

LBH-00132654 IP5-00176141
Master BOMMU RUSHIKESH
07-08-2023 2 Y 11 M 2 D (M)
Dr. SANDHYA VADDADI



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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
9/7/26	12:30pm	ER	onco	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

Signature

Further

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

A. MICHAEL QUINN AND J. CH.

[illegible]**ANY OTHER INFORMATION**

A series of horizontal lines for handwriting practice. Each line set consists of a solid top line, a dashed midline, and a solid bottom line. There are five such sets of lines arranged vertically.

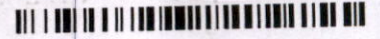
Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
-------------	--------------	-------------------	--------------------

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176141

Admit Date : 09-Jul-2026

Admit Time : 11:55 AM UHID : LBH-00132654

Patient Details :

Patient Name : Master BOMMU RUSHIKESH

Age : 2 Y 11 M 2 D

Guardian : Mr BOMMU ABHISHEK

DOB : 07-08-2023

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : H NO - 12-182/3/A/1, VIKAS EXLIENT SCHOOL
, VIDYA NAGAR , Kalwa Kurthy Nagar Kurnool
Telangana INDIA 509324

Phone No : 7718312345/ 9393949500

E-mail : an@gmail.com

Admission Details :

Bed Type : FOUR SHARING

Bed No : FSW 128

Ward Name : 1F-HEMATO-ONCOLOGY

Room No : FSW 128

Admission Type : First Visit

Contact Details :

Name : Mr BOMMU ABHISHEK

Relationship : Father

Contact Address : H NO - 12-182/3/A/1, VIKAS EXLIENT
SCHOOL , VIDYA NAGAR , Kalwa Kurthy Nagar
Kurnool Telangana INDIA 509324

Phone No : 7718312345 / 9393949500

[Signature]
Signature

Doctor Details :

Doctor Name : Dr. SANDHYA VADDADI

Specialisation : HEMATO ONCOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant : Dr. SIRISHA RANI

Payment Details :

Payment Mode : Cash

Deposit Amount : 25000.00

Payor Name : SELF PAY

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ADMISSION CRITERIA – ONCOLOGY

Admission / Transfer from:

☒ Emergency ☐ Outpatient (OPD) ☐ Ward ☐ Operation Theater ☐ Others:

Tick (✓) any of the following criteria requiring admission / transfer to ONCOLOGY

- ☐ For Chemotherapy-Day Care or IP Admission as per the Type of Chemotherapy
- ☐ Febrile Neutropenias (ANC <500 cells / mm3)
- ☐ Netropenic Enterocolitis
- ☐ Mucositis Induced Significant Diarrhea or Pain
- ☐ Neurological Complications (like Seizures, Bleeding, Thrombosis) that can arise while on Chemotherapy Treatment or at the Time of Presentation and also for other Systemic Problems like Pancreatitis during Chemotherapy
- ☐ Management of Oncological Emergencies
- ☐ Bleeding Problems (where it is indicated)
- ☐ Evaluation and Management of Severe Anemias
- ☐ Day Care Admissions for PRBC Transfusions
- ☐ Evaluation and Management of Sick Children who come with Hematological Problems like Severe Anemia like Autoimmune Hemolytic Anemia/ Bleeding/ Others
- ☐ Primary Immunodeficiency Disorders with Infections that Warrants Hospitalisation
- ☐ Management and Evaluation of Hemophagocytic LymphoHisticytosis
- ☐ Any Systemic Disorders with Significant Hematological issues like JRA / SLE with Secondary HLH

Signature of the Doctor:

Name of the Doctor:

Date & Time: 9/7/26 8 5 PM

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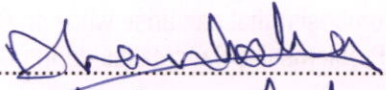
DISCHARGE CRITERIA – ONCOLOGY

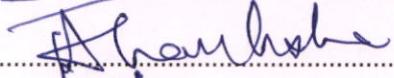
Discharge to:

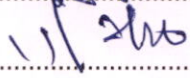
☐ HDU / Step down ICU ☐ Ward ☐ Outside Facility ☐ Others:

Tick (✓) any of the following criteria requiring discharge / transfer from ONCOLOGY

- ☐ Completion of chemotherapy, with no debilitating side effects.
- ☐ Resolution of febrile episode, with no fever > 24hrs and Absolute Neutrophil count (ANC) > 500cells/mm3.
- ☐ Admitted patients - Once the admitting problem gets resolved or made a plan to manage further on out-patient basis.

