

BAH-00660549 IP5-00175934
Master KRISHNA NAGLA
04-07-2024 2 Y 0 M 0 D (M)
Dr. NABEEL ALAM QADRI



Patient Sticker

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

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Sketcher
06/07/26

SURGERY DETAILS

8/026.

Entered

Date: 4/7/26

Patient Name: M. Krishna Nagla Date of Birth: Age: 27

Gender: Male Ward: P.O.T UHID No: 660544

Date of Surgery: 4/7/26 ☒ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery: LAPAROTOMY + RESECTION ANASTOMOSIS OF
ILEAL DUPLICATION CYST

Time in: 12:30 PM

Cash
AVA

Time Out: 2:30 PM

	NAME	AMOUNT
1. Surgeon	Dr. Nabeel	SV = 83,850
2. Anaesthetist	Dr. Sweta	AN = 25,155
3. Assistant Surgeon		OT = 67,080
4. OT Technician	Sibisha	OTC = 9300
5. Circulating Nurse	Samon	
6. Assistant Nurse	Theresa	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9687691

Order by: Zeeho

ESTIMATION SLIP

11:20 AM

Date: 03/07/2026 UHID / IP No.: BAH-00660549 SI No. 81026

Name of Patient: Madal Krishna Nigla Age: 14 Gender: M

Father's / Husband's Name: Mr. Vikas Corporate / Occupation: Business

Address: Phone: 6301604140 Email:

Procedure / Plan: Laparotomy + Resection & Anastomosis

MODE OF PAYMENT: ☒ SELF ☐ TPA: ☐ GIPSA: ☐ OTHERS: 52 h OT

TAFF INFORMATION: Dr. Laxman Karmayani (PGI-34)

ROOM CATEGORY	GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
Room Rent & Nursing Charges										
Doctor's Fee				21850						
L. Tax				per day						

PARTICULARS Surgeon's / Anesthetists's Fee / O.T. Charges 99235

O.T. Consumables Subject to approval by TPA / Insurance Company.

Instrument Charges Not Covered by TPA / Insurance company

Pharmacy, Consumables & Investigations As per actual - Not Included in Estimation

Equipment Charges	Monitor :	Oxygen :	Infusion pump / Syringe pump :
	Ventilator :	Conventional :	HFO-SLE 5000 :
	Phototherapy :	Single Surface :	Double Surface :
			Triple Surface :

Blood products / Implants / IP or Procedures / Cross Consultations, Etc. As per actual - Not Included in Estimation

Package

Others

Initial Minimum Deposit 3,80,000 & Final Bill

REMARKS: 15 days 12 h OT

The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.

The estimated surgical charges may vary subject to surgeon's decisions / Complications / Patient's requirements / Mode of Procedure (Like Laparoscopic, Thoracoscopic, etc) / Unilateral to Bilateral Procedure.

3. In case the patient is shifted from lower category to higher category, all charges for the consultant visit, investigations, operations and/or procedures from the date of admission will be according to the higher category.

4. Room eligibility is purely subject to TPA approval and the package/Room tariff starts from the time of admission.

5. Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA/Insurance Company at later stage.

6. For Non-Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/HbsAg, Medical Records, Double Occupancy and Registration Charges, etc, credit cannot be extended. These items are not payable to us as per Insurance Company norms.

7. During Non-working hours of O.T (8:00 PM to 7:00 AM), Sundays & Public Holidays, 30% extra charges are applicable on surgical cost, and this is not covered by TPA/Insurance company. In case the length of stay is beyond the package permitted, additional payment is applicable, for which kindly contact the Financial Counseling desk between 9am to 6pm

8. Difference, if any between the final bill amount and amount permitted/ approved by the TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.

9. Two attendants are permitted with patients in SDLX, DLX and PVT Rooms and only one is permitted in the rest of the categories of rooms. And no attendant is permitted in ICU's. Kindly check your billing status on day to day basis at IP Billing Department.

I, Mr. Pawan Kumar have attended the Financial Counseling desk and understood the expected costs and other conditions applicable. In case the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge, I promise to settle the claim with the hospital

Signature of the Client Pawan Kumar

Signature Relationship Girish Parthi

Signature of the Financial Counselor Shiffa

BAH-00660549
Master KRISHNA NAGLA
04-07-2024
Dr. NABEEL ALAM QADRI



Capotomy Resection
Commons
CONSUMABLES OF OT

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Technician :

Date : 6/7

Time : 12:30 PM

Circulating staff :

Anaesthesia Disposables		Qty	Surgical Disposables		Qty	Disposables (Baby Side)		Qty
		Issued			Issued			Issued
ET tube (3.5-4.0) 45		14/40	Major Pack		1	Inj Vit.K		
LMA		0/1	Sutures 9915-5003		2/2	Cord Clamp		
ECG leads : A/P/N		5/1	Vincyl 3.0 4.0 5.0		2/2	Suction Catheter		
HME filter : A/P/N		0/1	Gloves 6.6.5 7.7.5		2/2	Feeding Tube		
Syringes : 10 cc		10	Surgical blade		2/2	Vaccum Suction Set		
05 cc		10	NG tube		2/2	Surgical Gloves		
02 cc		5	Cautery pencil		1	Gauze Pack		
01 cc		8/1	Koochies PXL		1	Syringe 1ml / 2ml		
Cautery plate : A/P/N		2/4	Ointments		1	Surgical Blade # 20		
IV set + Blood set		1/1	Suction Catheter		1	Koochies (S)		2/1
RL + 25.0		5/1	Cap, Mask		1	NS 500ml		1/1
NS : 10ml 100ml 500ml 1000ml		0/1	Gauze Pack		1	Transo Hx		1/1
min spine		0/1	Mop Pack		1	Jelly		2/2
wavy str		0/1	Steristrip		1	100cc Gcc		
Fentanyl		0/1	Underpad		1			
Morphine		0/1	Draw sheet		1			
Ketamine		0/1	Abgel		1/1			
Propofol		0/1	Foleys catheter 8.10		1/1			
Rocuronium		0/1	Urobag meter		1/1			
Glycopyrolate		0/2	Chest Drainage Catheter					
Myopyrolate		0/1	Romodrain bag					
Ondansetron		0/1	Bandage					
Pencan 25g/ Spinal Needle 22		0/1	Tegaderm					
Bupivacaine 0.25%		0/1	Ioban					
Bupivacaine 0.25%(Heavy)		0/1	Double J Stent					
Antibiotics		0/1	Vaccum Suction set					
Suppositories		0/1	Plastic Bed Sheet					
Amol : 80mg / 250mg / 170 mg		0/1	Betadine Solution					
Supridol : 100mg		0/1	Microshield		100			
Justin 12.5 mg / 25mg / 100mg		0/1	Cotton Balls		100			
Tab. Misoprost : 200mg		0/1	Latex Gloves		100			
2.5mg 10cm + 100cm		1/1	Ramdione Scrub					
Cane + gloves		1/1	Saral					
Nurse + Transo		1/1						
SV canal 2.5/24		1/1						
Q. 8.5Lc splint 1/2		1/1						

Surgeon

Order No. :
Doc. No. : RCH / FRM / GENERAL / 125

Anaesthesiologist

Ordered by :

Nurse

OT Technici

10 CONSUMABLES

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175934 Admit Date : 03-Jul-2026 Admit Time : 05:06 PM UHID : BAH-00660549

Patient Details :

Patient Name : Master KRISHNA NAGLA Age : 1 Y 11 M 29 D
Guardian : Mr VIKAS NAGLA DOB : 04-07-2024
Gender : Male Religion :
Occupation : Martial Status : Single
Address (H) : H NO - 6-26-134, NEW GUNJ ROAD , NEAR
HDFC BANK , Nizamabad Nizamabad
Telangana INDIA 503174 Phone No : 6301604140/ 7842781294
E-mail : pavan12kumar@gmail.com

Admission Details :

Bed Type : PRIVATE ROOM Bed No : PVT 338 Ward Name : 3F-ZONE B
Room No : PVT 338 Admission Type : First Visit

Contact Details :

Name : Mr VIKAS NAGLA Relationship : Father
Contact Address : H NO - 6-26-134, NEW GUNJ ROAD , NEAR Phone No : 6301604140 / 7842781294
HDFC BANK , Nizamabad Nizamabad Telangana
INDIA 503174


Signature

Doctor Details :

Doctor Name : Dr. NABEEL ALAM QADRI Specialisation : PEDIATRIC SURGERY
Referral Doctor : SELF Phone No :
Co-Consultant

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : SELFPAY

9/7/26 / Thursday

2 AM - Abdomen girth - 47

4 AM - " - 47

6 AM - " - 47

10 PM -

2 PM - Abdominal girth - 45 (Kvathu)

6 PM - Abdominal girth - 47 (Kvathu)

10 PM - Abdominal girth 48 (slender)

2 AM - Abdominal girth 48 slender

6 AM - Abdominal girth 46 slender

1 PM - 47 cm Abdominal girth

ACTIVITY RECORD FOR BILLING

Name : **BAH-00660549 IP5-00175934**
Master KRISHNA NAGLA
04-07-2024 1 Y 11 M 29 D (M)
Dr. NABEEL ALAM QADRI
UHID No. : 

Consultant: _____ Dept: _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/7/26	6:10 pm	ER	Ward	Pooja
4/7/26	11:45 am	3rd floor (zone 13)	OT	Annamma
4/7/26	7:45 pm	OT	338	Devi

Cross Consultation Visit

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

[illegible]

Investigations

Order No.

Signature

3/7/26

BGT, CBP, S/E

6702



8/7/26

X-ray - abdomen

033977

Wings

9/7/26

USG Abdomen

033986

Mya

9/7/26

CBP, electrolytes

26068635

Dinger

10/7/26

X-ray Erect abdomen

034193

Pring

10/7/26

Upper GI

034209

Diya

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
3/7/20	In placement	①	6077	Chen
3/12/20	PAC	①	9686692	Slomg

ANY OTHER INFORMATION

.....

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.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Krishna

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

BAH-00660549 IP5-00175934
Master KRISHNA NAGLA
04-07-2024 1 Y 11 M 29 D (M)
Dr. NABEEL ALAM QADRI





Pediatric Multiorgan History & Physical Examination

Name : Krishna Nagla Age/Sex 2/F
Information given by: mother Relationship good

Chief Presenting Complaints & Duration (Chronologically)

Chf: recurrent vomiting 8 days ago
now admitted for duplication cyst
resection

History of present illness :

↓
child previously well

Chf ~~the~~ multiple vomitings (bilious)
8 days ago.
no vomiting since 2 days
evaluated outside & referred.

USG w/A : 8/0 enteric duplication
cyst & partial volvulus
passing stools

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

normal antenatal scan.

Term / 2.8kg / CLAB / no NICU stay

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

(2)

Developmental History :

appropriate

Immunization History :

immunised for age

(P.T.O.)

Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Enteric intestinal duplication cyst
for Laparotomy

Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): 84 cm (Centile _____)
Weight (kgs) : 10.8 kg (Centile _____)

On Examination :

Temperature : 98.3°F Pulse Rate : 116/min B.P. 113/62 SP02 100%
Resp. rate and type of breathing : 20/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

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04-07-2024 Dr. NABEEL ALAM QADRI

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

& blood loss / adhesions

Desired goals of the treatment : _____

surgical resolution

Planned Labs:

BGT
CBP
S/E

Reserve 10 PRBC

NO
Chrom

Planned Management

- 1) PAE due
- 2) NPO as per anesthesia orders
- 3) IVF DNS 40ml/h from NPO
- 4)

Signature of the Doctor: _____

Name of the Doctor: _____

Date & Time: _____

Shubh
Dr. Shubh
3/7/26

Signature of the Consultant: _____

Name of the Consultant: _____

Date & Time: _____

Dr. Nabeel Alam Qadri
Reg. No. 75241
3/7/26
6:20pm



Patient Stick

OPERATION THEATER NOTES

Patient's Name : M. Krishna Neeta Age : 27 Gender : ☒ Male ☐ Female
UHID No.: 660549 Weight : 10.8kg Height :

Surgeon : Dr. Nabeel Asst. Surgeon : Dr. Nikitha

Anesthetist : Dr. Surya OT Nurse : Thejas OT Technician : Sibigha

Pre-Operative Diagnosis: Ileal Duplication Cyst

Surgical Procedure :

LAPAROTOMY + ILEA RESECTION ANASTOMOSIS
(ILEAL DUPLICATION CYST)

Indications for Surgery :

Ileal Duplication Cyst

Date : 4/7/24

Start Time : 12:56pm

End Time :

Pre Operative Preparations:

Post Operative Diagnosis: Ileal Duplication Cyst

Peri-Operative Complications:

Operation Notes:

FINDINGS:-

1) Ileal duplication cyst of 7x3cm
40-50cm from IC junction.

2) Bowel walk done - otherwise normal.

Procedure

1) Right supraumbilical incision made.
Incision deepened upto subcutaneous tissues.

2) Rectus abdominis and peritoneum opened.
Findings noted.

3) Bowel walk done.

Amount of Blood Loss: ~1ml

Blood Transfused (in ML) —

Name and Number of Surgical Specimen sent for examination:

1) Ileal Duplication Cyst for HPE.

Peri-Operative Complications: —

4) Resection of the cyst done and end to end
ileoileal anastomosis done $\bar{c}$ Vicryl 4-0
(extramucosal)

5) Rectus abdominis closed $\bar{c}$ Vicryl 2-0 interrupted
sutures

6) Subcutaneous tissue and skin closed $\bar{c}$ Rapid
vicryl $\&$ 5-0.

Name of the Surgeon: Dr. Nabeel Alam

Signature of the Surgeon: Dr. Nabeel Alam
Reg. No: 75241

Date & Time: 4/7/26 1:35 pm

POST-SURGICAL CARE PLAN FORM

Procedure Done: LAPAROTOMY + RESECTION ANASTOMOSIS OF
ILEAL DUPLICATION CYST
Post-Surgical Diagnosis: ILEAL DUPLICATION CYST

Post-Operative Monitoring Parameters /Frequency:

TPR every 15 minutes for first 1 hour

Wound Care:

Dressing

Drain /Special Lines/Catheters:

1) NG Aspiration 2nd hourly + continuous
drainage

Special Patient Positioning and Requirements:

—

Nutritional Instructions:

NPO until further orders

When to Start Mobilization:

As early as possible

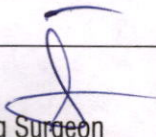
Special Referrals:

—

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

☐ Yes ☒ No

Any Other Post-Operative Care Needed including Required Follow Up


Treating Surgeon
(Signature & Stamp)

Date: 4/7/26 Time: 1:35 pm

Note: Plan of care will be readjusted if necessary.



