

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175949

Admit Date : 04-Jul-2026

Admit Time : 02:47 AM UHID : BAH-00611379

Patient Details :

Patient Name : Master SYED AZLAN UDDIN

Age : 2 Y 0 M 26 D

Guardian : Mr SYED AHSAN UDDIN

DOB : 08-06-2024

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : PILLAR NO. 203 Attapur Hyderabad
Telangana INDIA 500048

Phone No : 9700078604/ 8464891856

E-mail : NOEMAILID@GMAIL.COM

Admission Details :

Bed Type : GENERAL WARD

Bed No : GW 139

Ward Name : 1F-GENERAL WARD II

Room No : GW 139

Admission Type : First Visit

Contact Details :

Name : Mr SYED AHSAN UDDIN

Relationship : Father

Contact Address :

Phone No : 7702490835 / 8464891856


Signature

Doctor Details :

Doctor Name : Dr. FAISAL B NAHDI

Specialisation : GENERAL PEDIATRICS

Referral Doctor : Self

Phone No :

Co-Consultant : Dr. UJJWALA DESAI

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELF PAY

ACTIVITY RECORD FOR BILLING

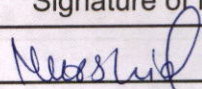
Name : _____

UHID No. : _____ IP **BAH-00611379** **IP5-00175949**
Master SYED AZLAN UDDIN
08-06-2024 **2 Y 0 M 26 D** (M) ant: _____ Dept : _____
Dr. FAISAL B NAHDI

Date of Admission: _____  Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
08/06/24	3:15 am	ER	139.	
			↓	
			121A	

Cross Consultation Visit

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

[illegible]

42

ex. Good Ch

66803

Kopilay

4/12

QRS - PQT (99 mg/dl)

66812

2019

5/7/26

Stool culture

260869B7

Suh

51 H26

CSE, CUG

262669 40

Sungh

[illegible]

Date _____

Name of Equipment

Connecting Time

Disconnecting Time

Order No.

Signature

1/07

Infusion Pump

3:40am

9686828

Graves, K.

[illegible]

Signature

Rodney

Surek

2014

Prepared By : Amalika

Billing Supervisor

Crew I

BAH-00611379 IP5-00175949
 Master SYED AZLAN UDDIN
 08-08-2024 2 Y 0 M 26 D (M)
 Dr. FAISAL B NAHDI



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	31/7/26 outside 0800	4/7/26				
Time						
Hb	12.8					
PCV	36.5					
RBC	4.45					
WBC	5320					
N/L	65/29					
Platelets	3.37					
CRP		45				
ESR						
PCT						
RBS						
Na	135					
K	4					
Cl	107					
Ca/Mg						
Phosphate						
Urea	23					
Creatinine	0.4					
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date	4/2/26					
Time						
CUE - Alb	1					
CUE - Sugar	Nil					
CUE - Ketones						
CUE - PUS Cells	3-4					
CUE - RBC Cells	1-2					
CUE	1-2 EC					
Stool Pus Cell	8-10					
OVA / Cyst	Nil					
Occult Blood	absent					
	occ. RBC					
	microbes (+)					

Culture and Sensitivities : Blood US- NG @ 48H
 stool US-

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI :

Others (ECG, Contrast Studies etc.,) :



MEDICATION RECONCILIATION FORM

Drug Allergies: Amoxicillin; Cefuroxime.

☐ 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: [Signature]

Date & Time: 04/7/26 @ 3am

Nurse Name & Signature: [Signature]

Date & Time: 04/7/26 @ 3am



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : PRO AQ SACHET				Date Time	4/7	5/7	6/7													
Dose	Route	Frequency	Start Dt.																	
1 sachet	PO	BD	4/7																	
Name & Signature of the Doctor Starting the Drugs:				<i>Ahmed</i> <i>Sub</i> <i>Private</i>																
Additional Instructions:				<i>Aug</i> <i>10/7</i>																
Daily Doctor's Endorsement by a Sign				<i>g g g</i>																
DRUG : 2 & D Drops				Date Time	4/7	5/7														
Dose	Route	Frequency	Start Dt.																	
1 ML	PO	OD	4/7																	
Name & Signature of the Doctor Starting the Drugs:				<i>Ahmed</i> <i>10/7</i> <i>Sub</i>																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				<i>g g g</i>																
DRUG : PROCTAGARD -T				Date Time	4/7	5/7														
Dose	Route	Frequency	Start Dt.																	
4A		TID	4/7																	
Name & Signature of the Doctor Starting the Drugs:				<i>Ahmed</i> <i>10/7</i> <i>Sub</i>																
Additional Instructions:				<i>2 PM</i> <i>10 PM</i> <i>wound perianal lesion</i>																
Daily Doctor's Endorsement by a Sign				<i>g g g</i>																
DRUG : W.Cefprozole				Date Time	4/7	5/7														
Dose	Route	Frequency	Start Dt.																	
600mg	IV	BD	4/7/26																	
Name & Signature of the Doctor Starting the Drugs:				<i>Madhusai</i> <i>10 AM</i> <i>5 PM</i>																
Additional Instructions:				<i>10 PM</i> <i>Sub</i> <i>10 PM</i>																
Daily Doctor's Endorsement by a Sign				<i>g g</i>																

BAH-00611379 IP5-00175949
 Master SYED AZLAN UDDIN
 08-08-2024 2 Y 0 M 27 D (M)
 Dr. FAISAL B NAHDI



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																			

Signature
 VERIFIED BY : Name



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

SYED AZLAN.