Signature of the Doctor: 

Name of the Doctor : 

Date & Time:  11/2/20



PEDIATRIC IN-PATIENT MEDICAL RECORD

LBH-00132654 IP5-00176141
Master BOMMU RUSHIKESH (M)
07-08-2023 2 Y 11 M 2 D
Dr. SANDHYA VADDADI



Patient Name:

Rushikesh

UHID ID:

Department:

Consultant:



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

IC/O Acute Myeloid leukemia / ALL3 Negative / CNS Negative
on DA-2

Now came for chemotherapy + LP + BMA

History of present illness :

No H/o fever, cold, cough, vomitings, loose stools.

No fresh complaints.



Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

70

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

} Upper middle class.

Developmental History :

② development

Immunization History :

Vaccination KU



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 12.54 kg (Centile _____)

On Examination :

Temperature : 98.2° F Pulse Rate : 102/min B.P. 95/45(53) SP02 100% on RA

Resp. rate and type of breathing : RR = 24/min.

Rash _____

Lymphadenopathy _____

Oedema : nil

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : Bilateral

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S1S2

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : soft, n.t.

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 : _____

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____

Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Acute myeloid leukemia / FLT3 negative / CNS negative

↓
Came for chemotherapy + LP + BMA

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

CRP Done in op
bas
N/S
Bhav
9/7/26

Planned Management

Chemotherapy
LP
BMA
NPO to continue
Ij orders
Syp. Domstel.

Signature of the Doctor: Ramya

Name of the Doctor: Dr. Ramya

Date & Time: 9/7/26; 12pm

Signature of the Consultant: _____

Name of the Consultant: _____

Date & Time: _____

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/23 8:30 AM	<u>C/I/B Resident</u> Adm: AML Admitted for HiDac-1. No clo Vomiting. No New Seizures. O/S Child Alert & Active Vitals Stable. CX: (I/L) RU: (B/LA) PLA: Soft CNS: NAD.	<u>Plan</u> - Continue chemotherapy. - monitor vitals - Inform (S-1) Rpt CBP on 13/7 R. OK on 12/7 N/B Rajannani 10/7/23 @ 11am 10/7/23 10am

Date & Time	Progress Notes	Doctor's Order
11/2/16 9AM	<u>Morning rounds</u> AML for Hi-Dar-2. CBFB ⊕ / High count / cws ⊖ Aphidite, Alert No fresh issues V, file (N) S/E → PMW/UT/200 WS NG (N) PLA	<u>Adv.</u> 1) ch. chemo 2) DL tm 3) Q1 on 12/7 4) flu report 5) monitor while 6) Enfram 808
		<u>Shankar</u> MIB/MO/M/ta 11/7/28 10AM
	<u>Summary</u> 46499 CS: 11AM	

[illegible]

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RESULT SHEET

Date	09/07/26	09/7/26			
Time					
Hb	9.2	10.2			
PCV MCV	27/84.4	30.3/88.3			
RBC	3.20	3.43			
WBC	4.94	3.82			
N/L	24/65	35/53			
Platelets	5,34,000	6,90,000			
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :



DRUG CHART

Date of Admission: 9/7/26 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG :				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:																			

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

Weight. 12.54 kg Ward.

3mg
hair

VARIABLE DOSE

Date►
Time

Nurse Sig.

Nurse Sig.

Nurse Sig.

Nurse Sig.

Route

Start Date

Name & Signature of the Doctor

Additional Instructions:

VARIABLE DOSE

Date
Time

Nurse Sig.

Nurse Sig.

Nurse Sig

Nurse Sig

Route

Start Date

Name & Signature of the Doctor

Additional Instructions:

STAT / ONCE ONLY DRUGS

Date _____

Time

Medication

Dosage & Other Instructions

Route

Signature

Nurses



I.V. FLUIDS CHART

Weight. Ward.

