

Dr 3

ACTIVITY RECORD FOR BILL

BCH-00015267 IP5-00176726

Master MICHAEL CLEOPHAS

09-02-2015 11 Y 5 M 12 D (M)

Dr. DR.V.V.R.SATYA PRASAD

Name : _____

UHID No. : _____ IP No. : _____



Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
21/7/26	4:35pm	ER	PICU	Abhishek

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	DR. Harish Jayaram	21/7	9715167	[Signature]
2	DR. Sandeep Reddy	21/7/26	9716822	
3	DR. Sandeep Reddy	22/7/26	9716823	
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)					
Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
2/12	Inv monitor	4.40 PM		9214982	Subram
	Inf pump				
	Inf pump				
	Syr pump				
	Oxygen				
22/2	Inv & Monitor		4.40 PM	9214982	Subram
	Inf 2 Pump				
	Inf 2 Pump				
	Syr 2 Pump				
	O2				
	Syr. Pump				
	Control				

2172

Inv monitor

Inf pump

Inf pump

Syr pump

Oxygen

Connecting Time

Disconnecting Time

Order No.

Signature

9214982

Subgraph

У.УОРМ

22/2

17th 2 March

Inf₂ Pump

Inf 2 P vmp

Apr 2 Pump

02

84x. PCMP

Conclusion

9/4/21

21498

2/14/04

Figure

PROCEDURE

[illegible]**ANY OTHER INFORMATION**

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

SELF INDENT**ADMISSION SHEET****Registration Details :**

Admission No : IP5-00176726

Admit Date : 21-Jul-2026

Admit Time : 06:14 PM UHID : BCH-00015267

Patient Details :

Patient Name : Master MICHAEL CLEOPHAS

Age : 11 Y 5 M 12 D

Guardian : Mr JANNAPUREDDY RAJKUMAR

DOB : 09-02-2015

Gender : Male

Religion : Christian

Occupation :

Marital Status : Single

Address (H) : H.NO 2-86/3, VILLAGE:- GEESUKONDA
Dharma Rao Cheruvu Warangal Telangana
INDIA 506330

Phone No : 8074178058/ 9391226814

E-mail : JRKMBA777@GMAIL.COM

Admission Details :

Bed Type : PICU-ISO

Bed No : PICU ISO 232

Ward Name : 2F-PICU II

Room No : PICU ISO 232

Admission Type : First Visit

Contact Details :

Name : Mr JANNAPUREDDY RAJKUMAR

Relationship : Father

Contact Address : H.NO 2-86/3, VILLAGE:- GEESUKONDA
Dharma Rao Cheruvu Warangal Telangana
INDIA 506330

Phone No : 8074178058 / 8074178058


Signature**Doctor Details :**

Doctor Name : Dr. DR.V.V.R.SATYA PRASAD

Specialisation : PEDIATRIC NEPHROLOGY

Referral Doctor : SELF

Phone No :

Co-Consultant : Dr. SHAIKH FARHAN A RASHID

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELFPAY

SELF INDENT



ADMISSION CRITERIA – PICU

Admission / Transfer from:

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

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

- ☐ All patients requiring mechanical ventilation;
 - ☐ Patients with impending respiratory failure;
 - ☐ Upper airway obstruction;
 - ☐ Lower airway obstruction;
 - ☐ Alveolar disease; and
 - ☐ Unstable airway;
 - ☐ All Paediatric patients after successful resuscitation;
 - ☐ **Comatose Patients;**
 - ☐ Meningitis, encephalitis; ☐ Hepatic encephalopathy; ☐ cerebral malaria;
 - ☐ Head injury; ☐ Poisonings; and ☐ Status epilepticus;
 - ☒ **All types of shock/hemodynamic instability:**
 - ☒ Septic shock;
 - ☐ Hypovolemic shock; (Bleeding emergencies such as gastrointestinal bleeding, bleeding diathesis, disseminated intravascular coagulation; Cardiogenic shock; myocarditis, cardiomyopathy, congenital heart disease; Neurogenic shock; and Multiple trauma;
 - ☐ Cardiac arrhythmias after consulting with the treating consultant
 - ☐ Hypertensive Emergencies;
 - ☐ Severe acid base disorders;
 - ☐ Severe electrolyte abnormalities;
 - ☐ Diabetic ketoacidosis (Ph<7.2, altered sensorium, hyperglycemia)
 - ☐ Acute renal failure; Patients requiring acute hemodialysis, hemofiltration and peritoneal dialysis;
 - ☐ **Post-Operative Patients;**
 - ☐ Requiring ventilation;
 - ☐ Unstable patients; and
 - ☐ Post-operative patients after open heart surgery, neurosurgery, thoracic surgery and other patients after major general surgery with potential for respiratory/haemodynamic instability;
 - ☐ Patients requiring nitric oxide therapy;
 - ☐ Malignant hyperpyrexia;
 - ☐ Acute hepatic failure
 - ☐ Severe dehydration with mental status change;
 - ☐ Asthma requiring hourly nebulization/getting tired with increasing oxygen requirement/mental status change.
- "UNSTABLE" PATIENT IS DEFINED AS**
- ☐ HR < 50 or > 160 per minute or more than upper normal limit according to age. BP<90 systolic and < 50 diastolic and or requiring inotropic support. Arrhythmia or risk of sudden arrhythmia.
 - ☐ Signs of peripheral poor perfusion or suspicion of any type of shock.
 - ☐ Capillary refill time > 4seconds.
 - ☐ Children Blood pressure (Syst.) < [70 + (2× age "Years")].
- Respiratory failure or high risk of failure or airway obstruction:**
- ☐ Respiration rate < 5 per minute below the normal or > 10-15 per minute above the normal range for age.
 - ☐ O2 Saturation <90 % or need for O2 >4 Litres per minute by normal face mask. Abnormal ABG: PH < 7.25, PaO2 < 60 torr, PaCO2 > 50 torr.
 - ☐ Distress and risk of exhaustion
 - ☐ **Change of level of consciousness: GCS < 13.**
 - ☐ **Persistent oliguria with acidosis.**

Signature of the Doctor:

Name of the Doctor:

Date & Time:

BCH-00015267 IP5-00176726
Master MICHAEL CLEOPHAS
09-02-2015 11 Y 5 M 12 D (M)
Dr. DR.V.V.R.SATYA PRASAD




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

 **BirthRight[™]**
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DISCHARGE CRITERIA – PICU

Discharge to:

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

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

- ☐ Stable hemodynamic parameters.
- ☐ Stable respiratory status (patient extubated with stable arterial blood gases) and airway patency at least for 24 hours with no respiratory distress needing continuous monitoring.
- ☐ Minimal oxygen requirements that do not exceed patient care unit guidelines.
- ☐ Intravenous inotropic support, vasodilators, and antiarrhythmic drugs are no longer required or, when applicable, low doses of these medications can be administered safely in otherwise stable patients in a designated patient-care unit.
- ☐ Cardiac dysrhythmias are controlled.
- ☐ Neurologic stability with control of seizures.
- ☐ Removal of all hemodynamic monitoring catheters.
- ☐ Routine peritoneal or hemodialysis with resolution of critical illness not exceeding general patient care unit guidelines.
- ☐ Patients with mature artificial airways (tracheostomies) who no longer require excessive suctioning.

