Ortho Consultation

Date & Time: 1/7/26 : ✓

Date & Time: 12/1/2021

DR. ANURAMAY
Registration No: 5085

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/7/22 7PM	ds/B picu fellow.	
	Δs:- Septic arthritis left sigmoid sinus & transverse sinus thrombosis.	plan.
	t/o fall unwitnessed 5 days ago. t/b left knee pain swelling.	1. Trace CBP, CRP, PT/INR.
	Initially treated on OPD basis	2. Continue IV antibiotics
	Aspiration of left knee fluid was done.	3. w/f fever spikes
	In view of fever spikes & left pain full scalp swelling child admitted at Dolphin hospital 27/6 to 1/7.	4. monitor vitals.
	sinovial fluid } Blood culture } HRSA sent to vancomycin	5. encourage oral intake.
	Referred to Rainbow for further management.	6. DLW or Anupama man regarding inj Enoxaparin
	Left knee pain present.	or mother
	Chest - Clear	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/126 7pm	MDW Dr Anupama nam	
	labs informed	plan.
	PT-14	1. start Iij Enoxaparin.
	TNR-1.0	
	APTT-30	
	CRP-78	
		Dr. natheer
2/7/26 8am	CLIB piro fellow	
	ASIS:- septic arthritis	
	left isomord sinus &	plan.
	transverse sinus thrombosis	1. wif fever spikes
	On room A/R	2. monitor vitals.
	hemodynamically stable	
	two fever spikes 10pm-10H	3. encourage oral intake
	5Am-100F	
	Chest-clear	
	Iij ceftriaxone - D2	
	Iij vancomycin ^{azithromycin} - D2	Dr. natheer
	Quezolid	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/2026 5:30pm	e/s/B Dr. Chandana (ENT)	
	Tympanic membrane ↓ No congestion	<u>Plan</u>
	- Post-Aural fluctuant swelling	① HRCT Temporal Bone
	- Tenderness (+)	② Continue Same Antibiotics
	post Aural Nodes (+) level ④ Nodes (+)	
	Neck Movement (+)	
	facial Nerve intact	
		Dr. Chandana Dollipally
2/7/2026 5:00pm		<u>Plan for CECT Temporal Bone @ 8:00 AM</u>
		① NPO from 2:00 AM
		② Send urea/Creatinine
		③ Urea & ALS @ 25ml/hour



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 10am	SIB Dr. Anupama	
	Septic Arthritis ① Sigmoid sinus thrombosis Mastoiditis	Plan
	HRCP done (temporal bone)	PAC done To do
	fever in water.	Dr. Sanjay To Review.
		Plan Surgery + Ion
		Stop Suroptam
		DR. ANUPAMA Y Registration No: 5089
3/7/26 5pm	c/s/B Resident 1. Septic arthritis ① / mastoiditis ② sigmoid sinus thrombosis child on Room air 2 fever spikes - morning Resp 7 HA 7 @ CVS ✓ Vitals - stable Post-aural swelling @ Tenderness @ 1 fever at 1pm	Plan ① 1) Planned for Costal mastoidectomy Tympanoplasty Sigmoid sinus decompression 7/1m @ 11:30am 2) PAC to be done 3) On Tix Ceftioaxone Tix Linezolid Rifampicin. 4) Monitor Vitals fever spikes 5) Inform SIB 6) NPO from 5AM. Dr. Jayal

Dr. Jayal
NIB
Pranav

BAH-00660352 IP5-00175831
Master BAKKA BHAVYANSH
15-06-2022 4 Y 0 M 17 D (M)
Dr. ANUPAMA Y

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26 8 AM	C/S/B Diagnosis:- septic arthritis left mastoiditis left sigmoid & transverse sinus thrombosis on 2000 APB hemodynamically stable one fever spike at 2:30 AM 100.1 F Chest clear Ivg ceftriaxone - D4 Ivg linezolid - D4 Sip rifampicin - D3	pic fellow plan. 1. keep NPO. 2. Radical mastoidectomy surgery at 11:30 AM 3. Monitor vitals. 4. Continue IV fluids. 30ml/hr Dr. Nathan
4/7/26 9:45 AM	S/B Dr. Anupama Septic Arthritis ① Mastoiditis fever is high	Plan Plan for surgery today Send Puc for C/S DR. ANUPAMA Y Registration No: 50853

Date & Time	Progress Notes	Doctor's Order
4/7/26 6:20 PM	C/S/B picu fellow.	
	Δ 8/5! - septic arthritis. left sigmoid sinus transverse sinus thrombosis	plan. 1. keep NPO for 4 hours
	9/p left cortical mastoidectomy Left myringotomy & Grommet	2. once awake start Gauds f/b solid food.
	on room Air hemodynamically stable.	3. Infuids DNS 80 ml/hr to continue
	one fever spike at 11 AM - 100.3°	4. monitor vitals.
	Chest - clear	5. w/f fever spikes.
		6. <u>change to IV ceftriaxone.</u>
		1/7 no further



PROGRESS NOTES AND DOCTOR'S ORDER

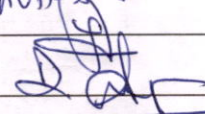
Date & Time	Progress Notes	Doctor's Order
5/7/2026	C/S/B Resident	
8:30 AM	1:- Septic arthritis ② sigmoid sinus Transverse sinus thrombosis S/P left cortical mastoidectomy Left myringotomy & Grommet Insertion (POA) child on Room air Hemodynamically stable No further fever spikes Resp PIA CVS } ② Vitals - stable	Plan 1) Encourage orally. 2) On Inj ceftriaxone (D2) Inj linezolid (D5) Syrup Rifampicin 3) w/ fever spikes. 4) Trace c/s & HPE 5) Monitor Vitals 6) Inform SDC
		Dr. Jayashri
5/7/2026	Seen By Dr. Anupama	
11 AM	1:- Septic arthritis ② Sigmoid Sinus Transverse sinus thrombosis child on Room air. Hemodynamically stable.	Plan 1) R/v with Dr. Ranjya (Neuro) Dr. Venkat Ram (Ortho). 2) Plan Discharge t/m 3) Trace labr. 4) No PICC line today.
		DR. ANUPAMA Y Registration No: 50853

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/8/26	<u>C/S/B Resident</u>	
3 PM	Dis:- ① Septic arthritis ② Sigmoid sinus Thrombosis Transverse sinus thrombosis S/P ① left costal mastoidectomy ② myringotomy & grommet child on Roemair Hemodynamically stable No fever spikes Resp } P/A } ② CVS } Vital - stable.	<u>Plan</u> c) Continue Inj ceftriaxone (D2) Inj Linezolid (DS) Syrup Paracetamol a) Ortho (Venkat Ram S.S.) Consultation Paed (Dr. Ramya) consultation 3) Trace C/S & HPE 4) Monitor Vital Dr. Jayash Dr. Prabhu



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7 10am	SB Dr. Anupama	
	Septic Aemia	
	Sinoid sinus thrombosis	Plin
	Meningitis	
	RTA	1) Do Remy (Paed Neurology) Review
	MRSA sepsis	
	afabre	2) DO CRP/CRP
		3) Discharge
		4) Ceftriaxone x 5 days Amoxicillin x 10 days Rifampin x 3 days
		5) Trace 4e + inform
		6) Show Discharge summary to Dr. Anupama
		7) Dr. Anupama
		
		6/7 10am
		DR. ANUPAMA Y Registration No: 50853

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Master BAKKA BHAVYANSH
15-06-2022 4 Y 0 M 16 D (M)
Dr. ANUPAMA Y



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RESULT SHEET

Date	1/7/26	21/7/26.	6/8/26.			
Time	6 PM	6:30pm	11 AM			
Hb	12.0		10.8 ↓			
PCV	37.4		35.0			
RBC	4.62		4.25			
WBC	20030		12810 ↓			
N/L	67/25		58/35			
Platelets	579000		837000 ↑			
CRP	78		35 ↓			
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea		16				
Creatinine		0.3				
ALP		251				
SGPT		20				
SGOT		27				
T.Bill/Conj		0.3/0.1				
T.Protein		7.4				
S.Albumin		3.5				
S.Globulin		3.8				
A/G Ratio		0.9				
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR	14/1.0					
APTT	30					
CSF Protein / Sugar						
Cells						
N/L						

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Master BAKKA BHAVYANSH (M)
15-06-2022 4 Y 0 M 16 D
Dr. ANUPAMA Y

OUTSIDE

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RESULT SHEET

Date	25/6/26	27/6/26			
Time	08:00				
Hb	11.7	10.6			
PCV					
RBC	4.2	3.9			
WBC	15,500	21,400			
N/L	80/14	85/10			
Platelets	4.21 lakhs	3.34 lakhs			
CRP		61			
ESR	46				
PCT					
RBS					
Na		137			
K		4.0			
Cl		103			
Ca/Mg					
Phosphate					
Urea		20			
Creatinine		0.5			
ALP		249			
SGPT		22			
SGOT		37			
T.Bill/Conj		0.5/0.2			
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					

9 ca²⁺

1.21



CROSS CONSULTATION FORM

Doctor Name : Date : Time :

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 :

- History Noted : H/o unnoticed fall (+)
- Swelling of (Lt) mastoid region noted (+) ; No discharge
- No H/o headache, vomiting

O/E:

Child conscious.

