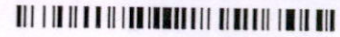


ADMISSION SHEET

Registration Details :

Admission No : IP5-00176410

Admit Date : 15-Jul-2026

Admit Time : 09:36 AM **UHID :** BAH-00661676

Patient Details :
Patient Name : Baby GOLI SRI TRISHIKA PRASANNA

Age : 0 Y 1 M 17 D

Guardian : Mr GOLI THARUN REDDY

DOB : 28-05-2026 09:33 AM

Gender : Female

Religion :
Occupation :
Martial Status : Single

Address (H) : HALLMARK TREASOR, SURVEY NO 155 & 156, FLAT NO 504, GANDIPET MAIN ROAD, NARSINGI, Gandipet Hyderabad Telangana INDIA 500075

Phone No : 8179563510/ 9704715494

E-mail : GOLITARUNREDDY@GMAIL.COM

Admission Details :
Bed Type : PRIVATE ROOM

Bed No : PVT 305

Ward Name : 3F-ZONE B

Room No : PVT 305

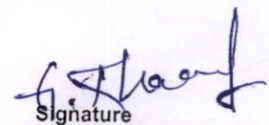
Admission Type : First Visit

Contact Details :
Name : Mr GOLI THARUN REDDY

Relationship : Father

Contact Address : HALLMARK TREASOR, SURVEY NO 155 & 156, FLAT NO 504, GANDIPET MAIN ROAD, NARSINGI, Gandipet Hyderabad Telangana INDIA 500075

Phone No : 8179563510 / 9704715494


Doctor Details :
Doctor Name : Dr. VIJAYANAND JAMALPURI

Specialisation : GENERAL PEDIATRICS

Referral Doctor : SELF

Phone No :
Co-Consultant :
Payment Details :
Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

Date of Birth	:		New Born Screening	:	
Time of Birth	:		TFT	:	
Mode of Delivery	:		OAE	:	
Birth Weight	:		Mother's Blood Group	:	
Head Circumference	:		Baby's Blood Group	:	
Length	:		Anomaly Scan	:	
Red Reflex	:		Vaccination	:	

[illegible]

[illegible]

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

Date of Admission : _____

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

Consultant : _____ Dept : _____

Date of Discharge : _____ Time : _____

BAH-00861676 IP5-00176410
Baby GOLI SRI TRISHIKA PRASANNA
28-05-2026 0 Y 1 M 17 D (F)
Dr. VIJAYANAND JAMALPURI



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
15/7/26	10:20 AM	ER	305	R
15/7/26	7:15 PM	305	Niece	Suchu
15/7/26	9:45 PM	MICU	305	Durga

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Abhishek sir	16/7/26	9705914	Jessie
2	Dr. Manu chandhary	16/7/26	9712615	Jessie
3	Dr. Abhishek	20/7/26	9705914	Jessie
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]



1

1

Prepared By :

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



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD



Patient Name: Trishika

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Fever since 6 days.

~~Cold~~ Rash over body since 6 days.

Loose stools since 6 days.

Cold since 1 day.

History of present illness :

Child with above mentioned complaints admitted in outside hospital & treated as A/E C Acute Gastroitis.

Inj taxim }
Inj Amikacin } given for 5 days.

↓
Discharged from the local hospital, but the baby is still having high grade fever spikes.

↓
Hence came to our hospital for further management.

Fever - High grade fever

- upto 101.5°F max.

- multiple

Rash → Started on stomach → Trunk → Back → UL → LL

↓
After Atarax bolus & IV medication ⇒ Rash faded & presently on LL, UL (+).

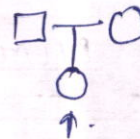


Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

3.56 kg / LSCS no non progression of labour
CTAB / NNJ - 1 day PT given



Birth & Socio Economic History:

About Father : _____
About Mother : _____
Any additional Information : _____
} upper middle class.

Developmental History :

② development

Immunization History :

Birth vaccine given



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 4.73kg (Centile _____)

On Examination :

Temperature : 101.5°F Pulse Rate : 171/min B.P. 83/62(76) SP02 99% on RA

Resp. rate and type of breathing : RR = 30/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/LAE (+)

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S1S2 (+)

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Soft, tenderness all over abdomen (+)

Auscultation : _____

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____

Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

AFI e Rash



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

CBP, CRP, RP2, LFT, ~~+~~
Blood Gc, . Dengue IgM, ~~+~~
Perip Blood for MP, ~~---~~
CVE, Urine Gc → (Catheter ~~sample~~)

~~SSB~~

~~NS~~

~~15/7/26~~

~~10 AM~~

Planned Management

- IV fluids
- ~~1st~~ IV antibiotics after reports
- Inform to Dr. V J Sir
- Enoxin drops sos
- Nasoclear nasal drops
- Atarex lotion - LA

