

ACTIVITY RECORD FOR BILLING

Name : _____
UHID No. : _____
Date of Admission : _____
Room / Bed No : _____ Ward : _____
Suggested Billable bed type : _____



Consultant: _____ Dept : _____

Date of Discharge : _____ Time: _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
18/12/26	12:50 pm	ER	ward	pooje

Cross Consultation Visit

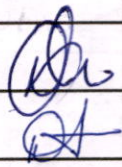
	Doctors Name	Date	Order No.	Signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
19/2 2014	24 placement done on op basis underflow PHA.	① 1	9711336 95031	

ANY OTHER INFORMATION

EXR-1

Date : 21/7/26

Time :

10:30 a

Prepared By :

Am

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Amr	Geo-11 (1440)		

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176563 Admit Date : 18-Jul-2026 Admit Time : 12:47 PM UHID : BAH-00653649

Patient Details :

Patient Name	: Master THAMBALA ETHAN STEVENSON	Age	: 0 Y 8 M 18 D
Guardian	: Mr THAMBALA MANOJ	DOB	: 30-10-2025 08:03 PM
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: FLAT NO 444, MH1, RAJHIV GANDHI NAGAR Karkhana Secunderabad Telangana INDIA 500009	Phone No	: 9182449021/ 8686717617
		E-mail	: T.MANOJSTEVE@GMAIL.COM

Admission Details :

Bed Type : GENERAL WARD Bed No : GW144(C) Ward Name : 1F-GENERAL WARD II
Room No : GW144(C) Admission Type : First Visit

Contact Details :

Name : Mr THAMBALA MANOJ Relationship : Father
Contact Address : FLAT NO 444, MH1, RAJHIV GANDHI NAGAR Phone No : 9182449021
Karkhana Secunderabad Telangana INDIA
500009

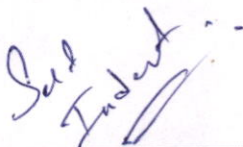

Signature

Doctor Details :

Doctor Name	: Dr. Prashant Bachina	Specialisation	: PEDIATRIC GASTROENTEROLOGY AND HEPATOLOGY
Referral Doctor	: Self	Phone No	:
Co-Consultant	: Dr. M N V POUSHYA SAI		

Payment Details :

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



144-C

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	5			
7	Nursing plan of care and handover sheets	3			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation	1+1			
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	3			
30	Intake and Out take chart (fluid chart)	2			
31	Drug chart (Regular Prescription)	2			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
		4			
	Total No. of Pages	33			

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-00653649 IP5-00176563



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Ethan Stevenson

UHID ID:

BAH-00653649 IP5-00176563
Master THAMBALA ETHAN
30-10-2026 0 Y 8 M 18 D (M)
Dr. Prashant Sachina

Department:



Consultant:



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Dehydration, sepsis

Desired goals of the treatment:

Hemodynamic stability

Planned Labs:

CSE / stool culture
sent

Planned Management

1x IV fluids
2x cyclical feeds as
advised
3x Economy / PM 44 /
Zinc drops

4x monitor stool / freq

Signature of the Doctor:

[Signature]

Name of the Doctor:

Prashant

Date & Time:

18/10/25 / 1:30 pm

Signature of the Consultant:

[Signature]

Name of the Consultant:

Dr. Prashant Bachina

Date & Time:

18/10/25
4:12

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/07/26 1 PM	C/S/B - Gastro team	
	No sign of dehydration	Plan [Target - 120ml/kg/day 1x cyclical feeds - 5ml/hr + Neo care
		↓ to look for loose stools - consistency & frequent
		↓ if no loose stools - to increase 2ml/every cycle
		2x IV fluids - 30ml/hr - DNE
		3x S. & Electrolyte - in next prick / or persistent stool
		4x Pro GG / Econorm / Zinc drops
		5x Trace CSE / stool culture
		6x Racecadolol sachet (200) - if large volume stools.
18/07/26 7 PM	Seen by Resident / Discussed - Gastro team. Dr. Kurl	
	1. NPO for 6 hrs.	
	40 5 ep of large vol. watery stools in 3 hrs.	P.T.O

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/07/26 7:30 PM	O/E child alert, seems dull. 1. NPO for 6 hrs,	followed by, 2. if no loose stools, to start cyclical fluids @ 2ml/hr [3hr on 1hr off] 3. continue IV fluids @ 100% 120°/l. To increase 1ml alternate cycle if no loose stools. 4. check diaper wt. if >10ml/kg [>70 ml]-80ml consider loose. 5. Add PIPTAZ. to inform METRONIDAZOLE RACECADOTRIL 6. monitor vitals Send electrolytes RP2] now. Ca, Mg
19/7/26 2 AM	Seen by Resident Discussed - Gastro team. 3 ep. of loose stools.	Adv 1. stop cyclical feed. 2. NPO Till 6 AM, 3. Restart cyclical feed at 2ml/hr at 6 AM Dr. Kurnaf