[illegible]



MEDICATION RECONCILIATION FORM

Drug Allergies: NA

☐ Not known any Drug Allergies

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

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

Shifting From: ER

Shifted to: Ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Syp. Septran	3.5ml	PO	BD	8/7/26	☒ C ☐ DC
2	Syp. Zincovit	2.5ml	PO	OD		☒ C ☐ DC
3	Syp. Celebrex plus	2.5ml	PO	OD		☒ 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 : Dr. Ramya

Date & Time : 9/7/26; 12pm

Nurse Name & Signature : [Signature]

Date & Time : 9/7/26

LBH-00132654

IP5-00176141

Master BOMMU RUSHIKESH

07-08-2023

2 Y 11 M 2 D

(M)

Dr. SANDHYA VADDADI



CHEMOTHERAPY PRESCRIPTION

All the chemotherapy medications are high risk / high alert drugs.
While administering chemotherapy drugs watch for nausea, vomiting, rashes,
urine output and any local extravasation of the drug.

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Sheet No.: ①		Weight (kg): 12.5	Body Surface Area: 0.55	Diagnosis: AML	Protocol: AML - 15 / H.DAR					
DATE	TIME	Composition of Chemotherapy (if infusion, mention ml / hr = Mcg / kg / min. etc.)	DOSE	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
9/7/26	2 PM	INT METHOTREXATE INT CITARABINE INT HYDROCORTISONE	10mg. 25mg 10mg	INTRA THECAL	stat	Kg	POSSA Anuradha	9/7/26	Kg	POSSA Anuradha
9/7/26	4:53 PM	INT CITARABINE with 200ml NS	800mg	IV	@ 50ml/hr	Kg	Rajamam Veena	9/7/26	Kg	Savitri Bhuvana
D1 10/7/26	6 AM	INT CITARABINE with 200 ml NS	800mg	IV	@ 50ml/hr	Kg	Subraman Savitri	10/7/26	A	Rajamam Veena
D3 11/7/26	3 PM	INT CITARABINE with 200ml NS	800mg	IV	@ 50ml/hr	Kg				
12/7	7:30 AM	INT CITARABINE with 200ml NS	800mg	IV	@ 50ml/hr	Kg				
D5 13/7	10 am	INT CITARABINE with 200 ml NS		IV	@ 50ml/hr	Kg				

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Sheet No. ②	Weight (kg) :	Body Surface Area:	Diagnosis:			Protocol:				
DATE	TIME	Composition of Chemotherapy (if infusion, mention ml / hr = Mcg / kg / min. etc.)	DOSE	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
13/7	10 pm	INT CYTARABINE with 200ml NS		IV	@ 50ml/hr	Re	[Signature]			



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
9/7/26	12pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Bhavan
10/7/26	6am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shrey
10/7	2pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shrey
10/7	10pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shrey
11/7/26	6am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shrey
11/7	2PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shrey
				☐ 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:

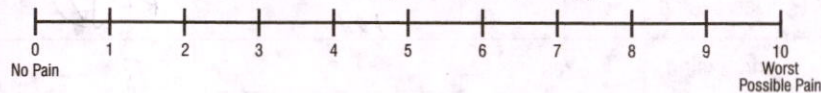
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



Date : 11/7/26 Time: 10AM 10m

[illegible][illegible][illegible]

130
120
110
100
90
80
70
60
50

112 100
↕ ↕ (65)
73 59

$\begin{array}{c} \updownarrow \\ 73 \end{array}$
 $\begin{array}{c} \updownarrow (65) \\ 59 \end{array}$

Heart Rate (Number)	119 bpm	101 bpm
---------------------	---------	---------

Resp Rate (Number)	25b/m	26b/m
--------------------	-------	-------

[illegible][illegible][illegible]

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

[illegible][illegible][illegible][illegible]

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)



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/24 Time: 8:50 AM 1pm 4pm 7PM 10pm 3Am 6Am
Doctor / Nurse / Family Concern?

Temperature (F)	104						
	103						
	102						
	101						
	100						
	99	98.8 F	98.8 F	98.6 F	98.6 F	98.2 F	98.1 F
	98						
	97						
	96						
	95						
	94						

Heart Rate (bpm)	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100	90	91	92	90	95	100
	90						
	80	80	81	81	81	80	87
	70						
	60						
	50						
Blood Pressure (mmHg) *							
Note: BP does not score in early warning scoring							
Heart Rate (Number)		108 bpm	106 bpm	104 bpm	105 bpm	102 bpm	101 bpm