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ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

BAH-00660549 IP5-00175934
Master KRISHNA NAGLA
04-07-2024 1 Y 11 M 29 D (M)
Dr. NABEEL ALAM QADRI



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/26 6:30pm	CSI 8 Dr. Naseel PIA - Sglt Active Vitals Stable PIA - Sglt	<u>Adv</u> — Shifts to OT in call — Reserve 10 PRBC — NPO as per Anesthetist order — IV fluids as charted.
	→ post for Laparotomy & Resection & Anastomosis	
	Dr. NABEEL ALAM QADRI Reg. No: 73241	<u>Dr. Nabeel</u> 3/1 6:30pm M. B. Subhan

Date & Time	Progress Notes	Doctor's Order
4/7/26 6:30p	C/S/B Dr. Nabeel	
	POD-0	
	No v/o vomiting, abd-distension, fever spikes.	Adv
	O/E - Abdomen vital - stable	① NBM till further order ② NG aspirate 2nd hly + continuous drainage ③ v/o monitoring 4th hly
	P/A - soft Dressing - Intact	
	Dr. Nabeel Alam Qadri Reg. No: 75241	Dr. Nabeel Alam Qadri 4/7/26 6:30p
	4/7 6:30pm	



Date & Time	Progress Notes	Doctor's Order
8/2/26	8/13 Dulyy	
10:00am	AOD, Ideal duplicate	Dermidex concentration
	na - m)	
	40 - medical	
	1st d	
		1/1m
		Continue with.
		Kym
		Wynn
		Al-B. Anama

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 4:30pm.	C/S/B Dr. Malika / Dr. Nikhita	
	POD-2 Resection anastomosis for Ileal duplication cyst	
	No episodes of fever spikes, abdominal distension or vomiting	Adv
	O/E - Afebrile vitals - stable	① Sips of clear liquids ② Clear liquids ad lib ③ U/O monitoring with h/b by diaper weights
	P/A - soft did not pass stool	
	Dr. NABEEL ALAM QADRI Reg. No: 75241	Dr. Nikhita 6/8/26 4:30p Noted by Shirisha



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/2/26 8:30am	C/S/B Dr. Malinaf Dr. Shreyas POD-8 Resection & Anastomosis of Ileal Duplication cyst. O/E - stable Vitals stable. ↓ fever spike 7:40am - 101.8°F P/A - soft. passed stools after suppository U/O - 1ml/kg/hr. wound - healthy.	<u>Advice</u> - Allow clear liquids orally → (liquids) - Continue IV fluids - Ambulate the child - Send CBP on next commutation.
2/2/26 8:30am Dr. Shreyas	Dr. NABEEL ALAM QADRI Reg. No: 75241	Dr. Shreyas 2/2/26 9:30am N/By Shreyas



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/12/24 3pm	C/S/B Dr. Shreeja	
	POD-3 Resection & Anastomosis of Ileal Duplication cyst.	
	O/E - febrile.	
	2 fever spikes - High grade.	Advice.
	Vitals stable.	
	P/A - Soft.	- Allow liquids orally.
	passed Stools yesterday	- Continue IV fluids
	after suppository.	- Ambulate the child.
		- Send CBP (after rounds).
		- Antibiotic upgraded to Piptaz.
7/12/24 3-30pm Dr. Shreeja		
	Dr. NABEEL ALAM QADRI Reg. No: 75247	7/12 6.15pm

Date & Time	Progress Notes	Doctor's Order
8/7/26 8:30 AM	C/S/B Dr. Maliha	
	POD - (4)	
	1 fever spike 100.9°F at 10 pm. Vitals stable	<u>Adv</u> 1) Soft diet 2) IV fluids 1/2 maintenance
	P/A - soft. did not pass stool	
		Maliha 8/7/26 8:30 AM
8/7/26 <u>Toan</u>	<u>Case Reviewed</u> - passed Stool	Continue Same Dr. NABEEL ALAM QADRI Reg. No: 75241 8/7 <u>Toan</u>

Date & Time	Progress Notes	Doctor's Order
8/7/26 8:40pm	C/S Dr Nikkita	
	<u>POD-4</u>	
	No episodes of fever spikes.	<u>Adv</u>
	No c/o abd-distension, vomiting	(1) Soft diet as tolerated.
	Child active.	
	Accepting feeds.	
	O/E - Afebrile	
	Vitals - stable	
	P/A - soft	
	passed stools in the morning	
	 Dr Nabeel 8/7 5:20pm	 Dr Nikkita 8/7/26 6:45pm N.B. Drug 607072
	DR. NABEEL ALAM QADRI Reg. No: 75241	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26 2:10 AM	<u>C/S/B Dr. Maliha</u> 2 episodes of non billious vomitings Vitals stable. P/A - soft distension (+).	<u>Adw</u> 1) Conti Start IV fluids 2) Inj. ONDANSETRON 2mg IV stat 3) Hold feeds. 4) DULCOLAX SUPPOSITOR 5mg PR stat Maliha 8/7/26 2:10 AM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26. 8:32 AM.	C/S/B Dr. Maliha	
	Adv	
	1 episode of non bilioous vomiting	1) NPO
	Vitals stable.	2) Continue IV fluids
	P/A - soft distension ↓ did not passed stool.	3) Xray Erect Abdomen & USG Abdomen - 4/7
		4) Place NG if vomitings persist.
		5) Abdominal girth monitoring 4 th hourly.
		Maliha Dr. Maliha 9/7/26 8:32 AM.
7/26 10:30am	Case Reviewed	
	USG noted	Adv
		- Allow clear liquids
		- Continue IV fluids
		- Neonatal Exam - stat



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26 4:20pm	c/s/B Dr. Shreeja POD - 5 Resection & anastomosis of ileal duplication cyst afebrile. Vitals stable. P/A - soft.	Advice - Allow liquids orally - Continue IV fluids - Pediatrician consultant i/v/o Hypokalemia
k-5.8 ↑	No vomitings since morning Had coconut water. passed little stool after suppository. No fever spikes.	NOB. Bowel activity
	Dr. Shreeja 9/7/26 4:20pm Dr. Shreeja	
	Dr. Nabeel 9/7/26 6:15pm	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26 6:30pm	C/S / B Dr. Nikhita (as discussed - Dr. Nabeel) POD-5 Reoperation & anastomosis 2 episodes of vomiting (non-bilious) 1 episode of bilious vomiting No fever spikes. O/E - Afebrile Vitals - stable P/A - soft	Adv ① NG tube - 2nd hly aspirate + Continuous drainage ② NPO ③ Continue IVF ④ Abdominal girth monitoring 4th hly. ⑤ pediatric consultation w/ Hyperkalemia,
		Dr. Nikhita 9/7/26 6:30pm WB - Barakhi

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/2024 09/02/26 9:15pm	<u>AB Purotam</u> Key PDD - 5/ Decubiti 2 anatomical of iliac dephthecryst On exam hemodynamically stable NO ST-T changes. Chest Blat 00 Equal N/A RA Sp 80 cm. NO focal dysit	<u>AB</u> ① Give 3 back to back molydipone & serum sample 1 Dip & stretch ② Keep NAD ③ Calcium A/B <u>Ch</u> Thank
<u>10:30pm</u>	<u>AB Purotam</u> Sr electrolyte - 4.8 AB - 4.4	<u>AB</u> ① Shift to ward <u>Ch</u> Thank

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26 7:40am	Dr. Nikhita <u>P00-6</u> Resection anastomosis Child sleeping No episodes of vomiting / abdominal distension / no fever spikes. O/E - Afebrile Vital - PR - 120 bpm BP - 105/65 mmHg K⁺ - 5.8 → 4.8 SpO₂ - 97% - RA P/A - soft AG - 46 cm NG - 2ml (yellowish colour) passed stools - small quantity (normal colour yellow).	Adv ① NPO till further order ② Continue IVF ③ NG aspirate 2nd hly + continuous drainage ④ Abd. girth monitoring ⑤ Neostome enema 20ml P/R BD ⑥ Xray Erect Abdomen
10/7/26 9:40am	Care Renewed	Adv Continue upper GI follow up

4-00660549 IP5-00175934
 iter KRISHNA NAGLA
 17-2024 2 Y 0 M 5 D (M)
 NABEEL ALAM QADRI




PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00660549
Master KRISHNA NAGLA
04-07-2024 2 Y 0 M 0 D (M)
Dr. NABEEL ALAM QADRI



RESULT SHEET

Date	4/7/26	9/7/26				
Time		1:15 pm				
Hb	12.4	11.9				
PCV	38.1	38.3				
RBC	5.26	5.20				
WBC	10.62	8.64				
N/L		45/47				
Platelets	413	350				
CRP						
ESR						
PCT						
RBS						
Na		134				
K		5.8				
Cl		103				
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.) :

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04-07-2024 1 Y 11 M 29 D (M)
Dr. NABEEL ALAM QADRI

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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:

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Name & Signature:

Dr. Akhile

Time:

3/7/26 at 5:45pm

Name & Signature:

Dr. Nabeel

3/7/26 at 5:45pm

360549 IP5-00175934
KRISHNA NAGLA
024 2 Y 0 M 5 D (M)
EEL ALAM QADRI




Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
20ml	P/R	Q12H	9/7/26	9/7/10/2
Name & Signature of the Doctor Starting the Drugs:				Do Nicotine gww 10/1
Additional Instructions:				10/24 10/24 10/24
Daily Doctor's Endorsement by a Sign				mal as

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

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

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

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

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

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

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

VERIFIED BY : Name Signature

DRUG CHART

Date of Admission: 3/7/26 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 : INJ ONDANSETRON				Date Time															
Dose 2mg	Route IV	Frequency SOS	Start Date 9/7/26																
Doctor's Signature Muliha		Valid Period	Pharm.																
Additional Instructions: SOS For Vomiting																			

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. 10.8kg Ward.

VERIFIED

DRUG : INJ CEFZOLIN				Date Time	4/7	5/7	6/7	7/7												
Dose	Route	Frequency	Start Date																	
540mg	IV	Q8h	4/7/26	6am																
Name & Signature of the Doctor Starting the Drugs:				1:35pm																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

Malika
Dr-Malika

Stop Malika
7/7/26

VERIFIED

DRUG : INJ PARACETAMOL				Date Time	4/7	5/7	6/7	7/7	8/7	9/7	10/7	11/7								
Dose	Route	Frequency	Start Date																	
160mg	IV	Q8h	4/7/26	6am																
Name & Signature of the Doctor Starting the Drugs:				1:35pm																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

Malika
Dr-Malika

VERIFIED

DRUG : INJ ESOMEPRAZOLE				Date Time	4/7	5/7	6/7	7/7	8/7	9/7	10/7	11/7								
Dose	Route	Frequency	Start Date																	
10mg	IV	Q24h	4/7/26	6am																
Name & Signature of the Doctor Starting the Drugs:				1:35pm																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

Malika
Dr-Malika

VERIFIED

DRUG : INJ PIPERACILLIN				Date Time	4/7	5/7	6/7	7/7	8/7	9/7	10/7	11/7								
Dose	Route	Frequency	Start Date																	
1.1g	IV	Q8h	7/7/26	6pm																
Name & Signature of the Doctor Starting the Drugs:				6pm																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

Malika
Dr-Malika



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
4/7/26	12:10pm	Inj. CEPHAZOLIN	500mg	IV	<i>[Signature]</i>	<i>Teem</i> <i>Sirisha</i>
6/7/26	9:15AM	DULCOLAX SUPPOSITORY	5mg	PR	<i>Malika</i>	<i>[Signature]</i> <i>Sirisha</i>
8/7/26	8:30AM	DULCOLAX SUPPOSITORY	5mg	PR	<i>Malika</i>	<i>not given</i> <i>Sirisha</i>
9/7	2:30AM	DULCOLAX Suppository	5mg	PR	<i>[Signature]</i>	<i>Sirisha</i> <i>Kalya</i>
8/7						
7/7/26	2:10AM	INJ ONDANSETRON	2mg	IV	<i>Malika</i>	<i>Pratima</i> <i>Sirisha</i>
9/7/26	10:30am	NEOTOMIC CLOMID	20ml	PR	<i>[Signature]</i>	<i>[Signature]</i> <i>[Signature]</i>



I.V. FLUIDS CHART

Weight. 10.8 kg Ward.

Date	Time	Composition of I.V. Fluid (If infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
3/7	7AM	IVF DNS (NPO)	IV	40	<i>[Signature]</i>	<i>[Signature]</i>	4/7/26	<i>[Signature]</i>	<i>[Signature]</i>
4/7	12:30pm	10 RINGER'S LACTATE	IV	100ml/hr	<i>[Signature]</i>	<i>[Signature]</i>	4/7	<i>[Signature]</i>	<i>[Signature]</i>
4/7/26	2 pm	IVF DNS	IV	42 ml/hr	<i>[Signature]</i>	<i>[Signature]</i>	6/7/26	<i>[Signature]</i>	<i>[Signature]</i>
6/7/26	8:35AM	IVF DNS + 5cc KCL	IV	42 ml/hr	<i>[Signature]</i>	<i>[Signature]</i>	8/7/26	<i>[Signature]</i>	<i>[Signature]</i>
8/7/26	2:11								
9/7/26	2:10AM	IVF DNS + 5cc KCL	IV	42 ml/hr	<i>[Signature]</i>	<i>[Signature]</i>	9/7/26	<i>[Signature]</i>	<i>[Signature]</i>
9/7/26	6:30pm	IVF DNS	iv	42ml/hr	<i>[Signature]</i>	<i>[Signature]</i>			



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Name: KRISTINA NAGLA

Weight: 10.8 kg

[illegible]



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master Krishna Nagla Age : 1y 11m. Gender : ☒ Male ☐ Female
Date : 3/7/26 Time of Arrival : 4:30 pm Triage Completion Time : 4:32 pm
Allergies : ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify) : NA ☐ Not known any drug Allergies
Source of Information : ☒ Parents ☐ Others (Specify) : NA
Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance

- ☒ Normal
☐ Sick Looking

Circulation / Colour

- ☒ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing

- ☒ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

☒ Stable

☐ Unstable :

- ☐ Not - Life - Threatening
☐ Life - Threatening

Initial Vital Signs: Temp: 98.3°F PR: 116b/m BP: 113/62 (78) RR: 24b/m SpO₂: 100% RA

Chief Complaints: Came for Laparotomy resection and anastomosis +/m

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☒ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☐ 60 min
☐ Level 5 : NON - URGENT : May receive care when convenient	☐ 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian : [Signature]

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
3. Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☒ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☒ Not applicable

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☐ No
If yes, State Location:
2. Are your parents / close contacts at home healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☐ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : NR Subnur

Date & Time : 3/7/26 at 4:32 pm

Docu. No. : RCHBH / FRM / CLINICAL / 085

Signature of Triage Nurse : [Signature]

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

Time	Nursing Notes
5:35pm	AKUS the child condition - monitored vitals & succeeded - seen by AKH's - shifted to ward

Samples collected by: / NR. pranoj
Samples sent by: /

Time: / 5:15 pm
Time: /

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :	Details of Shift - out
HR: 112bpm BP: 113/62 CFT: 221cc RR: 28bpm SPO ₂ : 100% GCS: 4/5/6 Temperature: 98.2°F Pain Score: 0 Repeat RBS (if applicable): NA	Shift - out from ER to: ward Time of Shift - out: 5:55pm Handover given to: Subhagini (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):
IV placement done