UHID ID:

BAH-00811379 IP5-00175949
Master SYED AZLAN UDDIN
08-08-2024 2 Y 0 M 26 D (M)
Dr. FAISAL B NAHDI

Department:



Consultant:



Pediatric Multiorgan History & Physical Examination

Name : Syed Azlan Uddin Age/Sex 24 / male
 Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Vomitings ∴ 2 days
 Loose stools ∴ 2 days
 Fever ∴ 1 day

History of present illness :

Apparently asymptomatic 2 days,

1. Vomitings 5-6 e/day

Non-bilious.

∴ food particles as content
 not ass ∴ blood.

2. Loose stools 10-15 e/day

foul smelling
 greenish

not ass ∴ blood.

3. Fever ∴ 1 day

Intermittent

mild-mod. grade

subsiding ∴ medications

13/7/24

12.8 5.320
 65 29 2.32

135
 8 4.0
 10+

0.4 / 23



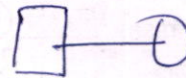
Pediatric Multiorgan History & Physical Examination

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

NOT significant

Birth & Neonatal History:

T.G / AUA / CLAB / NO H/O NICU stay.



Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Upper middle

Developmental History :

②

Immunization History :

till date as per IAP schedule



Allergic to 1. Amoxicillin
2. Cefuroxime

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 12.3kg (Centile _____)

On Examination :

Temperature : 98.3F Pulse Rate : 120/min B.P. 100/60 SpO2 98%

Resp. rate and type of breathing : 25/min

Rash —

Lymphadenopathy — CRITZ box

Oedema : — Peals +

Allergies (if any): — muscle mass

Respiratory System :

Inspection (any s/o distress) : (N)

Air entry & breath sounds : B/L VRS +

Any added sounds : —

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

Cardiovascular System :

Inspection of precordium : (N)

Heart Sounds : S1S2 +

Any murmur : —

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

Per Abdomen :

Inspection (N)

Palpation : Abn LTR

Auscultation : —

Spine : (N) External Genitalia : N/E

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Aw

Cranial Nerves : (7)

Motor System:

Nutriton : (7)

Tone: (7) Power (7)

Co-ordinator : (7)

Posture : (7)

Involuntary Movements : (7)

Reflexes :

DTR

Plantars (7)

Superficials:

Sensory System :

Bladder / Bowel : Loose stool

Clinical Summary & Diagnostic:

AGE = some dehydration

1 POTD viral gastroenteritis

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Dehydration

Desired goals of the treatment : _____

conep. hydration

Planned Labs:

CBP, S/E, Urea, Creatinine

outside

CRP, Blood c/s. Inow.
CSE, ure

Planned Management

IVF

-ORS

-Syp. OFM.

NB Nussup
Caf 10/12/26

Signature of the Doctor: _____

Name of the Doctor: M. Nahdi

Date & Time: 4/7/26; 2:45AM

Signature of the Consultant: _____

Name of the Consultant: DR. UJJWALA DESAI

Date & Time: 4/7/26 C

Registration No: 90550

Date & Time	Progress Notes	Doctor's Order
4/2/20 8:20 AM	SIB <u>Recurrent</u> A: AGE	Plan: ① continue medication as per chart
	No vomiting Loose stool since 1 day fever	② monitor vitals
	Admitted @ Apollo and taken LAMA.	③ send CUE CSE Stool C/S.
	D/E - child asleep. vitals stable	④ w/f fever / loose stools
	C/S R PIA	⑤ w/f fever.
	hydration - fair C/S u 36 C	⑥ cont. IVF
4/2/20	Anti gastroenteritis E dehydrated.	Madhus Gastroscopy.
		Send CSE X stool culture.
4/2/20 (pm)	Could not take gr. E dehydrated	Doc Dnyana aa. Continue same

Date & Time	Progress Notes	Doctor's Order
4/22/26 4pm	SIB Resident A: AGE no fever no vomiting 0/4 - poor 10 epitodes watery small greenish-yellow stools perianal rash (+) CRT L3sec PR good. H Cvs P/A Normal	Plan: ① continue IV ceftriaxone medication as per chart ② monitor vitals ③ w/ fever ④ w/ dehydration ⑤ cont. IV fluids ⑥ Inform G1 ⑦ trace stool G1 Blood G1
		Madhus