Resp. Rate (bpm) (Over 1 Minute) *	70						
	60						
	50						
	40						
	30						
	20						
	10						
Resp Rate (Number)		25 bpm	25 bpm	24 bpm	24 bpm	24 bpm	24 bpm
Resp Distress							
Mod/ Severe None / Mild							
Receiving O ₂ (l/min)							
O ₂ Saturations (%)		100%	100%	100%	100%	100%	100%
Conscious Level		15/15	15/15	15/15	15/15	15/15	15/15
Normal Altered							
GCS *		15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE		0	0	0	0	0	0
Number of shaded boxes		0	0	0	0	0	0
Pain Score		0	0	0	0	0	0
Observer's Initials		R	R	R	R	R	R

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)

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Master BOMMU RUSHIKESH
07-08-2023 2 Y 11 M 2 D (M)
Dr. SANDHYA VADDADI



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

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9/1/26 Time: 1:30 PM 5 PM 7 PM 10 PM 3 AM 6 AM

Doctor / Nurse / Family Concern?

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94

98.6 F 98.8 F 98.6 F 98.4 F 98.2 F 98.4 F

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

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

90 (65) 91 (55) 95 (65) 99 (60) 100 (60) 95 (60)
126/4 82/4 96/4 102/4 104/4 101/4

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

70
60
50
40
30
20
10

26/4 25/4 26/4 26/4 26/4 26/4

Resp Mod/ Severe
Distress None / Mild

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

100% 100% 100% 100% 100% 100%

Conscious Level
Normal Altered

GCS *

15/15 15/15 15/15 13/13 15/15 15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

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.

should be
leaf

low 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:

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S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	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)



FLUID CHART

Sheet No. : ①

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

		Intake				Output				IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G						
9/8	08:00 am										
	09:00 am										
	10:00 am										
	11:00 am										
	12:00 pm										
	01:00 pm										
	Total Intake :					Total Output :					
a/z	02:00 pm	NPO									
	03:00 pm										
	04:00 pm	H ₂ O	100ml	50ml							
	05:00 pm	H ₂ O	50ml	50ml					160ml		
	06:00 pm		50ml	50ml							
	07:00 pm		50ml	50ml					100ml		
	Total Intake :					Total Output :					
a/z	08:00 pm			BS							
	09:00 pm		200ml	50ml							
	10:00 pm	H ₂ O		50ml							
	11:00 pm			50ml							
	12:00 am			50ml							
	01:00 am			50ml					360ml		
	Total Intake :					Total Output :					
a/z	02:00 am			50ml							
	03:00 am			50ml							
	04:00 am			50ml							
	05:00 am			50ml							
	06:00 am			50ml							
	07:00 am			50ml					250ml		
	Total Intake :					Total Output :					
Total 24 hrs. Intake		1100 ÷ 64.70cc/kg									
Total 24 hrs. Output		870 ÷ 42.6cc/kg									



FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
10/7	08:00 am	Wt		50ml						150ml	1	Reg	
	09:00 am			50ml									
	10:00 am	Wt	100ml	100ml									
	11:00 am			100ml									
	12:00 pm			100ml					200ml				
	01:00 pm			100ml									
Total Intake :			400ml			Total Output :			380ml			M.O	
10/7	02:00 pm	Rice and		100ml							1	Reg	
	03:00 pm	on		100ml						250ml			
	04:00 pm	Wt	100ml	100ml									
	05:00 pm			100ml									
	06:00 pm			100ml					100ml				
	07:00 pm			100ml									
Total Intake :			380ml			Total Output :			350ml			M.O	
10/7	08:00 pm	Curd		100ml							1	Reg	
	09:00 pm	Wt	200ml	100ml									
	10:00 pm			100ml									
	11:00 pm			100ml									
	12:00 am	Wt		100ml									
	01:00 am			100ml					100ml				
Total Intake :			440ml			Total Output :			400ml				
11/7	02:00 am			100ml							1	Reg	
	03:00 am			100ml									
	04:00 am			100ml									
	05:00 am			100ml									
	06:00 am			100ml									
	07:00 am			100ml					200ml				
Total Intake :			240ml			Total Output :			280ml				
Total 24 hrs. Intake		1460 ± 121.6cc/kg											
Total 24 hrs. Output		1410 ± 47cc/kg											

FLUID CHART

Sheet No. : 3

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am			40ml								
	09:00 am	adi 2 piee		40ml						150ml		
	10:00 am	H2O 100ml		40ml								
	11:00 am			40ml								
	12:00 pm			40ml						200ml		
	01:00 pm			20ml								
Total Intake :						Total Output : 350ml						
	02:00 pm			20ml								
	03:00 pm	eggomet		50ml								
	04:00 pm	pieet		50ml								
	05:00 pm	dal		50ml								
	06:00 pm	H2O 100ml		50ml								
	07:00 pm			50ml								
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake												
Total 24 hrs. Output												