Alert ; active

Vitals - stable

Tone - (N) ; (N) power, DTR - (N)

Tracking of visual stimuli (+)

ECM - full ; B/L pupils NSRL

No vertigo / truncal ataxia

Adv

1) Start RIVA ROXABAN

2) Fundus examination
after discharge
on follow up.

Consultant :

Name :

Signature :

Date & Time :

CROSS CONSULTATION FORM

Doctor Name : Dr. Anupama Y Date : 6/7/26 Time : 8am

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 :

Dr. Anupama Y
Dr. Anupama Y

Dr. Anupama Y

Dr. Anupama Y

Dr. Anupama Y

Dr. Anupama Y

Dr. Anupama Y

Consultant :

Name : Dr. Anupama Y Signature : Dr. Anupama Y Date & Time : 8/7/26



CROSS CONSULTATION FORM

Doctor Name : Dr. Santosh Date : 3/7/26 Time :

Diagnosis : Septic arthritis / (L) Sigmoid sinus Transverse sinus thrombosis

Hospital : Rainbow children's 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:

l/u/o (L) - mastoiditis.

Signature: _____

Findings and Recommendations :

Pf - reviewed.

Left Acute Mastoiditis
C-Postaural
Abscess

Left cortical mastoidectomy
Abscess postaural
showing
2 finger breadth
PAC
AB

Consultant :

Name : Dr. M. Santosh Kumar Signature : [Signature] Date & Time :

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Master BAKKA BHAVYANSH
15-06-2022 4 Y 0 M 16 D (M)
Dr. ANUPAMA Y

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CROSS CONSULTATION FORM

Doctor Name : Dr. Venkat Anupama Date : 11/7/26 Time : 4:50 pm.

Diagnosis :

Hospital : RCH - BH

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]
Signature:

Findings and Recommendations :

[Signature]
Dr. Anupama
Knee cany Lyte with 1 @ one
① week to ② days

TRAY - 1/2
- on 1/2 cup
- on 1/2 cup

[Signature]
① day 1. ① day 2
cultural - mego -
in 1/2 cup

Consultant :

Name : Dr. Venkat Anupama Signature : [Signature] Date & Time : 11/7/26

Adams

BAH-00660352
Master BAKKA BHAVYANSH
15-06-2022 4 Y 0 M 19 D (M)
Dr. ANUPAMA Y

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INFORMED CONSENT FOR SURGERY / PROCEDURE

Authorization By: ☐ Patient ☒ Patient Attendant

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

1. Incision & Drainage of postaural Abscess (+)
2. +1- cortical mastoidectomy

I acknowledge the following:

1. I have been made aware of the benefits and reasons of the surgery / procedure as indicated by the clinical observations and / or diagnostics performed.
2. The benefits and risks of this surgery / procedure have been explained to me. I have also been told about the alternatives available for this surgery / procedure including the advantages and disadvantages of the alternatives.

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)

3. As with any procedure, I am aware that risks such as blood loss, infection, cardiac arrest, anesthetic allergic reactions, paralysis, Deep Vein thrombosis (DVT), Pulmonary thromboembolism (PTE) etc may arise necessitating attention. Therefore, in addition to consenting to the performance of the above-mentioned surgery/procedure(s), I also consent and authorize the rendering of such other care and treatment as patient/my surgeon or his / her designee reasonably believes necessary should one or more of these and or other unforeseeable events occur.

Apart from the listed above, I have also been explained about the possible complications of the surgery / procedure are as follows:

a.

b.

and his / her team to perform the procedural sedation

1. I authorize Dr. _____ upon the patient / myself.
2. I recognize that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes.
3. I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: _____

Name: _____

Relationship with patient: _____

Date & Time: _____

Witness:

Signature: _____

Name: _____

Date & Time: _____

Doctor (who is taking consent):

Signature: _____

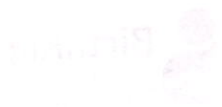
Name: _____

Date: _____

Time: _____

Docu. No.: RCHBH/FRM CLINICAL / 027 (26)

(P.T.O)



POST-SURGICAL PLAN FORM

1. Patient Name	2. Date
3. Surgeon	4. Hospital
5. Room	6. Bed
7. Age	8. Sex
9. Weight	10. Height
11. Blood Pressure	12. Heart Rate
13. Temperature	14. Respiratory Rate
15. Oxygen Saturation	16. Pain Level
17. Wound Status	18. Drainage
19. Medications	20. Diet
21. Activity	22. Discharge Instructions
23. Follow-up	24. Signature
25. Date	26. Initials

BAH-00660352 IP5-00175831
Master BAKKA BHAVYANSH
15-06-2022 4 Y 0 M 16 D (M)
Dr. ANUPAMA Y



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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						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : N. Prathibha - N.P.

Date & Time : 01/07/20, 3pm.

Nurse Name & Signature : Abhishek

Date & Time : 2/7/20 3pm

BAH-00660352 IP5-00175831
Master BAKKA BHAVYANSH
15-08-2022 4 Y 0 M 16 D (M)
Dr. ANUPAMA Y

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DRUG CHART

Date of Admission: 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>SYP-CROCN DS</u>				Date Time	<u>1/8</u>	<u>2/8</u>	<u>3/8</u>												
Dose	Route	Frequency	Start Date																
<u>4ml</u>	<u>PO</u>	<u>SOS</u>	<u>01/7</u>																
Doctor's Signature		Valid Period	Pharm.																
<u>N. Jm</u>		<u>48h</u>																	
Additional Instructions:																			
<u>for pain to max 6 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. 13.3 kg Ward.

DRUG: <u>inj. CEFTRIAXONE</u>				Date Time	1/7	2/7	3/7	4/7												
Dose	Route	Frequency	Start Date																	
650mg	IV	12H	01/7																	
Name & Signature of the Doctor Starting the Drugs: <u>N. Prathap</u>				6am 7am 8am 9am 10am 11am 12pm 1pm 2pm 3pm 4pm 5pm 6pm 7pm 8pm 9pm 10pm 11pm 12am																
Additional Instructions:				6pm 7pm 8pm 9pm 10pm 11pm 12am 1am 2am 3am 4am 5am 6am 7am 8am 9am 10am 11am 12pm																
Daily Doctor's Endorsement by a Sign				6pm 7pm 8pm 9pm 10pm 11pm 12am 1am 2am 3am 4am 5am 6am 7am 8am 9am 10am 11am 12pm																

DRUG: <u>inj. UNIZOLID</u>				Date Time	1/7	2/7	3/7	4/7	5/7	6/7										
Dose	Route	Frequency	Start Date																	
130mg	IV	8H	01/7																	
Name & Signature of the Doctor Starting the Drugs: <u>N. Prathap</u>				6am 7am 8am 9am 10am 11am 12pm 1pm 2pm 3pm 4pm 5pm 6pm 7pm 8pm 9pm 10pm 11pm 12am																
Additional Instructions:				6pm 7pm 8pm 9pm 10pm 11pm 12am 1am 2am 3am 4am 5am 6am 7am 8am 9am 10am 11am 12pm																
Daily Doctor's Endorsement by a Sign				6pm 7pm 8pm 9pm 10pm 11pm 12am 1am 2am 3am 4am 5am 6am 7am 8am 9am 10am 11am 12pm																

DRUG: <u>inj. PANTOPRAZOLE</u>				Date Time	1/7	2/7	3/7	4/7	5/7	6/7										
Dose	Route	Frequency	Start Date																	
10mg	W	2H	01/7																	
Name & Signature of the Doctor Starting the Drugs: <u>N. Prathap</u>				6am 7am 8am 9am 10am 11am 12pm 1pm 2pm 3pm 4pm 5pm 6pm 7pm 8pm 9pm 10pm 11pm 12am																
Additional Instructions:				6pm 7pm 8pm 9pm 10pm 11pm 12am 1am 2am 3am 4am 5am 6am 7am 8am 9am 10am 11am 12pm																
Daily Doctor's Endorsement by a Sign				6pm 7pm 8pm 9pm 10pm 11pm 12am 1am 2am 3am 4am 5am 6am 7am 8am 9am 10am 11am 12pm																