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	SIB Resident	
5/7/24 8 AM	A: Ate	Plan.
	no fever vomiting	① cont. ceftriaxone
	10-12 episodes loose watery stool	medication as per chart
	OR - fair	② w/ fever
	O/E -	③ Prace blood 4s
	child anke up	chole 4s.
	vitals stable	④ monitor vitals
	hydration - fair	⑤ Inform pos.
	U/O - fair	
(verbal) Blood 4s so far sterile		Madhni
	Gastroenteritis.	Continue IV fluids.
	Ongoing stools.	Gastro diet
5/7	Child is Ate 9h	
	Enterocolitis.	DR. UJJWALA DESAI Registration No: 90559
Child		Dry he
(in K)	Child stool	Plan
(10:30)		
	Dr. Faisal B Nahdi Reg. No: 66228	Continue Serum
		Gastro diet
		②



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/24 8:15 AM	Seen by Resident	
	Adm - Acute gastroenteritis	
	Dehydration	
	no fevers.	Plan
	4 ep. of stools yesterday.	
	Semisolid. non bloody.	1. Continue medications as charted.
	No vomitings	2. H/V to stop IV fluids
	no pain abdomen	3. R/V discharge today.
	oral intake fair	a. monitor vitals
	O/E	g. inform SOS
	Child alert asleep. afebrile	Salutini
	hemodynamically stable	
	Chest clear	
	Abdomen soft	
	perfusion good, hydration	
	well maintained.	
	Stool C/S - NG @ 4SH	
	stool C/S - so far NG (verbal).	
	Gastroenter.	Ceftriaxone 1gm iv
	Discharge	at 10am
		flb cefixime x 3 da
		gastro dx. Done
		follow up Dr. J. J. W.
		Dr. Faizal 9am
		after 3d.
		DR. UJJWALA DESAI
		Registration No. 90550



DRUG CHART

Date of Admission: Drug Allergies: ~~AMOXICILLIN~~, ~~CEFUROXIME~~ ☐ 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.

12kg

SOS / PRN (As Required Medication)

DRUG : SYP-CROU DS				Date Time
Dose	Route	Frequency	Start Date	
4ML	PO	6 th ly	4/7	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:		TS100° F		

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

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



REGULAR PRESCRIPTIONS

Weight. 12kg Ward.

DRUG : <u>1mg CEFTRIAXONE</u>				Date Time	
Dose <u>600mg</u>	Route <u>IV</u>	Frequency <u>BD</u>	Start Date <u>4/7</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Ahankshay</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>SYP OFM</u>				Date Time	<u>4/7</u>
Dose <u>5ML</u>	Route <u>PO</u>	Frequency <u>BD</u>	Start Date <u>4/7</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Ahankshay</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>1mg ONDANSETRON</u>				Date Time	<u>5/7 6/7</u>
Dose <u>2mg</u>	Route <u>IV</u>	Frequency <u>TID</u>	Start Date <u>4/7</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Ahankshay</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>1mg ESMOPRIVOL</u>				Date Time	<u>5/7 6/7</u>
Dose <u>10mg</u>	Route <u>IV</u>	Frequency <u>OD</u>	Start Date <u>4/7</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Ahankshay</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

VERIFIED

VERIFIED



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

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

STAT / ONCE ONLY DRUGS[illegible]

Weight. 12kg Ward.

[illegible]

Signature _____

VERIFIED BY: Name

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



PRESCHOOL (1-5 years)

Children's Observation &
Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	05/07/24	Time:	2 am	5 am	10 am	4 pm	5:30 pm	10 PM	
Doctor / Nurse / Family Concern?									
Temperature (F)	104								
	103								
	102								
	101								
	100								
	99	98.5	98.5				98.2	98.5	
	98								
	97								
	96								
	95								
94									
Heart Rate (bpm) and Blood Pressure (mmHg) *	190								
	180								
	170								
	160								
	150								
	140								
	130								
	120								
	110								
	100								
Note: BP does not score in early warning scoring	90	110	105				99	100	
	80	69	65				62	61	
	70								
	60								
	50								
	Heart Rate (Number)	110	105				100 bpm	102 bpm	
	Resp. Rate (bpm) (Over 1 Minute) *	70							
		60							
		50							
		40							
30									
20									
10									
Resp Rate (Number)		28	28				29 bpm	26 bpm	
Resp Distress		Mod/ Severe							
Receiving O ₂ (l/min)		None / Mild							
O ₂ Saturations (%)		99%	99%			100%	100%		
Conscious Level	Normal								
GCS *	Altered	15/15	15/15			15/15	15/15		
TOTAL SCORE									
Number of shaded boxes		1	1			1	1		
Pain Score		0	0			0	0		
Observer's Initials		D	D			O	O		

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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