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		4. monitor vitals
		5. Monitor G chart
		diaper wt. inform if > 70mg
19/07/26 10:30 AM	c/c/B - Galbro Team (Dr. Prashant B) & Saluthi. <u>Acute Enterocolitis</u>	<u>Plan</u> 1x Allow semisolid. (Neutrumne/
	Issue:- 1x ongoing loose stool	2x Feed - Novolac to get
	2x low bicarbonate	3x High chloride.
	Stool - ~ 14 times/day, last 7.	3x IVF - 120 ml MP 1/2 DNS +
	Stool watery, on NPO.	35ml H ₂ O ₃
	Urine - adequate	
	activity - Good.	
	oral intake - Asking for food	4x Continue drugs as per chart
	O/E - On Room air.	5x To replace stool losses -
	Hemodynamically	if diaper weight > 70gms
	stable.	& sum of RL.
	Chest - clear.	
	P/A - soft	6x To start TPN,
		PICCLINE
	No dehydration signs.	7x Recheck wt. - 7.4 Kg
	DR. PRASHANT BACHINA Registration No: 11818	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10:30 AM	Refresh order's. C/SB - Dr. Prashant	
		1x Total for Plan.
		1x PICC line in PICU (informed)
		2x NPO for 4hr. + IV fluids as advised.
	Post PICC line placement	3x To start TPN - olivindomel NG 550E.
	Total volume	100% maintenance -
	150% maintan	+ 50% maintenance - at IV fluids
		1/2 DNS + 35m H ₂ O ₃ .
		4x To procure - formula Novaloc - RICAR.
		5x Electrolyte, Ca, Mg, P - 12 hourly
		6x To Replace stoolbooster - 30ml/kg/day (50% replacement if stool output < 60ml/kg/day.
	8x To take Phosphate in morning sample.	7x monitor vitals.

Dr. Kunal
(P.T.O)

Date & Time	Progress Notes	Doctor's Order
		6hly after starting TPN
		9x . RP ₂ , Phosphorus - not help. Magnesium, Ca .
		10x if passing more than . 3 watery stools , to . replace $\bar{c}$ stool / stool $\bar{c}$. RL - if diaper weight $\times 10$ gm .
		11x TPN electrolyte , RP ₂ , Ca , Mg , P - T/m morning 8 AM .

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/07/26 10AM	C/S/B - Dr. Prashant B.	
	<u>Enterocolitis</u>	<u>Plan</u>
	No fever.	1x Drugs as per chart
	Stool - Septic - only 1 stool since 6PM.	2x Feeds - allow - see exact porridge.
	Urine output - adequate	+
	Oral acceptance - accepting see porridge.	↑ TPN @ 120ml/kg/day
	Activity - Good.	cyclical feeds - 1ml/hr - 3hr of 4ml/hr
	O/E - on Room air.	+
	Hemodynamically stable.	IV fluids - 20% maintenance.
	Chest - clear	
	P/A - soft.	3x monitor vitals, stool output
	No dehydration signs.	4x R _{P2} , C _A , M _E , P,
7.85kg	DR. PRASHANT BACHINA Registration No: 11816	7/11 morning 4 AM. Extr Dr. Kish

BAH-00653649 IPS-00176563
 Master THAMBALA ETHAN
 30-10-2025 0 Y 8 M 19 D (M)
 Dr. Prashant Sachina



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/04/26 4pm	<u>Enterocolike</u>	<u>Plan</u>
	No/weak stool :: 9am	1x Drug as per chart -
	o/e - Hemodynamically stable.	2x IV fluids & TPN as advised.
	No dehydration	
	c/o - child is mildly cranky	3x R _{P2} , Ca, Mg P T/m 4am.
		↓
		To correct if required.
Refer	Refer	(Signature)

BAH-00653649 IP5-00176563
 Master THAMBALA ETHAN
 30-10-2025 0 Y 8 M 19 D (M)
 Dr. Prashant Bachina



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/07/25 10 AM	C/S/B - Gastro team	
	Enterocolitis & some dehydration	
	No fever	Plan
	Stool - 1 stool - last 2 hrs 9 AM	1x continue TPN
	Activity - Good.	@ 120 ml/kg/day
	U/O - adequate	+
	Hemodynamic stable	Allow Rice + carrot porridge
	No dehydration	+
	Next meal rice - ~ 10 spoons	OK (OK) if necessary
	OK ~ 100 ml	
	taken	2x cyclical feeds
		Neocate
		1ml/kg - 3hr on
		1hr off
		to increase 1ml/kg every 24hrs
		cycle if no diarrhea
		3x Plan (D)
	DR. PRASHANT BACHINA Registration No: 11816	4x R. collect -
		extra EDTA sample for genetics



144C

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/10/25 8am	<u>NUTRITION REVIEW</u>	
	PBW: 7.3kgs (>5 th centile) REE: 390.57 kcal/d Fluids: 730ml/d	STOOL PASSED = 1 Bristol = 5,6 Hb: 11.1, WBC: 12880, PH: 7.3 Na: 134, K: 3.5, Cl: 106 U: 14, Cr: 0.2
TPN:	Oliclinomel N4 550E (Baxter) with lipid with 750mosml/L Current Rate of flow = 37ml/hr Recall volume = 867ml/day	Bag checked 1000 ml Bag
	<u>MACROS (RECALL)</u>	
	Oliclinomel N4	Recall volume 867ml/d
	Cal: 610	528.87
	Prot: 22	19
	Carbs: 80	69.36
	fat: 20	17.34
	Na: 211	18.2
	K: 16	13.8
	Ca: 2	1.73
	Mg: 2.2	1.9
	ph: 8.5	7.36
	Cl: 33	28.6
		Per kg/d
		72.4
		2.6
		9.5
		2.37 (RDA)
		2.49 (2-5)
		1.89 (2-4)
		0.23 (1-2)
		0.26 (0.25-0.5)
		1 (0.5-1)
		3.9 (2-6)
		Current Rate of flow = 37ml/hr
		Nickel Dietitian

BAH-00653649 IP5-00176563
Master THAMBALA ETHAN (M)
30-10-2025 0 Y 8 M 20 D
Dr. Prashant Bachina



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00653649 IP5-00176563
Master THAMBALA ETHAN
30-10-2025 0 Y 8 M 18 D (M)
Dr. Prashant Sachina