Signature of the Doctor:

Name of the Doctor :

Date & Time:

PEDIATRIC INTENSIVE CARE ADMISSION RECORD

Date: 24/01/16 Time: 5:20pm.

Patient Assessment Form:

Informant: ☒ Father ☒ Mother ☐ Other

Presenting Complaints / Chief Complaints :

11 year old Boy
 Known chronic systemic venous thrombosis
 with bilateral chylothorax with chronic hypoproteinaemia
 presented with
 - severe drain output
 - fluctuations in blood pressure since last 10 days
 - cold peripheries & dull activity
 - poor oral intake since 10 days.
 Also known to be on oxygen equipment since
 last 10 days.

Past History (Including previous treatment and investigations) :

Known chronic systemic
 venous thrombosis with bilateral recurrent
 chylothorax

Birth and Developmental History :



↑ HbA1c BW-2.4

Immunization History : upto 5 year age

H / O Allergy :

Family History :

INITIAL ASSESSMENT

RBS : B. Myell Temperature : 98.6°f Weight (kg) :

Respiratory System Findings:

Air Way: Open Maintainable Not Maintainable Intubated, If Intubated, size & position of ETT :

Respiratory Examination Finding: (Air entry, breath sounds, s/o distress etc.): Respiratory Rate : 20/min

SPO₂ : 85-86% O by NC / FM / NRB mask / Oxyhood, at 100% @ 10 L/min L / min

Ventilatory Support : Yes No Day # of Vent : Respiratory Efforts : diminished

Ventilatory Settings : Leak around ETT : Delivered Vt :

ABG : 7.48 - 34 - 17.8 EtCO₂ : P/F ratio : O.I :

Any Nebs : ICD? Yes No, If Yes, details :

CXR :

Cardio Vascular System Clinical Exam : Heart Rate : 106/min Cardiac Rhytho : sinus

(Heart sounds, murmur etc.) : S1 S2

Quality of Pulses : Feble cap refill Time : > 6 sec Liver Edge : 3m cm below Rt costal margin

Blood Pressures : NIBP : NR IBP : NR CVP :

Infusion of any Inotropes? : Yes No If yes, then details : Dobut @ 0.2 mcg/kg/min

Any Other Infusions :

Last 2D Echo Findings : Exc. collapul.

Size of the heart and lung fields in latest CXR :

Arterial line in Situ : Yes No Place of art. line & its condition :

Central line in Situ : Yes No Place of central line & its condition :

Infection and Antibiotics :

Febrile Afebrile Current Antibiotics Details (antibiotic name and day #) :

Cultures Done outside? Yes No If yes, details :

Describe c/s Reports :

Other Labs (Latex, Serology, etc) : Di. Panel

Ongoing Antibiotics :

Abdominal Exam : Soft

ENT Exam :

Central Nervous System :

Level of Consciousness (AVPU / GCS score) : 14/15

Neurological Findings : Bk. Punt. 2nd 2nd

Relevant data from outside (Neuro imaging any ongoing medications etc) :

Special Needs Screening: (If any of the below are Positive, Please fill "Cross Consultation Form" to Concerned Department)
(Please select and 'tick mark' [✓] the boxes as applicable)

a. Nutritional Screening Criteria: Screening is

☒ Positive ☐ Negative

☐ Diabetes Mellitus

☒ Needs Therapeutic Diet.

☐ Diarrhoea > 4days

☐ Food Allergy

☐ Overweight

☐ Psychological Eating Disorder

☐ Major Surgery

☐ Patient in ICU

☐ Under Weight

☐ Difficulty swallowing / Chewing

☐ Hyperemesis gravidarum

☐ Tube Feeding

☐ Poor Appetite > 3days

☐ Unplanned Change in Weight

b. Psychological Screening Criteria: Screening is

☐ Positive ☒ Negative

☐ Non-compliance to offered treatment Over weight

☐ Suspected Drug Abuse

☐ Emotional / Behavioural Problem (Tearful, uncooperative)

c. Functional Screening Criteria: Screening is

☐ Positive ☒ Negative

☐ Patient cannot position himself in bed

☐ Change in Muscle Power

☐ Restricted ROM

☐ Impaired Daily Living Activities

d. Socio-economic Screening Criteria: Screening is

☐ Positive ☒ Negative

☐ Living alone

☐ Suspected abuse or neglect

☐ Cultural or religious background that would need to know for the plan of care

☐ Unable to assess due to lack of family

e. Need for Interpreter Screening is

☐ Yes ☒ No

If Yes then plan

6. Patient needs additional specialized assessments:

☐ Yes ☒ No

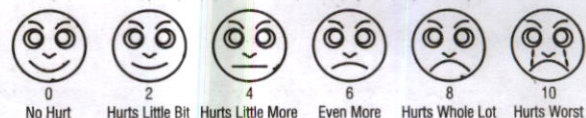
If yes, Please fill Individualized Initial Assessments Form for Special Populations

Others

Pain Screening:

Pain Scale used Wong Baker (Scale 0-10) FLACC (Scale 0-10)

Pain Score "Whenever Applicable"



Location:

Duration: days /weeks / months (Strike Out that is not applicable)

Character: ☐ localized ☐ diffuse ☐ sharp ☐ aching ☐ referred ☐ vague ☐ burning / soreness

Frequency: ☐ constant ☐ intermittent ☐ occasional

Pain Management done ☐ Yes ☐ No

Nutritional Evaluation:

Current Medications:

Provisional Diagnosis : Chronic Systemic Venous Thrombosis
On recent ~~pericarditis~~ chylotoma

Prism III score at 24 hrs of admission : 12 Worse SOFA Score :

☐ Referred Patient - ☒ Self Referral - ☐ Rainbow Patient "

Transferring Unit : ☐ Ward ☐ OT - Transported? ☐ Yes ☒ No - If yes : ☐ Long (> 30 kms) ☐ Short (< 30 kms)

Referring Consultant :

Admitting Consultant : Agarwal

Indication for PICU referral : Sepsis / Septic shock

PLAN OF CARE

Preventive aspects of the treatment :

Desired goals of the treatment :

PLANNED INVESTIGATIONS

- CBP
- RP2
- Procalcitonin
- Blood ds

PLANNED MANAGEMENT

- Dr. P. D. D. D.
- Dr. L. L. L. L.
- Dr. P. D. D. D.