Signature of the Doctor: Ramy

Name of the Doctor: Dr. Ramya

Date & Time: 15/7/26 ; 9:40am

Signature of the Consultant: Rajg-2

Name of the Consultant: _____

Date & Time: _____

Dr. VIJAYANAND JAMALPURI
Reg. No: 40526



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Fever started on. 8/7/26. night Admitted on 9/7/26. E high grade fever - Rash. Rash Stomach → Trunk → lower LL & UL. Started	
15/7 10:45am	C/S/B Resident Δ: <u>Acute exanthematous fever</u> - fever last at 8am. - 101°F Rash resolving O/E: - alert - vitals stable - rash (+) over forearm - blanching maculopapular. - AF @ level. - no dehydration - pallor (+) I ⊖ C ⊖ C ⊖ L ⊖ E ⊖ - R/S: BAE ⊕ / clear - P/A: soft / NT / no HSM.	Adv: 1.) Trace labs ↓ Inform SOS 2.) W/f fever spikes. 3.) Plan medications based on labs Atchile

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/7/26 1:30 pm	Discussed with Dr. Vijayanand informed labs	Adv. - Start Inj Piptaz - Start Inj Piptaz.
		<u>Abhile</u>
15/7/26 6:15 pm	4/5/6 Dr. V.J AFI-D ₆ = manto-papular rash. Rhinotheca :: yesterday. - 1 fever spike :: morning. - passed urine. O/E, vitals - stable RSZ G/L VRS P/A = soft; mild distention peripheries: warm manto-papular rash @	<u>Perns:</u> • Continue IV. Abx. • Send Mycoplasma IgM in existing samples • Yersinia in exist sample • True Dengue IgM. - Change to Noropenam 2.P. & ICSF analysis now. 2. CSF for c/s.

Dr. VIJAYANAND JAMALPURI
Reg. No: 40324

BAH-00661676 IP5-00176410
Baby GOLI SRI TRISHIKA PRASANNA
28-05-2026 0 Y 1 M 17 D (F)
Dr. VIJAYANAND JAMALPURI



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/26	MORNING ROUNDS	
9:00 AM	AFI-D ₇ = Mammulo-papular rash	
	<u>MENINGITIS</u>	<u>Plan</u>
	• 3 fever spikes / 24 hours	→ IVF - 1/2 maintenance
	• Oral intake good	- Denys as per chart
	• U/ stools - passed.	Trace Mycoplasma IgM
	O/E, sleeping	CSF analysis
	vitals - stable	Blood c/s; CSF c/s.
	pulse: good when	monitor vitals / 24 hrs
	% - NAD	
	AP: Normal.	<u>Plan</u>
16/7/26	c/s/b Dr. V.J	
9:10 AM	- 3 fever spikes.	- NSG now
	O/E, active.	- Neurology review
	Vitals - stable	- Microbiologist o/c
	% - AP: flat	for PCR of CSF.
	% - NAD.	noted by Jernie
	Dr. VIJAYANAND JAMALPURI Reg. No: 40526	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7 A: 30pm	C/S/B Resid <u>Seen Resident</u>	
	<u>Δ: Meningitis (D7)</u>	<u>Adv:</u>
	- 1 fever spike today - 100.1°F	1) Continue D1 Meropenam - 1/2 maintenance fluid
	- feeding well	2) Trace: CSF c/s Mycoplasma IgM.
	O/E: - alert	3) Send comprehensive CSF panel & CSF geneXpert
	- vitals stable	4) 48 hour blood c/s awaited
	- chest clear	5) W/f fever spikes dull activity seizures.
	- rash resolved	While
	- no dehydration	
	- spinal tap site - healthy.	
	- no s/o infection over back.	
	- AF at level activity - okay tone - good	
	S/E: NAD	

Dr. VIJAYANAND JAMALPURI
 Reg. No. 40000

noted by Junc.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/7 8am	<u>Seen by Resident</u> <u>Δ: Meningitis (D8)</u>	
	1) 3 low grade fever spikes yesterday	<u>Adv:</u> 1) Meropenam D2
	2) feeding well.	2) Trace CSF cfs & TB GeneXpert
	O/E: alert activity good. rash resolved AF at level. no dehydration CRT & 2s. chest clear abdomen soft NFND - no neurological deficit	3) W/F fever spikes 4) Send comprehensive CSF panel to out lab. 5) 48 hour blood traced.
		Akshita

BAH-00661676 IP5-00176410
 Baby GOLI SRI TRISHIKA PRASANNA
 28-05-2026 0 Y 1 M 18 D (F)
 Dr. VIJAYANAND JAMALPURI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/7 10 am	Seen by Dr. Vijayanand	
		<u>Adm:</u>
		1) Hc every alternate day
		2) Continue IV Meropenam
		3) Trace blood cfs / CSF cfs
		4) Cannula care
		5) CBP, CRP T/M
		6) Daily wt check <i>Dr. Ashish</i>
		7) Trace all the pending Investigations.
	Dr. VIJAYANAND JAMALPURI Reg. No: 40526	
		<u>Noted by</u> <i>Rina</i>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/7/26 3:45pm	SIB Dr. vijayanand Δ: meningitis no fever since 6am taking feeds well urine ✓ stool ✓ vitals stable	Plan: (1) Trace CSF q/s (2) Trace CBP CPP. (3) Trace Blood q/s (4) Trace pending Investigations (5) Cont. IV Abx
18/7/26 8:30am	Seen by Dr. Vijayanand Δ: Meningitis feeding well low grade fever spike O/E: vitals stable alert no RD. no dehydration chest clear abdomen - spleen & liver just palpable	Adm. 1.) Continue IV Meropenam 2.) D/w Neuro team regarding antibiotic therapy 3.) Trace CSF q/s 4.) Stop IVF Dr. Shikha