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

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

RESULT SHEET

Date	15/7/26	17/7/26	18/07/26	20/7/26	20/07/26	21/7/26
Time		4 PM		12 PM	8 AM	
Hb	10.5	11.1				
PCV		32				
RBC		4.7				
WBC	14450	12880				
N/L	26/55	25/70				
Platelets	5.7L	5.3L				
CRP	34	14				
ESR						
PCT						
RBS						
Na			144	142	137	134
K			4.5	4	3.7	3.5
Cl			119	111	110	106
Ca/Mg			10.2/2	9.7/2.1	9.6/2	9.3/2
Phosphate				4.9	4.5	4.8
Urea			8	12	13	13
Creatinine			0.3	0.3	0.3	0.2
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						
WBC	1103		11 ↓	17	17	23

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
	18/7/26.					
Stool Pus Cell	60-70					
OVA / Cyst	⊖					
Occult Blood	RBC 1-2					
	yeast cells 3+					
	fat globules +					

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From: ER

Shifted to: ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Sachina

Date & Time: 18/12/25 1:20 pm

Nurse Name & Signature: Dr. Sachina

Date & Time: 18/12/25 1:30 pm



DRUG CHART

Date of Admission: 18/12/26 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 : Colic aid drop				Date Time															
Dose 0.5ml	Route PO	Frequency SOS CTD	Start Date																
Doctor's Signature <i>[Signature]</i>		Valid Period	Pharm.																
Additional Instructions: if no excretion																			

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. 7-3 kg Ward.

VERIFIED

VERIFIED

VERIFIED

Page: 2/4

BAH-00653649
Master THAMBALA ETHAN
30-10-2025 0 Y 8 M 19 D (M)
Dr. Prashant Bachina



She

REGULAR PRESCRIPTIONS

Weight 7.3 kg Ward

DRUG : <u>3ij PIPERACILLIN TAZOBACTAM</u>				Date	Time
Dose	Route	Frequency	Start Dt.		
<u>700mg</u>	<u>IV</u>	<u>TID</u>	<u>18/7</u>	<u>6AM</u>	<u>X</u>
Name & Signature of the Doctor Starting the Drugs:					
<u>Saluntri</u>					
Additional Instructions:					
<u>@ 100 mg/kg/dose</u>					
Daily Doctor's Endorsement by a Sign					

DRUG : <u>3ij METRONIDAZOLE</u>				Date	Time
Dose	Route	Frequency	Start Dt.		
<u>55mg</u>	<u>IV</u>	<u>TID</u>	<u>18/7</u>	<u>6AM</u>	<u>X</u>
Name & Signature of the Doctor Starting the Drugs:					
<u>Saluntri</u>					
Additional Instructions:					
<u>@ 7.5 mg/kg/dose</u>					
Daily Doctor's Endorsement by a Sign					

DRUG : <u>1ij Pantoprazole</u>				Date	Time
Dose	Route	Frequency	Start Dt.		
<u>70mg</u>	<u>IV</u>	<u>OD</u>	<u>18/7</u>	<u>6AM</u>	<u>X</u>
Name & Signature of the Doctor Starting the Drugs:					
<u>Dr. Kunal</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

DRUG : <u>1 sachet RACECADOTRIL SALT</u>				Date	Time
Dose	Route	Frequency	Start Dt.		
<u>1 sachet</u>	<u>PO</u>	<u>TID</u>	<u>19/07</u>	<u>6AM</u>	<u>X</u>
Name & Signature of the Doctor Starting the Drugs:					
<u>Dr. Kunal</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					



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																				

Nurse Sig.

Nurse Sig.

Nurse Sig.

Nurse Sig.

VARIABLE DOSE

Date►
Time

Nurse Sig.

Nurse Sig.

Nurse Sig

Nurse Sig

STAT / ONCE ONLY DRUGSAq



I.V. FLUIDS CHART

Weight. 7.3 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
18/7/25	12:10 pm	DNS (100% maintenance)	IV	30ml/hr (60% maintenance)	Dr. Prashant Sachina	Chavani	19/07	Dr. Prashant Sachina	Chavani
19/07/25	12:00 pm	DNS (120% MF)		33ml/hr 35 ml/hr	Dr. Prashant Sachina	Chavani	19/07	Dr. Prashant Sachina	Chavani
19/07/25	10 AM	1/2 DNS + 35ml H ₂ O ₃ (120% MF)	IV	35ml/hr	Dr. Prashant Sachina	Chavani	19/07	Dr. Prashant Sachina	Chavani
19/07	6 pm	1/2 DNS + 35ml H ₂ O ₃ (after starting TPN)	IV	15ml/hr	Dr. Prashant Sachina	Chavani	20/07	Dr. Prashant Sachina	Chavani
19/07	6 pm	OLICLINOMEL N430E	IV (PILL line)	30ml/hr	Dr. Prashant Sachina	Chavani	20/07	Dr. Prashant Sachina	Chavani
20/07	10 AM	OLICLINOMEL N430E	IV (PILL line)	30ml/hr	Dr. Prashant Sachina	Chavani	20/07	Dr. Prashant Sachina	Chavani
20/07	10 A	1/2 DNS + 35ml H ₂ O ₃	IV	7ml/hr	Dr. Prashant Sachina	Chavani	21/07	Dr. Prashant Sachina	Chavani

Signature

VERIFIED BY: Name

BAH-00653649 IP5-00176563

Master THAMBALA ETHAN

30-10-2025

0 Y 8 M 19 D

(M)

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

Dr. Prashant Bachina



INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 20/7 Time:

Doctor/Nurse/Family Concern?