DRUG: <u>Tab LIMCEE</u>				Date Time	1/7	2/7	3/7	4/7	5/7	6/7										
Dose	Route	Frequency	Start Date																	
1tb	PO	OD	1/7/26																	
Name & Signature of the Doctor Starting the Drugs: <u>D. Ramya</u>				6am 7am 8am 9am 10am 11am 12pm 1pm 2pm 3pm 4pm 5pm 6pm 7pm 8pm 9pm 10pm 11pm 12am																
Additional Instructions:				6pm 7pm 8pm 9pm 10pm 11pm 12am 1am 2am 3am 4am 5am 6am 7am 8am 9am 10am 11am 12pm																
Daily Doctor's Endorsement by a Sign				6pm 7pm 8pm 9pm 10pm 11pm 12am 1am 2am 3am 4am 5am 6am 7am 8am 9am 10am 11am 12pm																



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : Symp. CALCIMAX PWS				Date Time	1/7	2/7	3/7	4/7	5/7	6/7										
Dose	Route	Frequency	Start Dt.																	
5ml	PO	OD	1/7/26																	
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Rang</i>				4pm Subcut 10pm Subcut																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				M M M M M																
DRUG : Sachet 360°				Date Time	1/7	2/7														
Dose	Route	Frequency	Start Dt.																	
1 Sachet	PO	OD	1/7/26																	
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Rang</i>				10pm Davit X X X X X																
Additional Instructions: Weekly once X 6 weeks																				
Daily Doctor's Endorsement by a Sign				M																
DRUG : INJ ENOXAPARIN				Date Time	1/7	2/7														
Dose	Route	Frequency	Start Dt.																	
13mg	S/C	BD	1/7/26																	
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Natheem</i>				10am Davit X																
Additional Instructions: SUBCUTANEOUS.				10pm Davit X																
Daily Doctor's Endorsement by a Sign				M M																
DRUG : CAP RITAMPICIN				Date Time	2/7															
Dose	Route	Frequency	Start Dt.																	
200mg	PO	OD	1/7/26																	
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Natheem</i>				6pm Davit X																
Additional Instructions: 1 CAP = 300mg mix 80 bml water give 6.6 ml																				
Daily Doctor's Endorsement by a Sign																				

VERIFIED BY : Name



Ward

VERIFIED BY : Name..... Signature



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
4/2/26	11:20AM	INJ PARACETAMOL	130mg	IV	M	Sailaya
4/2/26	3:15	INJ SUPRACLOECINAC	120mg	PR	A	Dr. S

Page: 4/4

BAH-00660352
Master BAKKA BHAVYANSH
15-06-2022
Dr. ANUPAMA Y 4 Y 0 M 19 D (M)



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

PRESCHOOL (1-5 years)

Children's Observation &
Early Warning Scoring Chart

Pratiksha
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	2AM	6AM	10AM	1PM	5pm	10pm	2AM	6AM	
Doctor / Nurse / Family Concern?										
Temperature (°F)	104									
	103									
	102									
	101									
	100									
	99	98.0°F	97.5°F	98.9°F	98.6°F	98.3°F	98.5°F	97.5°F	97.5°F	
	98									
	97									
	96									
	95									
94										
Heart Rate (bpm) and Blood Pressure (mmHg) *	190									
	180									
	170									
	160									
	150									
	140									
	130									
	120									
	110									
	100									
90										
80										
70										
60										
50										
Note: BP does not score in early warning scoring										
Heart Rate (Number)		91b/m	82b/m	90b/m	96b/m	108b/m	100b/m	102b/m	110b/m	
Resp. Rate (bpm) (Over 1 Minute) *	70									
	60									
	50									
	40									
	30									
	20									
	10									
	0									
	Resp Rate (Number)		26b/m	21b/m	21b/m	25b/m	26b/m	28b/m	26b/m	24b/m
	Resp Distress									
Mod/ Severe None / Mild										
Receiving O ₂ (l/min)										
O ₂ Saturations (%)		100%	99%	97%	99%	100%	100%	100%	100%	
Conscious Level										
Normal Altered										
GCS *		15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15	
TOTAL SCORE										
Number of shaded boxes		1	1	1	1	0	1	1	1	
Pain Score		0	0	0	0	0	0	0	0	
Observer's Initials										

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 4/1/26	Time: 2:30am	3:30am	6am	10:40 am	11:10 am	7pm	10pm
Doctor / Nurse / Family Concern?							
Temperature (F)	100.1°F	99.9°F	98.1°F	99.0°F	100.3°F	98.8°F	96.7°F
Heart Rate (bpm)							
Blood Pressure (mmHg) *		99/60	107/73	106/61	93/70		
Heart Rate (Number)		111bpm	122bpm			110	116bpm
Resp. Rate (bpm) (Over 1 Minute) *							
Resp Rate (Number)		29bpm	28bpm			28bpm	27bpm
Resp Mod/ Severe Distress None / Mild							
Receiving O ₂ (l/min)							
O ₂ Saturations (%)		100%	98%			98%	100%
Conscious Level Normal / Altered							
GCS *		15/15	15/15			15/15	15/15
TOTAL SCORE							
Number of shaded boxes		1	1			0	1
Pain Score		0	0			0	0
Observer's Initials							

ACTIONS

NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
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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.
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PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

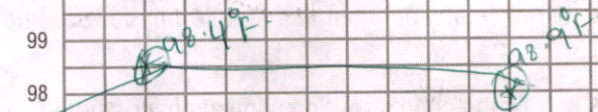
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 3/3/26 Time: 10pm

Doctor / Nurse / Family Concern? 4/3/26 2AM

Temperature (F)

104
103
102
101
100
99
98
97
96
95
94



Heart Rate (bpm)

and

Blood Pressure (mmHg) *

Note:
BP does not score in early warning scoring

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

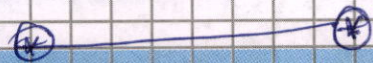


Heart Rate (Number)

116bpm 125bpm

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

70
60
50
40
30
20
10



Resp Rate (Number)

29bpm 21bpm

Resp Distress Mod/ Severe None / Mild

Receiving O₂(l/min) O₂Saturations (%)

99% 100%

Conscious Level Normal Altered

GCS *

15/15 15/15

TOTAL SCORE

Number of shaded boxes

1 1

Pain Score

0 0

Observer's Initials

AD AD

ACTIONS

NB: Scores 3 should be recorded overleaf

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- Score 2 : Shift in charge nurse to be informed and continue hourly observations
- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT : I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 3/07 Time: 3:03pm	
Doctor / Nurse / Family Concern? 3:03pm 4:30am 6am 10am 1pm 4pm	
Temperature (°F)	
Heart Rate (bpm)	
and	
Blood Pressure (mmHg) *	
Note: BP does not score in early warning scoring	
Heart Rate (Number)	110 bpm (78) 116 bpm 100 bpm (82) 110 bpm (74)
Resp. Rate (bpm) (Over 1 Minute) *	
Resp Rate (Number)	26 bpm 24 24
Resp Mod/ Severe Distress None / Mild	
Receiving O ₂ (l/min) O ₂ Saturations (%)	100% 100% 99%
Conscious Level Normal Altered	
GCS *	15/15 15/15 15/15
TOTAL SCORE	
Number of shaded boxes	1 1 1
Pain Score	0 0 0
Observer's Initials	

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1 : Continue normal observation by staff nurse
	Score 2 : Shift in charge nurse to be informed and continue hourly observations
	Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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	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.

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- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

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

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

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 01/07/2022	Time:	10am	1pm	4:30pm	6pm	10pm	2am	
Doctor / Nurse / Family Concern?								
Temperature (F)	104							
	103							
	102							
	101							
	100							
	99	97.6°F	98.9°F	100.7°F	98.9°F	99.8°F	99.0°F	
	98							
	97							
	96							
	95							
94								
Heart Rate (bpm)	190							
	180							
	170							
	160							
	150							
	140							
	130							
	120							
	110							
	100							
Blood Pressure (mmHg) *	190							
	180							
	170							
	160							
	150							
	140							
	130							
	120							
	110							
	100							
Note: BP does not score in early warning scoring	90							
	80							
	70							
	60							
	50							
	40							
	30							
	20							
	10							
	0							
Heart Rate (Number)		130b/m	135b/m		121b/m	146b/m	84b/m	
Resp. Rate (bpm) (Over 1 Minute) *	70							
	60							
	50							
	40							
	30							
	20							
	10							
	0							
	Resp Rate (Number)		28r	28r		25b/m	26b/m	26b/m
	Resp Distress	Mod/ Severe						
None / Mild								
Receiving O ₂ (l/min)								
	O ₂ Saturations (%)		100%	98%		99%	100%	100%
Conscious Level	Normal							
	Altered							
GCS *		15/15	15/15		15/15	15/15	15/15	
TOTAL SCORE								
Number of shaded boxes		0	0		1	1	1	
Pain Score		0	0		0	0	0	
Observer's Initials		AN	AN		AN	AN	AN	

ACTIONS

NB: Scores 3 should be
recorded overleaf

Score 1 : Continue normal observation by staff nurse

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

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

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00660352 IP5-00175831
Master BAKKA BHAVYANSH
15-06-2022 4 Y 0 M 16 D (M)