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7 5:05 pm	Seen by Dr. Vijayanand <u>Δ: Meningitis</u> - CSF c/s } CSF PCR } negative - one fever spike - 100.4°F at 4pm - feeding well O/E: activity good hydration fair chest clear cannula - okay	<u>Adv.</u> 1.) Trace F2h CSF - c/s 2.) Continue Meropenam 3.) Continue EBM + FF 4.) Dr. Nilesh to see t/m Akhila Dr. Akhila Dr. VIJAYANAND JAMALPURI Reg. No: 40520
18/7/26 10:pm	C/O/E Dr. VJSr, Persistent fever spikes (F)	Plan: • Inj Vancomycin (start now) • Rst CT cell • Inform sus. Dr. Ramya

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/12/26 11:50 pm	S/R Resident	
	Rash over face (f) body (r)	Plan: • Stop Inj Vancomycin do • Inj Anal Inj Hydrocortisone } stat given • Rest C7 all • Vitals recheck after 2hr • Inform nurses.
	O/E: HR = 168/min RR = 28/min BP = 74/30(22) mmHg SpO ₂ = 97% on RA	
	S/E: NAD-	
		Dr Penny

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B Dr. Nitasha	
	<u>Meningitis (D12)</u>	<u>Adv.</u>
	- 2 fever spikes yesterday feeding well	- Cont Meropenam - Hold Vancomycin
	O/E: hydration okay vitals stable chest clear	- Cont current feeding - Trace CSF c/s thm
	<u>ms</u>	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/07/26 2:30 PM	U/W Dr. Vijayanand	
	1 Episode of fever. ~101°F	dx
	Activity - (N)	CBP
	Urine output - (N)	CBP
		PCT
		S. Ferritin
		Blood Ue.
		- W admission to add.
		- MRI-Brain Contrast Thu.
		- vitals monitoring
		(N. Beathu)
		Noted by Durgar 20/7/26 @ 8am



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26 11am	SIB Resident 1. meningitis. low-moderate grade fever (+) no vomiting taken feeds ✓ O/E: child active vitals stable AF at level RU - BIL AEF (+) CVS - S/S (+) USG - ✓	plan: (1) cont. meropenem (2) colistin colistin (3) monitor vitals (4) waf fever (5) send bloods (6) MRI Brain report
20/7/26 11am	Seen by Dr. Vijayanand MRI brain done c contrast 3 low grade fevers (100.8°F) feeding well. O/E: alert vitals stable activity good	Adv: 1) Monitor vitals esp. sensorium 2) Continue IV antibiotics 3) Collect MRI films now 4) Consultation with Neurology & Pediatric ID. Shila



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7 4pm	C/S/B Resident Seen by Dr. Vijayanand	
	→ afebrile today → feeding well ↓	Adv.
	O/E: activity - okay - tone - ①	1.) Continue current antibiotics
	- AF @ level.	2.) Collect MRI report
	- no dehydration	R/v with Neurology & Infectious dx
	- S/E: NAD.	
		Akhila
		N/b jennice

Date & Time	Progress Notes	Doctor's Order
2/7 8:10am	Seen by Dr. Vijayanand	
	A : <u>Meningitis</u>	<u>Plan.</u>
	-afebrile since 32h	
	- feeds - accepting well.	1) Continue IV anti meo and colism for 7-10 days
	O/E: activity - good	2) Hc measurement on altdays.
	tone - normal.	
	AF at level	3) To discuss c IP consultant.
	stable vitals	
	chest clear	
	Hc - <u>38ants</u>	4) R/v Weil Felix in next prich
		Dr. VIJAYANAND JAMALPURI Reg. No: 40526
		noted by syothi

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/12/2026 3pm	ds: meningitis. No fresh complaints No fever for 3 days Feeding well. Passing urine and stool. - O/E Sleeping comfortably. Actively moving all limbs Vitals - stable Rt sup, liver felt. Ct - 28 sec, pulse - good Peripheries - warm	Plan - Ct by melo (D7) COLISTH (D3) - Rx antibiotics for 7-10 days - Rx well flex test - HC measurement on alternate day monitor vitals Prof Dr. Ramesh Babu
21/12/2026 4pm	ds: meningitis No TB contact N/Ho travel to hilly areas N/Ho pets	Plan - Send well flex in same sample - 2D Echo tomorrow - Ct antibiotics - Yamini 60000 Dr. VIJAYANAND Reg. No: 40520