Final Diagnosis:

Doctor's Signature : [Signature]

Name : Chait

Date : 21/01/14

Time: 6pm

Consultant's Signature :

Name :

Date :

Time:

Docu. No. : RCHBH /FRM / CLINICAL / 088

[illegible]

~~praktische~~

02-2013
DR. V. V. R. SATYA PRASAD



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date & Time	Progress Notes	Doctor's Order
2/10/2016 7:10pm	C/S/B Dr Satyabhadra H/O Extrinsic Venous thrombosis R/L Chyloma.	PLAN 1) On NPRME 1st time → et. 10 fluid 2) send R/L common carotid (H/O) 3) Add + 15ml H ₂ O in W. fluid 4) w/H Nodosis oral. 5) Nausea 1st in IV. 6) send Vitamin D ₃ levels
		N/B Narweeke

BCH-00015267

IP5-00176726

Master MICHAEL CLEOPHAS

09-02-2015

11 Y 5 M 12 D

(M)

Dr. DR.V.V.R.SATYA PRASAD



It takes a lot to treat the little.



BY RAINBOW HOSPITALS

Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

210716
7:20pm

DAILY ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 21/07/26 Day of Admission : 2 Today's Date & Time : 22/07/26

PRISM - III Score in first 24hrs. of Admission : Today's SOFA Score :

OVERVIEW	Diagnosis : <u>Acute Chronic Systemic nervous thrombosis TBL Cytation E chronic Hypoventilation</u>	Current Issues : <u>4 shock 4 distress</u>
	VITAL SIGNS Today's Wt. (kg) : Temp.: Blood sugar issues :	
RESPIRATORY SYSTEM	Respiratory System Findings : (Air entry, breath sounds, s/o distress etc.) : <u>HR 120, RR 20, SpO2 92% on 100% FiO2</u>	
	CXR : <u>done</u>	
	SPO ₂ : <u>92% on 100% FiO2</u> O ₂ by NC / FM / NRB mask / Oxyhood, at : L / min	
	Ventilatory Support : ☒ Yes ☐ No - Day # of Vent : <u>1</u> Nitric Oxide : ☐ Yes ☒ No - If Yes, details :	
	Ventilatory Settings : Leak around ETT : Delivered Vt :	
	ABG : EtCO ₂ : P/F ratio : O.I. :	
	Chest Physiotherapy Plan : Suctioning Needs :	
	Any Nebs : ICD ? ☒ Yes ☐ No, if Yes, details :	
	Plan of care : <u>4 palliative care</u>	
CARDIO VASCULAR SYSTEM	Cardio Vascular System Clinical Exam. (Heart sounds, murmur etc.) : <u>poor peripheral</u>	
	Quality of Pulses : cap refill Time : Liver Edge : cm below Rt costal margin	
	Blood Pressures : NIBP : <u>37/24 mmHg</u> IBP : CVP :	
	Infusion of : ☐ Dopamine mcg / kg / min - ☐ Dobutamine mcg / kg / min	
	☒ Epinephrine <u>0.5</u> mcg / kg / min - ☐ Nor Epinephrine mcg / kg / min	
	☐ Milrinone mcg / kg / min	
	Any Other Infusions :	
	Last 2D Echo Findings :	
	Size of the heart and lung fields in latest CXR :	
	Arterial line in situ : ☐ Yes ☒ No Place of art, line & its condition :	
Central line in situ : ☐ Yes ☒ No Place of central line & its condition :		
Day of arterial line : Day of Central line :		
Plan of Care : <u>palliative care</u>		
CNS	Neuro Exam :	
	Pupils : Sedation Used ☒ Yes ☐ No Any paralysis ? ☐ Yes ☐ No	
	Types of Sedation : <u>Morphine 5mg/kg</u> Types of Paralysis :	
	Relevant CT Scan, MRI EEG, Neurosonogram etc. :	
	Plan of Care : Ramsay Sedation Score :	

FLUIDS STATUS NUTRITION AND G.I	☒ NPO ☐ PO feeds ☐ NG Feeds ☐ NJ Feeds ☐ GT Feeds	
	I / O / Balance : / (+/-) Input : ml/k/d UO : ml/kg/hr Stools :	
	NG output : PO intake :	
	Feed Formula : Feed Schedule :	
	IV Fluids - Type of IVF : <u>DNL</u> @ <u>90</u> ml / hr (..... times maintenance)	
INFECTION	TPN : ☐ Yes ☐ No - If yes, details :	
	 % of Dext, Glu Inf Rate (mg/kg/min) Amino Acids (gm/kg/day) Lipids (gm/kg/day)	
	 Cal/kg/d Nitrogen Trace elements & MVI	
	Labs : Na K Cl Ca Mg P HCO3 Sr. Amylase : Sr. Lipase :	
	Latest LFT : <u>3700 0.5 ml / 19 hr</u>	
NEPHROLOGY ISSUES	Abd Exam :	
	Any organomegaly ? ☐ Yes ☒ No - If yes, describe :	
	Plan (G.I. & Liver) :	
		
		
HEMATOLOGY	☐ Febrile ☒ Afebrile Current Antibiotics Details (antibiotic name and day #) :	
	Cultures Sent ? ☐ Yes ☒ No - If yes, details : <u>91st Pa (2)</u>	
	Describe c/s Reports :	
	Other Labs (Latex, Serology, etc) :	
	Ongoing Antibiotics :	
CARE PROTOCOLS	Sr. Creat : <u>0.3</u> Bld. Urea : <u>9</u> Other Relevant Labs :	
	P.D. ☐ Yes ☒ No - If yes, details :	
	Diuretics : ☐ Yes ☒ No - If yes, details :	
	Catheterized : ☒ Yes ☐ No - If yes, then day of Catheter :	
	Relevant Radiology (USC, MCUG radioisotope scan etc) :	
FINAL COMMENTS	Plan of Care :	
		
		
		
		
CARE PROTOCOLS	VAP Bundle Used ? : ☐ Yes ☐ No ☐ NA CRBSI Bundle Used ? : ☐ Yes ☐ No ☐ NA CA - UTI Bundle Used ? : ☐ Yes ☐ No ☐ NA Patient Managed as per Relevant Protocols : ☐ Yes ☐ No ☐ NA If yes, then details :	Pending Lab Results : ☐ Yes ☐ No If yes, then details : Pending Consultations : ☐ Yes ☐ No If yes, then details :
		