Name of the Nurse: pooja Signature of the Nurse: [Signature]

Date & Time: 31/8/2024 5:30pm

Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 6:20pm Mode of Arrival: Wheeled chair Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Body Weight: 10.8 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	NA	NA

Family History: NA

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

Temp.: 97 HR: 118 RR: 30 BP: 109/74 (86)

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

Fall Risk Assessment: ☐ Yes ☐ No Score: 12 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

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

Character of Pain: NA Location: NA Frequency: NA Duration: NA

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 Findings

Unusual 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 Parent's

Siblings 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 ☐ No Waste Disposal Explained: ☒ Yes ☐ No
- Infusion Pump : ☒ Yes ☐ No Hand hygiene Explained: ☒ Yes ☐ No ☐ Others
- Patient Rights & Responsibilities: ☒ Yes ☐ No

Information given to Parent's

Nurse Signature: [Signature]

Nurse Name: Soukhani

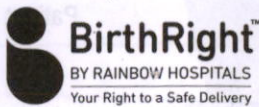
Date: 3/7/26

Time: 7pm

BAH-00660549
Master KRISHNA NAGLA
04-07-2024 1 Y 11 M 29 D (M)
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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD



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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
3/7/26	4:45 pm	8	diagnostic test/ procedures	F	4	0	1	1	na	puj/s
4/7/26	9:30 am	9	soft diet	F	1	0	1	1	—	saine

Part - III: CODES

Who was taught:
PT: Patient
F: Father
M: Mother
S: Spouse
Sn: Son
D: Daughter
C: Caregiver
O: Other (Specify)

Learning Barriers:

1. No Learning Barriers
2. Physical Impairment
3. Emotional Barriers

4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn

7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences

10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing

13. Cultural/Religion Practice
14. Others (Specify)

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

Mechanism/s to overcome barrier/s:

1. None
2. Obtain translator

3. Reassurance & Support
4. Teach Family / Others

5. Respect values & beliefs
6. Respect Cultural / Religion Preference

7. Other, Specify

Understanding:

1. Verbalizes Understanding

2. Demonstrates Understanding

3. Needs Review

IP-00660549
Master KRISHNA NAGLA
04-07-2024
Dr. NABEEL ALAM QADRI
1 Y 11 M 29 D
(M)

MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis:

Intest. duplication cyst

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
3/2/26 5:45 pm	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Intestinal duplication cyst	Surgical resection	Resection & anastomosis	Ahura	☒ Nursing ☐ Others:
3/2/26 5:45 pm	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Intestinal duplication cyst	U-Ability	Resection	Amr	☒ Medical ☐ Others:
4/2/26 9:30 am	☐ Medical ☐ Nursing ☒ Others:	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	Intestinal duplication of cyst	soft diet	<u>RDA</u> E → 1200 Kcal/d P → 20gm/d	Sing	☐ 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:



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If 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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RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation &
Early Warning Scoring Chart

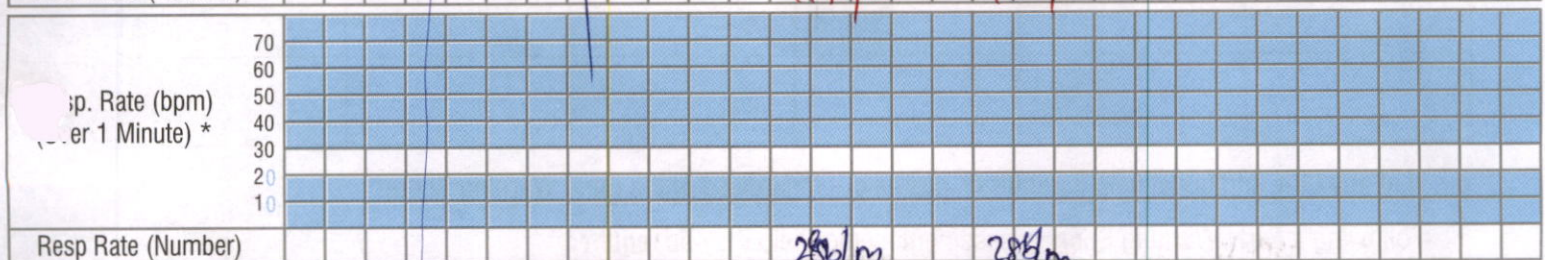
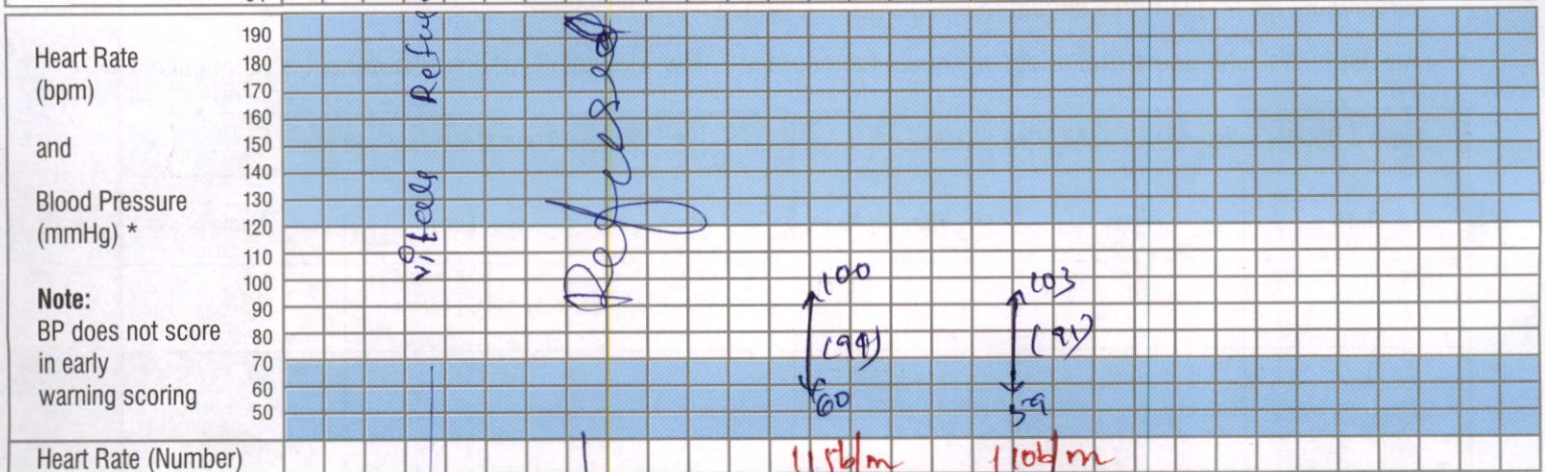
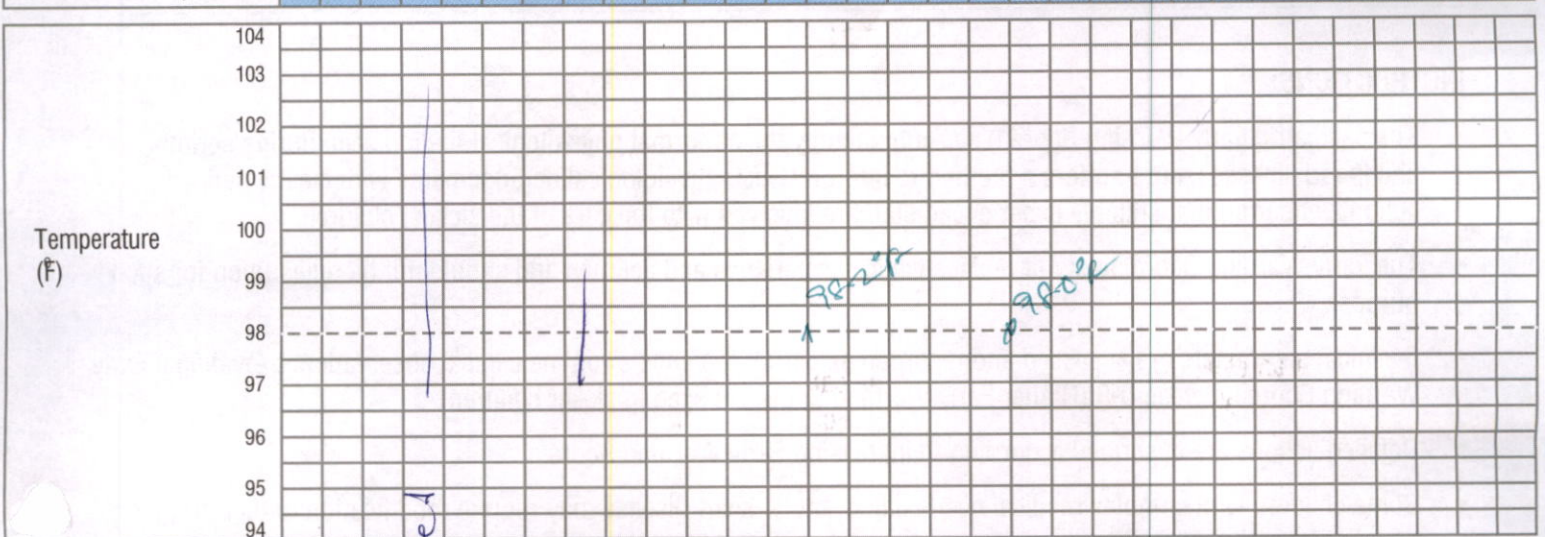
Rainbow
Children's
Hospital
It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 6pm 10pm 6am 6am

Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe	
Receiving O ₂ (l/min)	None / Mild	
O ₂ Saturations (%)		
Conscious Level	Normal	
	Altered	
GCS *		

TOTAL SCORE	
Number of shaded boxes	0
Pain Score	0
Observer's Initials	(Signature)

ACTIONS

B: 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.

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:

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- 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 :	Time: 11:24	1:35pm	5pm	10pm	6am
Doctor / Nurse / Family Concern?					
Temperature (°F)	104 103 102 101 100 99 98 97 96 95 94	Refused perousekrs	98.7		
Heart Rate (bpm)	190 180 170 160 150 140 130 120 110 100 90 80 70 60 50		Refused	Refused	Refused
Blood Pressure (mmHg) *		105 90 60			
Note: BP does not score in early warning scoring		115b/m			
Resp. Rate (bpm) per 1 Minute *	70 60 50 40 30 20 10		28b/m		
Resp Distress	Mod/ Severe None / Mild				
Receiving O ₂ (l/min)					
O ₂ Saturations (%)		99%			
Conscious Level	Normal Altered				
GCS *		15/14			
TOTAL SCORE		0			
Number of shaded boxes		0			
Pain Score		0			
Observer's Initials					
ACTIONS					
Score 1	: Continue normal observation by staff nurse				
Score 2	: Shift in charge nurse to be informed and continue hourly observations				
Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.				
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.				

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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Date	Time	Early Warning Score	Date	Time	Name

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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)
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R	RECOMMENDATION: I need you to ... come to see the child in the next (XX mins) AND is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 6/7/26	Time: 1:40 PM	SP ²	SP ²	10 PM	6 AM	7:40 AM	10:45 AM
Doctor / Nurse / Family Concern?							
Temperature (°F)	104						
	103						
	102						
	101						
	100						
	99						
	98						
	97						
	96						
	95						
94							
Heart Rate (bpm)	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
Blood Pressure (mmHg) *	130						
	120						
	110						
	100						
	90						
	80						
	70						
	60						
	50						
	40						
Note: BP does not score in early warning scoring	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
Heart Rate (Number)	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
Resp. Rate (bpm) (Over 1 Minute) *	70						
	60						
	50						
	40						
	30						
	20						
	10						
	0						
	0						
	0						
Resp Rate (Number)	70						
	60						
	50						
	40						
	30						
	20						
	10						
	0						
	0						
	0						
Resp Mod/ Severe Distress None / Mild	70						
	60						
	50						
	40						
	30						
	20						
	10						
	0						
	0						
	0						
Receiving O ₂ (l/min) O ₂ Saturations (%)	70						
	60						
	50						
	40						
	30						
	20						
	10						
	0						
	0						
	0						
Conscious Level Normal / Altered	70						
	60						
	50						
	40						
	30						
	20						
	10						
	0						
	0						
	0						
GCS *	70						
	60						
	50						
	40						
	30						
	20						
	10						
	0						
	0						
	0						
TOTAL SCORE	70						
	60						
	50						
	40						
	30						
	20						
	10						
	0						
	0						
	0						
Number of shaded boxes	70						
	60						
	50						
	40						
	30						
	20						
	10						
	0						
	0						
	0						
Pain Score	70						
	60						
	50						
	40						
	30						
	20						
	10						
	0						
	0						
	0						
Observer's Initials	70						
	60						
	50						
	40						
	30						
	20						
	10						
	0						
	0						
	0						

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.

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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

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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)
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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 :	Time:	10:40 AM	2:20 PM	6:20 PM	8 PM	10 PM	11 PM	6 AM
Doctor / Nurse / Family Concern?		7340						
Temperature (F)	104	101.8 F	102.3 F	99.2 F	99.0 F	100.9	99.5	98.0
Heart Rate (bpm)	190			99		110		110
Blood Pressure (mmHg) *	180			60		60		60
Note: BP does not score in early warning scoring	170							
Heart Rate (Number)	160			121 bpm		120 bpm		121 bpm
Resp. Rate (bpm) (Over 1 Minute) *	150							
Resp Rate (Number)	140			19 bpm		20 bpm		20 bpm
Resp Distress	130							
Receiving O ₂ (l/min)	120							
O ₂ Saturations (%)	110			99%		100%		99%
Conscious Level	100							
GCS *	90			15/15		15/15		15/15
TOTAL SCORE	80							
Number of shaded boxes	70			0		0		0
Pain Score	60			0		0		0
Observer's Initials	50			✓		✓		✓

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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BAH-00660549 IP5-00175934
Master KRISHNA NAGLA
04-07-2024 2 Y 0 M 2 D (M)
Dr. NABEEL ALAM QADRI



Unit : RCH/ FRM / CLINICAL / 125

PRE-SCHOOL (1-5 years)
**Children's Observation &
Early Warning Scoring Chart**

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 8/2/24	Time: 11am	5pm	10pm	2am	7am	6am	
Doctor / Nurse / Family Concern?							
Temperature (F)	104						
	103						
	102						
	101						
	100						
	99						
	98						
	97						
	96						
	95						
94							
Heart Rate (bpm) and Blood Pressure (mmHg) *	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
Note: BP does not score in early warning scoring	90						
	80						
	70						
	60						
	50						
	Heart Rate (Number)						
	Resp. Rate (bpm) (over 1 Minute) *	70					
		60					
		50					
		40					
30							
20							
10							
Resp Rate (Number)							
Resp Distress							
Mod/ Severe							
None / Mild							
Receiving O ₂ (l/min)							
O ₂ Saturations (%)							
Conscious Level							
Normal							
Altered							
GCS *							
TOTAL SCORE							
Number of shaded boxes							
Pain Score							
Observer's Initials							
ACTIONS	Score 1	: Continue normal observation by staff nurse					
	Score 2	: Shift in charge nurse to be informed and continue hourly observations					
	Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.					
	Score 4	: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see					
	Score 5 & 6	: Shift in charge AND PICU fellow or PICU consultant to be informed.					