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

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

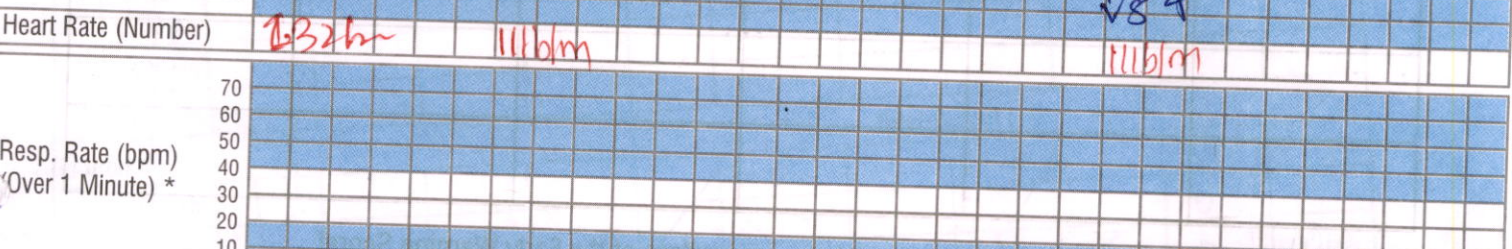
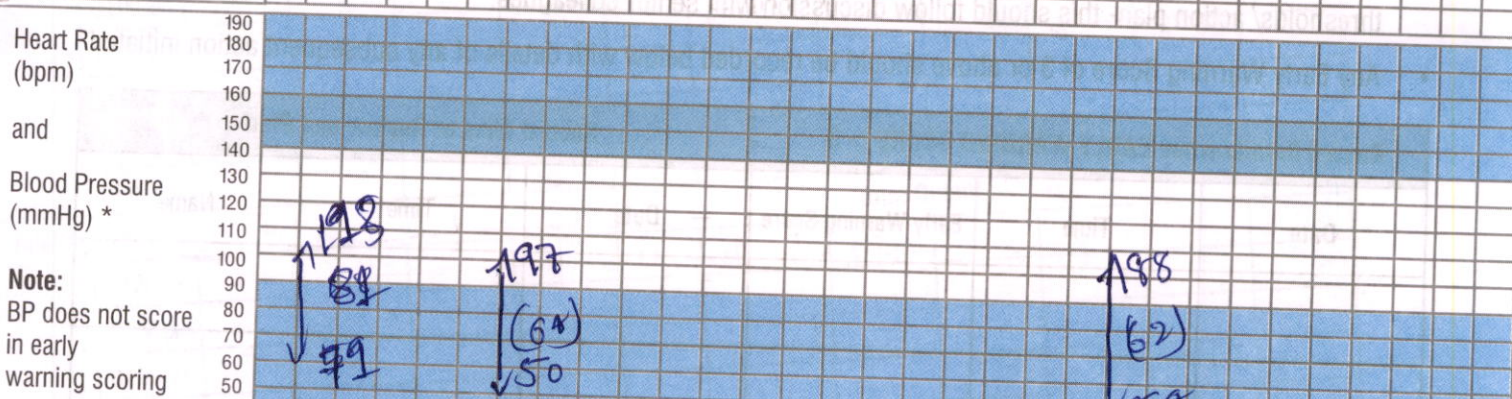
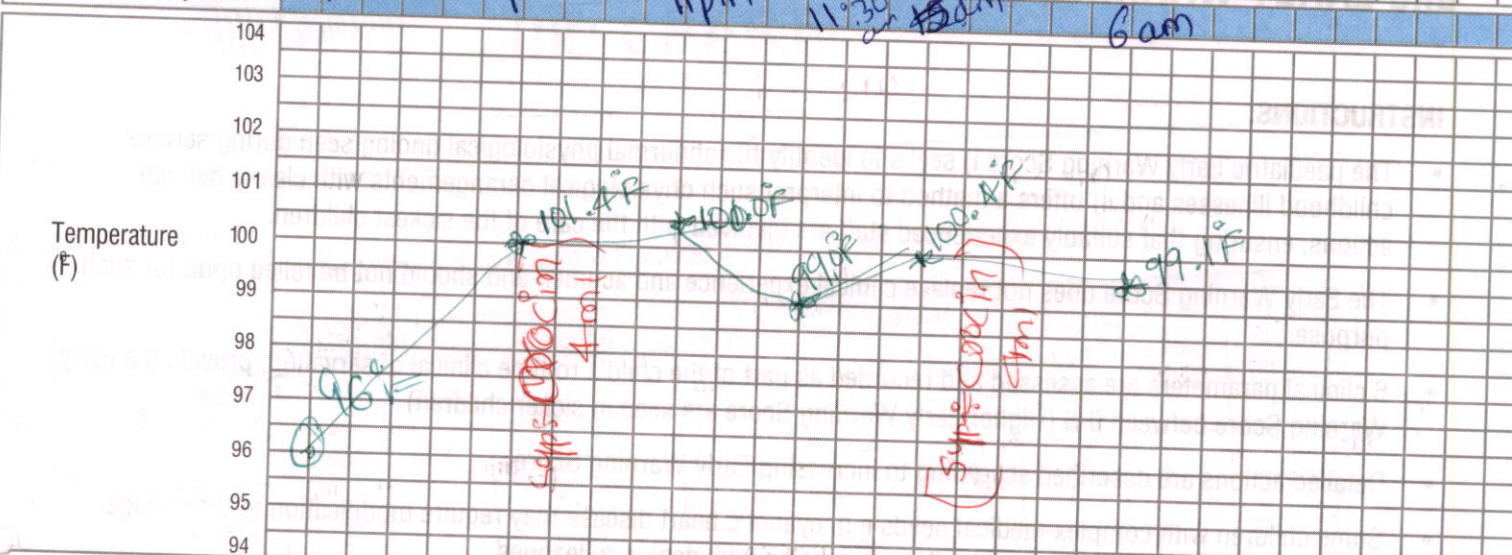
Pratiksha
Rainbow Children's Hospital
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BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 1/7 Time: 7pm

Doctor / Nurse / Family Concern?



Resp Rate (Number)	24bpm	26bpm	26bpm	28bpm
Resp Mod/ Severe Distress	None	None	None	None
Receiving O ₂ (l/min)	0	0	0	0
O ₂ Saturations (%)	98%	99%	99%	100%
Conscious Level	Normal	Normal	Normal	Normal
GCS *	15/15	15/15	15/15	15/15

TOTAL SCORE				
Number of shaded boxes	0	1	1	1
Pain Score	0	0	0	0
Observer's Initials	M			

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

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

BAH-00660352
Master BAKKA BHAVYANSH
15-06-2022 4 Y 0 M 17 D (M)
Dr. ANUPAMA Y



NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Assessment: Baby having dull activity. Date: 3/7/21

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
2p	* Assess the general condition of the patient.	2p	* Assessed the general condition of the patient.	By doing all the procedure the patient can be stable.
4p	* maintain personal hygiene.	4p	* maintained personal hygiene.	
6p	* monitor vitals.	6p	* monitored vital	
7p	* maintain good nutrition.	7p	* maintained good nutrition	

Re-Assessment: Monitor vitals.

Special Notes:

Nurse Signature: [Signature] Nurse Name: Dina

Docu. No: RCHBH / FRM / CLINICAL / 148

Date & Time: 3/7/21 @ 8am

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 31/7/26

Assessment: Baby having mild infection related to his disease condition.

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.	8:05pm	⇒ Assessed the pt general condition.	By doing all the procedures the baby condition is improving.
10pm	⇒ provide the comfortable position.	10:05pm	⇒ provided the comfortable position.	
12AM	⇒ Check the vitals.	12:05AM	⇒ Checked the vital signs.	
2AM	⇒ Maintain I.V fluids from Npo time	2:05AM	⇒ I.V fluids DNR	
4AM	⇒ provide side rail.	4:05AM	⇒ provided side rail.	
6AM	⇒ Administer the Medication as per doctor order.	6:05AM	⇒ Administered the Medication as per doctor order.	

Re-Assessment: Re-assessment is done by checking vital signs.

Special Notes: planned for cortical mastoidectomy I&D at 11:30AM. Npo from - 5AM.