Temperature
(F)

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

Heart Rate (Number)

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

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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

Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

Score 1 : Continue normal observation by staff nurse

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

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

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

Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 19/12	Time: 6:07	10 am	2 pm	6 pm	10 pm	2 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) *	90					
	80					
	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
Note: BP does not score in early warning scoring	90					
	80					
	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
Heart Rate (Number)	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	Resp. Rate (bpm) (Over 1 Minute) *	70				
60						
50						
40						
30						
20						
10						
0						
0						
Resp Rate (Number)		70				
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	Resp Distress	Mod/ Severe				
None / Mild						
Receiving O ₂ (l/min)						
O ₂ Saturations (%)						
Conscious Level						
Normal						
Altered						
GCS *						
0						
0						
TOTAL SCORE Number of shaded boxes	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	Pain Score	70				
60						
50						
40						
30						
20						
10						
0						
0						
Observer's Initials		70				
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					

ACTIONS

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

NB: Scores 3 should be recorded overleaf

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during *serious* childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
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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)

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time:

Doctor/Nurse/Family Concern?

Temperature
(F)

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

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

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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

Conscious Level
Normal Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

Score 1 : Continue normal observation by staff nurse

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

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

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

Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

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A	ASSESSMENT : I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

BAH-00653649 IP5-00176563
Master THAMBALA ETHAN
30-10-2025 0 Y 8 M 19 D (M)
Dr. Prashant Sachina

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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 :

18/7	02:00 pm										0	
	03:00 pm			30 ml	5 ml		✓				0	Asuna
	04:00 pm	DNS		30 ml	5 ml		✓			✓	0	
	05:00 pm			30 ml			✓				0	
	06:00 pm			30 ml	5 ml		✓			✓	0	Asuna
	07:00 pm						✓				0	

Total Intake :

Total Output :

18/7	08:00 pm			35 ml			✓			80 ml	0	
	09:00 pm			35 ml			✓			100 ml	0	(R)
	10:00 pm	DNS	NPO	35 ml							0	
	11:00 pm			35 ml							0	
	12:00 am			35 ml							0	(R)
	01:00 am			35 ml	2 ml		✓			60 ml	0	

Total Intake :

Total Output :

19/7	02:00 am			35 ml							0	
	03:00 am			35 ml							0	(R)
	04:00 am	DNS	NPO	35 ml			✓			100 ml	0	(R)
	05:00 am			35 ml			✓			100 ml	0	
	06:00 am			35 ml							0	(R)
	07:00 am										0	

Total Intake :

Total Output :

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

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

FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
19/07/16	08:00 am	↑	Mouth	I.V	N.G		✓			72ml	0	
	09:00 am										0	
	10:00 am										0	
	11:00 am	35ml								60ml	0	
	12:00 pm	35ml									0	
	01:00 pm	35ml								80ml	0	
Total Intake :						Total Output :						
19/07/16	02:00 pm						✓			50ml	0	
	03:00 pm										0	
	04:00 pm										0	
	05:00 pm										0	
	06:00 pm										0	
	07:00 pm									46ml	0	
Total Intake :						Total Output :						
19/7	08:00 pm	↑					✓			25ml	0	
	09:00 pm										0	
	10:00 pm										0	
	11:00 pm										0	
	12:00 am										0	
	01:00 am										0	
Total Intake :						Total Output :						
20/7	02:00 am										0	
	03:00 am						✓			emotio	0	
	04:00 am										0	
	05:00 am										0	
	06:00 am										0	
	07:00 am						✓			emotio	0	
Total Intake :						Total Output :						
Total 24 hrs. Intake												
Total 24 hrs. Output												

BAH-00653649 IP5-00176563
Master THAMBALA ETHAN
30-10-2025 0 Y 8 M 19 D (M)
Dr. Prashant Sachina



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			
20/10	08:00 am	↑		30+15ml		/					0	J. Shaiy	
	09:00 am	TPN	420	30+15ml					✓	0			
	10:00 am	DNS		30+15ml		✓				0			
	11:00 am	Puls		3+17ml						0			
	12:00 pm	HCO3		3+17ml					✓	0			
	01:00 pm	↓		3+17ml						0			
Total Intake :						Total Output :							
20/10	02:00 pm	↑		3+17ml		/				0	J. Shaiy		
	03:00 pm	TPN		3+17ml					✓	0			
	04:00 pm	DNS		3+17ml						0			
	05:00 pm	Puls		3+17ml						0			
	06:00 pm	HCO3		3+17ml					✓	0			
	07:00 pm	↓		3+17ml					✓	0			
Total Intake :						Total Output :							
20/10	08:00 pm	↓		37ml		/				0	Divya		
	09:00 pm	↓		37ml						0			
	10:00 pm	TPN		37ml					✓	0			
	11:00 pm	↓		37ml						0			
	12:00 am	↓		37ml						0			
	01:00 am	↓		37ml					✓	0			
Total Intake :						Total Output :							
21/10	02:00 am	↓		37ml		/				0	Divya		
	03:00 am	↓		37ml						0			
	04:00 am	TPN		37ml					✓	0			
	05:00 am	↓		37ml						0			
	06:00 am	↓		37ml					✓	0			
	07:00 am	↓		37ml					✓	0			
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

BAH-00662135 IP5-00176609
 Baby BOGA KEERTHI
 25-10-2013 12 Y 6 M 24 D (F)
 Dr. Prashant Sachina



FLUID CHART

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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											
	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						

BAH-00653649
Master THAMBALA ETHAN
30-10-2025 0 Y 8 M 18 D (M)
Dr. Prashant Bachina

NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 19/07/26

Assessment: pt having new activity

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
- ☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
8am	* Assess the pt general condition	9am	* Assessed the pt general condition	
10am	* maintain I/O chart	11am	* maintained I/O chart	
1pm	* provide comfortable position	1pm	* provided comfortable position	pt is stable
4pm	* maintain I/O chart	6pm	* maintained I/O chart	
7pm	* administer all medication given as per doctor order	8pm	* administered all medication given as per doctor order	

Re-Assessment:

Special Notes: TPN going in house. GEM connected

Nurse Signature: [Signature]

Nurse Name: shanthi

Date & Time: 19/07/26

BAH-00653649 IP5-00176563
Master THAMBALA ETHAN
30-10-2025 0 Y 8 M 18 D (M)
Dr. Prashant Bachina



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date:

Assessment: Baby having loose stools

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 general condition of the patient.	8pm	* Assessed the general condition of the patient.	By share all the procedure the patient can be stable.
10p	* maintain personal hygiene.	10p	* maintained personal hygiene.	
2am	* maintained IIR fluid.	2am	* maintained IIR fluid.	
4am	* monitor vitals.	4am	* monitored vitals.	
6am	* monitor for loose stools	6am	* monitored for loose stool.	

Re-Assessment:

T1m, RP₂, Ca, mg, IP

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Dhruva

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

BAH-00653649 IP5-00176563
Master THAMBALA ETHAN
30-10-2025 0 Y 8 M 19 D (M)
Dr. Prashant Bachina



NURSING CARE RECORD

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Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 20/07/26

Assessment: Baby having poor Intake and Stools in maternity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the baby General condition	8am	→ Assessed the baby General condition	By done the all procedures the baby condition is improved slowly
10am	→ provide comfort position	10am	→ provided comfortable position	
12pm	→ administered the all drugs as per doctor orders	12pm	→ administered the all drugs as per doctor orders	
2pm	→ Baby having TPN	4pm	→ TPN is going on 34ml/hr and	
4pm	→ orally allowed	6pm	Baby having allow orally	
6pm	→ IVF fluids	8pm	→ 1/2 DNS + 35 Sodium bicarbonate	
8pm	1/2 DNS + 35 Sodium bicarbonate			

Re-Assessment:

Done by giving TPN and fluids

Special Notes:

Baby having TPN (34ml/hr and 1/2 DNS + 35ml HCO₃ 7ml) Rpa. Ca mag + 7lm

Nurse Signature:

[Signature]

Nurse Name:

Shalaja (605567)

Date & Time:

20/7/26 (8pm)

BAH-00653649
Master THAMBALA ETHAN
30-10-2025
Dr. Prashant Bachina
0 Y 6 M 19 D
(M)

NURSING CARE RECORD

Rainbow
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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/7/25

Assessment: Baby on TPN feeds.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	⇒ Assess the pt general condition.	8:05pm	⇒ Assessed the pt general condition.	By done all the procedures the baby condition is Improving.
9pm	⇒ provide the comfortable position.	9:05pm	⇒ provided the comfortable position.	
10pm	⇒ Check the vitals.	10:05pm	⇒ Checked the vitals & documented	
12AM	⇒ Continue P.V fluids.	12:05AM	⇒ Continued P.V fluids.	
2AM	⇒ provide side rail.	2:05AM	⇒ provided side rail.	
4AM	⇒ Continue TPN feeds.	4:05AM	⇒ Continued T.P.N.	
6AM	⇒ provide side rail.	6:05AM	⇒ provided side rail.	
8AM	⇒ Administer the Medication as per doctors order.	8:05AM	⇒ Administered the Medication as per doctors order.	

Re-Assessment: Re-assessment is done by checking vitals.

Special Notes: TPN is going on 3ml/hr. No cannula.

Nurse Signature: 

Nurse Name: Divya

Date & Time: 21/7/26 @ 8AM



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Prashant Department: ER Date of Admission: 18/7/26

SITUATION	Diagnosis: <u>Ane</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:			
BACKGROUND	Area	<u>ER</u>	<u>1st floor</u>	<u>1st floor</u>	<u>1st floor</u>	<u>1st floor</u>
	Shift Time	<u>11:50 am</u>	<u>2-8pm</u>	<u>8pm-8am</u>	<u>8am-8pm</u>	<u>8-10pm</u>
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
RECOMMENDATIONS	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp: <u>97.8°</u>	<u>98.1°</u>	<u>98.2°</u>	<u>98.0°</u>	<u>98.3°</u>
	Res:	<u>24bpm</u>	<u>28bpm</u>	<u>28bpm</u>	<u>28bpm</u>	<u>28bpm</u>
	SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>99%</u>
	Pulse:	<u>128bpm</u>	<u>126bpm</u>	<u>126bpm</u>	<u>110bpm</u>	<u>118bpm</u>
	BP:	<u>98/56</u>	<u>95/73</u>	<u>98/59</u>	<u>100/60</u>	<u>109/60</u>
	Fall Risk Score:	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>
	Pain Score:	<u>0/12</u>	<u>0/12</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>
Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>
	Physiotherapy	☐ 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>
	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>	<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>
Handed Over By Name :		<u>Pooja</u>	<u>Aruna</u>	<u>Sowetha</u>	<u>Shanthi</u>	<u>Divya</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>18/7/26</u>	<u>18/7</u>	<u>19/7</u>	<u>19/7</u>	<u>20/7</u>
Time:		<u>2:00pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>
Taken Over By Name :		<u>Aruna</u>	<u>Sowetha</u>	<u>Shanthi</u>	<u>Divya</u>	<u>Shailaja</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>18/7</u>	<u>18/7/26</u>	<u>18/7/26</u>	<u>19/7</u>	<u>20/7/26</u>
Time:		<u>2pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>