BAH-00661676 IP5-00176410
 Baby GOLI SRI TRISHIKA PRASANVA
 28-05-2026 0 Y 1 M 23 D (F)
 Dr. VIJAYANAND JAMALPURI



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/2026 8AM	SIB Resident Δ: Meningitis no fever no new rashes O/E: Child alert vitals stable RS / normal CR / PIA pr good.	plan (1) cont. meropenem (2) trace urine fever (3) head circumference measurement on alternate day (4) monitor vitals (5) 2D Echo today (6) Inform doc. (7) Dr. Manu Chaudhary room (to discuss T).
22/7/26	Seen by Resident Δ: Meningitis afebrile for 64h. feeding well O/E: activity good vitals stable CR T < 35. pulse vol good S/E: NAD Weir fever - neg	Dr. VIJAYANAND JAMALPURI Reg. No. 40526 Adv: 1) Cont Meropenam & Colistin 2) Check HC T/m 3) 2D Echo today. Afebrile

Date & Time	Progress Notes	Doctor's Order
23/7/26 9:30 AM	<u>q/s/b Dr. V.J</u> <u>- MENINGITIS :</u> - Afebrile - Feeding well Q/G stable vitals - clear A/E - NAD.	<u>PLAN:</u> - plan discharge today Tomorrow - Colic aid - Sy cover sos. - I.V. Antibiotics • <u>NSG today</u> → <u>HOLD</u>. - Inform F.D team (incl. ^{MD} ^{si}) thru Monday/Tuesday. <u>N/B Jessie</u>

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



RESULT SHEET

RCH-E

Date	9/7/26	10/7/26	11/7/26	12/7/26	14/7/26	15/7
Time	← Outside labs →					10am
Hb	10.1			9.4	9.3	9.7
PCV	30.2			26.9	26.9	30.1
RBC	3.0			2.7	2.7	2.9
WBC	7500			7900	7800	15410
N/L	30/41			24/53	37/41	43/44
Platelets	3.37L			2.6L	2.29L	3.45L
CRP	19.2		30.2	28.2	20.2	62 ↑
ESR						
PCT		0.349			0.341	
RBS						
Na	134	136				134
K	5.2	4.5				4
Cl	104	99				103
Ca/Mg		10.1/				
Phosphate						
Urea		19				11
Creatinine		0.3				0.2
ALP						142
SGPT						15
SGOT						19
T.Bill/Conj						1.4/0.9
T.Protein						5.5
S.Albumin						3.1
S.Globulin						2.4
A/G Ratio						1.2
Uric Acid		3.4				
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells Ferritin →						310
N/L HCO ₃ ⁻						20

BAH-00661876 IP5-00176410
 Baby GOLI SRI TRISHIKA PRASANNA
 28-05-2026 0 Y 1 M 17 D (F)
 Dr. VIJAYANAND JAMALPURI



RESULT SHEET

Date	17/7/26	19/7/26			
Time	3.16 pm	4.19 pm			
Hb	8.9	8.8			
PCV	26.2	27.1			
RBC	2.76	2.78			
WBC	11.20	14.66			
N/L		34.3/45.4			
Platelets	358	459			
CRP	43.0	34 ↓			
ESR					
PCT		0.217			
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

ferretin 426

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

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

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

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

Signature
VERIFIED BY : Name

DRUG CHART

Date of Admission: 15/2/26 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 : CROUN DROPS				Date Time
Dose	Route	Frequency	Start Date	
0.7ml PO		SOS	15/2	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				
T > 100°F (1ml/100mg)				

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. 4.73kg Ward.

VERIFIED

DRUG : <u>Inj PIPERACILLIN</u>				Date/Time
Dose	Route	Frequency	Start Date	
<u>500mg</u>	<u>IV</u>	<u>TID</u>	<u>15/7</u>	<u>6AM</u>
Name & Signature of the Doctor Starting the Drugs:				
<u>Shihle</u>				
Additional Instructions:				
<u>100mg/kg/dose</u>				
Daily Doctor's Endorsement by a Sign				

VERIFIED

DRUG : <u>Inj ESOME PRAZOLE</u>				Date/Time
Dose	Route	Frequency	Start Date	
<u>5mg</u>	<u>IV</u>	<u>OD</u>	<u>15/7</u>	
Name & Signature of the Doctor Starting the Drugs:				
<u>Shihle</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

VERIFIED

DRUG : <u>Inj. MEROPENAM.</u>				Date/Time
Dose	Route	Frequency	Start Date	
<u>180mg</u>	<u>I.V</u>	<u>TID</u>	<u>15/7</u>	
Name & Signature of the Doctor Starting the Drugs:				
<u>Shihle</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : <u>Inj VANCOMYCIN</u>				Date/Time
Dose	Route	Frequency	Start Date	
<u>475mg</u>	<u>IV</u>	<u>TID</u>	<u>18/7</u>	<u>6AM</u>
Name & Signature of the Doctor Starting the Drugs:				
<u>A. Ramya</u>				
Additional Instructions:				
<u>47.5mg IV TID</u>				
Daily Doctor's Endorsement by a Sign				

0.1ml
5ml

Weight. Ward.

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.	

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

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
15/7	6:50pm	SYP. PEDICUREL	2ml.	P.O	Lahri	Suchi Suman
15/7	9:30pm	Inj. PARACETAMOL	50mg	I.V	Lahri	Durga Swarna mounita
18/7	12AM	Inj AVIL	0.1ml	IV	Sh	Suman mounita
18/7	12AM	Inj HYDROCORTISONE	10mg	IV	Sh	mounita samana

12:05
12:05



Weight. 4.7 kg Ward.