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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BAH-00660549 IP5-00175934
Master KRISHNA NAGLA
04-07-2024 2 Y 0 M 2 D (M)
Dr. NABEEL ALAM QADRI



No. : RCH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)

Children's Observation &
Early Warning Scoring Chart

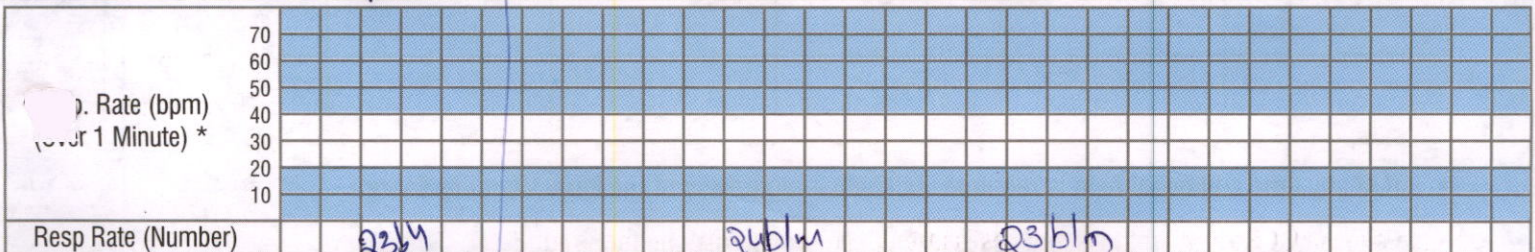
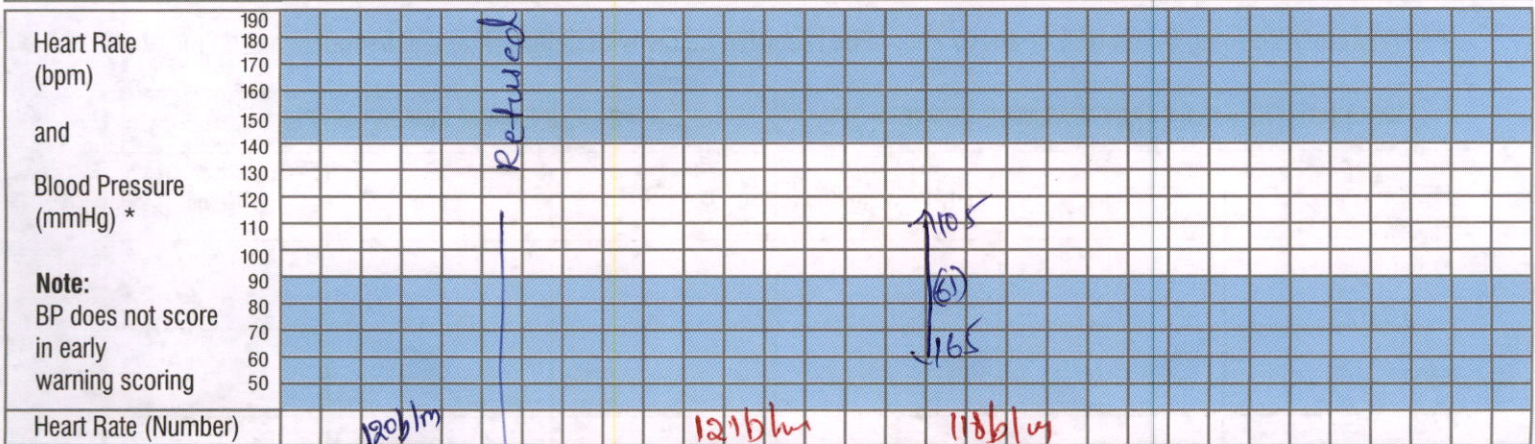
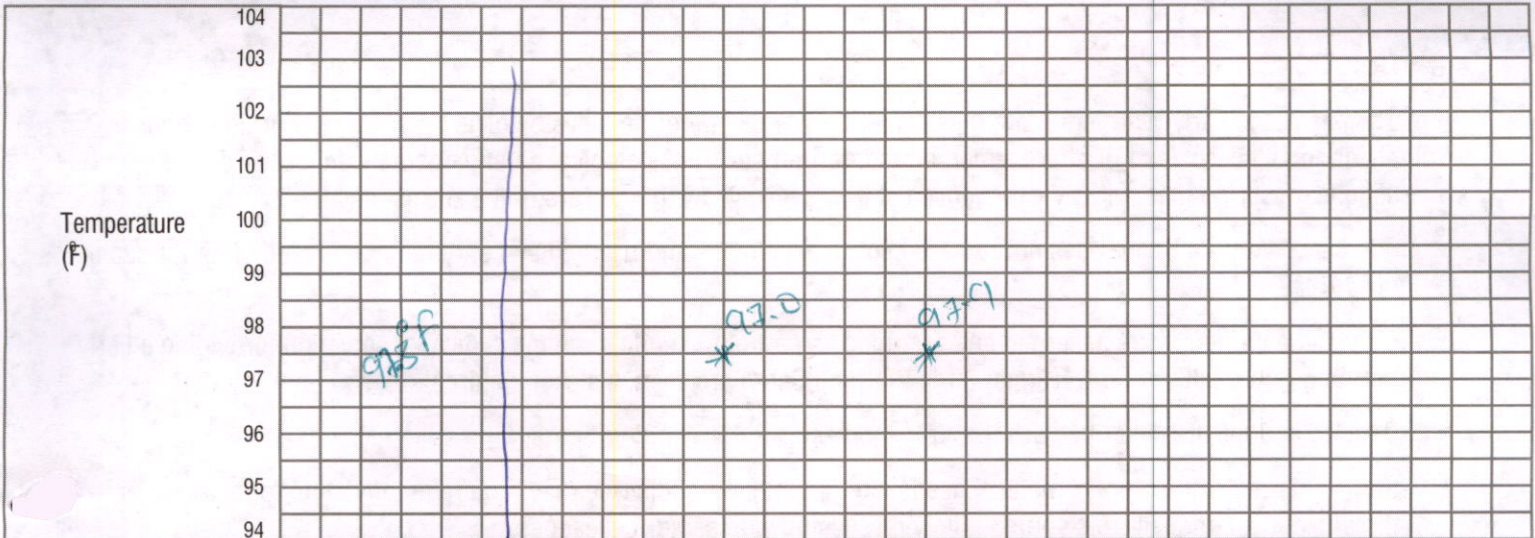
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Children's
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It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 04/07/2024 Time: 11PM 4PM 11PM 6AM

Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		
		100%
		99%
		100%

Conscious Level	Normal	
	Altered	
GCS *		15/15
		15/15
		15/15

TOTAL SCORE				
Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	Q	K	Q	Q

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

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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1405
SCHOOL AGE (5-12 years)
**Children's Observation &
Early Warning Scoring Chart**

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/3/24 Time: 11AM 1PM 10PM 6AM

Doctor / Nurse / Family Concern?

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94

98.0°F 97.5°F 98.1°F 98.0°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

129/61 (58) 110/65 (85) 110/61 (80)

Heart Rate (Number)

120b/m 129b/m 118b/m 120b/m

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

70
60
50
40
30
20
10

Resp Rate (Number)

28b/m 27b/m 27b/m 28b/m

Resp Mod/ Severe
Distress None / Mild

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

99% 97% 99% 100%

Conscious Level
Normal Altered

GCS *

15/15 15/15 15/15 15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0 0 0 0
0 0 0 0
P N S S

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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)

* 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:

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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-00660549
Master KRISHNA NAGLA
04-07-2024 1 Y 11 M 29 D
Dr. NABEEL ALAM QADRI (M)

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

FLUID CHART

Sheet No. :

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

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	NO LVP	Milk									
	07:00 pm											
Total Intake :						Total Output : m-o u-1						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output : m-o u-2						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am	DNS										
	06:00 am	DNS	N	40ml								
	07:00 am	DNS	P	40ml								
Total Intake :						Total Output : m-o u-2						
Total 24 hrs. Intake		IVF → 80ml										
Total 24 hrs. Output		m-o u-5										

BAH-00660549
Master KRISHNA NAGLA
04-07-2024 1 Y 11 M 29 D (M)
Dr. NABEEL ALAM QADRI

FLUID CHART

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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		
4/7/22	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											

Total Intake :

Total Output :

4/7	02:00 pm											
	03:00 pm	DWS		42ml								
	04:00 pm			42ml								
	05:00 pm	DWS	NPO	42ml		N/G						
	06:00 pm	DWS		42ml								
	07:00 pm			42ml								

Total Intake :

Total Output :

4/7	08:00 pm			42ml								
	09:00 pm			42ml		N/G						
	10:00 pm	DWS	NPO	42ml								
	11:00 pm	DWS		42ml		N/G						
	12:00 am			42ml								
	01:00 am			42ml								

Total Intake :

Total Output :

5/7	02:00 am			42ml								
	03:00 am			42ml		N/G						
	04:00 am			42ml								
	05:00 am	DWS	NPO	42ml		N/G						
	06:00 am			42ml								
	07:00 am			42ml								

Total Intake :

Total Output :

Total 24 hrs. Intake

IV = 714ml

Total 24 hrs. Output

NG Aspirin - 0ml

M=0, U=6



FLUID CHART

Sheet No. :

1. All measurements in ml.
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3. 24 hrs. total to be entered in the kardex in RED.

			Intake			Output							IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine					
			Mouth	I.V	N.G						0	Anwar		
	08:00 am			-						-	0			
	09:00 am			-		Nil				-	0			
	10:00 am	D	N	42ml			Nil				0			
	11:00 am	Nil	P	42ml		Nil				-	0			
	12:00 pm	S	O	42ml							0			
	01:00 pm			42ml		Nil				-	0			
Total Intake :			IV = 168ml			Total Output :								
	02:00 pm			42ml							0	Shirish		
	03:00 pm			42ml		Nil				✓	0			
	04:00 pm	D	N	42ml			NP				0			
	05:00 pm	W	P	42ml		Nil				✓	0			
	06:00 pm	S	O	42ml							0			
	07:00 pm			42ml		Nil				✓	0			
	Total Intake :			IV = 252ml			Total Output : M.O.U - 3							
5/7	08:00 pm			42ml							0	Kalyani		
	09:00 pm			42ml		Nil				✓	0			
	10:00 pm	ONS		42ml			NP				0			
	11:00 pm		NPO	42ml		Nil					0			
	12:00 am			42ml						✓	0			
	01:00 am			42ml		Nil					0			
	Total Intake :			IV = 252ml			Total Output :							
6/7	02:00 am			42ml							0	Kalyani		
	03:00 am			42ml		Nil				✓	0			
	04:00 am		NPO	42ml			NP				0			
	05:00 am	ONS		42ml		Nil				✓	0			
	06:00 am			42ml							0			
	07:00 am			42ml		Nil				✓	0			
	Total Intake :			IV = 252ml			Total Output :							

Total 24 hrs. Intake

IV = 924ml

Total 24 hrs. Output

M=0, U=10

ALG Aspiration = onl

FLUID CHART

Sheet No. :

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

		Intake			Output						IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am	DNS		42ml								
	10:00 am	Kcl		42ml			NP					
	11:00 am	sal		42ml								
	12:00 pm			42ml								
	01:00 pm			42ml								
Total Intake :						Total Output :						
	02:00 pm			42ml								
	03:00 pm	DNS		42ml								
	04:00 pm	Kcl		42ml								
	05:00 pm	sal		42ml								
	06:00 pm			42ml								
	07:00 pm			42ml								
Total Intake :						Total Output :						
	08:00 pm			42ml								
	09:00 pm	DNS		42ml								
	10:00 pm	sal		42ml								
	11:00 pm	Kcl		42ml								
	12:00 am			42ml								
	01:00 am			42ml								
Total Intake :						Total Output :						
	02:00 am			42ml								
	03:00 am	DNS		42ml								
	04:00 am	sal		42ml								
	05:00 am	Kcl		42ml								
	06:00 am			42ml								
	07:00 am			42ml								
Total Intake :						Total Output :						
	02:00 am			42ml								
	03:00 am	DNS		42ml								
	04:00 am	sal		42ml								
	05:00 am	Kcl		42ml								
	06:00 am			42ml								
	07:00 am			42ml								
Total Intake :						Total Output :						

Total 24 hrs. Intake

IV = 966ml

Total 24 hrs. Output

M = 1,025 + 254ml

FLUID CHART

Sheet No. :

7/7/26

Damp 4. wt checking.