BAH-00653649
Master THAMBALA ETHAN
30-10-2025 0 Y 8 M 19 D (M)
Dr. Prashant Bachina



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Prashant Bachina Department: ped Date of Admission: 10/12

SITUATION	Diagnosis: <u>ACF</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:					
	Area	Shift Time						
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>1st floor.</u> <u>8PM - 8AM</u> <u>nil</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>99°F</u>					
		Res:	<u>29b/m</u>					
		SpO ₂ :	<u>100%</u>					
		Pulse:	<u>65b/m</u>					
		BP:	<u>101/69</u>					
		Fall Risk Score:	<u>10</u>					
Pain Score:	<u>0</u>							
Recommendations	Safety Needs:	<u>side rail</u>						
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	<u>nil</u>						
	Special Diet:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>nil</u>						
Post Operative Procedure Special Orders:		<u>nil</u>						
Handed Over By Name :		<u>Divya</u>						
Signature :		<u>[Signature]</u>						
Date:		<u>21/12/25</u>						
Time:		<u>8AM</u>						
Taken Over By Name :		<u>[Signature]</u>						
Signature :		<u>[Signature]</u>						
Date:		<u>21/12/25</u>						
Time:		<u>6:00</u>						



THE HUMPTY DUMPTY SCALE

18/7 19/7 20/7 21/7

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	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 Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	
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 :		hooja	sonu	dhruv	divya
Signature :		de	de	de	de
Date :		18/7	19/7	20/7	21/7
Time :		7:15 pm	5:30	6:00	6:00 AM



BRADEN 'Q' SCALE

					Date :	10/7	11/7	20/7	21/7
					Time :	12:15 PM	5:07		6 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:tremitry 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	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	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	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	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 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	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Ri 3-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	28	28
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	poja	poja	poja	poja

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
18/10/25	1:15 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	poor
18/10	9pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
19/10	5:47	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
29/10	1pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shreel
20/10	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Divya
21/10	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Divya
				☐ 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:

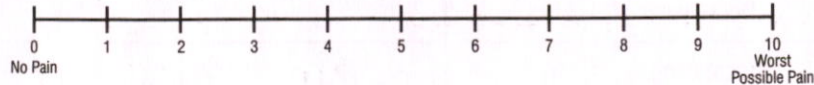
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 min after pain relief intervention.

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



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Patient's / Learner Language: luger 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		
18/7/26	1:15 PM	7	infection control measures	F	4	0	1	1	NA	proja
18/8/26	2:15 PM	9	child is on cyclic feeds (neo -cate (1:30ml) duration 5m/ldx	F	1	0	1	2		Niraj

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: Art

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
<u>18/7/26</u> <u>2pm</u>	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<u>Art</u>	<u>hemodynamic stability</u>	<u>ON fluids</u>	<u>Art</u>	☒ Nursing ☐ Others:
<u>18/7/26</u> <u>2pm</u>	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<u>loose stools</u>	<u>lt - stability</u>	<u>IV fluids</u>	<u>Art</u>	☒ Medical ☐ Others:
<u>18/7/26</u> <u>2:15pm</u>	☐ Medical ☐ Nursing ☒ Others: <u>diets</u>	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<u>KICLO cmpa</u> <u>AGE</u>	<u>Child is on cyclic feeds neocate (11:30am) dilution 5m/1hr stage II weaning foods the</u>	<u>RDA:-</u> <u>698 kcal/kg/d</u> <u>PI- 1.6g/kg/d</u>	<u>Niritha</u>	☐ 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:



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	E R	-	-	-	-	-	-	-	-	
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				Anura			[Signature]			[Signature]			

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 : Saurav Name : Saurav

Signature of Ward In Charge :

Signature : [Signature] Name : Neeraja

BAH-00653649 IP5-00176563
Master THAMBALA ETHAN
30-10-2025 0 Y 8 M 19 D (M)
Dr. Prashant Bachina



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									
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				<i>[Signature]</i>									

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 : *[Signature]* Name : *[Signature]*

Signature of Ward In Charge :

Signature : *[Signature]* Name : *[Signature]*

CONSENT FOR SPECIAL PROCEDURES

Patient Name : thambala. Ethan Gender: ☒ Male ☐ Female

UHID No : BAH-00653649 Department : PICU Date : 19/07/26

I S/D/W/O

Here by give consent for procedure of :

For my patient, Named :

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

Bleeding, Infection, Thrombosis

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. Nikhil Mendelkar

atient Attendant :

Signature : K. Josha

Name : K. Josha

Relationship with Patient: Mother

Date & Time : 19/7/26 @ 4:40pm

Witness :

Signature : Dingy

Name : Dingy

Date & Time : 19/7/26 @ 5pm

Doctor (who is taking the consent) :

Signature : Dr. Nikhil Mendelkar

Name : Dr. Nikhil Mendelkar

Date & Time : 4:30 pm
19/07

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

.....

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.....

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

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

CONSENT FOR SPECIAL SEDATION

Patient Name: THAMBALA ETHAN Gender: ☒ Male ☐ Female
UHID No: BAH-00653649 Department: PIU Date: 19/07

I S/D/W/O

Here by give consent for procedure for my patient :

The doctors have explained to me in language known to me the details of sedation as follows:

- Type of Sedation : Ketamine
- Possible complications from the procedure of sedation:
Hypotension, Respiratory difficulty

The doctors have explained to me about the benefits, risk, alternative of the procedure.