[illegible]

Signature

VERIFIED BY: Name



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Patier 15/5/26

te: 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 in charge 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.
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- 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

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S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
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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)

17/11/20

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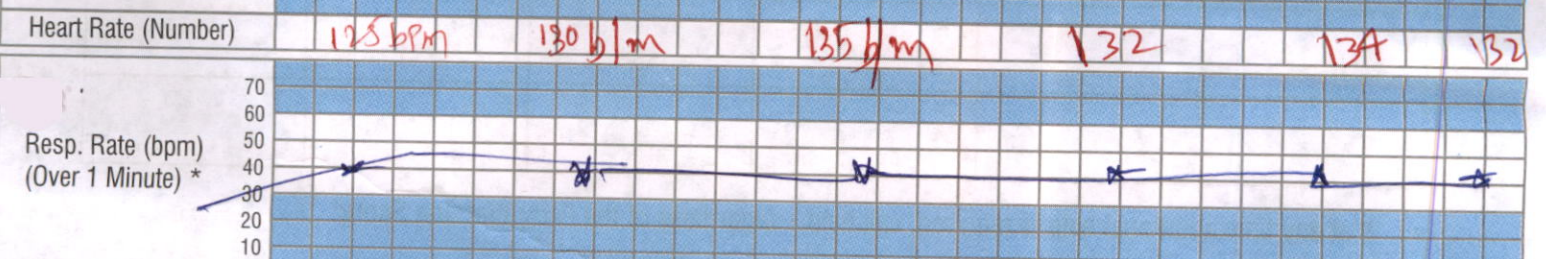
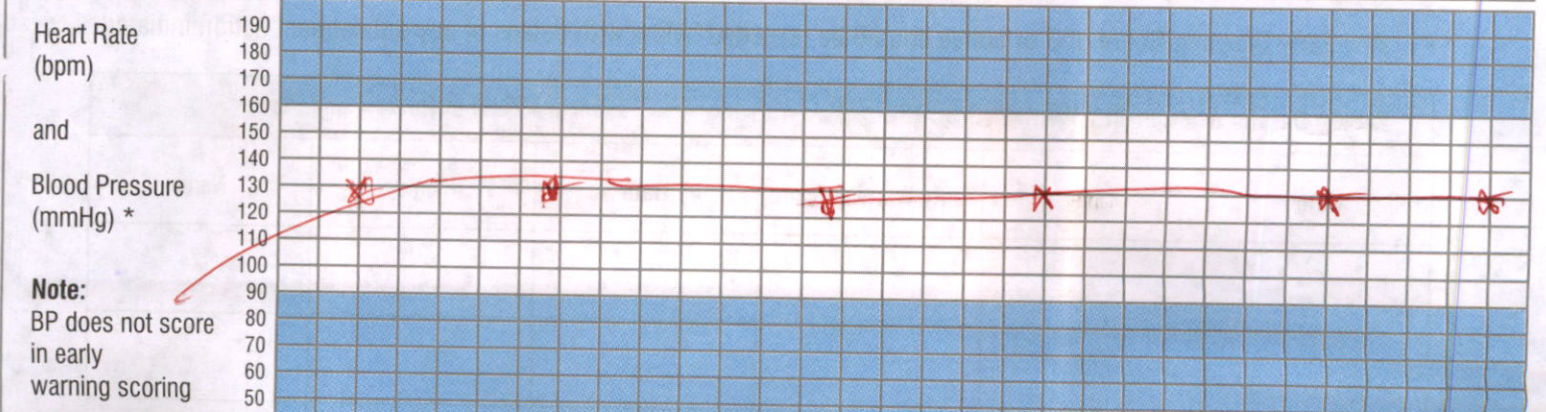
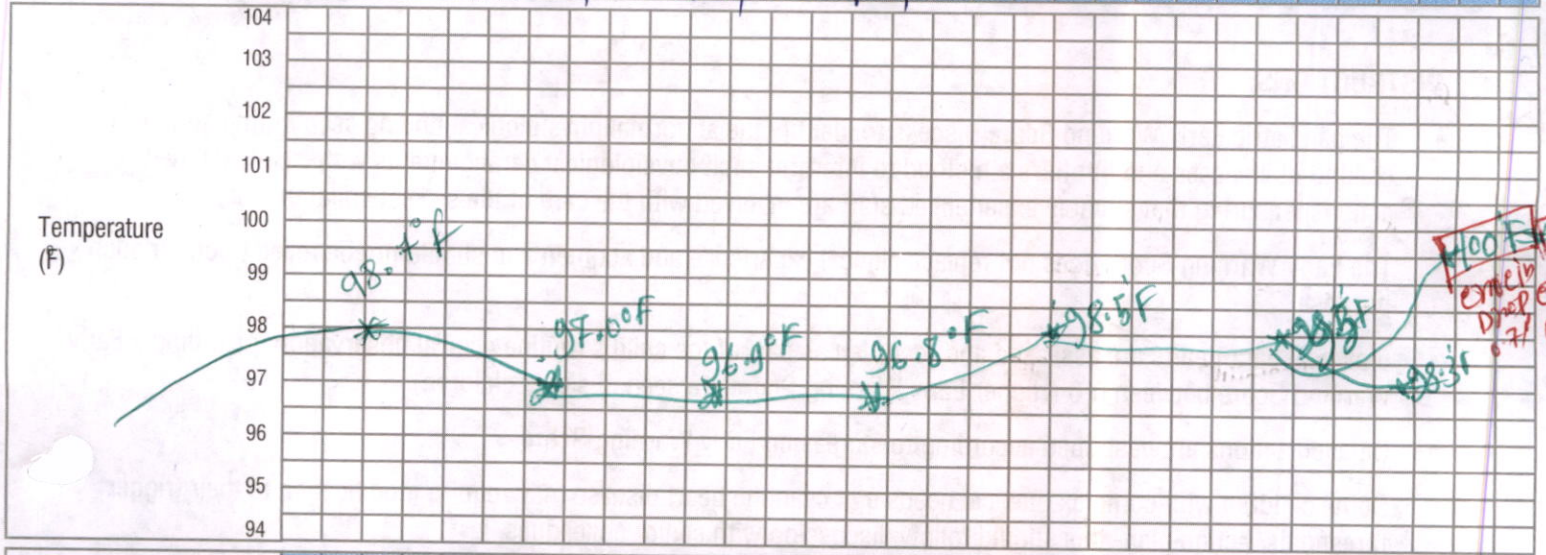
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INFANT (<1 year) Children's Observation & Early Warning Scoring Chart