Nurse Signature: [Signature] Nurse Name: prameela (015802) Date & Time: 4/7/26 @ 8AM

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 04/07/26

Assessment: Baby having pain in ear back side

Goals

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

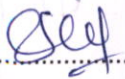
Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the General condition	8am	→ Assessed the general condition	By doing the all procedures the baby conditions improved slowly.
9am	→ provide comfort position.	9am	→ provided comfortable position	
10am	→ monitor the vitals & Recorded it	10am	→ monitored the vitals & Recorded it	
11am	→ baby having surgery today at 11:30am	11am	→ Surgery plan today	
	Plan to do and nro and → administer the all drugs as per doctor orders		→ Plan do and nro → administer the all drugs as per doctor orders	

Re-Assessment:

Done by giving pain relief

Special Notes:

Shift to OT on call

Nurse Signature: 

Nurse Name: Shalaja (605562)

Date & Time: 04/07/26 (pm)

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/7/26

Assessment: Baby Having surgical site pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8Am	→ Assess the Baby general condition.	9Am	Assess the pt general condition	By done all implementation as per order
9Am	monitor vital sign	10Am	monitor vital sign	
10Am	maintain NO chest	11Am	maintained NO chest	
11Am	provide comfortable position	12pm	provided comfortable position	
12pm	Administered medication	1pm	Administered medication as per order	

Re-Assessment:

Special Notes: wif fever spike

Nurse Signature: Sushma

Nurse Name: Sushma

Date & Time: 5/7/26 2PM

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/7/22

Assessment: pt having mild pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the pt General Condition	2pm	→ Assessed the pt General Condition	pt is stable
	→ Check the Vital signs	4pm	→ Checked the Vital Signs	
4pm	→ Plan for Administration medication	6pm	→ maintaining I/O Chart	
6pm	→ Plan for Strict I/O Chart		→ providing medication as per Chart	
8pm	→ Providing Ensuring Safety	8pm	→ providing Ensuring Safety	

Re-Assessment: Re-Assessment Every 4th hrly

Special Notes: D/c T/m

Nurse Signature: Cy

Nurse Name: Chandan

Date & Time: 5/7/22 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: Baby having mild pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the child general condition.	8:10 pm	→ Assessed the child general condition.	By done all procedure baby.
1pm	→ Monitor the vitals signs	10:15 pm	→ Monitored the vitals signs	
12am	→ provide comfortable position	2am	→ provided comfortable position.	
2am	→ TO give INJ PCM pain	5am	→ INJ: 10mg	
6am	→ maintain I/Q chart	6:30 am	→ monitored I/Q chart	
7:30 pm	→ Administer medication as per doctor order.	8am	→ Administered medication as per doctor order.	

Re-Assessment:

Special Notes:

DR. Ramya (Neuro) DR. Venkatesh (Orth) DIC Hm

Nurse Signature: 

Nurse Name: Swarna

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

BAH-00660352 IP5-00175831
Master BAKKA BHAVYANSH
15-06-2022 4 Y 0 M 20 D (M)
Dr. ANUPAMA Y



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. A. Y. Department: ER Date of Admission: 1/7/26

SITUATION	Diagnosis: <u>knee left Arthritis & Distal Transverse thrombosis</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	Area	Shift Time	<u>ER</u> <u>5:30pm - 8pm</u>	<u>1st floor</u> <u>8am - 2pm</u>	<u>1st floor</u> <u>2pm - 8pm</u>	<u>2nd floor</u> <u>8am - 2pm</u>	<u>2nd floor</u> <u>2pm - 8pm</u>	<u>PM</u> <u>8am - 2pm</u>
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:		Temp: <u>98.6°</u>	<u>98.6°</u>	<u>98.6°</u>	<u>98.6°</u>	<u>98.6°</u>	<u>98.6°</u>
			Res: <u>24b/m</u>	<u>28b/m</u>	<u>28</u>	<u>28b/m</u>	<u>28b/m</u>	<u>28b/m</u>
			SpO ₂ : <u>97%</u>	<u>99%</u>	<u>98%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>
			Pulse: <u>115b/m</u>	<u>120b/m</u>	<u>130</u>	<u>121b/m</u>	<u>120b/m</u>	<u>110b/m</u>
			BP: <u>91/54</u>	<u>90/70</u>	<u>110/66</u>	<u>98/62</u>	<u>100/60</u>	<u>99/62</u>
Fall Risk Score:		<u>11</u>	<u>13</u>	<u>13</u>	<u>13</u>	<u>13</u>	<u>13</u>	
Pain Score:		<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	
Recommendations	Safety Needs:		<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<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>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Recommendations	Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Handed Over By Name :			<u>Abhishek</u>	<u>Ravina</u>	<u>Marlin</u>	<u>Chander</u>	<u>Rashmi</u>	<u>Suh</u>
Signature :			<u>Abhishek</u>	<u>Ravi</u>	<u>Marlin</u>	<u>Chander</u>	<u>Rashmi</u>	<u>Suh</u>
Date:			<u>1/7/26</u>	<u>2/7/26</u>	<u>2/7</u>	<u>2/7/26</u>	<u>3/7/26</u>	<u>3/7/26</u>
Time:			<u>5:30pm</u>	<u>8am</u>	<u>2pm</u>	<u>2pm</u>	<u>8am</u>	<u>8pm</u>
Taken Over By Name :			<u>Marlin</u>	<u>Marlin</u>	<u>Chander</u>	<u>Rashmi</u>	<u>Suh</u>	<u>praveen</u>
Signature :			<u>Marlin</u>	<u>Marlin</u>	<u>Chander</u>	<u>Rashmi</u>	<u>Suh</u>	<u>praveen</u>
Date:			<u>1/7/26</u>	<u>2/7/26</u>	<u>2/7</u>	<u>2/7/26</u>	<u>3/7/26</u>	<u>3/7/26</u>
Time:			<u>6:15pm</u>	<u>8am</u>	<u>2pm</u>	<u>2pm</u>	<u>8am</u>	<u>8pm</u>



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. A.Y. Department: PLCU Date of Admission: 1/07/26

SITUATION	Diagnosis: <u>Knee left Arthritis C and distal-transvers.</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	Area	Shift Time	<u>1st Floor</u> <u>8pm-8am</u>	<u>1st Floor</u> <u>8 to 2 am pm</u>	<u>1st Floor</u> <u>8pm-8am</u>	<u>1st Floor</u> <u>8am-2pm</u>	<u>1st Floor</u> <u>2pm-8pm</u>	<u>1st Floor</u> <u>8pm-8am</u>
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>98.4°F</u>	<u>98.0</u>	<u>98.4°F</u>	<u>98.1°F</u>	<u>98.3°F</u>	<u>96.3°F</u>
		Res:	<u>29b/m</u>	<u>26b/m</u>	<u>21b/m</u>	<u>28</u>	<u>28b/h</u>	<u>28</u>
		SpO ₂ :	<u>100%</u>	<u>99%</u>	<u>100%</u>	<u>99</u>	<u>99%</u>	<u>100%</u>
		Pulse:	<u>116b/m</u>	<u>115b/m</u>	<u>106b/m</u>	<u>102</u>	<u>101b/h</u>	<u>110</u>
		BP:	<u>115/75</u>	<u>110/60</u>	<u>106/71</u>	<u>100/60</u>	<u>98/60</u>	<u>99/62</u>
	Fall Risk Score:		<u>13</u>	<u>13</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>
Pain Score:		<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	
Recommendations	Safety Needs:		<u>side rails</u>	<u>yes</u>	<u>side rails</u>	<u>side rails</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>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		<u>NA</u>	<u>NPO</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Post Operative Procedure Special Orders:			<u>NA</u>	<u>Surgery</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Handed Over By Name :			<u>praveela</u>	<u>Shailaja</u>	<u>Priyanka</u>	<u>Sushma</u>	<u>Chandana</u>	<u>Swarna</u>
Signature :			<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:			<u>4/7/26</u>	<u>4/7/26</u>	<u>5/7</u>	<u>5/7</u>	<u>5/7/26</u>	<u>5/7/26</u>
Time:			<u>8AM</u>	<u>(2pm)</u>	<u>8AM</u>	<u>2pm</u>	<u>2pm</u>	<u>8am</u>
Taken Over By Name :			<u>Shailaja</u>	<u>Praveela</u>	<u>Sushma</u>	<u>Chandana</u>	<u>Swarna</u>	<u>Shailaja</u>
Signature :			<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:			<u>4/07</u>	<u>4/7</u>	<u>5/7</u>	<u>5/7/26</u>	<u>5/7</u>	<u>6/7</u>
Time:			<u>8am</u>	<u>12pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3				
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2				
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1				
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	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				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1				
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3	1				
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1				
TOTAL			11				

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓				
Call device within reach		✓				
Wheels Locked		✓				
Room free of clutter		✓				
Adequate Lighting		✓				
Wheel Chair Support		X				
Other Intervention(s) Specify		X				
Nurse's Name :		Swamy				
Signature :		[Signature]				
Date :		6/7				
Time :		am				



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 04/07/2026

Assessment: pain & Discomfort

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
5:00pm	Maintain Hand Hygiene. Provide Comfortable position. Assess the pt condition. Monitor vitals.	5:30pm	Maintained Hand Hygiene. Provided comfortable position. Assessed the pt condition Monitored vitals.	pt is fully awake. No complaint regarding pain.
6pm	Maintain I/O chart. pt is in NPO. pt having drain inside dressing (and Fading tube)	6:30pm	Maintained I/O chart. pt NPO Break & sips of water.	NPO break. Had frootie. No other issue.
8pm	Watch for pain & discomfort.	8pm	No complaint regarding pain & discomfort.	