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

		Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	
			Mouth	I.V	N.G						
	08:00 am	1	cond water	42ml			1			✓	0
	09:00 am	1	cond water	42ml			np			✓	0
	10:00 am	1	cond water	42ml			1			✓	0
	11:00 am	1		42ml			1			✓	0
	12:00 pm	1	DBP	42ml			1			✓	0
	01:00 pm	1		42ml						✓	0
Total Intake :					Total Output :						
	02:00 pm	1	milk	42ml						✓	0
	03:00 pm	1		42ml						✓	0
	04:00 pm	1	juice	42ml			np			✓	0
	05:00 pm	1	cond	42ml			np			✓	0
	06:00 pm	1	milk	42ml						✓	0
	07:00 pm	1		42ml						✓	0
Total Intake :					Total Output : M - 0						
	08:00 pm	1	cond	42ml			1			✓	0
	09:00 pm	1		-			1			✓	0
	10:00 pm	1	cond	42ml			np			✓	0
	11:00 pm	1	cond	42ml			np			✓	0
	12:00 am	1		42ml			1			✓	0
	01:00 am	1		42ml						✓	0
Total Intake :					Total Output : M - 0						
	02:00 am	1		42ml			1			✓	0
	03:00 am	1		42ml			1			✓	0
	04:00 am	1	cond	42ml			np			✓	0
	05:00 am	1	cond	42ml			np			✓	0
	06:00 am	1		-			1			✓	0
	07:00 am	1		-						✓	0
Total Intake :					Total Output : m - 0 -						
	02:00 am	1		42ml			1			✓	0
	03:00 am	1		42ml			1			✓	0
	04:00 am	1	cond	42ml			np			✓	0
	05:00 am	1	cond	42ml			np			✓	0
	06:00 am	1		-			1			✓	0
	07:00 am	1		-						✓	0
Total Intake :					Total Output : m - 0 -						

Total 24 hrs. Intake

DEF: 882ml

Total 24 hrs. Output

m - 0 -

FLUID CHART

Sheet No. :

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

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
8/7/24	08:00 am	tho	42ml							✓	0	} Saty	
	09:00 am	food	-								0		
	10:00 am	Edhy	-				✓				0		
	11:00 am	milk	42ml								0		
	12:00 pm	tho	42ml							✓	0		
	01:00 pm		42ml								0		
Total Intake :						Total Output : M-1						U-2	
8/7/24	02:00 pm										0	} Diya	
	03:00 pm	Food					✓			✓	0		
	04:00 pm	42ml									0		
	05:00 pm									✓	0		
	06:00 pm	mo									0		
	07:00 pm	milk								✓	0		
Total Intake :						Total Output : M-1						U-3	
	08:00 pm						1				0	} skinish	
	09:00 pm	90gl								✓	0		
	10:00 pm										0		
	11:00 pm	110					NP				0		
	12:00 am						1			✓	0		
	01:00 am	110									0		
Total Intake :						Total Output : M-0U-2							
	02:00 am	1	42ml				1	✓			0	} skinish	
	03:00 am	1	42ml				1	✓		✓	0		
	04:00 am	DNS	42ml				NP	✓			0		
	05:00 am	1	42ml				1	✓			0		
	06:00 am	1	42ml				1			✓	0		
	07:00 am	1	-				1				0		
Total Intake :						Total Output : M-0U-2							

Total 24 hrs. Intake

8/7/24

Total 24 hrs. Output

M-2U-9



FLUID CHART

Sheet No. :

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

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
9/7/24	08:00 am			60ml								0	
	09:00 am			70ml						✓		0	
	10:00 am		NPO	-								0	
	11:00 am			-				MD		✓		0	
	12:00 pm	15ml relaxo		-								0	
	01:00 pm			-				little				0	

Total Intake :

Total Output : m - 1 u - 2

9/7	02:00 pm			uoml								0	
	03:00 pm		coconut water	uoml						✓		0	
	04:00 pm	onset smeared		uoml				NP		✓		0	
	05:00 pm			-						✓		0	
	06:00 pm		milk	-						✓		0	
	07:00 pm	ONS		uoml								0	

Total Intake :

Total Output : u2 m2

	08:00 pm			40ml								0	
	09:00 pm			40ml								0	
	10:00 pm	ONS	NPO	40ml	2ml					✓		0	
	11:00 pm			40ml								0	
	12:00 am			40ml	0.5ml			✓				0	
	01:00 am			40ml						✓		0	

Total Intake :

Total Output : M - 1 U - 2

	02:00 am			40ml	0.2ml							0	
	03:00 am			40ml								0	
	04:00 am	ONS	NPO	40ml	0.1ml					✓		0	
	05:00 am			40ml				NP				0	
	06:00 am			-	0.2ml							0	
	07:00 am			-						✓		0	

Total Intake :

Total Output : M - 0 U - 2

Total 24 hrs. Intake	24hrs: 644ml
----------------------	--------------

Total 24 hrs. Output	M - 1 U - 9
----------------------	-------------

FLUID CHART

Sheet No. :

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

		Intake			Output					IV Site	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score		
10/2			Mouth	I.V	N.G							
	08:00 am									0	Kerathi	
	09:00 am									0		
	10:00 am									0		
	11:00 am									0		
	12:00 pm									0		
	01:00 pm									0		
Total Intake :					Total Output :					m-0		u-1
10/7	02:00 pm									0	Kerathi	
	03:00 pm									0		
	04:00 pm									0		
	05:00 pm									0		
	06:00 pm									0		
	07:00 pm									0		
	Total Intake :					Total Output :						u-2
	08:00 pm									0	Shenish	
	09:00 pm									0		
	10:00 pm									0		
	11:00 pm									0		
	12:00 am									0		
	01:00 am									0		
	Total Intake :					Total Output :						m-0
	02:00 am									0	Shenish	
	03:00 am									0		
	04:00 am									0		
	05:00 am									0		
	06:00 am									0		
	07:00 am									0		
	Total Intake :					Total Output :						m-0
Total 24 hrs. Intake		GVF: 2800										
Total 24 hrs. Output		m-20 u-8										

0660549 IP5-00175934
KRISHNA NAGLA
2024 2 Y 0 M 6 D (M)
BEEL ALAM QADRI

FLUID CHART

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Sheet No. :

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

		Intake				Output					IV Site	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
11/7/24			Mouth	I.V	N.G						6	Riya
	08:00 am	Milk								✓	0	
	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												

FLUID CHART

Sheet No. :

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

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: 3/7/24

Assessment: patient came for Laparotomy + resection procedure

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 patient condition	8:30 pm	* Assessed the patient condition, patient is stable.	* patient is stable.
10pm	* plan to monitor vitals	10:20 pm	* monitor vitals stable.	
11pm	* plan to maintain I/O chart.	11:30pm	* maintain I/O chart	
12am	* plan to PAC on POE	12:20 Am	* PAC on POE done.	
6am	* plan to blood reservec.	6:10am	* 10 PRBC reservec.	
7am	* plan to NPO	7:30 Am	* patient having NPO at 6am.	

Re-Assessment:

Special Notes:

provide comfortable position
10 PRBC reservec confirm by bottom prakash. blood grouping ok
shift to OT on call

Nurse Signature:

Nurse Name:

Date & Time:

BAH-00660549 IPS-00175934
Master KRISHNA NAGLA
04-07-2024 1 Y 11 M 29 D (M)
Dr. NABEEL ALAM QADRI



NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 4/7/26

Assessment: patient come for laparotomy

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 patient general condition	8:30 am	Assessed the patient's general condition on bed	
9am	To monitor I/O chart	9:30 am	monitored patient I/O chart	
10am	To provide comfortable position	10:45 am	provided patient comfortable position.	
11am	plan for NPO	11:15 am	Started NPO Sam done.	

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name: Annamma

Date & Time: 4/7/26 at 11:15 AM

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 4/7/26

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.....

Acute Pain & Discomfort

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the pt General Condition	2:05pm	Assessed the pt General Condition.	pt is Conscious & oriented
3pm	Relieve pain & Discomfort	3:05pm	Relieved Pain & Discomfort	vital stable
4pm	monitor vital signs	4:05pm	monitored vital signs	no bleeding
5pm	monitor for bleeding	5:05pm	monitored for bleeding	no malodour
6pm	maintain I/O chart	6:05pm	maintained I/O chart	no vomiting
7pm	maintain NPO status	7:05pm	NPO broken, water given	shifted
7:15pm	pt shift to the ward	7:15pm	pt shifted to the ward	

Re-Assessment:

After surgery pt is Conscious & oriented

Special Notes:

NPO till further order Continue I/O fluids

Nurse Signature: *[Signature]*

Nurse Name: *[Signature]*

Date & Time: 4/7/26

BAH-00660549 IP5-00175934
Master KRISHNA NAGLA
04-07-2024 2 Y O M O D (M)
Dr. NABEEL ALAM QADRI



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 9/2/26

Assessment: Irritability, Pain at surgical 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
6pm	→ To assess the general condition of the pt	8:10pm	→ Assessed the general condition of the patient	Patient stable Vitals normal
11pm	→ To monitor vital signs	11:30pm	→ Monitored vitals	
1am	→ To continue NPO	1:15am	→ Continued NPO	
3am	→ To do NG aspiration	3:20am	→ NG aspiration 2nd bly done	
5am	→ To maintain fluid balance	5:15am	→ Maintained ORS 42ml/hly fluid balance	
7am	→ To administer medicines	7:40am	→ Administered medicines	

Re-Assessment: Pain and discomfort has reduced, after administered Dr. Paracetamol

Special Notes: Continues NPO

Nurse Signature:

Nurse Name: Talyani

Date & Time: 5/2 at 8am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/7/26

Assessment: Irritability/pain at surgical 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
8am	⇒ To assess the patient general condition	8:30 am	⇒ Assessed the patient general condition	⇒ patient stable.
9am	⇒ To monitor vital	9:30 am	⇒ monitored patient vitals	
10am	⇒ To monitor I/O chart	10:30 am	⇒ monitor I/O chart	
11am	⇒ To continue NPO	11:15 am	⇒ continues NPO	
12pm	⇒ To do N/G aspiration	12:30 pm	⇒ N/G aspiration 2nd hour/2hr	
1pm	⇒ To maintain fluids balance ⇒ To administered medication	1:30 pm	⇒ maintained ONS 2nd hour ⇒ administered medication	

Re-Assessment:

pain and discomfort has reduced after administered 2nd paracetamol

Special Notes:

continue NPO

Nurse Signature: Annamma

Nurse Name: Annamma

Date & Time: 5/7/26 2pm

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Master KRISHNA NAGLA
04-07-2024 1 Y 11 M 29 D (M)
Dr. NABEEL ALAM QADRI



NURSING CARE RECORD


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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/7/26

Assessment: Irritability and discomfort at surgical 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
2pm	Assess the patient.	2:05pm	Assessed the patient.	Patient was stable.
3pm	General condition	3:05pm	General condition	
3pm	Monitor the vitals.	4:05pm	Monitored the vitals.	
4pm	maintain Ilo chart.	4:05pm	Maintained Ilo chart.	
5pm	Provide comfortable position	5:05pm	provided comfortable	
6pm	to patient.	6:05pm	position to patient.	
6pm	Continue and maintain I.V.	6:05pm	Continue I.V. fluids and	
6:30pm	fluids.	6:30pm	per hour.	
7pm	2nd hourly. Nlg Aspiration	7:05pm	2nd hourly. Nlg Aspiration	
	To Administer medication.	7:05pm	done.	
			Administer medication.	

Re-Assessment: Pain and discomfort has reduce after administer medication

Special Notes: NPO -

Nurse Signature: 

Nurse Name: shishu

Date & Time: 5/7/26 8pm

BAH-00660549
Master KRISHNA NAGLA
04-07-2024
Dr. NABEEL ALAM QADRI
IP5-00175934
1 Y 11 M 29 D (M)

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: Irritability, Crying, pain and discomfort at surgical site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ To assess the general condition of the patient	8:30pm	→ Assessed the general condition of the patient.	Patient is stable
4pm	→ To monitor vital signs	11:10 pm	→ monitored vitals and recorded	
1am	→ To continue NPO	11:30am	→ Continued NPO	Vitals normal
3am	→ To maintain fluid balance	3:15am	→ maintained oral fluid balance	
5am	→ To do N/G aspiration	5:40am	→ N/G aspiration 2nd bly done	
7am	→ To administer medicines.	7:05 am	→ Administered medications	

Re-Assessment:

Pain and discomfort has reduced, after administered 2g. Paracetamol

Special Notes: Continued NPO

N/G aspiration 2nd bly

Nurse Signature: [Signature] Nurse Name: Kalyani Date & Time: 6/7 at 8am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 6/7/26

Assessment: Irritability and discomfort at surgical site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the patient General condition	8:30 am	Assessed the patient General condition on bed	⇒ patient is stable vitals normal
9am	To monitor vitals	9:30 am	monitored patient vitals	
10am	To monitor I/O chart	10:30 am	monitored patient I/O chart	
11am	To Administer medication	11:30 am	Administered medication	
12pm	To plan I/O fluids	12:30 PM	continue I/O fluids DNR	
1pm	To plan Suppositories	1:30pm	given Dolco and Suppositories	
1pm	To plan NPO	1:40pm	continue ^{done} NPO done	

Re-Assessment: Re-assessment done pain and discomfort has reduce after administered medication

Special Notes: — NPO — Sips of ORS water.

Nurse Signature: Annamma

Nurse Name: Annamma

Date & Time: 6/7/26 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 6/1/26

Assessment: Irritability and discomfort at surgical 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
2pm	Assess the patient General condition	2:05pm	Assessed the patient General condition.	Baby was stable.
3pm	Monitor the vitals.	3:05pm	monitored the vitals.	
4pm	Maintain I/O chart.	4:05pm	Maintained I/O chart.	
5pm	Provide comfortable position to Patient.	5:05pm	provided comfortable position to patient.	
6pm	Plan to give sips of ORS water and coconut water.	6:05pm	giving the baby sips of ORS water.	
6:30pm	Plan to continue IV fluids.	6:35pm	continued IV fluids.	
7pm	To Administer medication.	7:05pm	Administer medications.	

Re-Assessment: after providing comfortable position Patient was stable.

Special Notes: continue IV fluids and giving sips of ORS and coconut water to baby.

Nurse Signature: [Signature]

Nurse Name: Shirshe

Date & Time: 6/1/26 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6/7/26

Assessment: Irritability and crying due to hungry

Pain and discomfort at surgical site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ To assess the general condition of the patient	8:10 pm	→ Assessed the general condition of the patient	Patient is stable Vitals normal No vomitings
11am	→ To monitor vital signs	11:30 pm	→ Monitored vitals and recorded.	
2am	→ To allow sips of clear liquids	2:40 am	→ Allowed water, ORS and coconut water.	
4am	→ To maintain fluid balance	4:15 am	→ Maintained D&S + Sml kel fluid balance	
7am	→ To administer medications	7:20 am	→ Administered medications	

Re-Assessment:

Pain and discomfort has reduced after administered 2x's Paracetamol

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Kalyani

Date & Time: 7/07/26 at 8am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 7/7/26

Assessment: patient having pain and fever irritability

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 patient general condition	8.10am	→ patient is stable	pt stable
10am	→ monitor vitals	10.10a	→ vitals stable	
12pm	→ monitor I/O chart	12.00pm	→ monitored I/O chart documented	
2pm	→ to administer medication	2.30p	→ administered medication	
6pm	→ to encourage orally	6.30pm	→ oral intake good	

Re-Assessment: Re-assessed after 2 hrs pt stable

Special Notes: next prick sample CRP

Nurse Signature: Satya

Nurse Name: Satya

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



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 7/7/20

Assessment: Irritability and crying due to hungry pain and discomfort of surgical site

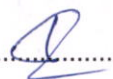
Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
3pm	Assess the patient General condition	3:05pm	Assessed the patient General condition.	Patient was stable
10pm	monitor the vitals.	10:05pm	monitored the vitals.	
12AM	Maintain I/O chart.	12:05AM	Maintained I/O chart.	
2AM	provide comfortable position to patient	2:05AM	provided comfortable position to patient	
4AM	To maintain personal Hygiene.	4:05AM	Maintained personal Hygiene.	
6AM	To allow liquids orally.	6:05AM	allowing liquids orally.	
7AM	To Administer medication.	7:05AM	Administer medication	

Re-Assessment: after Administer medication reduced the Pain and discomfort.