17/7/26 EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 7 AM 10 AM 2 PM 6 PM 10 PM 2:30 AM 4 AM 6 AM 7 AM
 Doctor/Nurse/Family Concern? Am Pm Pm



Heart Rate (Number)	125 bpm	130 bpm	135 bpm	132	134	132
Resp Rate (Number)	38 bpm	38 bpm	38 bpm	32	34	32
Resp Mod/ Severe Distress						
Receiving O ₂ (l/min)						
O ₂ Saturations (%)	99%	98%	98%	99%	98%	99%
Conscious Level						
GCS *	(15/5)	(14)	(14)	(14/15)	(13/15)	(14/15)
TOTAL SCORE						
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	Dr	Dr	Dr	Dr	Dr	Dr

ACTIONS

- Score 1 : Continue normal observation by staff nurse
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- 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

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Date	Time	Early Warning Score	Date	Time	Name

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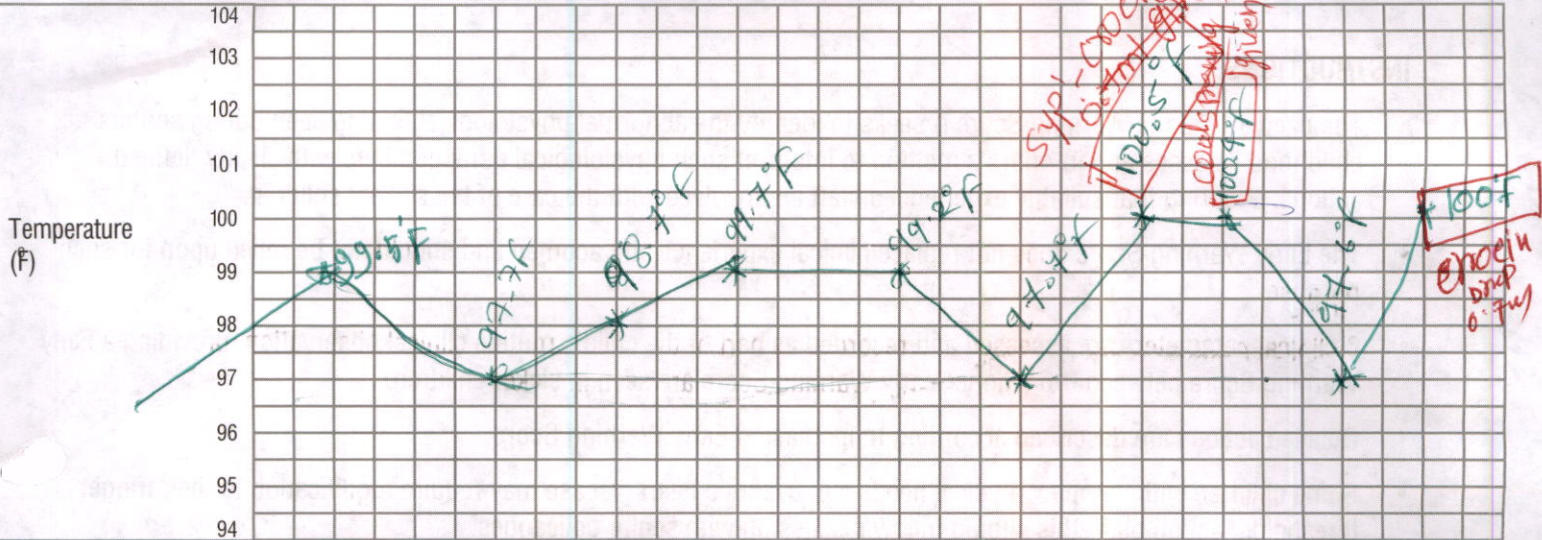
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INFANT (<1 year)
Children's Observation &
Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 7:20 AM 8:30 AM 10:30 AM 12:30 PM 2:30 PM 4:30 PM 6:30 PM 8:30 PM 8:50 AM
Doctor/Nurse/Family Concern?