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

Patient Attendant :

Signature : K. Joshua
Name : K. Joshua
Relationship with Patient: mother
Date & Time : 19/7/26 @ 5pm

Witness :

Signature : [Signature]
Name : Nitya
Date & Time : 19/7/26 @ 5pm

Doctor (who is taking the consent) :

Signature : [Signature]
Name : Dr Kaitiwa Ambata
Date & Time : 19/07/26 4:30pm

BAH-00653649 IP5-00176563
Master THAMBALA ETHAN
30-10-2025 0 Y 8 M 19 D (M)
Dr. Prashant Bachina

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Hospital
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BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 11:50p Mode of Arrival: walking Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: Body Weight: 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: Length: Head Circumference (< 2 years):

Temp.: 98.32 HR: 128 RR: 28h BP: 101/62

Pain Score: Specify Site: (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: Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker

Character of Pain Location Frequency Duration

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

Inform consultant for positive criteria

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

Inform consultant for positive criteria

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

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify Inform consultant for positive criteria.**Social History:** Lives With FamilySiblings in household ☐ Yes ☐ No (if yes How Many?)All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach : ☒ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump : ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ NoInformation given to motherNurse Signature: [Signature]Nurse Name: ShanthiDate: 12/12/26Time: 2pm

BAH-00653649
Master THAMBALA ETHAN
30-10-2026
Dr. Prashant Bachina
IP5-00176563
0 Y 8 M 18 D (M)

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DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: by per doctor order

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☐ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication ☒ Yes ☐ No

☐ Bathing ☐ Yes ☒ No

☐ Eating ☐ Yes ☒ No

☐ Walking ☐ Yes ☒ No

☐ Dressing ☐ Yes ☒ No

☐ Toileting ☐ Yes ☒ No

explain to mother

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: hand hygiene

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

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: Shanthi

Nurse Name: Shanthi

Date and Time: 18/07/26

Docu. No. : RCHBH / FRM / CLINICAL / 191



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Thambala Ethan Age : 8 months Gender : ☒ Male ☐ Female
Date : 18/12/26 Time of Arrival : 11:30 am Triage Completion Time : 11:32 am
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		INITIAL PHYSIOLOGICAL STATUS	
Appearance	Work of Breathing	☒ Stable	
☒ Normal	☒ Normal	☐ Unstable :	
☐ Sick Looking	☐ Increased	☐ Not - Life - Threatening	
Circulation / Colour	☐ Decreased	☐ Life - Threatening	
☒ Normal	☐ Gasping / Apnea		
☐ Abnormal			
☐ Bleeding			

Initial Vital Signs: Temp: 38.2° PR: 152b/min BP: 95/63 RR: 20b/min SpO₂: 100%
Chief Complaints: C/O loose stools x 1 day (9 epis)

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 _____

Communicable Disease Triage Screening

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

- Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
- Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
- 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

- 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: _____
- 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 : Shavani

Signature of Triage Nurse : _____

Date & Time : 18/12/26 @ 11:32 am



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 18/12/26 Time of arrival : 11:33 AM
Chief Complaints: loose stools 8 days (9 epi) RBS: NA
Height : NA Weight : 7.3 kg BMI : NA Head Circumference (<2 years) : NA
Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: NA
If yes, identify NA
Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker
☐ Character NA ☐ Location NA ☐ Frequency NA ☐ Duration NA

RISK FOR FALL:

☒ If patient is < 6 years
tick below fall risk intervention directly

☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☐ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☐ No
- Uses furniture for support ☐ Yes ☐ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☐ No
- Weak ☐ Yes ☐ No
- Impaired ☐ Yes ☐ No

Mental Status: Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- ☐ Escort while ambulating
- ☒ Assist Patient
- ☒ Educate patient and family on fall precautions/prevention

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
- ☐ Feeding Problem
- ☐ Special diet
- ☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☒ No

If Yes Consultant Notified: NA (Date/Time): NA

Social History: Lives With parents

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

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify NA Inform consultant for positive criteria.

Time of initial assessment completed by ER Nurse : 11:35 AM

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

Time	Nursing Notes
11:40am	- Assess the child condition
	- monitored vitals & recorded
	- seen by paediatrics
	- shifted to ward

Samples collected by:

Time:

Samples sent by :

Time:

Medication given in ER:

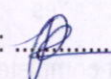
Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
		nil			

Condition of patient at time of shift - out :	Details of Shift - out
HR: 112 bpm BP: 96/54 CFT: 2 sec RR: 32 bpm SPO ₂ : 100% GCS: 4.1.6 Temperature: 97.8 F Pain Score: 0 Repeat RBS (if applicable): NA	Shift - out from ER to: Ward Time of Shift - out: 11:50 pm Handover given to: _____ (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

Name of the Nurse : pooja

Signature of the Nurse : 

Date & Time : 18/12/2022 1:30 pm

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00653649 IP5-00176563 Master THAMBALA ETHAN (M) 30-10-2025 0 Y 8 M 18 D Dr. Prashant Bachina 		Date & Time of Admission 18/7/26 @ 12:42 pm	Date & Time of Transfer Order 18/7/26 @ 1:50 pm
		Transfer Ordered by Dr. Prashant Bachina	Reason for Transfer Admission
From Unit CC	To Unit Ward	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 19	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what? ... op... files	Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films NA			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	ONS (room)	(1)	
2.	Intratix	(1)	
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring NR. pooja		Name of Person Ordered Transfer Dr. Prashant Bachina	
Patient & Clinical Records Received by : Anna			
Date & Time of Patient Received : 18/7/26 @ 2pm			