Re-Assessment:

Special Notes:

Dressing should not wet.

Nurse Signature:

Alam

Nurse Name:

Alam

Date & Time:

04/07/26 @ 5:30pm

BAH-00660352 IP5-00175831
Master BAKKA BHAVYANSH
15-06-2022 4 Y 0 M 19 D (M)
Dr. ANUPAMA Y



NURSING CARE RECORD

Date: 4/7/26

Shift: ☐ Morning ☐ Afternoon ☒ Night

Assessment:

pain & site

- 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 PM	Assess general condition of the patient.	8:10 PM	Assessed general condition of the patient.	By done all implementation as per doctor's order.
10 PM	Monitor vital signs.	10 PM	Monitored vital signs.	
11 PM	Provide comfortable position to the patient.	11 PM	Provided comfortable position to the patient.	
6 AM	Administer medication as per doctor's order.	6 AM	Administered medication as per doctor's order.	
7 PM	Maintain I/O chart.	7 AM	Maintained I/O chart.	

Re-Assessment:

Re-Assessment done by checking vitals.

Special Notes:

W/F & Fever spikes.

P.B

Nurse Name:

Pragya

Date & Time: 5/7/26 8 AM

Patient



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	3	3	3
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2				1	1
	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			11	11	11	11	11

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
Call device within reach		✓	yes	yes	yes	yes
Wheels Locked		✓	yes	yes	yes	yes
Room free of clutter		✓	yes	yes	yes	yes
Adequate Lighting		✓	yes	yes	yes	yes
Wheel Chair Support		✓	yes	no	no	no
Other Intervention(s) Specify		✓	no	no	no	no
Nurse's Name :		Abhishek Raina	Prachi	Prachi	Prachi	Prachi
Signature :		Abhishek Raina	Prachi	Prachi	Prachi	Prachi
Date :		15/6/22	27/6/22	27/6/22	4/7/22	5/7/22
Time :		4:30pm	6am	6am	6am	6am



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/7	12am	1/10	S-S	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inj PCM	Swamy
6/7	6am	1/10	S-S	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inj PCM	Swamy
				☐ 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		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

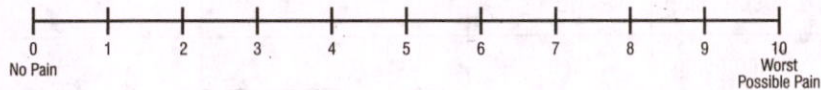
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



BAH-00680352 IP5-00175831
Master BAKKA BHAVYANSH
15-08-2022 4 Y O M 16 D (M)
Dr. ANUPAMA Y



PAIN ASSESSMENT FORM

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Your Right to a Safe Delivery

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
2/7/26	4:30 PM	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Abhishek
2/7/26	12:30 PM	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Ravina
2/7/26	8:30 AM	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Ravina
3/7/26	4:36 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Ru
3/7/26	10 PM	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	praveela
4/7/26	6 AM	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	praveela
4/7/26	2 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shreev
4/7	10 PM	1/10	Sx site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Inf. PCM Comfortable position	Priganka
5/7	6 AM	1/10	Sx site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Inf. PCM	Priganka
5/7	6 PM	1	S/S	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	Inf. p. can Cim	Chandu

Re-assessment Frequency:

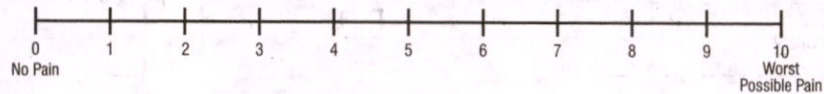
- Every eight hours for all hospitalized patients.
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PAIN ASSESSMENT TOOLS

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CATEGORY	SCORING		
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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

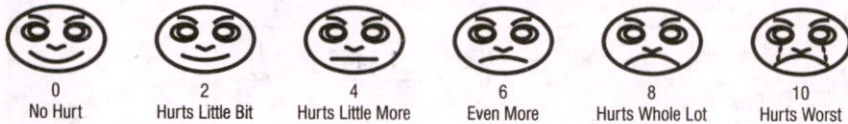
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Wong - Baker (Pediatrics) Above 7 Years





CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 4/7			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0	0	0	0				
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		-	-	-	-	-				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		-	-	-	-	-				
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		-	-	-	-	-				
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		-	-	-	-	-				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		-	-	-	-	-				
Signature of the Nurse													

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

Signature of Shift In Charge :

Signature : Ranadevi Y Name : Ranadevi Y

Signature of Ward In Charge :

Signature : Alan Name : Alan

BAH-00652633
Baby Of HARI PRIYA IP5-00175841
05-11-2025 0 Y 7 M 27 D (M)
Dr. HARISH JAYARAM

CHECKLIST FOR THROMBOPHLEBITIS

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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0	1	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		1	1	1	1	1	1	1	1	cannula changed
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		1	1	1	1	1	1	1	1	cannula change
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	1	1	1	1	1	1	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	1	1	1	1	1	1	1	
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		1	1	1	1	1	1	1	1	
Signature of the Nurse					Meek Ravina	Meek	Meek	Meek	Meek	Meek	Meek	Meek	

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

Signature of Shift In Charge :

Signature :  Name : Sourav

Signature of Ward In Charge :

Signature :  Name : Neeraj

BAH-00660352 IP5-00175831
Master BAKKA BHAVYANSH
15-06-2022 4 Y 0 M 19 D (M)
Dr. ANUPAMA Y



BRADEN 'Q' SCALE

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Your Right to a Safe Delivery

				Date: 5/7	6/7		
				Time: 6AM	6u		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	
"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	
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	
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	D
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	S
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.	2	3	
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	
				TOTAL SCORE	21	27	
				Evaluator's Name	Pragathi		

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Docu. No. : RCHBH /FRM / CLINICAL / 119

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

BAH-00660352
Master BAKKA BHAVYANSH
15-06-2022 4 Y 0 M 16 D (M)
Dr. ANUPAMA Y

BRADEN 'Q' SCALE

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					Date :	16/7/2026	27/7/26	03/07	04/7
					Time :	4:30 PM	6 AM	02	6 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
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Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4	
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TOTAL SCORE					28	28	28	28	
Evaluator's Name					Abhishek	Pranav	Pranav	Pranav	

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
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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



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:

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

Remarks

explains to the mother

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: [Signature]

Nurse Name: Meen

Date and Time: 17/06 @ 8:30pm

BAH-00660352 IP5-00175831
Master BAKKA BHAVYANSH
15-06-2022 4 Y 0 M 19 D (M)
Dr. ANUPAMA Y



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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

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: P. Dressing should not wet

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

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: Alan

Nurse Name: Alan

Date and Time: 04/07/26 @ 5:30pm

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

BAH-00660352 IP5-00175831
Master BAKKA BHAVYANSH
15-06-2022 4 Y 0 M 18 D (M)
Dr. ANUPAMA Y



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Name: BAKKA BHAVYANSH Age: 4 Sex: Male UHID.No: BAH 00660352
Date: 3/7/2020 Time: 7.45pm Proposed Operation: Left cortical mastoidectomy
Diagnosis: Septic arthritis / (L) sigmoid sinus transverse sinus thrombosis
B.P / CRT: 91/56 H.R: 115 Weight: 13.3Kg ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 10.6 Glucose: 20 Protein: 0.5 HIV: --- X-Ray: ---
PCV: 3.3 Urea: 137 Alb: --- HBS Ag: --- ECG: ---
WBC: --- Creat: --- Total Bill: --- HCV: --- 2D Echo: ---
Plate: --- Na: --- Dir. Bill: --- Blood group: --- Stress/Angio: ---
PT: --- K: --- LDH: --- T3: --- Other: ---
PTT: --- Ca++: --- Alk phos: --- T4: ---
INR: --- Mg++: --- Amylase: --- TSH: ---
Cl-: --- SGOT/SGPT: ---

Allergies: Nil

Medical History: CVS:

RESP: h/o knee pain → 7 days back Diabetes: ---
swelling aspirated
CNS: h/o → ear discharge → 2 days
Renal: fever

Hepatic / GE:

Others:

Physical Activity: patient on pain

Past Anaesthetic History: (-)

Physical Exam: No obvious facial asymmetry

Airway: MP 1 2 3 4 Mouth Opening: Mentohyoid Distance: Neck: Teeth:

Lungs: clear

Heart: S1, S2

CNS: Acute

Pregnant: ☐ Yes ☐ No ☐ NA

Venous Access Site:

Spine Exam for regional:

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

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

CURRENT MEDICATIONS	DOSAGE
<u>Ty CEFTRIAXONE</u>	
<u>Ty LINEZOLID</u>	

Pre-Operative instructions:

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

(L) cortical mastoidectomy

Signature: [Signature] Name: M. Shash

BAH-00660352 IP5-00175831
Master BAKKA BHAVYANSH
15-06-2022 4 Y 0 M 19 D (M)
Dr. ANUPAMA Y



ANAESTHESIA CHART

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Pre Induction Assessment

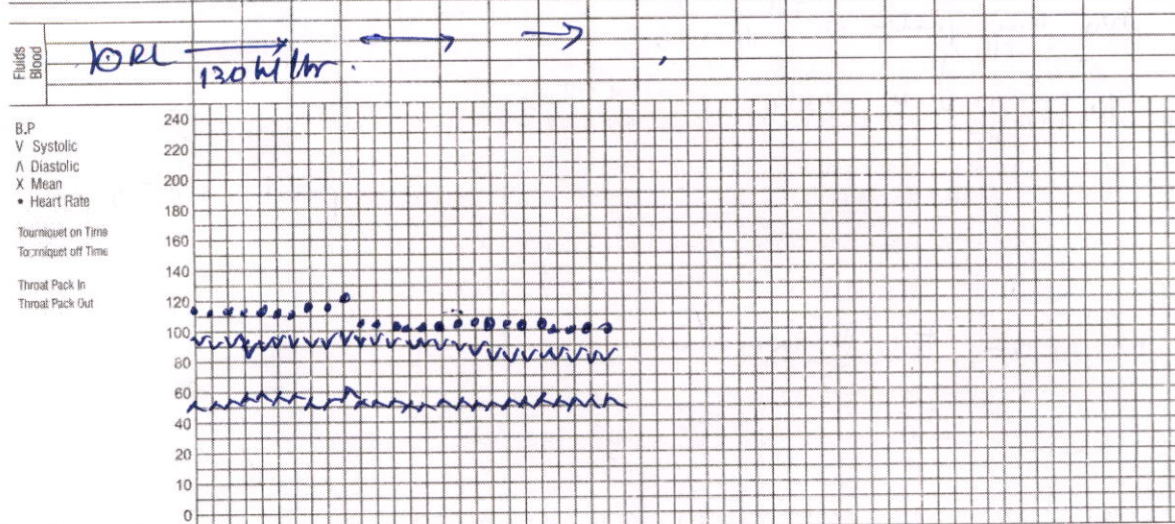
Change in Patient Condition:	☐ Yes ☒ No	Fasting Status:	Continued
Physical Status:	☒ Patient Identified	☒ Consent Present	☐ Chart Reviewed

H.R.:	B.P / CRT:	SpO ₂ :	R.R.:	Last Feed:
Pre-OP Diagnosis: Septic arthritis / Pseudomonas Operation: Critical Mastoidectomy Date: 24/06/22				
Surgeon: DR. SANJOY Anaesthesiologist: DR. DR. DR. R. S. Technician: Goutham				

TIME	N ₂ O (AIR)	O ₂ (PM)	HALO ISO SEVO	Drugs
03:00	100	100	100	3-4% N ₂ O
03:05	100	100	100	2% MIDA TOLUOL - 0.5mg
03:10	100	100	100	1% PENTANYL - 30mg + 10mg
03:15	100	100	100	1% PROPOFOL - 10mg
03:20	100	100	100	1% ROCURONIUM - 10mg + 50mg
03:25	100	100	100	1% MORPHINE - 1mg

FiO ₂ / SaO ₂	100	100	100	100	100	100	100	100	100
ETCO ₂	42	42	40	44	40	42	40	40	41
ECG	52	52	52	52	52	52	52	52	52
Temperature	34	34	36	36	36	36	36	36	36
Urine Output									

Antibiotic
Suppository
Sup D/CLOPENAC
12-5-8
Blood Loss
NOTES



LAB Values

ABG	
GRBB	
Others	

☒ Equipment Checked and Functional ☒ BP ☐ Cuff Site: _____ ☐ Art Site: _____ ☒ EKG Lead 3 lead ☒ Temp Site: Skin ☒ FIO ₂ Monitor ☒ Agent Monitor ☒ Pulse Oximeter ☐ Capnograph ☒ Ventilator ☐ Nerve Stimulator Position: Supine ☒ Pressure Points Checked Eye Care: ☐ Oint ☒ Tape ☐ Padding ☐ Awake	Temp: ☐ HME ☐ Fluid Warmer ☐ Cling Film ☐ OH Warmer ☒ Hugger's ☐ Cotton Wool ☐ Other Times: Anaes Start: 2:00 PM OP Start: 2:30 PM OP End: _____ Leave OR: 4pm Anaesthesia: ☒ GA ☐ Monitored Anaesthesia Care ☐ Regional Line (Size & Location) ☐ CVP: _____ ☐ ART: _____ ☒ IV: _____ ☐ IV: _____ ☐ IV: _____	Induction ☒ IV ☐ Inhal ☐ Pre O ₂ ☐ RSI ☐ Others ☐ Mask ☐ SGA ☐ Airway ☐ Oral ☐ Nasal ETT# _____ at _____ cm ☐ Oral ☐ Nasal ☐ Cuff ☐ Tracheostomy ☐ Topical ☐ Drug: _____ ☐ Awake ☒ Direct Vision ☐ Video Laryngoscopy ☐ Stylette / Bougie ☐ Fiberoptic Blade# _____ Attempts: _____ Difficulty Why? _____ ☒ Bilat = BS ☐ Semi-Closed Circle ☒ Closed Circle ☐ Other	Regional: Extremity _____ Specific: _____ ☐ Spinal ☐ Epidural ☐ Caudal Others: _____ Position: _____ Site: _____ Needle Size: _____ Depth: _____ Parasthesia ☐ Yes ☐ No Catheter at skin _____ cm Drug Name & Conc: _____ Bolus: _____ Infusion: _____ Block Level: _____ Comments: _____ Transportation to ☐ PACU ☐ ICU ☐ Other Relaxant Reversed ☐ Yes ☐ No ☐ NA Name of the Doctor: _____ Signature of the Doctor: _____
---	--	---	--



POST-ANALGESIA RECORD

Received in PACU by : Divya Time Received : 04:05 pm Time Discharged :

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPD	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site :	☒ O ₂ Mask	☒ Nasal Prongs
		☒ Tracheostomy	☒ T-Piece	
		☒ Oral Airway	☒ Nasal Airway	
		Vomiting : ☐ Yes ☒ No Drug: NG Tube : ☐ Yes ☒ No Drain: ☐ Yes ☒ No Urinary Catheter: ☐ Yes ☒ No Chest Tube: ☐ Yes ☒ No Nil Oral ☐ Yes ☒ No IV Fluids: <u>stop</u> Oral Feeds: <u>allow</u>		

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

Pain Tool Used: ☐ N PASS ☐ FLACC ☐ Wong Baker ☐ NPS

Anaesthesiologist Name : DR. SHIN Y

Anaesthesiologist Signature: [Signature]

Date & Time: 04/07/26, 5:45 pm

PACU Nurse Name : Alam

PACU Nurse Signature: [Signature]

Date & Time: 04/07/26

Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU):

Date & Time:

EPIDURAL ANALGESIA RECORD

Date and Time :



CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: cortical mastoidectomy

Anaesthesiologist: Dr SHABNA Surgeon: Dr Sanmush

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk(s): The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders
☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease
☐ Others Desaturation, Laryngospasm, Bronchospasm

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☐ Regional Anaesthesia ☒ General Anaesthesia ☐ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: [Signature]
Name: Sandhya Rani
Relationship with patient: Mother
Date & Time: 04/7/26 @ 12pm

Witness:

Signature: [Signature]
Name: B.P.R.
Date & Time: 04/7/26 @ 12pm

Doctor (who is taking consent):

Signature: [Signature] Name: Dr SHABNA Date: 3/7/26 Time: 7:50pm

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్థావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

లిజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్మల్ బ్లడ్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ లిజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సింట్రిల్ వెనెస్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, లిజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందాని నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00660352 IP5-00175831 Master BAKKA BHAVYANSH 15-06-2022 4 Y 0 M 19 D (M) Dr. ANUPAMA Y 		Date & Time of Admission 01-07-2026 @ 3:25 pm	Date & Time of Transfer Order 04-07-2026 @ 6:30 pm
		Transfer Ordered by Dr. Shilpa	Reason for Transfer post OP care
From Unit OT	To Unit 110	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 52+	Number of Imaging Films	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.	op file	1	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Girvanj		Name of Person Ordered Transfer Dr. Shilpa,	
Patient & Clinical Records Received by : Meelish			
Date & Time of Patient Received : 4/7/26 @ 6:30 pm			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