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Dr. SANDHYA VADDADI



FLUID CHART

Rainbow
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It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No. :

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

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

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 9/7/20

Assessment: Baby has nausea related to chemotherapy

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess General condition of the baby	2pm	assessed General condition of the baby	Baby has reduced Nausea
3pm	Monitored vital signs	3pm	Monitored vital signs	
4pm	administered medications as per chest & administer inj. order.	4pm	administered medications as per chest	
5pm	to provide comfort	5pm	provided comfort	
6pm	to ensure safety	6pm	provided side rail	
7pm	Maintain 1/2 chest	7pm	Maintained 1/2 chest	

Re-Assessment: Baby don't have no Nausea

Special Notes:

Nurse Signature: [Signature] Nurse Name: Rajamma Date & Time: 9/7/20 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/2/16

Assessment: Baby hungry at birth level low

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the child on	9pm	Assess the child	
10pm	monitor vital signs	11pm	monitor vital signs	
12AM	maintain D6 chart	1AM	maintain D6 chart	
2AM	Administer medication as per doctor's order	3AM	Administer medication as per doctor's order	
5AM	monitor condition	7am	monitor condition	

Re-Assessment: with heavy urine output

Special Notes: watch for dehydration signs

Nurse Signature: [Signature]

Nurse Name: Bhun

Date & Time: 10/2/16 @ 8am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 10/14

Assessment: Baby has poor oral intake

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess General condition of the baby	8am	assessed General condition of the baby	Baby has eating well.
8:30 am	Monitor vital signs	8:10 am	monitored vital signs	
10AM	administer medication as per chart	10AM	administered medication as per chart	
12PM	to encourage oral intake	12PM	encouraged oral intake	
2PM	Maintain fluid balance	2PM	administered IV fluids	
4PM	to ensure safety	4PM	provided safe care	
6PM	Maintain 16 chart	6PM	Maintained 16 chart	

Re-Assessment:

Baby has eating well.

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Ryan

Date & Time: 10/14/2023

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 07/20

Assessment: Baby living with hydration looks good

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's Genus condition	8:30pm	* Assessed the child's Genus condition	
9pm	* monitor vital signs	9:40pm	* monitor vital signs	
10pm	* maintain S/O chart	11pm	* maintain S/O chart	
12am	* Administer medication given by	1am	* Administer medication given by	
2am	not lost order	4am	* Baby in contact	
5am	* Baby for good	7am		

Re-Assessment: with hourly vital monitoring

Special Notes: watch for lost & any changes

Nurse Signature: [Signature]

Nurse Name: Shree

Date & Time: 11/7/20 @ 8am

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 11/7/26

Assessment: Patient having chemotherapy

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	TO Assess the baby condition	9AM	Assessed the baby condition	Patient feel better
10AM	TO monitor vitals and Record	11AM	monitored vitals and Recorded	
12PM	TO maintain fluid balance	1PM	maintained fluid balanced	
2PM	TO maintain Personal Hygiene	3PM	provided supportive care	
4PM	TO Ensure safety	5PM	continue chemotherapy	
6PM	Administer medication as per doctor's order	7PM	medication given as per doctor's order	

Re-Assessment: Re-assessment done

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Moumita

Date & Time: 11/7/26 8PM

Patient Sticker

NURSING CARE RECORD


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Your Right to a Safe Delivery

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:

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NURSING CARE RECORD


**Rainbow
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It takes a lot to treat the little.


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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:

LBH-00132654 IP5-00176141
Master BOMMU RUSHIKESH
07-08-2023 2 Y 11 M 2 D (M)
Dr. SANDHYA VADDADI



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 12:50pm Mode of Arrival: By Walk Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Nil Body Weight: 12.54 Kg
Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
NA	Nil	Nil

Family History: Not significant

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

If Yes please list:

Was the child's birth normal? ☐ Yes ☒ No If No, please describe problems:

Are the child's immunization up to date? ☒ Yes ☐ No

Current Medication: ☐ None ☐ Yes, If Yes, fill reconciliation form

Observations: Weight: 12.54kg Length: 110cm Head Circumference (< 2 years): 24.6cm