➔ ct Ballist can <u>21/7/26</u> @ SA		

Doctor's Name (Handover given) :

Signature :

Date & Time :

Doctor's Name (Handover taken) :

Signature :

Date & Time :

21/7/26 @ SA

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



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

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26	Event notes	
4:40pm		
	child had bradycardia	
	HR < 60/min	
	On A/C/Vc:- TV - 8 ml/kg,	
	FiO ₂ - 100%, pressures - 29/8	
	↓	
	DOPE checked. ET tube	
	in correct position	
	↓	
	CPR started	
	2ij. Adrenaline 1st dose given	
	↓	
	HR - not recordable	
	BP - not recordable	
	↓	
	CPR continued.	
	2ij. Adrenaline 2nd dose given	
	↓	
	HR - not recordable	
	BP - not recordable.	
	↓	
	CPR continued	
	2ij. Adrenaline 3rd dose given	
	2ij. calcium gluconate given	
	2ij. Sodium bicarbonate given	
	↓	
		— P.T.O. —

DR.V.V.R.SATYA PRASAD

IP5-00176726

BCH-00015267

BCH-00015267
MICHAEL CLEOPHAS

09-02-2015

11 Y 5 M 13 D

(M)

09-02-2015
Dr. DR.V.V.R.SATYA PRASAD



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	HR - not recordable	
	BP - not recordable	
	pupils - B/L 5mm, not reacting to light.	
	No brainstem reflexes	
	↓	
	patient declared dead on 22/07/2026	
	at 5:10 pm.	
	Dr. Pratyusha.	

BCH-00015267 IP5-00176726
Master MICHAEL CLEOPHAS
09-02-2015 11 Y 5 M 13 D (M)
Dr. DR.V.V.R.SATYA PRASAD



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

CROSS CONSULTATION FORM

Doctor Name : DR. Harish Jayaram Date : 21/7/26 Time : 6pm

Diagnosis :

Hospital : Ren. Bangara HCU

Type of Referral :

- ☒ Emergency
☐ Urgent
☐ Non Urgent

Referred for : ☒ Opinion ☐ Co-Management ☐ Transfer of care

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

Red Trenchant bloods
Signature: A.B. Monuh

Findings and Recommendations :

c/o ? Chronic Vascular Thrombosis -

c/o (L+) thoracic
knockoff
tube block

↓
tube flushed
+
connected to
ICD Bag.

Actw

1) Plan

(R+) hemithorax
Aspiration
SUS -

Consultant :

Name : Dr. Harish Jayaram Signature : [Signature] Date & Time : 21/7/26 6pm

BCH-00015267 IP5-00176726
Master MICHAEL CLEOPHAS
09-02-2015 11 Y 5 M 12 D (M)
Dr. DR.V.V.R.SATYA PRASAD



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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RESULT SHEET

Date	21/07/20				
Time					
Hb	12.3				
PCV					
RBC	6.4				
WBC	11.29K				
N/L	89/3.5				
Platelets	5.69L				
CRP	74				
ESR					
PCT					
RBS					
Na	119				
K	4.1				
Cl	89				
Ca/Mg	8.0				
Phosphate	4.8				
Urea	9				
Creatinine	0.3				
ALP	156				
SGPT	13				
SGOT	35				
T.Bill/Conj	0.3/0.2				
T.Protein	3.8				
S.Albumin	1.7				
S.Globulin					
A/G Ratio					
Uric Acid	4.1				
S.Amylase	30				
Sr.Lipase					
Blood Lactate					
S.Cholesterol	153				
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					



MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From: ER

Shifted to: PICU

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Teb Pan	1tab	PO	OD		☒ C ☐ DC
2	Teb Rivaroxaban	1tab	PO	BD		☒ C ☐ DC
3	Teb Ecosprin 75mg	1tab in (8mi) 12hr	PO	OD	20/7/26	☐ C ☒ DC
4	Teb Nodons 1000mg	1tab	PO	BD		☒ C ☐ DC
5	Teb Tolvaptan 15mg	1tab	PO	OD		☒ C ☐ DC
6	Teb Aldactone 25mg	1tab	PO	BD		☐ C ☒ DC
7	Teb Laxa 4mg	1/2tab	PO	BD		☐ C ☒ DC
8	Syp. Lupizyme	5ml	PO	BD		☒ C ☐ DC
9	3% Nacl	35ml in food	PO	QID		☐ C ☒ DC
10						☐ C ☒ DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. RAMYA

Date & Time : 21/7/26 : 4:30pm

Nurse Name & Signature : Abhishek

Date & Time : 21/7/26 4:30pm

DRUG CHART

Date of Admission: 21/7/26 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

Weight. 16 kg Ward. pu

Page: 2/4

BCH-00015267 IP5-00176726
 Master MICHAEL CLEOPHAS
 09-02-2015 11 Y 5 M 12 D (M)
 Dr. DR.V.V.R.SATYA PRASAD

Sheet No:

REGULAR PRESCRIPTIONS

Weight 16 kg Ward PCU

DRUG : <u>1 tab NODOSIS 1000mg</u>				Date Time	<u>21/7</u>
Dose <u>1 tab</u>	Route <u>PO</u>	Frequency <u>BD</u>	Start Dt. <u>21/7/24</u>	<u>6 AM</u>	<u>X</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr Ranga</u>				<u>6 PM</u>	<u>X</u>
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>1 tab TOLVAPTAN 15mg</u>				Date Time	<u>21/7</u>
Dose <u>1 tab</u>	Route <u>PO</u>	Frequency <u>OD</u>	Start Dt. <u>21/7/24</u>	<u>10 PM</u>	<u>X</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr Ranga</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>1 tab ALDACTONE</u>				Date Time	<u>21/7</u>
Dose <u>25mg</u>	Route <u>PO</u>	Frequency <u>BD</u>	Start Dt. <u>21/7/24</u>	<u>Stop</u>	<u>21/7/24</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr Ranga</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>1/2 tab LASIX 40mg</u>				Date Time	<u>21/7</u>
Dose <u>1/2 tab</u>	Route <u>PO</u>	Frequency <u>BD</u>	Start Dt. <u>21/7/24</u>	<u>Stop</u>	<u>21/7/24</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr Ranga</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

Sheet No:

REGULAR PRESCRIPTIONS

Weight 16kg

Ward 810

DRUG : 3% NACL				Date Time	21/7	22/7														
Dose	Route	Frequency	Start Dt.	12	X	X														
35ml	PO	8n food/	21/7/26	AM	X	X														
Name & Signature of the Doctor Starting the Drugs:				6	X	X														
				AM	X	X														
Additional Instructions:				12	X	X														
				PM	X	X														
QGH				6	AM															
				PM	AM															
Daily Doctor's Endorsement by a Sign																				