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

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



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 04.07.24	Time: 4am	6am	10Am	2pm	6pm	10pm
Doctor / Nurse / Family Concern?						
Temperature (°F)	104					
	103					
	102					
	101					
	100					
Heart Rate (bpm)	190					
	180					
	170					
	160					
	150					
Blood Pressure (mmHg) *	130					
	120					
	110					
	100					
	90					
Heart Rate (Number)	118bpm	110bpm	101bpm	98bpm		
Resp. Rate (bpm) (Over 1 Minute) *	70					
	60					
	50					
	40					
	30					
Resp Rate (Number)	26bpm	28bpm	29bpm	28bpm		
Receiving O ₂ (l/min) O ₂ Saturations (%)	100%	100%	99%	100%		
Conscious Level	15/15	15/15	15/15	15/15		
TOTAL SCORE	1	1	1	1		
Observer's Initials						

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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Patient

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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 Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
08/08/24	02:00 am											
	03:00 am		H ₂ O	40			✓		✓	0		Draves
	04:00 am			40						0		
	05:00 am	ORS		40			✓		✓	0		Draves
	06:00 am			40						0		
	07:00 am						✓		✓	0		Draves
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 Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
4/7/26	08:00 am		10ml	40ml		/			/		0	Siddh
	09:00 am			newml		/			/		0	
	10:00 am	pus		10ml		/	✓			✓	0	
	11:00 am			10ml		/					0	
	12:00 pm			10ml		/	✓			✓	0	
	01:00 pm			10ml		/					0	
Total Intake :					Total Output :							
4/7	02:00 pm	1	Rice	—		/	✓		/	✓	0	Chander
	03:00 pm			40ml		/			/		0	Chander
	04:00 pm	pus		40ml		/	✓		/	✓	0	Chander
	05:00 pm			40ml		/			/		0	Chander
	06:00 pm	1		40ml		/			/		0	Chander
	07:00 pm			40ml		/	✓		/	✓	0	Chander
Total Intake :					Total Output :							
4/7	08:00 pm	1	one			/			/		0	
	09:00 pm			10ml		/	✓		/	✓	0	Ch
	10:00 pm	pus		10ml		/			/		0	
	11:00 pm			10ml		/			/		0	
	12:00 am	1		10ml		/			/	✓	0	Shu
	01:00 am			10ml		/			/		0	
Total Intake :					Total Output :							
4/7	02:00 am			10ml		/			/		0	Shu
	03:00 am			10ml		/			/		0	
	04:00 am			10ml		/			/		0	
	05:00 am	pus		10ml		/			/		0	Shu
	06:00 am	1		—		/			/		0	
	07:00 am			—		/			/		0	
Total Intake :					Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

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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.

		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							
5/7	08:00 am	↑		40ml		/			/		0	Jahangir
	09:00 am	↑	only	40ml		/	✓		/	✓	0	
	10:00 am	DNS	tho	-		/			/	✓	0	
	11:00 am	↓		-		/			/	✓	0	
	12:00 pm	↓		40ml		/			/	✓	0	
	01:00 pm			40ml		/			/		0	
Total Intake :					Total Output :							
5/7	02:00 pm	↑		-		/			/		0	Sukh
	03:00 pm	↑	Kichadi	40ml		/	✓		/	✓	0	
	04:00 pm	DNS	water	40ml		/			/		0	
	05:00 pm			-		/	✓		/	✓	0	
	06:00 pm	↓		40ml		/			/		0	
	07:00 pm	↓		40ml		/			/	✓	0	
Total Intake :					Total Output :							
5/7	08:00 pm	↑		40ml		/	✓		/		0	Priyanka
	09:00 pm	DNS	phichini	40ml		/			/	✓	0	
	10:00 pm		fruit	-		/			/		0	
	11:00 pm			-		/			/		0	
	12:00 am	↓		40ml		/	✓		/	✓	0	
	01:00 am	↓		40ml		/			/	✓	0	
Total Intake :					Total Output :							
6/7	02:00 am	↑		40ml		/	✓		/		0	Priyanka
	03:00 am			40ml		/			/		0	
	04:00 am	DNS		40ml		/			/		0	
	05:00 am			40ml		/			/		0	
	06:00 am			-		/			/	✓	0	
	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.
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		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							



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 03/07/26

Assessment: Baby having loose stools & dehydrated

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
3:30 am	Assess the baby general condition and monitor the vitals and record.	3:40 am	Assessed the baby general condition and monitored the vitals and recorded.	By doing all above procedure baby condition
4 am	After the doctor review advice. Inj- Esomeprazole 10mg, Ondansetron 20mg	4:30 am	After the doctor review inj- Esomeprazole 10mg, Ondansetron 20mg given.	Improving well
5 am	Progg sachet, 24 D drops, Probiogard 1/4	5:30 am	Continued Dns @ 40ml/hr	
	Continue Dns @ 40ml/hr.	6:30 am	Collected CUE, CSE	
6 am	Collect CUE, CSE	7:30 am	Provided comfortable position	
7 am	Provide comfortable position.	8:10 am	Ensured the safety needs	
8 am	Ensure the safety needs			

Re-Assessment: Re assessment done

Special Notes: Baby having allergic reaction to medication - Amoxicillin, ceftriaxone, tomatoes

Nurse Signature: Graunth Nurse Name: Graunth ID: 607682 Date & Time: 4/07/26 @ 8am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 4/7/26

Assessment: Baby having loose stool.