Special Notes: next prick CBP sample collection

Nurse Signature: 

Nurse Name: Shinsu

Date & Time: 8/7/20 9pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/7/24

Assessment: patient having fever

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 patient general condition	8.10am	patient is stable & active	pt stable
9am	monitor vitals	9.10am	vitals stable	
10am	Dr. Nabeel advised supp. Dulcolax	10.10am	not given supp. he passed motion without supp.	
11am	monitor I/O chart	11.10am	monitored I/O chart documented	
12pm	to administer medication	12.20pm	administered medication	
1pm	to encourage orally	1.30pm	oral intake good	

Re-Assessment: Re-assessed after 2 hrs pt stable

Special Notes:

Nurse Signature: Satya

Nurse Name: Satya

Date & Time: 8/7/24 @ 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 8/7/26

Assessment: patient was 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
2pm	⇒ Assess the patient General condition	2:10 pm	⇒ Assessed the patient General condition	patient is comfortable
4pm	⇒ Assess the patient vitals signs	4:10 pm	⇒ Assessed the patient vitals signs	
5pm	⇒ To maintain I/O chart	5:20 pm	⇒ To maintained I/O chart	
6pm	⇒ To encourage oral intake	6:20 pm	⇒ encouraged oral intake	
8pm	⇒ To maintain I/V fluids	8:20 pm	⇒ maintained I/V fluids	
	⇒ To provide comfortable position	8:40 pm	⇒ provided comfortable position	

Re-Assessment:

Special Notes:

I.V. fluids

Nurse Signature:

Nurse Name: Alviya

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

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/7/26

Assessment: patient was mild pain at s/s and 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
8pm	Assess the patient.	8:05pm	Assessed the patient.	Patient - very stable.
10pm	General condition	10:05pm	General condition	
12am	monitor the vitals.	12:05am	monitored the vitals.	
2am	maintain S to chart.	2:05am	maintained S to chart.	
4am	provide comfortable.	4:05am	provided comfortable.	
7am	position to patient.	7:05am	position to patient.	
	To Encourage orally Intake.		Encouraged orally Intake.	
	To Administer medication.		Administer medication.	

Re-Assessment: After Administer medication. Patient was telling comfort.

Special Notes: baby having vomiting 2am & 4pm episodes. Dr. Malika advised baby keep nro in fluids continue abdominal girth every 2 hrs
Shishu

Nurse Signature:

Nurse Name:

Date & Time: 9/7/26 8am

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Master KRISHNA NAGLA
04-07-2024 2 Y 0 M 3 D (M)
Dr. NABEEL ALAM QADRI



NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 9/7/26

Assessment: patient is 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
8am	=> Assess the patient General condition	8:10 am	=> Assessed the patient General condition	patient is stable
10am	=> Assess the patient vitals signs	10:20 am	=> Assessed the patient vitals signs	
12pm	=> To maintain I/O chart	12:20 pm	=> To maintained I/O chart	
1pm	=> To encourage oral intake	1:10 pm	=> Encouraged oral intake	
2pm	=> To maintain IV fluids	2:10 pm	=> maintained IV fluids	
	=> To plan Netonic enema		=> Netonic is given	
	=> Ensure safety		=> ensure safety	

Re-Assessment:

patient is stable

Special Notes:

Usg, x-ray abdomen Done today

Nurse Signature: [Signature]

Nurse Name: Deepa

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



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9.7.26

Assessment: patient having emesis and abdominal distension

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 the patient general condition	2:30 pm	→ assessed the patient general condition	→ patient was stable now
4pm	→ To monitor vitals	4:30 pm	→ monitored vitals	
5pm	→ To maintain I/O chart	5:30 pm	→ maintained I/O chart	
5:30 pm	→ To continue IV fluids	6:10 pm	→ continued IV fluid one time per 10ml/hr	
7pm	→ To administer the medication	7:30 pm	→ administered the medication as per chart	

Re-Assessment:

Re-assessment has done after 1 hour the pt was stable now.

Special Notes: continue IV fluids and liquids only
measure abdominal girth with bxy and NG aspiration 2nd bxy, NPO now

Nurse Signature:

Nurse Name: Revathi

Date & Time: 9.7.26 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/26

Assessment: patient having discomfort and Abdomen distension.

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
3pm	Assess the patient.	8:05pm	Assessed the patient.	patient was stable.
10pm	General condition	10:05pm	General condition	
	Monitor the vitals.		Monitored the vitals.	
12AM	Maintain G/I chart	12:05AM	Maintained G/I chart.	
2AM	Plan to keep NPO	2:05AM	Patient is in NPO.	
4AM	Maintain fluids balance.	4:05AM	Maintained IV fluids.	
6AM	Provide comfortable position.	6:05AM	Provided comfortable position.	
7AM	To administer medication.	7:05AM	Administered medication.	

Re-Assessment: After providing comfortable position patient was stable.

Special Notes: patient is in NPO
ons fluids continue.

Nurse Signature: [Signature]

Nurse Name: shishu

Date & Time: 10/7/26 8AM

Master KRISHNA NAGLA
-07-2024 2 Y 0 M 4 D (M)
NABEEL ALAM QADRI



NURSING CARE RECORD

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BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 10/2/26

Assessment: patient having vomittings & discomfort

Goals

- ☐ Maintain Airway and Oxygenation
- ☒ Maintain Personal Hygiene
- ☐ Identify Potential Complications

- ☒ Relieve Pain & Discomfort
- ☒ Prevent Infection
- ☐ Any Others. Specify.....

- ☒ Maintain Fluid Balance
- ☐ Meet Elimination Needs

- ☐ Improve Activity Tolerance
- ☒ Ensure Safety

- ☒ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety

- ☒ Maintain Skin Integrity
- ☐ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	=> Assess the patient General condition	8:10 AM	=> Assessed the patient General condition	Baby is stable
10 AM	=> Assess the patient vitals	10:20 AM	=> Assessed the patient vitals	
12 PM	=> To plan X-ray Abdomen	12:10 PM	=> X-ray Done	
1 PM	=> To plan N.G Aspiration	1:10 PM	=> planned N.G Aspiration	
	=> To plan Abdominal girth Measurement		=> Upper GI P Done	
2 PM	=> To plan Upper G.I	2:10 PM	=> Insertion cathy	

Re-Assessment:

Babys Good

Special Notes:

Allow liquids X-ray 3pm

Nurse Signature: [Signature] Nurse Name: [Signature] Date & Time: 10/2/26 @ 2pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 10/7/24

Assessment: patient having mild 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
2pm	→ Assess the patient general condition	2:30 pm	→ Assessed the patient general condition on the Bed	→ patient was stable now
4pm	→ To monitor vitals	4:30 pm	→ monitored vitals	
5pm	→ To maintain I/O chart	5:30 pm	→ maintained I/O chart	
6:30 pm	→ To remove NG tube	6:40 pm	→ removed NG tube	
6pm	→ To continue IV fluids	6:30 pm	→ continued D5W 100ml/hr	
7pm	→ To administer the medications	7:30 pm	→ administered the medications as per chart	

Re-Assessment: Re-assessment has done after 1 hour pt was stable now

Special Notes: liquid diet

Nurse Signature: 

Nurse Name: Revathi

Date & Time: 10/7/24 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/7/26

Assessment: Patient having mild 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
8pm	Assess the patient General condition	8:05pm	Assessed the patient General condition	Patient was stable
10pm	Monitor the vitals.	10:05pm	Monitored the vitals.	
12AM	Maintain I/O chart.	12:05AM	Maintained I/O chart.	
2AM	provide comfortable position to patient.	2:05AM	provided comfortable position to patient,	
4AM	To Encourage orally Intake	4:05AM	Encouraged orally Intake.	
7AM	To Administer medications.	7:05AM	Administer medications.	

Re-Assessment: after providing comfortable position Patient was stable.

Special Notes: N/A

Nurse Signature:

Nurse Name: Shresh

Date & Time: 11/7/26 8AM

IP660549 IP5-00175934
KRISHNA NAGLA
024 2 Y 0 M 5 D (M)
BEEL ALAM QADRI

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. Nabeel Department: CR Date of Admission: 3/2/26

SITUATION		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:						
BACKGROUND	Diagnosis:	<u>Intestinal duplication cyst</u>						
	Area	<u>CR</u>	<u>3rd floor</u>	<u>OT</u>	<u>3rd floor</u>	<u>3rd floor</u>	<u>3rd floor</u>	
BACKGROUND	Shift Time	<u>5:55 pm</u>	<u>8am</u>	<u>8am</u>	<u>8am</u>	<u>8am</u>	<u>8pm</u>	
	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>98.3°F</u>	<u>98.2°F</u>	<u>98.6°F</u>	<u>98°C</u>		<u>98.1°F</u>
		Res:	<u>24bpm</u>	<u>26b/m</u>	<u>25b/m</u>	<u>28b/m</u>		<u>28b/m</u>
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>		<u>99.1</u>
		Pulse:	<u>116bpm</u>	<u>97b/m</u>	<u>84b/m</u>	<u>129b/m</u>	<u>Refused</u>	<u>114b/m</u>
		BP:	<u>113/62</u>	<u>74/49</u>	<u>84/62</u>	<u>90/60</u>		<u>95/60</u>
		Fall Risk Score:	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>
	Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>1/10</u>	<u>1/10</u>	<u>1/10</u>	<u>1/10</u>	
	Recommendations	Safety Needs:	<u>Yes</u>	<u>Yes</u>	<u>Yes</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	
Recommendations	Other Special Orders / Medications:	<u>NA</u>	<u>Shift OT on call</u>	<u>NA</u>	<u>NA</u>	<u>NPO</u>	<u>NPO</u>	
	Post Operative Procedure Special Orders:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NG Aspirin 3mg bly</u>	<u>NG Aspirin 2mg bly</u>	<u>NG Aspirin 2mg bly</u>	
Handed Over By Name :		<u>Pooja</u>	<u>Seema</u>	<u>Deep</u>	<u>Pooja</u>	<u>Annam</u>	<u>Shrisha</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>3/2/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>5/7/26</u>	<u>5/7/26</u>	<u>5/7/26</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>8am</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	
Taken Over By Name :		<u>Seema</u>	<u>Seema</u>	<u>Pooja</u>	<u>Annam</u>	<u>Shrisha</u>	<u>Pooja</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>3/2/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>5/7/26</u>	<u>5/7/26</u>	<u>5/7/26</u>	
Time:		<u>8pm</u>	<u>11am</u>	<u>8am</u>	<u>8am</u>	<u>2pm</u>	<u>8am</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Nabeel Department: Surgeon Date of Admission: 3/7/20

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known					
	<u>Enteric Intestinal Duplication Cyst</u>		If Yes Specify: <u>Nil</u>					
BACKGROUND	Area	Shift Time	<u>3rd</u> 6am	<u>3rd</u> 7AM	<u>3rd</u> 8pm	<u>3rd</u> 8am	<u>3rd</u> 8:30 AM	<u>3rd</u> 8:30 AM
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NO</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°F</u>	<u>97.2°F</u>	<u>97.9°F</u>	<u>98°F</u>	<u>102.3°F</u>	<u>99.5°F</u>
	Res:		<u>28b/m</u>	<u>28b/m</u>	<u>27b/m</u>	<u>28b/m</u>	<u>30b/m</u>	<u>30b/m</u>
	SpO ₂ :		<u>100%</u>	<u>99</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>
	Pulse:		<u>110b/m</u>	<u>105b/m</u>	<u>107b/m</u>	<u>115b/m</u>	<u>114</u>	<u>114</u>
	BP:		<u>60/41</u>	<u>105/60</u>	<u>100/60</u>	<u>102/66</u>	<u>100/70</u>	<u>100/60</u>
	Fall Risk Score:		<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>
	Pain Score:		<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
	Safety Needs:		<u>Side rails</u>	<u>Yes</u>	<u>Yes</u>	<u>Side rails</u>	<u>Yes</u>	<u>Yes</u>
Recommendations	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>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Post Operative Procedure Special Orders:		<u>NPO</u>	<u>NPO</u>	<u>Sip of water and spoon feed</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Handed Over By Name :		<u>Kalyani</u>	<u>Anamika</u>	<u>Shishu</u>	<u>Kalyani</u>	<u>Satyam</u>	<u>Shishu</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>6/7</u>	<u>6/7</u>	<u>6/7/26</u>	<u>7/7</u>	<u>7/7/26</u>	<u>8/7/26</u>	
Time:		<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>8pm</u>	<u>8am</u>	
Taken Over By Name :		<u>Anamika</u>	<u>Shishu</u>	<u>Kalyani</u>	<u>Anamika</u>	<u>Shishu</u>	<u>Satyam</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>6/7</u>	<u>6/7/26</u>	<u>6/7</u>	<u>7/7/26</u>	<u>7/7/26</u>	<u>8/7/26</u>	
Time:		<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>8pm</u>	<u>8am</u>	

BAH-00660549 IP5-00175934
Master KRISHNA NAGLA
04-07-2024 2 Y 0 M 3 D (M)
Dr. NABEEL ALAM QADRI

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RSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Nabeel Department: Luxation Date of Admission: 31/7/24

SITUATION		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify: <u>Nil</u>						
BACKGROUND	Diagnosis:	<u>Enteric Intestinal duplication cyst</u>						
	Area							
BACKGROUND	Shift Time	<u>3rd Floor 2pm</u>	<u>3rd Floor 8pm</u>	<u>3rd Floor 8pm</u>	<u>3rd Floor 2pm</u>	<u>3rd Floor 8pm</u>	<u>3rd Floor 8pm</u>	
	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>97.8°F</u>	<u>98.0°F</u>	<u>98.1°F</u>	<u>97.3°F</u>	<u>98.1</u>	<u>98.1°F</u>
		Res:	<u>31b/min</u>	<u>32b/min</u>	<u>31b/min</u>	<u>32b/min</u>	<u>2</u>	<u>23b/min</u>
		SpO ₂ :	<u>99%</u>	<u>99%</u>	<u>100%</u>	<u>99%</u>	<u>1</u>	<u>99%</u>
		Pulse:	<u>124b/min</u>	<u>120b/min</u>	<u>120b/min</u>	<u>120b/min</u>	<u>1</u>	<u>121b/min</u>
		BP:	<u>92/60</u>	<u>93/72</u>	<u>95/70</u>	<u>92/62</u>	<u>82</u>	<u>95/60</u>
	Fall Risk Score:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</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>side rails</u>	<u>side rails</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>-</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>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>Satyra</u>	<u>Rajya</u>	<u>Shresh</u>	<u>Rajya</u>	<u>Shresh</u>	<u>Shresh</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>8/7/24</u>	<u>8/7/24</u>	<u>9/7/24</u>	<u>9/7/24</u>	<u>9/7/24</u>	<u>10/7/24</u>	
Time:		<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	
Taken Over By Name :		<u>Rajya</u>	<u>Shresh</u>	<u>Rajya</u>	<u>Ravathi</u>	<u>Shresh</u>	<u>Rajya</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>8/7/24</u>	<u>9/7/24</u>	<u>9/7/24</u>	<u>9/7/24</u>	<u>9/7/24</u>	<u>10/7/24</u>	
Time:		<u>2pm</u>	<u>9pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. A. Alam Qadri Department: 3rd floor Date of Admission: 21/7/24