DRUG : Inj PIPERACILLIN Tazobactam				Date Time	21/7	22/7														
Dose	Route	Frequency	Start Dt.	6	X	X														
1.6g	IV	TID	21/7/26	AM	X	X														
Name & Signature of the Doctor Starting the Drugs:				2	X	X														
				PM	X	X														
Additional Instructions:				10	AM															
				PM	AM															
Daily Doctor's Endorsement by a Sign																				

DRUG : INF LAIN				Date Time	21/7	22/7														
Dose	Route	Frequency	Start Dt.	10	X	X														
16ml	IV	BD	21/7/26	AM	X	X														
Name & Signature of the Doctor Starting the Drugs:				10	X	X														
				PM	X	X														
Additional Instructions:				10	AM															
				PM	AM															
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																				

BCH-00015267 IP5-00176726
 Master MICHAEL CLEOPHAS
 09-02-2015 11 Y 5 M 13 D (M)
 Dr. DR.V.V.R.SATYA PRASAD



Weight. Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
21/07/20	2:40pm	Infid NS	160ml over 2 hours	IV	W. [Signature]	at [Signature] Rahul [Signature]
22/7	9AM	NS Bolus	160ml over 2 hours	IV	[Signature]	(N) [Signature] S. [Signature]

Weight. 16 kg Ward. POW

[illegible]

Signature _____

VERIFIED BY: Name

IV INFUSION MEDICATION CHART (INOTROPES & VASOPRESSORS)

(All the drugs in this category belong to "High Risk / High Alert" medicines. Please watch for tachycardia / bradycardia, hypertension / hypotension any cardiac f skin at IV site and color and perfusion of the fingers and toes while administering these drugs)

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name: Master MICHAEL CLEOPHAS
09-02-2015 11 Y 5 M 13 D (M)
Dr. DR.V.V.R.SATYA PRASAD
Weight : ...

Age : Gender : ☐ Male ☐ Female

Sheet No. :

Date	Time	Name of Drugs	Composition	Dose Range	Dr's Sign.	Nurse Sign.	Stop Date	Dr's Sign.	Nurse Sign.
21/07	6:00p	Adrenaline	4.8ml + 50ml NS	1-5ml/hour = 0.1-0.5mcg/kg/min	Wt	Abhishek			

CALCULATIONS FOR SOME COMMONLY USED DRUGS :

Dopamine : Wt. x 30 mg in 50ml of 5% Dextrose ; 0.5 - 1ml/hr - 5-10mcg/kg/min
Dobutamine : Wt X 30mg in 50ml of 5 Percent Dextrose 0.5-1ml/hr; 5-10 mcg/kg/min
Epinephrine : Wt. x 0.3mg in 50ml of 5% Dextrose ; 0.1-0.5mcg/kg/min - 1-5ml/hr
Nor-epinephrine : Wt. x 0.3mg in 50ml of 5% Dextrose ; 1-5ml.hr - 0.1-0.5mcg/kg/min

Milrinone : Wt. X 1.5mg in 50ml of 5% Dextrose ; 1ml/hr - 1.5ml/hr - 0.5-0.75mcg/kg/min
Sodium Nitroprusside : 3mg/kg in 50ml D5 ; 0.5ml/hr - 4ml/hr (0.5-4mcg/kg/hr)
Nitroglycerine : 3ml/kg in 50ml D5 ; 0.5ml/hr - 5ml/hr (0.5-mcg/kg/min)
Labetalol : 0.25 - 3mg/kg/hr ; (1ml=5mg) ; take 2ml in 18ml NS(1ML-0.5 MG) 0.5- 1.5ml/kg/hr (0.25 - 3mg/kg/hr)

IV INFUSION MEDICATION CHART (SEDATION & PARALYTICS)

(All the drugs in this category belong to "High Risk / High Alert" medicines.

Please write and respiratory depression while administering these drugs)

Patient Name: **Master MICHAEL CLEOPHAS**
IP5-00176726
09-02-2015 11 Y 5 M 13 D (M)
Dr. DR.V.V.R.SATYA PRASAD

Weight :  Age : Gender : ☐ Male ☐ Female
No. : Sheet No. :

Date	Time	Name of Drugs	Composition	Dose Range	Dr's Sign.	Nurse Sign.	Stop Date	Dr's Sign.	Nurse Sign.
24/07/16	6:00pm	Atenolol							
24/07/16	4:20 am	Morphine	16mg in 50ml 5TD	1-3ml/hr 20-60mcg/kg/hr	WV	nr			

CALCULATIONS FOR SOME COMMONLY USED DRUGS :

Fentanyl : 1ml = 50mcg vial, take 4ml in 16 ml NS thus 1ml = 10mcg ; 0.1-0.4 ml/kg/hr (1-4mcg/kg/hr)
NOTE : In older children more than 20kg weight, take 8ml in 12ml of NS thus 1ml=20 mcg;0.2-0.8ml/kg/hr (1-4 mcg/kg/hr)
Midazolam : (Undiluted) 1ml = 1mg ; 0.1-0.5 ml/kg/hr (1.6-8 mcg/kg/min)
Ketamine : Weight x 30 mg/kg in 50ml NS ; 1-4ml/hr (10-40mcg/kg/min)
Dexmedetomidine : 1ml (100mcg) in 24 ml NS ; 1ml = 4mcg ;0.05 -0.2 ml/kg/hr (0.2 - 0.7 mcg/kg/hr)

Docu.No: RCHBH /FRM / CLINICAL / 154

Morphine : Weight x 1 mg/kg in 50ml 5% Dextrose 1-3 ml/hr - 20-60 mcg/kg/hr
Propofol : 1ml = 10mg ; 0.1-0.4 ml/kg/hr (1-4mg/kg/hr)
Vecuronium Powder : 4mg, diluted with 4ml NS (1ml-1mg), take 2ml in 8ml NS (1ml-0.2mg)
0.25 ml/kg/hr - 1.3 ml/kg/hr (0.05-0.15mg/kg/hr)
Pancuronium : (1ml -2mg) take 1ml in 9ml NS(1ml-0.2mg) 0.1ml/kg/hr-0.3ml/kg/hr (0.02-0.06mg/kg/hr)

BCH-00015267 IP5-00176726
Master MICHAEL CLEOPHAS
09-02-2015 11 Y 5 M 12 D (M)
Dr. DR.V.V.R.SATYA PRASAD

II.. ERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Language: Urdu

Patient / Learner Literacy: ☐ Read ☒ Write ☐ Speak

Willingness to Learn: ☒ Yes ☐ No

Healthcare Literacy: ☒ Yes ☐ No

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
21/7	3pm	♀	Infection Control/ measles	M	1	0	1	1	-NA	-Abha
22/7/26	8am	♀	Child is on NPO	M	1	0	1	1	-	Flourica