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's general condition. monitor vital signs	8am	* Assessment baby general condition. monitored vital signs	Baby condition is improving slowly
10am	* provide comfortable position	10am	* provided comfortable position.	
12p	* Administer medication as per doctor's orders	12p	* Administered medication as per doctor's order	
2p	* Ensure safety side rails.	2p	* Ensure safety side rails	

Re-Assessment:

Special Notes: watch for loose stool, fever, vomiting

Nurse Signature: [Signature]

Nurse Name: Sushma (021086)

Date & Time: 4/7/26 @ 2p

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 4/2/24

Assessment: pt having loose stools

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the pt General Condition	2:10pm	→ Assessed the pt General Condition	
4pm	→ Monitor the Vital Signs	4:10pm	→ Checked the Vital Signs	
6pm	→ Plan for Administration medication	6:10pm	→ providing medication as per doctor Order	
8pm	→ Plan for Stool Chart	8:10pm	→ maintaining Stool Chart	
	→ P		→ providing Comfortable Position	Pts stable

Re-Assessment: Re-Assessment Every 4th hrly

Special Notes:

Nurse Signature: @

Nurse Name: Chandan

Date & Time: 4/2/24 2:00pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 04/07/24

Assessment: pt having some activity

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	9pm	*Assessed the pt General condition	pt is stable
10pm	*check the pt all vitals	11pm	*checked the pt all vitals	
11pm	*maintain 20 chart	12am	*maintained 20 chart	
12am	*provide comfortable position	1am	*provided comfortable position	
1am	*administer all medication given by per. doctor order	2am	*administered all medication given as per doctor order	

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name: chunh

Date & Time: 05/07/24 8am

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NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 15/07/26

Assessment: Baby having Pyrexia and

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the baby general condition	8am	Assessed the baby general condition	By doing the all procedures the baby condition is improved slowly
9am	provide comfort position	9am	provided comfortable position.	
10am	monitor the vitals & Recorded it	10am	monitored the vitals & Recorded it	
11am	administer the all drugs as per doctor	11am	administer the all drugs as per doctor orders	
12pm	maintain IV fluid	12pm	ensured the safety of the baby	
1pm	ensure the safety	1pm		
2pm		2pm		

Re-Assessment:

Re-assessment done by giving sup: - 100%

Special Notes:

Plan ok. Tm

Nurse Signature:

[Signature]

Nurse Name:

Shailaja (60564)

Date & Time:

15/7/26 (2pm)

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NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/7/26

Assessment: Baby having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	* Assess the baby general condition	2pm	* Assessed the baby general condition.	Baby condition is improving.
	monitor vital signs		monitored vital signs.	
3pm	* provide comfortable position	3pm	* provided comfortable position	
4pm	* maintain unintentional I/O charting	4pm	* maintained I/O charting	
6pm	* Administer medication as per doctor order	6pm	* Administered medication as per doctor order	
7pm	* Ensure safety side rails.	7pm	* Ensured safety side rails.	

Re-Assessment:

Special Notes: watch for fever, loose stool

Nurse Signature:

Nurse Name: Sneekha (021086)

Date & Time: 5/7/26

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/20

Assessment: Dehydration

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess general condition of the patient.	8-10 pm	Assessed general condition of the patient.	By done all implementation, as per doctor's order.
10pm	Maintain I.v fluid balance.	10pm	Maintained fluid balance.	
12AM	Maintain No chart.	12AM	Maintained No chart.	
5AM	Monitor vital signs.	5:30 AM	Monitored vital signs.	
6AM	Administer medication as per doctor's order.	6:5 AM	Administered medication as per doctor's order.	

Re-Assessment: w/f Fever Spikes

Special Notes: Gastro diet

Nurse Signature:

P.B

Nurse Name:

Priganya

Date & Time:

6/7/20 8AM

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Master SYED AZLAN UDDIN

08-06-2024

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(M)