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

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

~~patient~~ not weeping sample



144C

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 18/9/26 Time: 2pm

Weight: 7.3 kgs Centile: >5th

Height: 66.5 cm Centile: >5th

Inference: underweight child

RDA: — Calories: 98 kcal/kgld Protein: 1.6g/kgld

Diet Recommendations: child is on cyclical feeds neocate (1:30ml) dilution 5ml/hr

Re-Assessment: stage II weaning foods, HEE advised (3hr on, 1hr off)

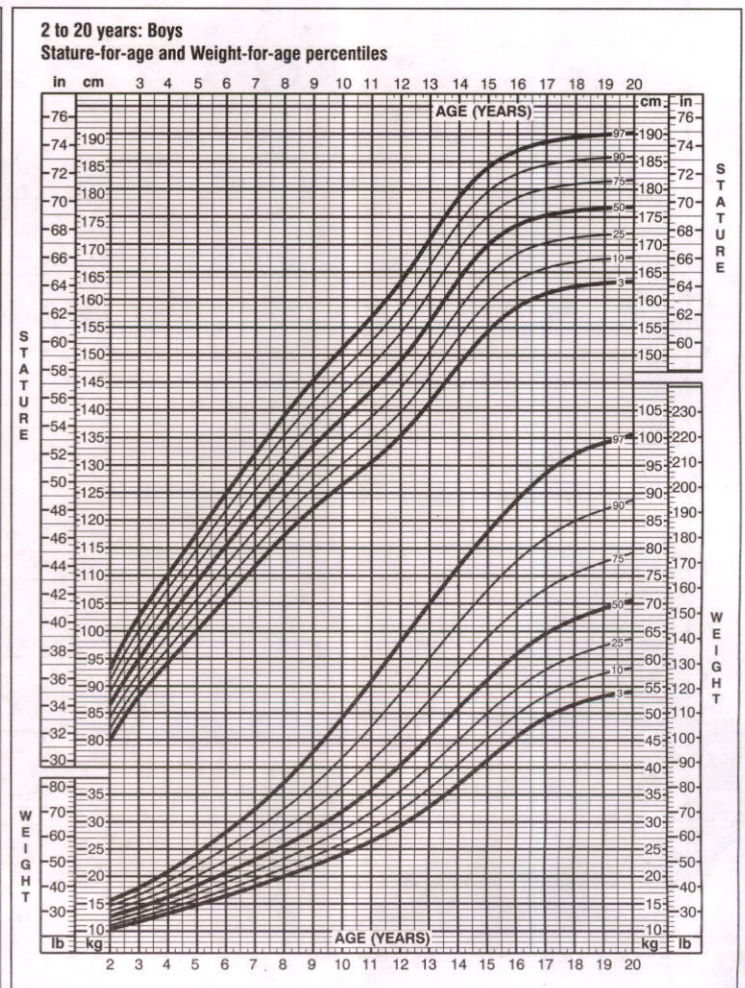
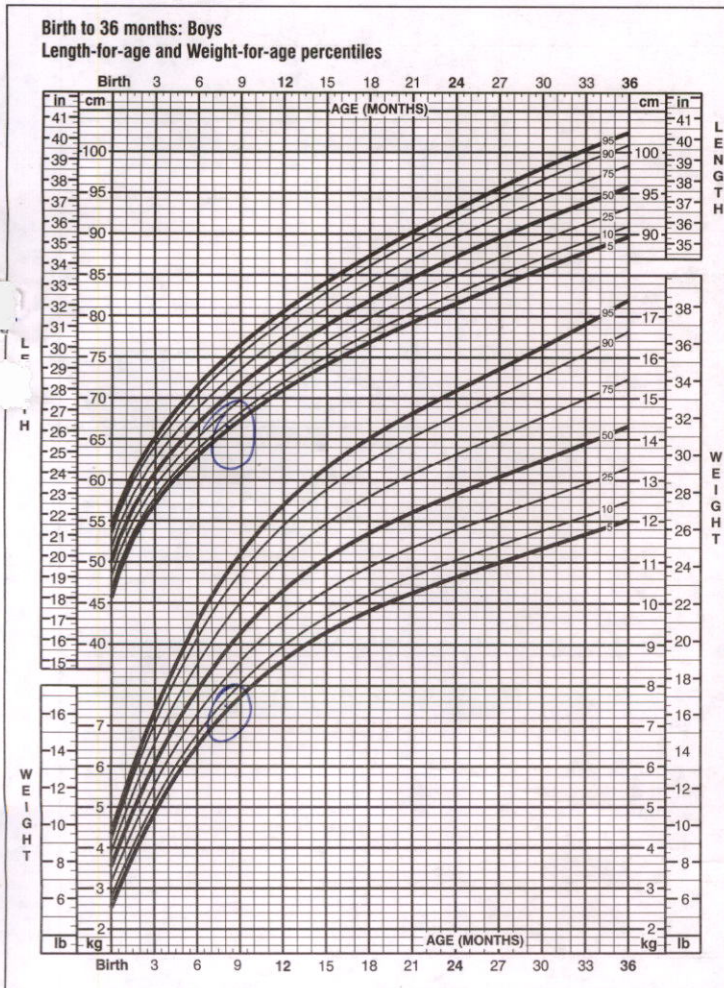
Food Allergies: Dairy products Veg/Non-veg: veg

Diagnosis: K1C10 CMAA, AGE

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: I. Manoj

GROWTH CHART (BOYS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha

Daily Notes:

10/17/16
11AM

Child is stable Intake is optimal.

Continue to Neocate. to stage II weaning foods. - Nikola

10/17/16
11AM

Child is stable Intake is accepting

Continue to TPN to stage II weaning foods. - Nikola