Part - III: CODES

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



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
20/7/26	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	11/40 Chronic systemic venous thrombosis	Hemodynamic stability	IV medication	[Signature]	☐ Nursing ☐ Others:
20/7/26 3pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	11/40 Chronic systemic venous thrombosis	H-Stability	IV medication	[Signature]	☒ Medical ☐ Others:
22/7/26 8am	☐ Medical ☐ Nursing ☒ Others: Dietician	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Breathing difficulty Ch. systemic venous thrombosis	Child is on NPO	NPO till further advice	[Signature]	☐ 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:

NURSING INITIAL ASSESSMENT FOR PICU

Date of Admission: 21/7/26 @ 6:40pm

Source of Admission: ☒ OPD ☐ Ward ☐ Other:

Reason for Admission: clo. Fast Breathing x 3 days.

Admission Diagnosis:

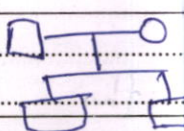
Accompanied By: ☒ Parent ☐ Guardian ☐ Other Name:

Primary Language: ☒ Telugu ☐ English ☐ Hindi ☐ Other Specify

Do you require an interpreter? ☐ Yes ☒ No

Allergies: ☐ Yes ☐ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:

If yes, identify

Source of Information : ☒ Family ☐ Patient ☐ Others, Specify			
SIGNIFICANT HISTORY	Past Medical History	Past Surgical History	Last Hospital Admission
	chronic systemic venous thrombosis	Tenckhoff catheter placement left pleural space	20/1/26 Rainbow hospital.
	Family History: 		
	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 MEDICATIONS	Taking Medications? ☒ Yes ☐ No If yes, Fill the reconciliation form Medicine brought to the hospital? ☒ Yes ☐ No		
Observations: Weight: 15 kgs Length: Head Circumference (< 2 years): Temp.: 99.1°F HR: 109b/m RR: 29b/m BP: 56/38 (42) Pain Score: 0/10 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 19.) (Document in the Braden Q Assessment Sheet)			



Behavioural Status on Admission :

☐ Sleeping ☐ Crying ☐ Calm ☒ Distressed/Console ☐ Drowsy

FUNCTIONAL SCREENING: If a patient needs assistance with any of the following inform consultant

☐ Mobility problem ☐ Walking Problem ☐ No Abnormality Detected
☐ Developmental Delay ☒ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

☒ 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):

Social History: Lives With

Siblings in household ☒ Yes ☐ No (if yes How Many?)

Orientation has been given regarding the following aspects:

☒ ID Band in situ
☒ Bedside safety explained
☒ PICU Routine: Doctor's rounds/Medication time
☒ Visiting policy explained

Orientation given to: ☒ Family ☐ Others specify

Name of Person Orientation was given to:

Orientation not given Reason:

Nurse Name: Navaneetha

Nurse Signature: [Signature]

Date & Time: 21/7/26

DISCHARGE PLAN

Source of Information: ☒ Family ☐ Friend

Will patient require transportation arrangements to go home: ☒ Yes ☐ No

Will Physiotherapy require at home: ☐ Yes ☒ No

Is home medical equipment anticipated: ☒ Yes ☐ No

Is home oxygen therapy anticipated: ☐ Yes ☒ No

Are dressing needs at home anticipated: ☒ Yes ☐ No

Any other needs anticipated: ☐ Yes ☒ No If Yes Specify

Discharge Medications: ☐ Yes ☐ No

Details:

Final Diagnosis:

Nurse Name: Navaneetha

Nurse Signature: [Signature]

Date & Time: 21/7/26 @ 6:10pm

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA : 21/7/26		Diagnosis : Chronic Thrombocytopenia		Surgery / Procedures :		
	Allergies :				Post OP Day :		
	Date :	21/7/26	22/7/26				
	Area	PICU	PICU				
	Shift Time	Night	DAY				
INVASIVE LINES	Diet :	NPO					
	Ventilation (RA, NP, NIV, VENTI)	Venti-(VC)					
	1.	Cannula					
	2.	②					
	3.	Catheter					
	4.	RA-O					
	ASSESSMENT	Infusions / Transfusions	⇒ DMS + NaCl ⇒ 3% NaCl ⇒ morphine ⇒ Adrenaline				
		PU Prophylaxis	NA				
		DVT Prophylaxis					
		Vitals	BP	40/28			
			PR	110			
			RR	30			
			SpO ₂	76%			
			Temp	48.3° F			
		Pain Score	5/10				
LOC (Alert, Conscious, Confusion, Unconscious)		Unconscious					
Skin Integrity (Intact / Bedsores / Any other condition)		Intact					
Restraints If any		Physical					
		Chemical	morphine				
Fall Risk (Vulnerable (Y/N) if yes score)		Yes					
(Ambulation, walking, moving with assistance, bed ridden)		moving					
ADL (Dependent / Non-Dependent)	Dependent						
Critical Lab Test / Values (if any)	NA						

RECOMMENDATIONS	Investigations Procedures	Date :	21/7/26	22/7/26					
		Area							
		Shift Time	PIU NIGHT	PIU DAY					
		Ordered / Planned	Followed doctor's order	Followed doctor's order					
		Due	No Due	NO due.					
		Reports Pending	No reports pending	NO report pending					
Referrals (If any)	No referral	NO referral							
	Remarks (Special Interventions like, Drainage Tube flushing etc.)	No remarks.	NO remark N/A						
Handed Over By Name :		Mahesh	Tamal						
Signature :		(Signature)	(Signature)						
Date :		22/7/26	22/7						
Time :		8pm	8pm						
Taken Over By Name :		Tamal							
Signature :		(Signature)							
Date :		22/7							
Time :		8am							

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 21/7/20

Assessment: Chronic decreased level of O2 sat & hypotension

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
9am	Assess the condition	10pm	Assess general condition	All plans are implemented
12am	Checked vital of pt	1pm	checked vitals of pt	
2pm	Administer medication as per order	3pm	Administered medication as per order	
4am	w/k status	5pm	w/k status	
7am	to intubate	7:30am	Assisted in intubation	

Re-Assessment: Done

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Matthew T. J.

Date & Time: 22/07/20 1pm

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 22/07/26

Assessment:

Baby on ventilator.