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

Score 1 : Continue normal observation by staff nurse

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

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BAH-00661676 IP5-00176410
Baby GOLI SRI TRISHIKA PRASANNA
28-05-2026 0 Y 1 M 20 D (F)
Dr. VIJAYANAND JAMALPURI



18/7/26
: RCH / FRM / CLINICAL / 124

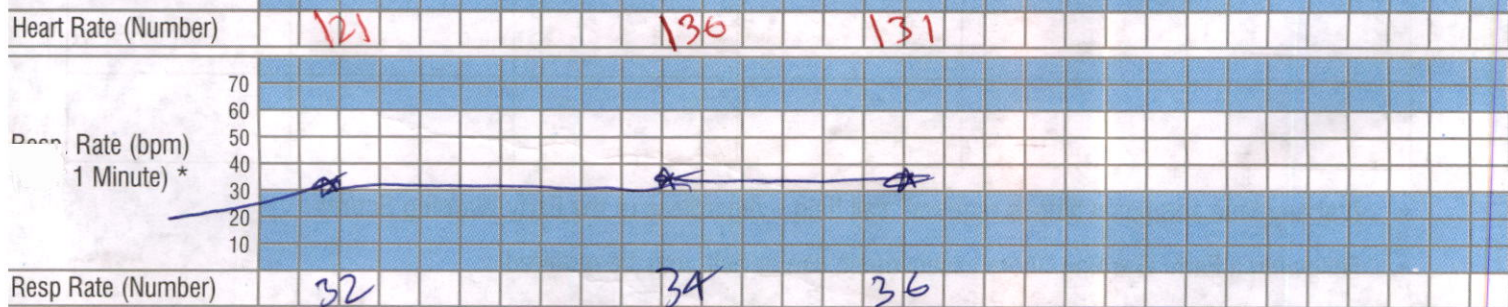
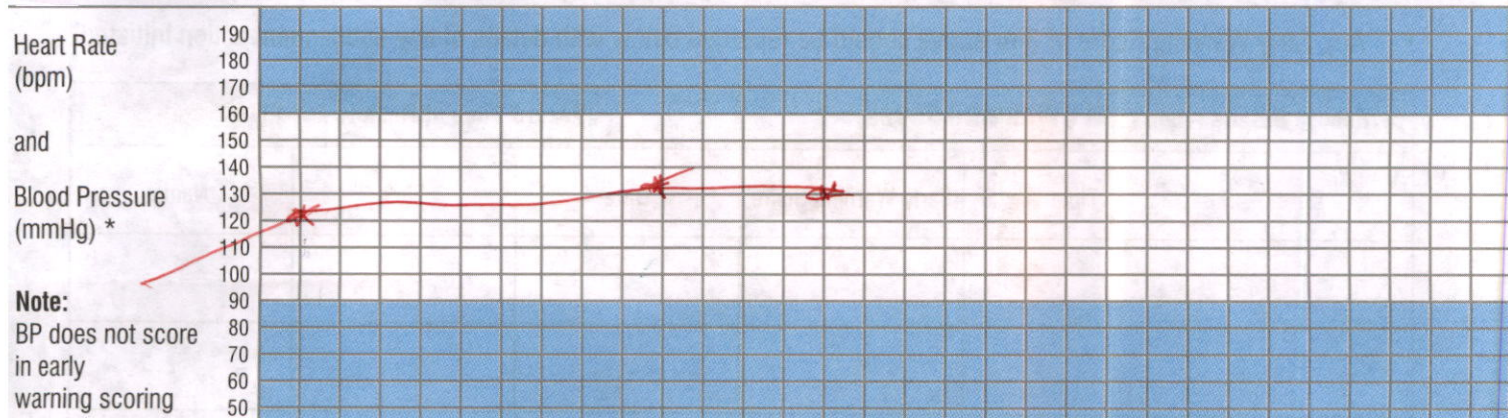
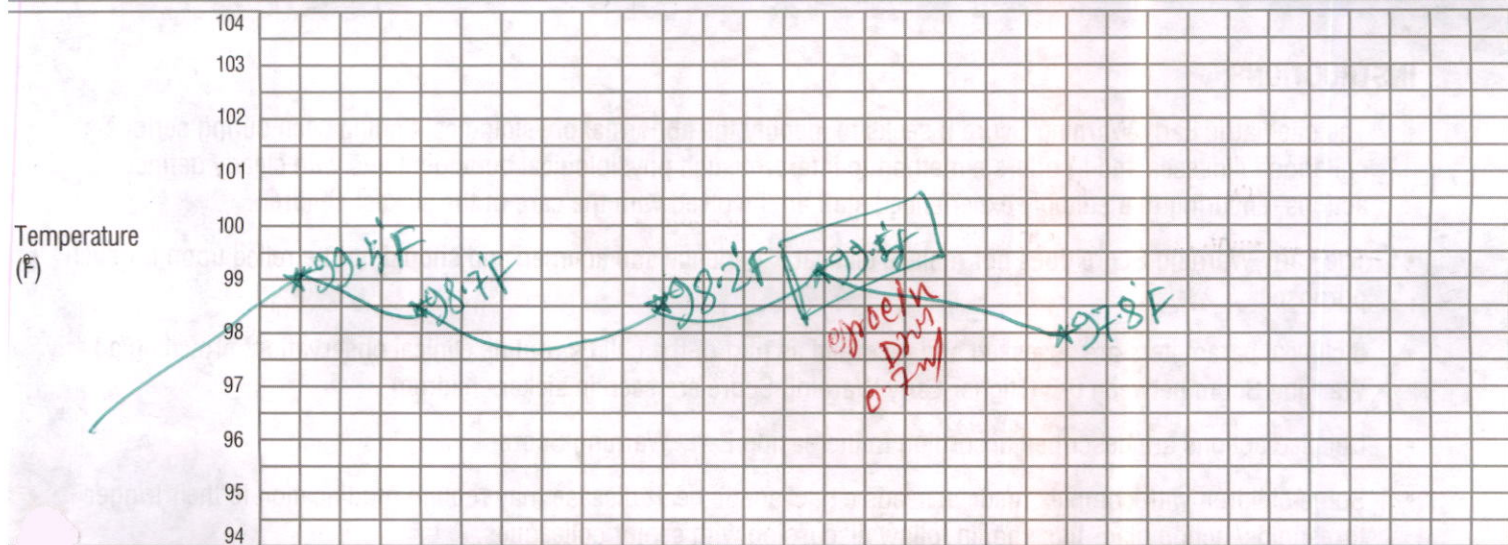
INFANT (<1 year) Children's Observation & Early Warning Scoring Chart