Temp.: 98.8°F HR: 110b/min RR: 24b/min BP: 101/61

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

Fall Assessment: ☒ Yes ☐ No Score: 28 (Document in the Humpty Dumpty Sheet)

Braden Q Score (Braden Q Score) (Document in the Braden Q Assessment Sheet)

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

Location Frequency Duration

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

Inform consultant for positive criteria

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

Inform consultant for positive criteria

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

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☐ Yes ☐ No if Yes specify Inform consultant for positive criteria.**Social History:** Lives With FamilySiblings in household ☐ Yes ☐ No (if yes How Many?)All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach : ☒ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump : ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No☐ OthersPatient Rights & Responsibilities: ☐ Yes ☐ NoInformation given to motherNurse Signature: RajNurse Name: RajamurariDate: 9/7/25Time: 1:20 PM



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Sandhya Vaddadi Department: ER Date of Admission: 9/2/26

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known		If Yes Specify:		
BACKGROUND	Area	<u>ER</u>						
	Shift Time	<u>12:30pm to 8pm</u>						
ASSESSMENT	Medical Condition (Any special condition to be noted):	NA NA NR NR NR NA						
	Allergy:	☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No						
ASSESSMENT	Tubes/Drains/Catheter:	☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No						
	Vital Signs:	Temp:	<u>98.2°f</u>	<u>98.6°f</u>	<u>98.0</u>	<u>98.6°f</u>	<u>98.0°f</u>	<u>98.5°f</u>
		Res:	<u>24b/m</u>	<u>25b/m</u>	<u>20w</u>	<u>24b/m</u>	<u>20w</u>	<u>25b/m</u>
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>99.1</u>	<u>100%</u>	<u>100%</u>
		Pulse:	<u>132b/m</u>	<u>180b/m</u>	<u>130</u>	<u>100b/m</u>	<u>112</u>	<u>101b/m</u>
		BP:	<u>98/78</u>	<u>100/50</u>	<u>100/6</u>	<u>100/61</u>	<u>100/6</u>	<u>100/1</u>
	Fall Risk Score:	<u>12</u>	<u>12</u>	<u>12</u>	<u>1</u>	<u>1</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</u>		
Recommendations	Safety Needs:	<u>yes</u> <u>yes</u> <u>yes</u> <u>side rails</u> <u>side rails</u> <u>side rails</u>						
	Physiotherapy	☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No						
	Others Specify:	<u>yes</u> <u>NA</u> <u>no</u> <u>NA</u> <u>NA</u> <u>NA</u>						
	Special Diet:	☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No						
	Other Special Orders / Medications:	<u>NA</u> <u>NA</u> <u>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>B. Ravani</u> <u>Rajamani</u> <u>Raj</u> <u>Rajamani</u> <u>Raj</u> <u>Mammi</u>						
Signature :								
Date:		<u>9/2/26</u> <u>9/2/26</u> <u>10/2</u> <u>10/2</u> <u>10/2/26</u> <u>11/2</u>						
Time:		<u>12:30pm</u> <u>8pm</u> <u>8am</u> <u>8pm</u> <u>8am</u> <u>8pm</u>						
Taken Over By Name :		<u>Rajamani</u> <u>Subramaniam</u> <u>Raj</u> <u>Subramaniam</u> <u>Mammi</u>						
Signature :								
Date:		<u>9/2</u> <u>9/2</u> <u>10/2</u> <u>10/2</u> <u>11/2</u>						
Time:		<u>12:30pm</u> <u>8pm</u> <u>8am</u> <u>8pm</u> <u>8am</u>						



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

Moderate Sedation Flow-Sheet

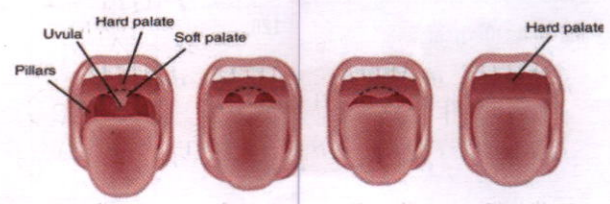
Immediate Pre-Sedation Assessment

B.P	PR	R.R	Temp	SPO ₂	Pain Score	Weight
105/61	138bpm	20bpm	98.8°	100%	02	12.5kgs

Diagnosis: AML / FLT3 Negative / CNS Negative

Procedure: chemotherapy + LP + BMA

Comorbidities: ⊙

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

Procedure Monitoring

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

Level of Consciousness (LOC):