PATIENT TRANSFER FORM

Patient Name & UHID No.		Date & Time of Admission	Date & Time of Transfer Order
BAH-00660352 IP5-00175831 Master BAKKA BHAVYANSH 15-06-2022 4 Y 0 M 16 D (M) Dr. ANUPAMA Y 		2/7/26 at 3:25pm	2/7/26 at 5:30pm
		Transfer Ordered by	Reason for Transfer
		Dr. prathibha	Admission
From Unit	To Unit	Information to Attendant	
ER	110	Yes ☐ No ☐	
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant	
25	CXR - (1) USG LT knee - (1) 2D Echo - (1)	OP file Yes ☒ No ☐ If yes, what? B. vijender	
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		Name of Person Ordered Transfer	
Mr. Abhishek		Dr. prathibha	
Patient & Clinical Records Received by : Meelin			
Date & Time of Patient Received : 1/7/26 @ 6.15 pm			

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

- ☐ Unavailable Bed
 ☐ Nurse not Available
 ☐ Available Bed not ready

BAH-00660352 IP5-00175831
Master BAKKA BHAVYANSH
15-06-2022 4 Y 0 M 16 D (M)
Dr. ANUPAMA Y

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part I

Patient / Learner Literacy: ☒ Read ☐ Write ☒ Speak

Telegraph

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		
1/7/26	4:30pm	7	Infection Control measures	M	1	0	1	1	NA	Ablishe
2/7/26	8am	9	soft diet	M	1	0	1	1	-	Nikita

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					

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
1/7/26	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Septic arthritis	Hemodynamic stability	IV medication	<i>[Signature]</i>	☒ Nursing ☐ Others:
1/7/26 4:30pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Septic Arthritis	H. Stability	IV medication	<i>[Signature]</i>	☒ Medical ☐ Others:
2/7/26 8am	☐ Medical ☐ Nursing ☒ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Septic arthritis left sigmoid & transverse sigmoid	Soft diet	<u>ROA:-</u> E:- 1350 kcal/d P:- 23 g/d	<i>[Signature]</i>	☐ 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:



110

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 21/7/26 Time: 8 am

Weight: 13.3 kgs Centile: 5th

Height: 102 cms Centile: 50th

Inference: underweight child

RDA: - Calories: 1350 kcal/d Protein: 23 g/d

Diet Recommendations: soft diet

Re-Assessment: Avoid spicy, chilled & outside foods

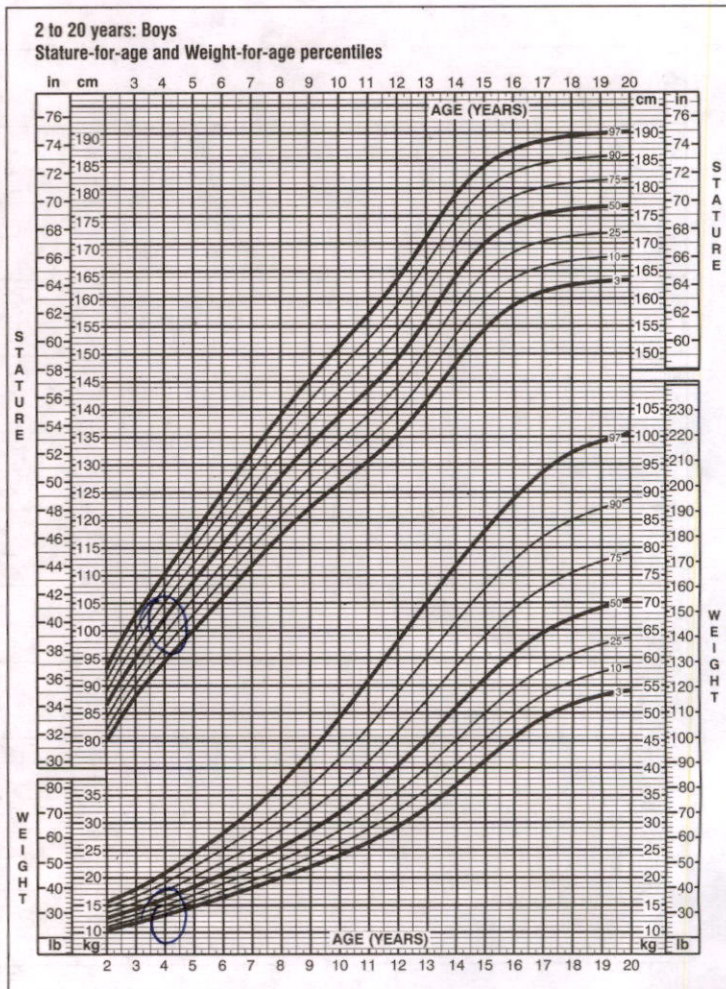
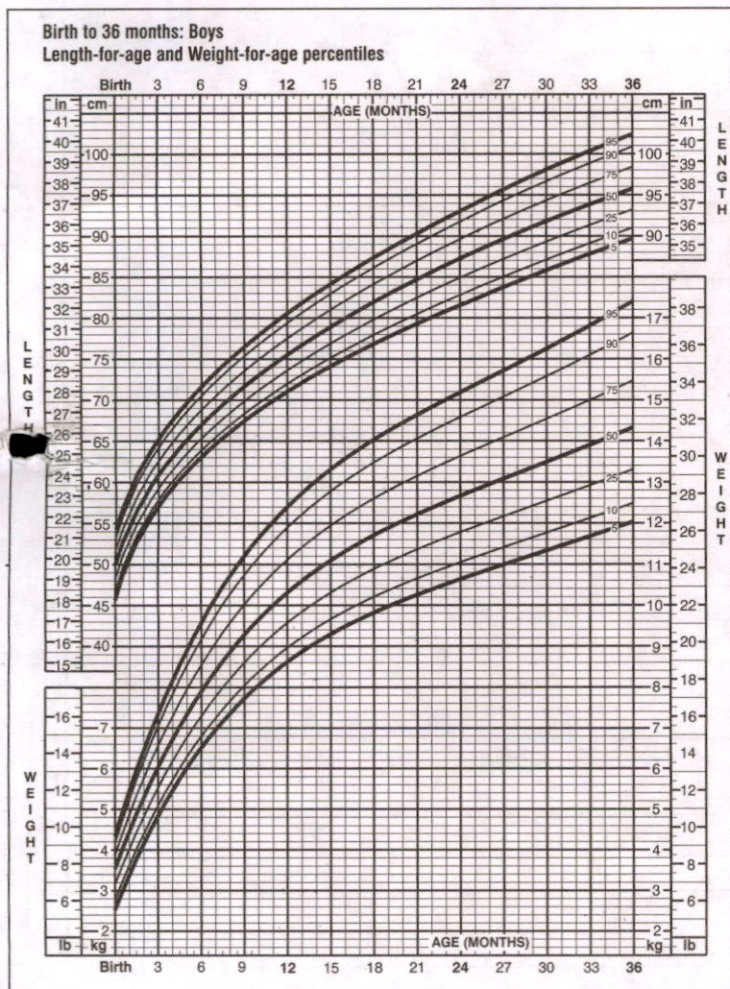
Food Allergies: NO Veg/Non-veg: Non-veg

Diagnosis: Septic arthritis left sigmoid & transverse sinus thrombosis

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: Mounica

Dietician's Signature: Mounica

3/12/26

team ch1 of 15 stable. oral intake is well.

continue 2 soft diet — mounding

4/12/26
10:50am

ch1 of 15 on NPO — mounding

5/12/26
8am

child is stable. intake is fair
encourage orally soft diet

15/12/26

BAH-00660352 IP5-00175831
Master BAKKA BHAVYANSH
15-06-2022 4 Y 0 M 19 D (M)
Dr. ANUPAMA Y



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OPERATION THEATER NOTES

Patient's Name : Master. Bakka Bhavyansh Age : 4 Y Gender : ☒ Male ☐ Female

UHID No. : BAH - 00660352 Weight : Height :

Surgeon : Dr. Santosh Kumar Asst. Surgeon : Dr. Chandana

Anesthetist : Dr. Brander OT Nurse : Alam. Sarai OT Technician : Gouthami

Pre-Operative Diagnosis : Left Post-Aural Abscess & Acute Mastoiditis

Surgical Procedure : Left Cortical Mastoidectomy
Lt. Myringotomy & Grommet

Indications for Surgery :

Date : 4/7/2020 Start Time : 02:10pm End Time : 3:50pm

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:

Left Myringotomy, pus cleared, Grommet
Insertion ch
Left Postaural Incision
Pus about 20ml drained.
Cortical Mastoidectomy done
Granulation in antrum & over
sigmoid sinus cleared
Wound closed in layers
Dram placed
Tissue for HPE, C&S

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Master BAKKA BHAVYANSH
15-06-2022 4 Y 0 M 19 D (M)
Dr. ANUPAMA Y

Patient Sticker

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POST-SURGICAL CARE PLAN FORM

Procedure Done:

Post-Surgical Diagnosis:

Post-Operative Monitoring Parameters /Frequency:

Wound Care:

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

When to Start Mobilization:

Special Referrals:

The new order for all required medications documented in the doctor order/medication sheet:

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

Date: 4/6/2020 Time:

Note: Plan of care will be readjusted if necessary.