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Faisal Department: paed. Date of Admission: 04/04/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	<u>Afe</u>							
BACKGROUND	Area	Shift Time	<u>ER</u> <u>3:15a</u>	<u>1st floor</u> <u>2:30am</u> <u>8am</u>	<u>1st floor</u> <u>8am</u> <u>2pm</u>	<u>1st floor</u> <u>2pm</u> <u>8pm</u>	<u>1st floor</u> <u>8pm</u> <u>2am</u>	<u>1st floor</u> <u>2am</u> <u>8am</u>
	Medical Condition (Any special condition to be noted):		<u>nil</u>	<u>NA</u>	<u>nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>99.0F</u>	<u>98.1F</u>	<u>97.9F</u>	<u>98.3F</u>	<u>98.1F</u>	<u>98.0</u>
		Res:	<u>26b/min</u>	<u>26b/min</u>	<u>24</u>	<u>26b/min</u>	<u>26b/min</u>	<u>26b/min</u>
		SpO ₂ :	<u>97%</u>	<u>98%</u>	<u>98%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>
		Pulse:	<u>125b/min</u>	<u>120b/min</u>	<u>120b/min</u>	<u>121b/min</u>	<u>120b/min</u>	<u>120b/min</u>
		BP:	<u>108/62</u>	<u>102/61</u>	<u>100/62</u>	<u>101/60</u>	<u>100/60</u>	<u>98/60</u>
	Fall Risk Score:		<u>14</u>	<u>14</u>	<u>14</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>
Pain Score:		<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	
Recommendations	Safety Needs:		<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		<u>nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		<u>nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Post Operative Procedure Special Orders:		<u>nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Musnad</u>	<u>K. Braanth</u>	<u>Suekh</u>	<u>Chendau</u>	<u>Shanth</u>	<u>Shailig</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>04/04</u>	<u>04/04</u>	<u>4/4/26</u>	<u>4/4/26</u>	<u>4/4/26</u>	<u>5/4/26</u>	
Time:		<u>3:20am</u>	<u>@ 8am</u>	<u>2pm</u>	<u>2pm</u>	<u>2pm</u>	<u>(2pm)</u>	
Taken Over By Name :		<u>K. Braanth</u>	<u>Suekh</u>	<u>Chendau</u>	<u>Shanth</u>	<u>Shailig</u>	<u>Suekh</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>4/04</u>	<u>4/4/26</u>	<u>4/4/26</u>	<u>4/4/26</u>	<u>5/4/26</u>	<u>5/4/26</u>	
Time:		<u>3:30am</u>	<u>8am</u>	<u>2pm</u>	<u>2pm</u>	<u>(8am)</u>	<u>2pm</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. Faisal B. Nahdi Department: Pediatrics Date of Admission: 5/1/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:						
	AGUE								
BACKGROUND	Area	Shift Time	1st Floor 2pm-8pm	1st Floor 8pm-8AM					
	Medical Condition (Any special condition to be noted):		NA	NA					
ASSESSMENT	Allergy:	☒ Yes ☐ No	☐ 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	☐ Yes ☐ No	
	Vital Signs:	Temp:	98.2°F	98.1°F					
		Res:	29b/m	26b/m					
		SpO ₂ :	99%	100%					
		Pulse:	100b/m	106b/m					
		BP:	94/47	98/59					
		Fall Risk Score:	14	14					
Pain Score:	0/10	0/10							
Recommendations	Safety Needs:	yes	side rails						
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	NA	NA						
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	NA	NA						
Post Operative Procedure Special Orders:		NA	NA						
Handed Over By Name :		Sunekha	Pmyanka						
Signature :		[Signature]	[Signature]						
Date:		5/1/26	6/1/26						
Time:		8pm	8AM						
Taken Over By Name :		Pmyanka	Arshita						
Signature :		[Signature]	[Signature]						
Date:		5/1/26	6/1/26						
Time:		8pm	8AM						



Patient

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4		
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2		
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1		
Cognitive impairments	Not Aware of Limitations	3	3	3	3		
	Forget Limitations	2					
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2		
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1		
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1		
TOTAL			14	14	14		

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes	yes		
Call device within reach	yes	yes	yes		
Wheels Locked	yes	yes	yes		
Room free of clutter	yes	yes	yes		
Adequate Lighting	yes	yes	yes		
Wheel Chair Support	yes	yes	yes		
Other Intervention(s) Specify	yes	yes	yes		
Nurse's Name :	Amal	Amal	Amal		
Signature :	Amal	Amal	Amal		
Date :	4/7	4/7	4/7		
Time :	3:00	3:00	3:00		



CHECKLIST FOR THROMBOPHLEBITIS

03/07/26

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

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 : Neeraja Devi Name : Neeraja Devi



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	6									
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 : Kirish Name : Krishnade

Signature of Ward In Charge :

Signature : Neeraj Name : Neeraja Devi



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										
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 of Ward In Charge :

Signature : Name :

Signature : Name :



BRADEN 'Q' SCALE

					Date : 4/4/2024	6/7	6/7	
					Time : 6:00	6:00	6:00	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	
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	
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	3	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	
TOTAL SCORE					28	28	27	
Evaluator's Name					Musad	R	Pradyan	

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

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

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
04/10/26	3:30 am	0/10	neck	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	nil nil	Shaukat
4/10/26	12pm	0/10	neck	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	nil	Shaukat
4/10/26	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chondane
5/10/26	8am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shaukat
5/10/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shaukat
5/10	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shaukat
6/10	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shaukat
				☐ 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:

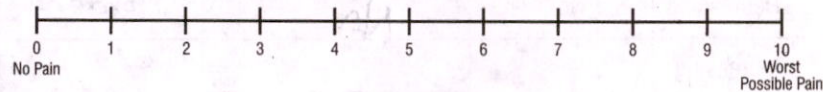
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 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

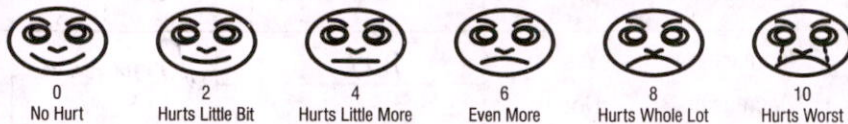
Numerical Pain Scale (Obstetric and Gynecology)



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: Arabic 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		
04/07	3am	5	medication.	M	1	0	1	1	Nil	Mushar
11/7/20	0830 Am	9	Gastro diet (Exclude Rice foods) [Avoid Egg, wheat, Ragi, oats, citrus fruits, milk, nuts]	M	1	0	1	1	-	Mushar

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:	<table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								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	
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Teaching Tools Used:	A: Audio	D: Demonstration	V: Video	O: Oral	P: Printed																		
Mechanism/s to overcome barrier/s:	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

AGE

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
09/07	☒ Medical ☐ Nursing ☐ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	AGE	H stability	- IV fluids - IV anti biotics	[Signature]	☒ Nursing ☐ Others:
09/07	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	AGE	Haemodynamic stability	- IV fluids - IV med	[Signature]	☐ Medical ☐ Others:
11/7/26 8:30am Dr. F. S. Nahdi	☐ Medical ☐ Nursing ☒ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	AGE & dehydration	Gastro diet	RDA E: 1250 kcal/d P: 21g/d	[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 General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 3:30 PM Mode of Arrival: By walk Admitting From: ☒ ER ☐ OPD ☐ Direct
Allergy / Adverse Reaction Amoxicillin, Cefazolin, Tomatoes Body Weight: 12.16 Kg
Height: 93.0 cm cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>NA</u>	<u>NA</u>	<u>NA</u>

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: TA / LGA CAB NO HLB
NICU stay

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

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

Observations: Weight: 12.16 Length: Head Circumference (< 2 years):

Temp.: 98.9°F HR: 126 RR: 26 bpm BP: 10.8/6.2

Pain Score: 0/10 Specify Site: NA (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☒ Yes ☐ No Score: 0/14 (Document in the Humpty Dumpty Sheet)

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

Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker

Character of Pain NA Location NA Frequency NA Duration NA

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

Inform consultant for positive criteria

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

Inform consultant for positive criteria

Psychological Screening:☒ No Significant 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 parentsSiblings in household ☒ Yes ☐ No (if yes How Many?) one baby boy youngerAll 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 ☐ No

Information given to parents

Nurse Signature: *Gravik*Nurse Name: *K. Sravanthi*Date: *4/07/20*Time: *@ 4am*



DISCHARGE PLANNING FORM

Nationality: Indean

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

1. Anticipated Date of Discharge: as per doctor's 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

Explain to mother & father.

☐ Bathing ☒ Yes ☐ No

☐ Eating ☒ Yes ☐ No

☐ Walking ☒ Yes ☐ No

☐ Dressing ☒ Yes ☐ No

☐ Toileting ☒ Yes ☐ No

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: personal Hygiene

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

☐ Patient ☐ Family Member

☐ Others:

Nurse Signature: Srauth

Nurse Name: K. Srauth

Date and Time: 4/6/24 @ 4pm

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00611379 IP5-00175949 Master SYED AZLAN UDDIN 08-06-2024 2 Y 0 M 26 D (M) Dr. FAISAL B NAHDI		Date & Time of Admission 04/07/26 @ 2:47a	Date & Time of Transfer Order 04/07/26 @ 3:15a
		Transfer Ordered by Dr. Rahul.	Reason for Transfer Admission
From Unit ER	To Unit 139	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 19	Number of Imaging Films nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Mr. Musound-		Name of Person Ordered Transfer Dr. Rahul.	
Patient & Clinical Records Received by : K. Srawanthi			
Date & Time of Patient Received : 04/07/26 @ 4am			

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



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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 4/7/26 Time: 8:30am

Weight: 12.3 Kgs Centile: >50th

Height: 93.5 cm Centile: 79th

Inference: well chelated

RDA: — Calories: 1250 kcal/d Protein: 21g/d

Diet Recommendations: Crustacean diet (rice based foods, sago, etc)

Re-Assessment: Avoid Egg, wheat, oats, Ragl, sugars, citrus fruits, Ragl, milk, nuts, etc
color powder, #