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

2

TIME	BP	PR	RR	O ₂ Sat%	O ₂ Supplementation	Comments / Initials
Baseline	105/61	130b/min	30b/min	100%	-	-

DRUG & IV Fluid: (including Nitrous Oxide)	ROUTE	DOSE	TIME GIVEN	SUBSEQUENT DOSES AND TIME
Inj. ketamine	10mg - IV	10mg	1:30pm	
Inj. Midazolam	1mg - IV	1mg	1:30pm	

Doctor Notes:

Time of transportation to post sedation care room: LOC:

Doctor Name: Signature:

Post Sedation Care Room

[illegible]

TOTAL ALDRETTE SCORE AT DISCHARGE =
(If 9 and more patient can discharge from post Sedation care unit)

Activity :	Consciousness:	Respiration:	Oxygen Saturation:	Circulation:
Four extremities = 2	Fully awake = 2	Breathe Deep= 2	Sat O ₂ >92 % on room air = 2	BP +/- 20 mm hg of pre-op = 2
Two extremities = 1	Arousal on calling=1	Dyspnea, limited breathing = 1	Needs oxygen to maintain Sat O ₂ >90% = 1	BP +/- 20-50 mm hg of pre-op = 1
No extremities = 0	Unresponsive=0	Apnea = 0	Saturation <90% with oxygen = 0	Bp +/-50 mm hg of Pre-Op = 0

Patient Discharge Time: 0000 2pm

Nurse Name: poola

Date: 9/7/26 Time: 2pm

Consultant Name: DR Sankhya

Stamp

Signature: _____

Signature: Dr. Carolyn



CONSENT FOR PROCEDURAL SEDATION

Authorization By: ☐ Patient ☒ Patient Attendant

I, the undersigned do hereby acknowledge the following:

- I have been made aware by the doctors in language known to me the details of sedation planned for the procedure

Sedation.

- I have been made aware of the possible complications from the procedure of sedation as follows:
- Changes in heart rate, blood pressure, need for oxygen supplementation, allergic reactions, upper airway obstruction, laryngospasm, conversion to general anaesthesia

I have been made aware that the sedation is being advised to relieve pain and anxiety during the procedure. It will help me remain calm, comfortable, and cooperative, allowing the procedure to be performed smoothly and safely.

- I have been clearly explained about the benefits, risk, and alternative of the sedation which is General Anaesthesia.
- I authorize Dr. Sandhya and his / her team to perform the procedural sedation upon the patient / myself.
- 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: B. Ashish
Relationship with patient: Mother
Date & Time: 9/7/20 @ 1:20pm

Witness:

Signature: [Signature]
Name: Ashish
Date & Time: 9/7/20 @ 1:15pm

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. prathank Date 9/7/20 Time: 1:10pm

ప్రాసీజరల్ సెడేషన్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, క్రింది విషయాలను అంగీకరిస్తున్నాను:

నాకు తెలిసిన భాషలో, వైద్యులు ఈ క్రింది ప్రాసీజర్ కు ఇచ్చే సెడేషన్ గురించి పూర్తి వివరాలు నాకు తెలిపారు:

- సెడేషన్ వల్ల సంభవించగల సాధ్యమైన క్రింది సమస్యలు/ప్రమాదాలు గురించి నాకు తెలిపారు: గుండె వేగం మారడం, రక్తపోటు మారడం, ఆక్సిజన్ అవసరం, అలర్జిక్ ప్రతిచర్యలు, ఎగువ శ్వాసనాళ అడ్డంకి, లాలింజోస్టాసమ్, జనరల్ అనస్థీషియాగా మారాల్సిన అవకాశం.
- ప్రాసీజర్ సమయంలో నొప్పి, భయం, అందోళన తగ్గించేందుకు సెడేషన్ ఇవ్వడం అవసరం అని నాకు వివరించారు. ఇది ప్రాసీజర్ సజావుగా, సురక్షితంగా జరగడానికి సహాయపడుతుంది.
- సెడేషన్కు సంబంధించిన ప్రయోజనాలు, ప్రమాదాలు, ప్రత్యామ్నాయం (జనరల్ అనస్థీషియా) గురించి నాకు స్పష్టంగా వివరించారు.
- డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ ప్రాసీజర్ సెడేషన్ చేయడానికి నేను అనుమతిస్తున్నాను.
- పై సమాచారాన్ని నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ఉన్న ప్రశ్నలన్నీ, నాకు అర్థమయ్యే భాషలో సమాధానమిచ్చారు. ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్:

సంతకం: పేరు: తేదీ & సమయం:



CONSENT FOR SPECIAL PROCEDURES

Patient Name : Rushikesh Gender: ☒ Male ☐ Female

UHID No : _____ Department : Hematology Date : 9/2/23

I Geetha S/D/W/O _____

Here by give consent for procedure of : BMA + LP + chemotherapy

For my patient, Named : _____

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

Pain / headache / Bleeding

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

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

Name of the Doctor performing the procedure: Dr. Sandhya

Patient Attendant :

Signature : Geetha

Name : B. Adhithyan

Relationship with Patient: Mother

Date & Time : 9/7/26 @ 1:45pm

Witness :

Signature : Geetha

Name : B. Adhithyan

Date & Time : 9/7/26 @ 1:15pm

Doctor (who is taking the consent) :

Signature : Dr. Prachin

Name : Dr. Prachin

Date & Time : 9/8/23 @ 1:10pm

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

.....

.....

.....

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము



CONSENT FOR CHEMOTHERAPY

Patient Name : Bommu Rushikesh Age : 2y 11mths Gender: Male ☒ Female ☐
UHID No : Department : Oncology Date : 9/7/26
Type of Chemotherapy : intravenous

The type of reactions, nature of the major risks and complications arising from the treatment despite precautions has been explained to me. These can include Bone Marrow depression with subsequent infections, bleeding, nausea, vomiting, diarrhea, mouth ulcers, alopecia, fever, phlebitis, ulceration at the site of injection organ injuries etc.

The doctor have explained to me about the benefits and alternative for this procedure that
explained.

I understand that no promise of cure or freedom from risk can be given. During the course of treatment I will report any symptoms if they become bothersome.

I have read the above and have no further questions about the treatment to be given.

Patient Attendant :

Signature : [Signature]
Name : B. Abhishek
Relationship with Patient : Father
Date & Time : 9-7-26 @ 1:15pm

Witness :

Signature : [Signature]
Name : Rani
Date & Time : 9/7/26 @ 1:15pm

Doctor (who is taking the consent):

Signature : [Signature]
Name : Dr. Sandhya
Date & Time : 9-7-26 @ 1:10pm



THE HUMPTY DUMPTY SCALE 9/7 10/12 11/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4		
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	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					
	Other Diagnosis	1	1	1	1		
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1		
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2		
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1		
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1		
TOTAL			12	12	12		

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

Bed in low position	Yes	Yes	Yes		
Call device within reach	Yes	Yes	Yes		
Wheels Locked	Yes	Yes	Yes		
Room free of clutter	Yes	Yes	Yes		
Adequate Lighting	Yes	Yes	Yes		
Wheel Chair Support	No	No	No		
Other Intervention(s) Specify	No	No	No		
Nurse's Name :		Sagan	2/7	N	
Signature :		[Signature]	[Signature]	[Signature]	
Date :		9/7	10/12	11/7	
Time :		12pm	12pm	12pm	

BRADEN 'Q' SCALE

					Date :	9/7	10/7	11/7	
					Time :	12pm	12	8pm	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	
TOTAL SCORE						28	20	28	
Evaluator's Name						Bhawan			

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

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

LBH-00132654 IP5-00176141
Master BOMMU RUSHIKESH
07-08-2023 2 Y 11 M 2 D (M)
Dr. SANDHYA VADDADI

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Par
Pati

Language:

Telugu

Patient / Learner Literacy:

☐ Read

☒ Write

☐ Speak

Willingness to Learn: ☒ Yes ☐ No

Healthcare Literacy: ☒ Yes ☐ No

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
9/7	12pm	2	Infection control measures	M	1	0	1	1	-	Shavari
10/7	12pm	1	Diagnosis	m	1	0	1	1	-	Naik
11/7	11am	1	infection control measure	m	1	0	1	1	-	De

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
9/8/26	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	AML	Hemodynamic stability	chemotherapy + LP + DMA	[Signature]	☐ Nursing ☐ Others:
9/8/26 12pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Acute myeloid leukemia	Hemodynamic stability	chemo + LP	[Signature]	☐ Medical ☒ 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:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge:

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

Explained to 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: Saji

Nurse Name: Rajamani

Date and Time: 9/8/26 @ 2pm