- 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	- Monitor vitals	9am	- Monitored vitals,	All plan implemented
9am	- Maintain I/O chart.	10am	- Maintained I/O charts,	
10am	- Administer medication as per doctor order.	11am	- Administered medication as per doctor order.	
1pm	- Baby NPO,	3pm	- Continue NPO	

Re-Assessment:

Special Notes:

14-ICD

Nurse Signature:

Nurse Name:

Date & Time:

22/07/26 @ 8pm



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
21/7	4pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	- NA -	Abhishek
22/7	12AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Hester
22/7	7AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sho
22/7	10 AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Continue sedation	(m)
22/7	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Continue sedation	(m)
				☐ 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:

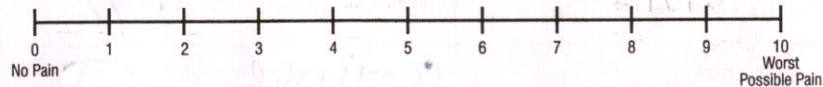
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

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





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					
2	One of the following signs is evident: * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		-	-	-	-					
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		-	-	-	-					
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		-	-	-	-					
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		-	-	-	-					
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		-	-	-	-					
Signature of the Nurse													

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

Signature of Shift In Charge

Signature : Name :

Signature of Ward In Charge :

Signature : Name :



THE HUMPTY DUMPTY SCALE 21/2 22/2

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2			
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3	3	3			
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	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			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1			
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
TOTAL			12	12			

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓			
Call device within reach		✓	✓			
Wheels Locked		✓	✓			
Room free of clutter		✓	✓			
Adequate Lighting		✓	✓			
Wheel Chair Support		✓	✓			
Other Intervention(s) Specify		✓	✓			
Nurse's Name :		Abhishek	moten			
Signature :		Abhishek	moten			
Date :		21/2	24/2			
Time :		4 PM	6 AM			

BRADEN 'Q' SCALE

					Date :	21/7	22/7		
					Time :	4pm	5pm		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		2	2		
"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		
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.		3	3		
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.		3	3		
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."		3	3		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		3	3		
					TOTAL SCORE	19	19		
					Evaluator's Name	Dr. V.V.R. Satya Prasad			

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



BED SIDE CHECK LIST FOR NURSES

Date:	21/7/20	22/7/20							
Doctor's Orders	Followed	Followed							
Carried out or not	Carried out	Carried out							
Bed Side									
Structured Handover done	Yes	Yes							
IV Site	Yes	Yes							
Central Lines	NO	NO							
Arterial Lines	NO	NO							
Feeding Catheter	NO	NO							
Urinary Catheter	NO	NO							
Skin Care	Given	Given							
Eye Care	Given	Given							
Mouth Care	Given	Given							
Sterillum Bottle, Stethoscope	Bed side	Bed side							
Suction Bottle (Should be clean & empty)	clean	clean							
Intubation Tray	NO	NO							
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	Yes	Yes							
Ventilator Tubing, (Any Water, Blood)	NA	NA							
Humidification	NA	NA							
Check all Infusion (Labelling, Correct Preparation)	checked	checked							
Chest Physio & Neb	NA	NA							
Handed Over By Name :	Manan	Matthew							

Checked & Handover given by

Name of the Nurse : Manan

Signature : [Signature]

Date & Time : 21/7/20 @ 8pm

Doc. No. : RCHBH/FRM/GENERAL /088

Checked & Handover taken by

Name of the Nurse : Matthew

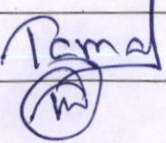
Signature : [Signature]

Date & Time : 21/7/20 @ 8pm

URINARY CATHETER BUNDLE CHECK LIST

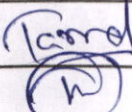
Date of Insertion: 22/07/26

Date of Removal:

Parameters	Date	Shift Time						
Need for the Catheter	<u>22/07/26</u>	<u>Day</u>	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse			<u>Ramal</u>					
Signature of the Nurse								

VENTILATOR CARE BUNDLE CHECK LIST

Date of Intubation: 22/06/26 No of Days on Ventilation: Date of Tracheostomy:

Parameters	Date	Shift Time						
Ready for Extubation today? (Discuss during the clinical round)	22/06/26	Day	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Sedation holiday discussed? (Discuss during the clinical round)			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Ventilator Circuit visibly soiled? (If Yes - Please Change)			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Suction container visibly Soiled? (If Yes - Please Change)			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Inline Suction Used?			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is AMBU bag soiled? (If Yes - Please Change)			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check AMBU bag kept in a clean, Non-Sealed plastic bag? (If No - please change)			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there condensate in the ventilatory circuit? (If Yes - drain away from the patient)			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Head End elevated by 15°-30° (for neonates 10°-15°)? (If No - please change)			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Oral and Nasal Care every 4 Hrs			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Mouth Care with EBM (Only for Neonatal Patient)			☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA
Is ET / Oral Suction needed (2nd hrly)			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sterile Suctioning Done			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DVT Prophylaxis			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse			Laxmi					
Signature of the Nurse								

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Docu. No. : RCHBH /FRM / CLINICAL / 013

**పిల్లల ఇంటర్నల్ కేర్ యూనిట్ లో
అడ్మిషన్ కొరకు సమ్మతి**

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

 **BirthRight[™]**
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

రోగి పేరు వయస్సు లింగం ☐ పు ☐ స్త్రీ

యు.పా.బి.డి s/o. d/o. w/o.

నేను అనే బాలుడు / బాలిక యొక్క చికిత్స మేరకు రెయిన్ బోవ్ పిల్లల అనువత్తి లోని పిల్లల ఇంటర్నల్ కేర్ యూనిట్

వేటి నాడు పూర్తి సమ్మతితో చేర్చితిని.

మా బాలుడి / బాలిక లో ఈ కింద తెలిపిన ఆరోగ్య సమస్యల గురించి విద్య నిపుణుడు నాకు అర్థమగు భాషలో వివరించితిరి.

రెయిన్ బోవ్ బిల్డ్ హాస్పిటల్ లోని పీడియాట్రిక్ ఇంటర్నల్ కేర్ విభాగం లో చేరింది జిడ్డుకు ఆరోగ్య సంబంధిత సమస్యలు ఉన్నాయని వైద్యులు నాకు అర్థమయ్యే భాషలో వివరించారు. రోగి పీడియాట్రిక్ ఇంటర్నల్ కేర్ విభాగం లో ఉన్న సమయంలో అతను వివిధ వైద్య మరియు శస్త్ర చికిత్సలకు లోనవుతారని వైద్యులు నాకు స్పష్టంగా వివరించారు. ఎయిర్ వే మేనేజ్ మెంట్, మెకానికల్ వెంటిలేషన్, బొడ్డు ధమని కాథెటర్, బొడ్డు సిర మరియు ధమనుల కాథెటర్ వంటివి. పెరిపెరల్ ఇన్ఫర్షన్ చేయబడిన సెంట్రల్ కాథెటర్ లైన్ మరియు ఆర్థో లైన్ ప్లేస్ మెంట్, ఛాతీ ట్రెయిన్ లేదా పెరిటోనియల్ డ్రైయిన్ ఇన్ఫర్షన్ మొదలైనవి.