SITUATION	Diagnosis: <u>Intestinal 9n intestinal Duphys catarrh Cyst</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
BACKGROUND	Area	Shift Time	<u>3rd floor</u> <u>2pm</u>	<u>3rd floor</u> <u>2pm</u> <u>8pm</u>	<u>3rd floor</u> <u>8AM</u>		
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>		
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	<u>98.0 F</u>	<u>98.1</u>	<u>98.0 F</u>		
		Res:	<u>24/4</u>	<u>28b/m</u>	<u>24b/m</u>		
		SpO ₂ :	<u>99% 100b/m</u>	<u>99%</u>	<u>100%</u>		
		Pulse:	<u>120b/m</u>	<u>120</u>	<u>118b/m</u>		
		BP:	<u>-</u>	<u>108/70</u>	<u>110/70</u>		
		Fall Risk Score:	<u>-</u>	<u>-</u>	<u>-</u>		
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>				
Recommendations	Safety Needs:	<u>C/S</u>	<u>side rails</u>	<u>side rails</u>			
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>			
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>			
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>			
Handed Over By Name :		<u>Shayy</u>	<u>Shayy</u>	<u>Shayy</u>			
Signature :		<u>(Signature)</u>	<u>(Signature)</u>	<u>(Signature)</u>			
Date:		<u>10/7/26</u>	<u>10/7/26</u>	<u>11/7/26</u>			
Time:		<u>@ 2pm</u>	<u>@ 8pm</u>	<u>8AM</u>			
Taken Over By Name :		<u>Shayy</u>	<u>Shayy</u>	<u>Shayy</u>			
Signature :		<u>(Signature)</u>	<u>(Signature)</u>	<u>(Signature)</u>			
Date:		<u>10/7/26</u>	<u>10/7/26</u>	<u>11/7/26</u>			
Time:		<u>@ 2pm</u>	<u>@ 8pm</u>	<u>@ 8AM</u>			



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/7/26	4:45 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	poofs
3/7/26	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	seema
4/7/26	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	seema
4/7	9:40 pm	1/10	SS	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Seema
4/7	6pm	1/10	SS	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Shweta
4/7	11pm	3/10	S/S	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Dr. Paracetamol	Kalyani
5/7	12am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under Observation	Kalyani
5/7	6am	3/10	S/S	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Dr. Paracetamol	Kalyani
5/7	7am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under Observation	Kalyani
5/7	2pm	0/10	S/S	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Dr. Paracetamol	Shweta

Re-assessment Frequency:

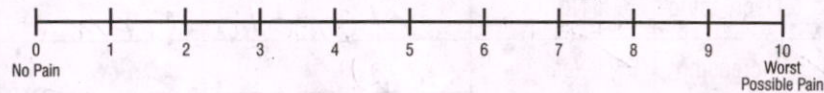
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

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 of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

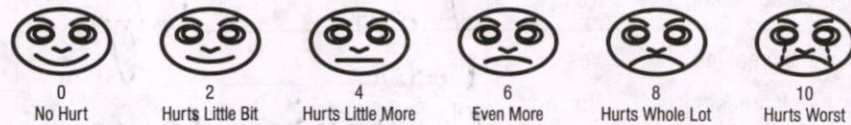
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
5/7	3pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	skinish
5/7	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	skinish
5/7	10pm	4/10	S/S	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inf. Paracetamol	Kalyani
5/7	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Kalyani
6/7	6am	4/10	S/S	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☒ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inf. Paracetamol	Kalyani
6/7	7am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Kalyani
6/7	11AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Annamma
6/7	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Annamma
6/7/26	2pm	2/10	S/S	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inf. Paracetamol	skinish
6/7/26	3pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	skinish.

Re-assessment Frequency:

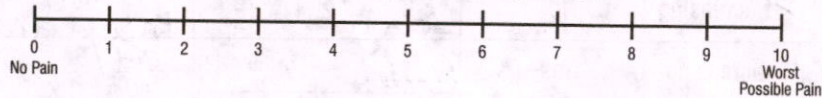
- Every eight hours for all hospitalized patients.
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 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

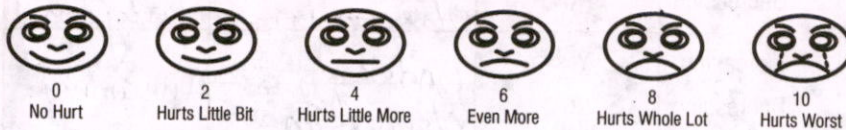
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/7/24	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	skin's ho.
6/7	10pm	4/10	S/S	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inf. Paracetamol	Kalyani
6/7	1upm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Kalyani
7/7	6am	4/10	S/S NA	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inf. Paracetamol	Kalyani
7/7	7am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Kalyani
7/7/24	2:15 pm	2/10	Sever. side of Surgical	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	Inf. paracetamol given.	Sign
7/7/24	3:30pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Saty
7/7/24	10pm	2/10	S/S	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inf. paracetamol - not	skin's
7/7/24	11pm	0/10	NA	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	skin's
8/7/24	6am	2/10	S/S	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☐ Yes ☐ No	Inf. paracetamol	skin's

Re-assessment Frequency:

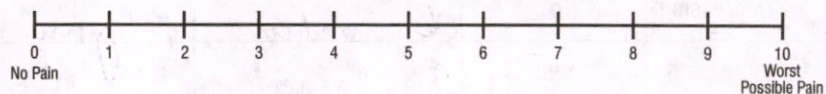
- Every eight hours for all hospitalized patients.
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 - Within 30 – 60 minutes after pain relief intervention.

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

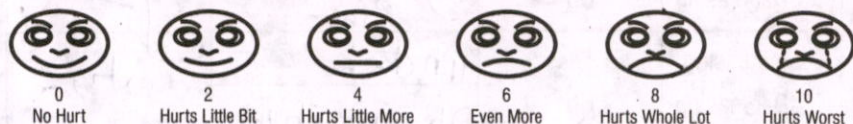
Numerical Pain Scale (Obstetric and Gynecology)



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)
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Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
8/7/26	7pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	stings
8/7/26	9am	02/10	s/s	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☒ Sharp ☐ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	7pm	stings
8/7/26	10am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	stings
8/7/26	7pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	stings
8/7/26	9pm	2/10	s/s	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inj paracetamol	stings
8/7/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	stings
9/7/26	6am	2/10	s/s	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inj paracetamol	stings
9/7/26	7am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	stings
9/7/26	1pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	stings
9/7/26	2pm	0/10	s/s	☐ Continuous ☒ Intermittent	☒ Acute ☒ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☐ Yes ☐ No	under observation	stings

Re-assessment Frequency:

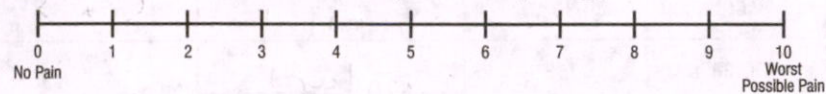
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PAIN ASSESSMENT TOOLS

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

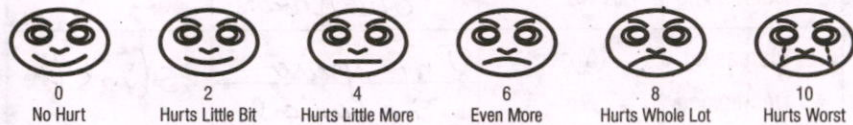
Numerical Pain Scale (Obstetric and Gynecology)



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

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Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
9/7/26	5pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Revathi
9/7/26	10pm	3/10	S/S	☒ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inf: paracetamol	shinsh
9/7/26	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	shinsh
9/7/26	6AM	3/10	S/S	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inf: paracetamol	shinsh
9/7/26	7AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	shinsh
10/7/26	1pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Deepa
10/7/26	3:30 pm	0/10	S/S	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inf: paracetamol given	Revathi
10/7/26	4:30 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Revathi
10/7/26	10pm	2/10	S/S	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inf: paracetamol	shinsh
10/7/26	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	shinsh

Re-assessment Frequency:

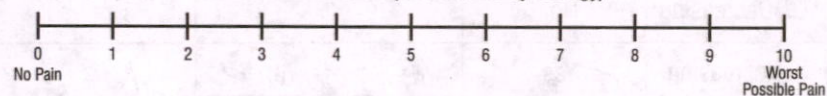
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PAIN ASSESSMENT TOOLS

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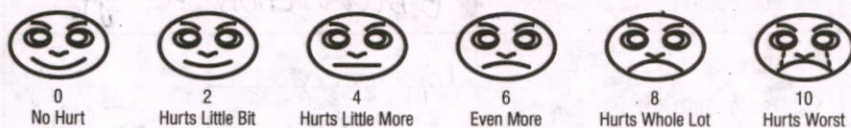
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	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State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

Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/7/28	6AM	3/10	S/S	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inj: paracetamol	skinish
11/7/26	7AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	skinish
				☐ 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:

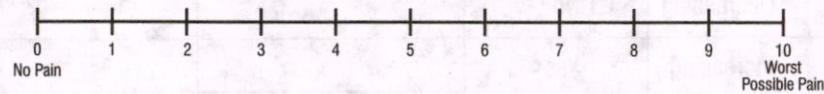
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

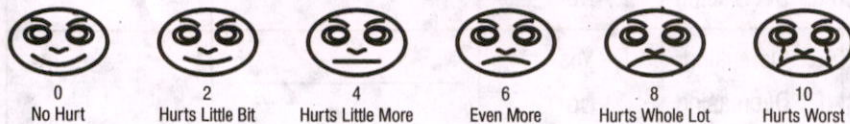
Numerical Pain Scale (Obstetric and Gynecology)



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





Patient

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	3/2	4/2	5/7	6/7	7/7
	3 to less than 7 years old	3	4	4	4	4	4
	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					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not Aware of Limitations	3		1	1	1	1
	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	4				
	Other Medications / None	1	1	1	1	1	1
TOTAL			12	12	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	Yes	Yes
Call device within reach		Yes	Yes	Yes	Yes	Yes
Wheels Locked		Yes	Yes	Yes	Yes	Yes
Room free of clutter		Yes	Yes	Yes	Yes	Yes
Adequate Lighting		Yes	Yes	Yes	Yes	Yes
Wheel Chair Support		No	No	No	No	No
Other Intervention(s) Specify		No	No	No	No	No
Nurse's Name :		poor	seema	kalyani	kalyani	kalyani
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :		3/2	4/2	5/7	6/7	7/7
Time :		4:45 pm	8 AM	6 AM	6 AM	6 AM

THE HUMPTY DUMPTY SCALE 8/2 9/2 10/2 11/2

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	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	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	1	
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	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	
	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	
Medication age	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	0				
	Other Medications / None	1	1	1	1	1	
TOTAL			12	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	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	no	no	no	no
Other Intervention(s) Specify	no	no	no	no
Nurse's Name :	clint	clint	clint	clint
Signature :	8	8	8	8
Date :	8/2	9/2	10/2	11/2
Time :	6AM	6AM	6AM	8AM



BRADEN 'Q' SCALE

					Date :	3/22	4/7	5/7	6/2
					Time :	4:47pm	2pm	6am	6am
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	1	1	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4	
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	1	1	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
TOTAL SCORE					28	28	22	22	
Evaluator's Name					poor's	seema kalyani	kalyani	kalyani	

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-00660549 IP5-00175934
Master KRISHNA NAGLA
04-07-2024 2 Y 0 M 2 D (M)
Dr. NABEEL ALAM QADRI



BRADEN 'Q' SCALE

					Date :	7/2	8/2	9/2	10/2
					Time :	6am	6am	6am	6am
Mobility	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	7	7	7
"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.		1	1	1	1
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	7	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	7	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	7	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.		2	2	2	2
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	7	4
TOTAL SCORE						23	23	23	23
Evaluator's Name						Kalyani	Shruti	Shruti	Shruti

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



BRADEN 'Q' SCALE

					Date :			
					Time :			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:tremitry position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	9			
"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.	1			
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.	7			
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.	7			
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4			
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	2			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4			
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	23		
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Shane		

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

CHECKLIST FOR THROMBOPHLEBITIS

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

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 : Soukha Sema

Signature of Ward In Charge :

Signature : Name : Anwar

BAH-00660549

Master KRISHNA NAGLA

04-07-2024

IP5-00175934

2 Y 0 M 1 D

Dr. NABEEL ALAM QADRI

(M)



CHECKLIST FOR THROMBOPHLEBITIS

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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

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 : Subhash Name : Subhash

Signature of Ward In Charge :

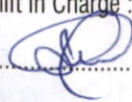
Signature : Praveen Name : Praveen

CHECKLIST FOR THROMBOPHLEBITIS

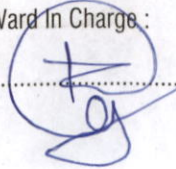
S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	.	0	0	0	0	0				
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first 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	2	-	-	-	-	-				→ cannula removed
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					Khatishle's			Rajy evadishle					

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 : Soubhormi

Signature of Ward In Charge :

Signature :  Name : Dr. Nabeel Alam Qadri

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. Laparotomy (+) Resection & Anastomosis
2. CA Cyst Excision

I acknowledge the following:

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

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
<u>To prevent Infection & Rupture of cyst</u>	<u>- Nil -</u>

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. Bleeding, wound Infection
b. postop Adhesione obstruction, leak rarely

- I authorize Dr. Nabeel Qadri and his / her team to perform the procedural sedation upon the patient / myself.
- 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.
- 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: PARAN KUMAR
Relationship with patient: Grand father
Date & Time: 4/7/26 @ 12pm

Witness:

Signature: [Signature]
Name: manju
Date & Time: 4/7/26 @ 12pm

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Nabeel Qadri Date: 4/7/26 Time: 12pm

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అబెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్బో చిల్డ్రెన్ హాస్పిటల్లో చేయబడబోయే క్రింది శస్త్రచికిత్స(లు) / ప్రాసీజర్(లు) చేయడానికి అంగీకరిస్తున్నాను. (టెక్నికల్ పదాలు వాడవద్దు మరియు ఖాళీ స్థలం వదిలివేయకండి)

1

2

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

- క్లినికల్ పరిశీలనలు మరియు/లేదా చేసిన పరీక్షల ఆధారంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
- ఈ శస్త్రచికిత్స / ప్రాసీజర్ కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి.
ఈ శస్త్రచికిత్స / ప్రాసీజర్ కు ఉన్న ప్రత్యామ్నాయాల గురించి, వాటి ప్రయోజనాలు మరియు నష్టాలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

- ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్ లాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీసియా వల్ల అలెర్జిక్, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు.
అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్ నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినప్పుడు, రోగి/నా కోసం అవసరమని వైద్యుడు భావించే ఇతర చికిత్సలను చేయడానికి కూడా నేను అనుమతిస్తున్నాను.

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

a.
b.

4. డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్ ను చేయడానికి నేను అనుమతిస్తున్నాను.
- వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
- పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భాష సమాధానం ఇచ్చారు.
ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో, స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అబెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

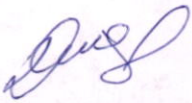
పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00660549 IP5-00175934 Master KRISHNA NAGLA 04-07-2024 2 Y 0 M 0 D (M) Dr. NABEEL ALAM QADRI 		Date & Time of Admission 3/7/26 @ 5:40pm	Date & Time of Transfer Order 4/7/26 @ 4:50pm
		Transfer Ordered by Dr. Habib	Reason for Transfer Post-op
From Unit OT	To Unit 338	Information to Attendant Yes ☐ No ☐	
Number of Sheets in Clinical File	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.	f		
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. Habib	
Patient & Clinical Records Received by :		Shamsy	
Date & Time of Patient Received :		7:30pm	

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

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Krishna nagla Age: 1y 11m Sex: male UHID.No: BAH 00660549
Date: 3/7/2026 Time: 8:50pm Proposed Operation: Laparotomy + Pericdn
Diagnosis: Intestinal duplication cpl
B.P / CRT: 104/74 H.R: 118 Weight: 10.6kg ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 12.4 Glucose: 86 Protein: HIV: X-Ray:
PCV: 38.1 Urea: 2.1 Alb: HBS Ag: ECG:
WBC: 10.62 Creat: 0.3 Total Bill: HCV: 2D Echo:
Plate: 418000 Na: 137 Dir. Bill: Blood group: O positive Stress/Angio:
PT: 14.3 K: 4.7 LDH: T3 Other:
PTT: Ca++: Alk phos: T4
INR: 1.2 Mg++: Amylase: TSH
Cl -: 104 SGOT/SGPT:

Allergies: nil

Medical History: CVS: ⊖ - LSCS/2.6kg/CRAB/NO NICU adn

RESP: ⊖ Diabetes: - normal development

CNS: ⊖

Renal: ⊖

Hepatic / GE: vomiting, pain, fever → rdy Physical Activity: active
Others: 8 days

Past Anaesthetic History: —

Physical Exam: No obvious facial anomaly

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

Lungs: clear

Heart: S, S, S

CNS: acc-ful

Pregnant: ☐ Yes ☐ No ☒ NA Venous Access Site: Spine Exam for regional:

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

(6) CAB, Blood groups
(7) Many 10ml/kg PRBC.

Signature: [Signature] Name: Dr. Nabeel



ANAESTHESIA CHART

Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☒ No		Fasting Status: <u>Confirmed</u>																																																																																																																																																																																																																																																																																																																																																																															
Physical Status: ☒ Patient Identified		☒ Consent Present																																																																																																																																																																																																																																																																																																																																																																															
		☒ Chart Reviewed																																																																																																																																																																																																																																																																																																																																																																															
H.R: <u>112 bpm</u>	B.P / CRT: <u>90/60</u>	SpO ₂ : <u>98% on RA</u>	R.R: <u>24/min</u>																																																																																																																																																																																																																																																																																																																																																																														
Pre-OP Diagnosis: <u>Int Duplication Cyst</u>		Operation: <u>Laparectomy + Resection Anastomosis</u>																																																																																																																																																																																																																																																																																																																																																																															
Surgeon: <u>Dr. Nabeel</u>		Anaesthesiologist: <u>Dr. K. Srinivasa</u>																																																																																																																																																																																																																																																																																																																																																																															
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<table border="1"><thead><tr><th>TIME</th><th>12:20</th><th>12:30</th><th>12:45</th><th>1:00</th><th>1:15</th><th>1:30</th><th>1:45</th><th>2:00</th><th>2:30 pm</th></tr></thead><tbody><tr><td>N₂O (AIR) / O₂ / LPM</td><td>100 / 50 / 1</td><td>100 / 50 / 1</td><td>100 / 50 / 1</td><td>100 / 50 / 1</td><td>100 / 50 / 1</td><td>100 / 50 / 1</td><td>100 / 50 / 1</td><td>100 / 50 / 1</td><td>100 / 50 / 1</td></tr><tr><td>HALO / SQ / SEVO</td><td>100 / 50 / 1</td><td>100 / 50 / 1</td><td>100 / 50 / 1</td><td>100 / 50 / 1</td><td>100 / 50 / 1</td><td>100 / 50 / 1</td><td>100 / 50 / 1</td><td>100 / 50 / 1</td><td>100 / 50 / 1</td></tr><tr><td>Drugs:</td><td colspan="9"><u>MIDAZOLAM 0.1mg</u> <u>FENTANYL 2mcg</u> <u>RODOPOL 40mg + 20mg + 10mg</u> <u>RODOPOL 6mg + 2mg</u> <u>NEOSTIGMINE - 0.6mg</u> <u>GLYCOPOLATE - 120 mg</u></td></tr><tr><td>FiO₂ / 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POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Deep Time Received : 2:35pm Time Discharged : 2:38

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site : <u>228</u> ☐ O ₂ Mask ☐ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway
		Vomiting : ☐ Yes ☒ No NG Tube : ☐ Yes ☒ No Drain : ☐ Yes ☒ No Urinary Catheter : ☐ Yes ☒ No Chest Tube : ☐ Yes ☒ No Nil Oral ☐ Yes ☒ No IV Fluids : _____ Oral Feeds : _____

POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES			OUT	SCORING INTERPRETATION
			30	60	90		
Able to move 4 extremities voluntary or on command	= 2	ACTIVITY	1	1	1	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		2	2	2	2	
Able to move 0 extremities voluntary or on command	= 0		2	2	2	2	
Able to deep breathe & cough freely	= 2	RESPIRATION	2	2	2	2	
Dyspnea or limited breathing	= 1		2	2	2	2	
Apneic	= 0		2	2	2	2	
BP $\pm$ 20 of Pre Anaesthetic level	= 2	CIRCULATION	2	2	2	2	
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1		2	2	2	2	
BP $\pm$ 50 of Pre Anaesthetic level	= 0		2	2	2	2	
Fully awake	= 2	CONSCIOUSNESS	1	1	2	2	
Arousable on calling	= 1		1	1	2	2	
Not responding	= 0		1	1	2	2	
Pink	= 2	COLOR	2	2	2	2	
Pale, dusky, blotchy, jaundiced, other	= 1		2	2	2	2	
Cyanotic	= 0		2	2	2	2	
TOTAL			8	8	9	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
11/7/24	2:35pm	1/10	—	Deep

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

Anaesthesiologist Name : Dr. Tejaswini

Anaesthesiologist Signature : [Signature]

Date & Time : 11/7/24 2:35pm

PACU Nurse Name : Deep

PACU Nurse Signature : [Signature]

Date & Time : 11/7/24 2:38pm

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): 338

Date & Time : 11/7/24 2:38pm

Patient Sticker

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

CSE /Spinal /Epidural Position : Space : Technique (LOR/LOS)

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution *Composition* :

Any other issues :

a)

b)

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

Delivery Details : Time : APGAR: SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :



CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: Laprotomy and Resection

Anaesthesiologist: Dr. Shabna

Surgeon: Dr. Nabeel

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: Dehydration, Bronchospasm, Laryngospasm, Blood Transfusion

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: Dr. Nabeel

Signature: _____

Name: Deepak

Relationship with patient: Uncle

Date & Time: 3/7/2026 10:45pm

Witness: Dr. Nabeel

Signature: _____

Name: Manju Nagla

Date & Time: 3/7/2026 10:45pm

Doctor (who is taking consent):

Signature: Dr. Shabna

Name: Dr. Shabna

Date: 3/7/2026 Time: 10:45pm

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 తీర్చిదిద్దడానికి నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్మల్ బ్లడ్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై లిస్ట్:

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 ☐ తీర్చిదిద్దడానికి 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 సెంట్రల్ వెన్స్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, లిజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి 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 స్వేచ్ఛగా భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

PEDIATRIC SURGERY CHECKLIST

Patient's Name : Krishna nagla Age : 1y 11m Gender : ☒ Male : ☐ Female

UHID : BAH-660549

Diagnosis : Intestinal duplication cyst

Planned Procedure : Laparotomy (+) Resection & Anastomosis

Operating Time : 2 hrs Expected Stay in Hospital : Ward 4-5 days PICU _____ days

Type of Admission : ☒ Regular ☐ Day Care ☐ OP Basis Day Care

Reporting for Admission : ☐ Previous Morning ☒ Previous Evening ☐ Same Day 2 Hours Prior

Pre-OP Instructions :

Investigations : CRP / Electrolytes - done
& false crossmatch sample

Bowel Wash : _____

Enema : _____

Blood Products :

Reserve : 1 @ PRBC

Blood Donation : _____

Pre-OP Antibiotic (At Least One Hour Prior To Incision)

Injection : Cefazolin

Special Equipment / Instructions

☐ C-ARM ☐ STAPLER ☐ FROZEN SECTION ☐ CYSTOSCOPY ☐ URS SCOPE ☐ HORMONIC

Instruction For Parents

Place of Reporting for Admission - ER (Emergency Room In Lower Ground Floor)

_____ of Reporting to ER _____

Important : Please be on time as delays may result in postponement or cancellation of surgery

Fasting Instruction: _____

- 6 hrs prior - all types of solid food and liquids to be stopped
- 4 hrs prior - breast feeds can be given
- 2 hrs prior - water, ORS and Coconut Water can be given

Important : Please follow these instructions correctly for the safety of the operation and for starting the surgery on time : failure to do so may result in postponement or cancellation.

Please Bring All Medical Records including X-Rays, CT Scans / MRI Scans

Doctor's Name : Dr. Anand Chandra

Doctor's Signature : _____

Date & Time : 3/7/26

Doc. No. : RCHBH / FRM / CLINICAL / 221



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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 27/7/26 Time: 9:30

Weight: 10.8 kg's Centile: <10th

Height: 79cm Centile: <5th

Inference: underweight child

RDA: — Calories: 1200 kcal/d Protein: 20 gm/d

Diet Recommendations: child is on NPO

Re-Assessment:

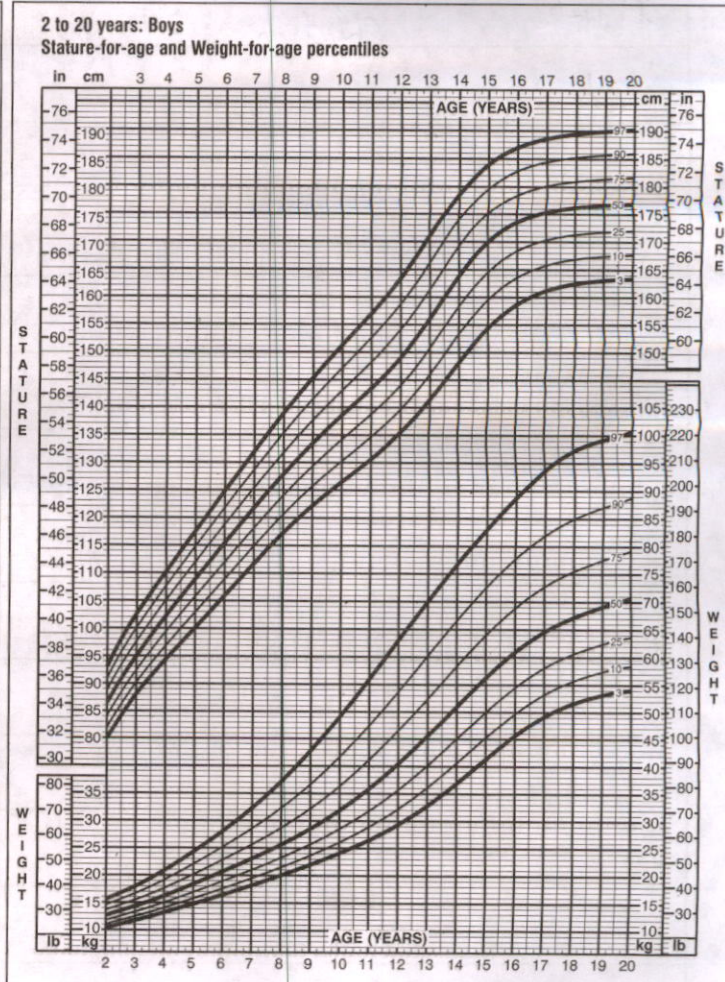
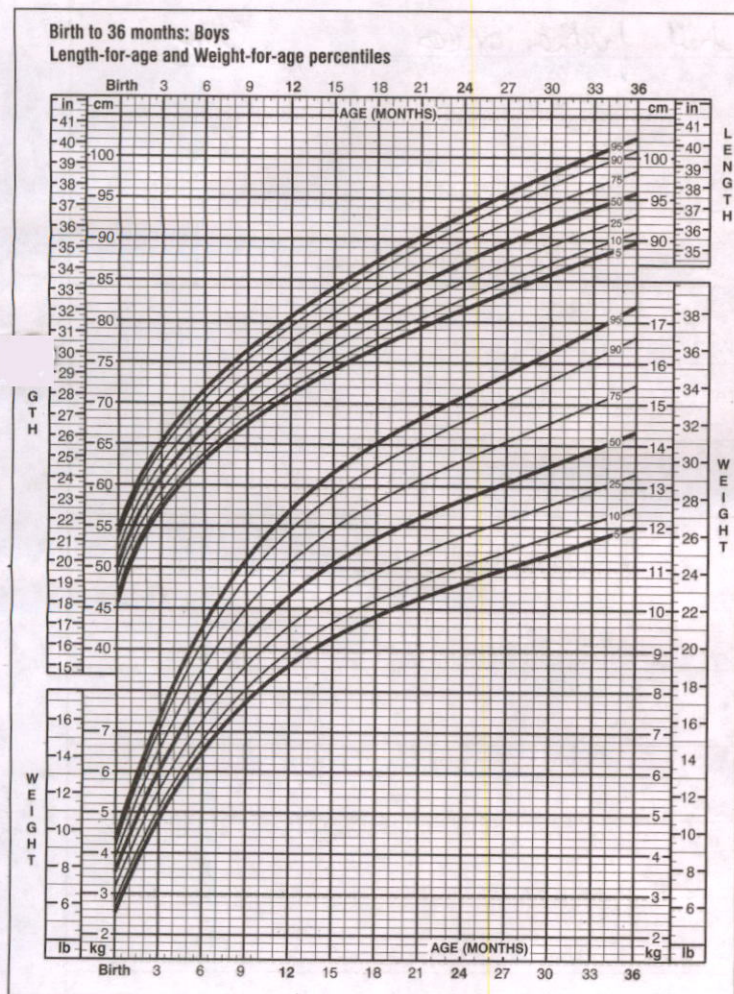
Food Allergies: No Veg/Non-veg veg

Diagnosis: intestinal duplication of cyst

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: Saine

Dietician's Signature: Saine

Daily Notes:

5/7/26

child is on NPO until further orders

12pm

Saings

6/7/26

child is stable, continue ^{clear} liquid diet

Nikky

11:30
am

7/7/26

child is stable, oral intake is good

11:50
am

continue liquid diet

Saings

8/7/26

child is stable, oral intake is optimal

9:40
am

continue soft diet

Saings

9/7/26

child is on NPO till further orders

Saings

8am