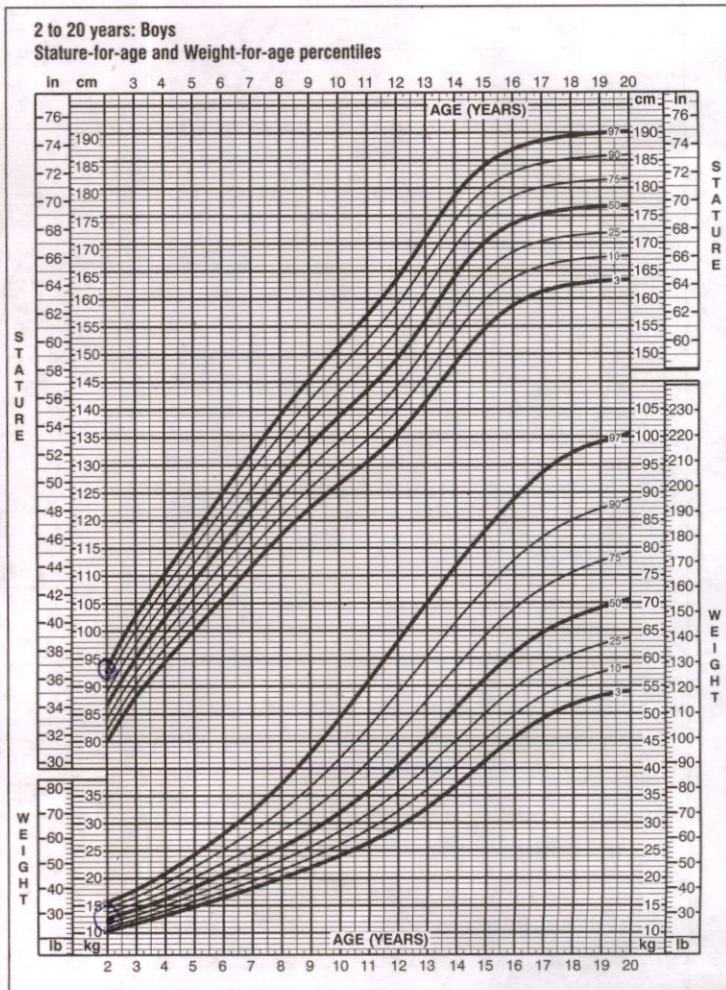
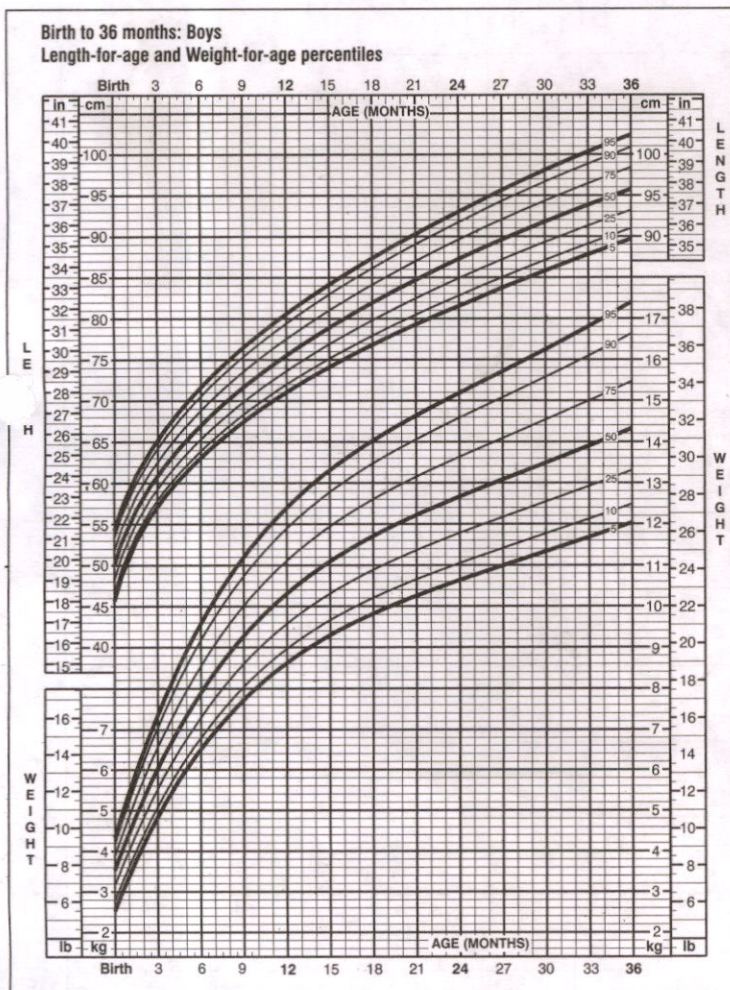
Food Allergies: Tomato, Milk, condiments Veg/Non-veg: veg

Diagnosis: AGE 2 some dehydration? ROTA viral diarrhea

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Nila

GROWTH CHART (BOYS)



Dietician's Name: Mouda

Dietician's Signature: Mouda

Daily Notes:

5/7/26
8am

Child is stable. Intake is fair
continue c Gastro diet

Wells

6/7/26
10Am

Child is stable Intake is fair.
Continue c Gastro diet

- monitor