అటువంటి ప్రక్రియలు చేస్తున్నప్పుడు నాకు సమాచారం ఇవ్వబడుతుందని మరియు దీనికి ప్రత్యేక సమ్మతి ఉంటుందని వైద్యులు నాకు చెప్పారు. ఏదేమైనప్పటికీ, ఏదైనా ప్రాణాంతక అత్యవసర పరిస్థితుల్లో సమాచారం తీసుకోవడానికి సమయం లేకపోతే నా జిడ్డు ప్రాణాన్ని కాపాడేందుకు ఇతర వైద్య ప్రక్రియలకు నేను సమ్మతి ఇస్తున్నాను.

పీడియాట్రిక్ ఇంటర్నల్ కేర్ విభాగం లో అనారోగ్యంతో ఉన్న పిల్లవాడికి ప్రాణాంతకమైన వైద్య పరిస్థితులు ఉన్నాయని అర్థం చేసుకోవడమైనది.

ఒక జిడ్డు అనారోగ్యంతో పీడియాట్రిక్ ఇంటర్నల్ కేర్ విభాగం లో ఉన్నప్పుడు అతని/ఆమెపై నిర్వహించబడు అనేక వైద్య మరియు శస్త్రచికిత్సా విధానాలతో ఈ అధిక ప్రమాదకరమైన విధానాల వల్ల సంభవించు నష్టాలు మరియు అధిక ప్రమాదకరమైన మందుల రూపంలో అంటువ్యాధులు, రక్తస్రావం, శ్వాసపరమైన, చర్మం మరియు ఇతర కణజాల నష్టం మొదలైనవి కలగవచ్చు డాక్టర్లు నాకు బాగా అర్థమయ్యే భాషలో వివరించారు.

మా బాలుడు / బాలిక ను ఇంటర్నల్ కేర్ యూనిట్ (పి.బి.సి.యు) లో చేర్చుకొని అవసరమయ్యే వైద్యం చేయుటకు నేను వైద్య బృందానికి నా సమ్మతి ద్వారానున్నాను.

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకము

పేరు

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

తేదీ మరియు సమయము

సంతకము

పేరు

BCH-00015267 IP5-00176726
Master MICHAEL CLEOPHAS
09-02-2015 11 Y 5 M 13 D (M)
Dr. DR.V.V.R.SATYA PRASAD



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CONSENT FOR SPECIAL PROCEDURES

Patient Name : Michael Cleophas Gender: ☒ Male ☐ Female

UHID No : BCH-095267 Department : PW Date : 21/07/20

I Rajkumar S/D/W/O

Here by give consent for procedure of : Needle punctures

for my patient, Named : Michael Cleophas

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

- Risk - Bleeding
- Infection - Pneumothorax
- Trunk tapping

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

- Nil -

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

Name of the Doctor performing the procedure: Dr. Harish Jayaram

Patient Attendant :

Signature : [Signature]

Name : Rajkumar

Relationship with Patient: Father

Date & Time : 21/7/20 @ 5:30 PM

Witness :

Signature : [Signature]

Name : Naraneetha

Date & Time : 21/7/20 @ 5:30 PM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Chand

Date & Time : 21/7/20 @ 5:30 PM

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

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

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

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు (అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

BCH-00015267 IP5-00176726
Master MICHAEL CLEOPHAS
09-02-2015 11 Y 5 M 12 D (M)
Dr. DR.V.V.R.SATYA PRASAD



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CONSENT FOR SPECIAL PROCEDURES

Patient Name : Michael Cleophas Gender: ☒ Male ☐ Female

UHID No : Department : PICU Date : 22/7/20

I S/D/W/O

Here by give consent for procedure of : Endotracheal intubation

For my patient, Named :

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

Bradycardia, Cardiac arrest, Hypotension.

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

NIV

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

Name of the Doctor performing the procedure: Dr. Venkati

Patient Attendant :

Signature : [Signature]

Name : JASMINIE

Relationship with Patient: Mother

Date & Time : 22/7/20 3:30a

Witness :

Signature : Mathew

Name : Mathew

Date & Time : 22/7 @ 3:35am

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Sathy

Date & Time : 22/7/20 3:30am

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

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

.....

.....

.....

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

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: ER Date of Admission: 21/7/26

SITUATION	Diagnosis: <u>k/clo systemic venous thrombosis</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	Area	Shift Time	<u>ER</u> <u>4:35pm</u>					
BACKGROUND	Medical Condition (Any special condition to be noted):		<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</u>					
		Res:	<u>29b/m</u>					
		SpO ₂ :	<u>88%</u>					
		Pulse:	<u>96b/m</u>					
		BP:	<u>87/52</u>					
		Fall Risk Score:	<u>12</u>					
Pain Score:		<u>0/10</u>						
Recommendations	Safety Needs:		<u>Yes</u>					
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:		<u>NA</u>					
	Special Diet:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:		<u>NA</u>					
Post Operative Procedure Special Orders:		<u>NA</u>						
Handed Over By Name :		<u>Abhishek</u>						
Signature :		<u>Abhishek</u>						
Date:		<u>21/7/26</u>						
Time:		<u>4:35pm</u>						
Taken Over By Name :		<u>Shanmugam</u>						
Signature :		<u>Shanmugam</u>						
Date:		<u>21/7/26</u>						
Time:		<u>4:40pm</u>						

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

PATIENT TRANSFER FORM

BCH-00015267
Master MICHAEL CLEOPHAS
09-02-2015 11 Y 5 M 12 D (M)
Dr. DR.V.V.R.SATYA PRASAD
IP5-00176726

D No.		Date & Time of Admission 21/7/26 at	Date & Time of Transfer Order 21/7/26 at 4:37pm
Treating Consultant Name		Transfer Ordered by Dr. Ramya	Reason for Transfer Admission
From Unit ER	To Unit PICU	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 25	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If Yes, what?	Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films Nil			

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Op Folw	1
2.	DNS	1
3.	Inhaler	1
4.	Soc	1
5.	High pressure	1

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☒ NRM 1

Name & Signature of Person who is Transferring Mr. Abhishek	Name of Person Ordered Transfer Dr. Ramya
--	--

Patient & Clinical Records Received by :

Abhaneetha

Date & Time of Patient Received : 4:50 pm 21/7/26

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