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: Time: 10PM 11PM 2AM 5:15AM 7AM
Doctor/Nurse/Family Concern?



Resp Distress	Mod/ Severe None / Mild			
Receiving O ₂ (l/min)				
O ₂ Saturations (%)	99%	99%	99%	
Conscious Level	Normal Altered			
GCS *	(14/5)	(14/5)	(14/5)	
TOTAL SCORE				
Number of shaded boxes	0	0	0	
Pain Score	0	0	0	
Observer's Initials	1	9	9	

ACTIONS	Score 1	: Continue normal observation by staff nurse
	Score 2	: Shift in charge nurse to be informed and continue hourly observations
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name
		151	151		

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28-05-2026 0 Y 1 M 20 D (F)
Dr. VIJAYANAND JAMALPURI



CH / FRM / CLINICAL / 124

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: Time: 10am 11am 12pm 12.45pm 2pm 6pm 6.45pm 7.45pm 9pm 11.30pm 12.30am 1.05am 1.35am

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)
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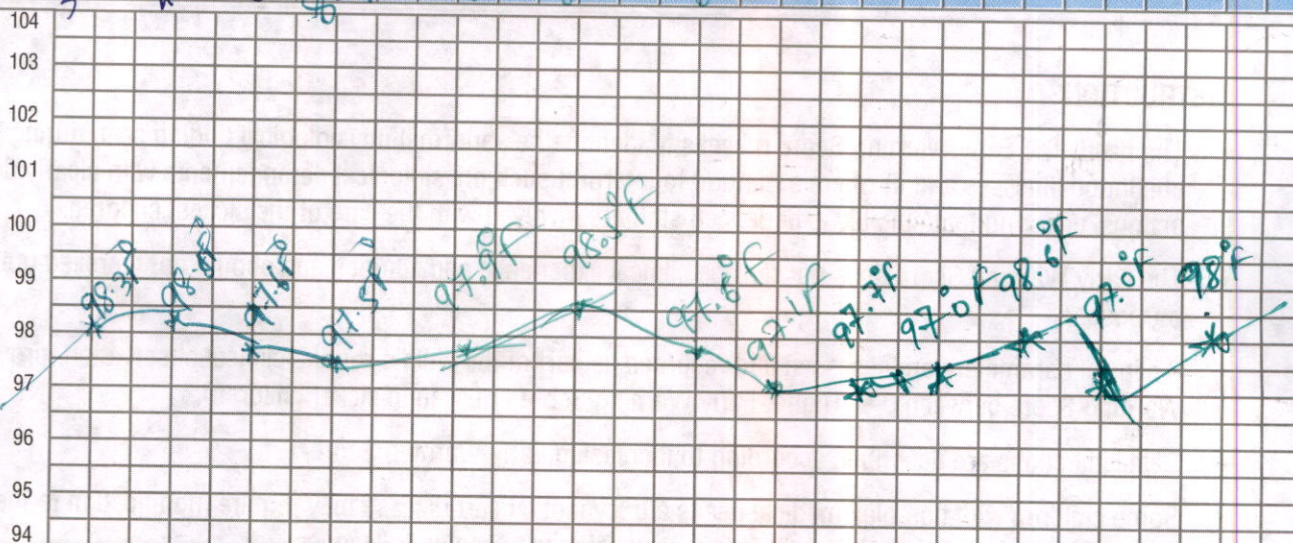
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 20/7/26 Time: 2:00pm

Doctor/Nurse/Family Concern?

Temperature
(F)

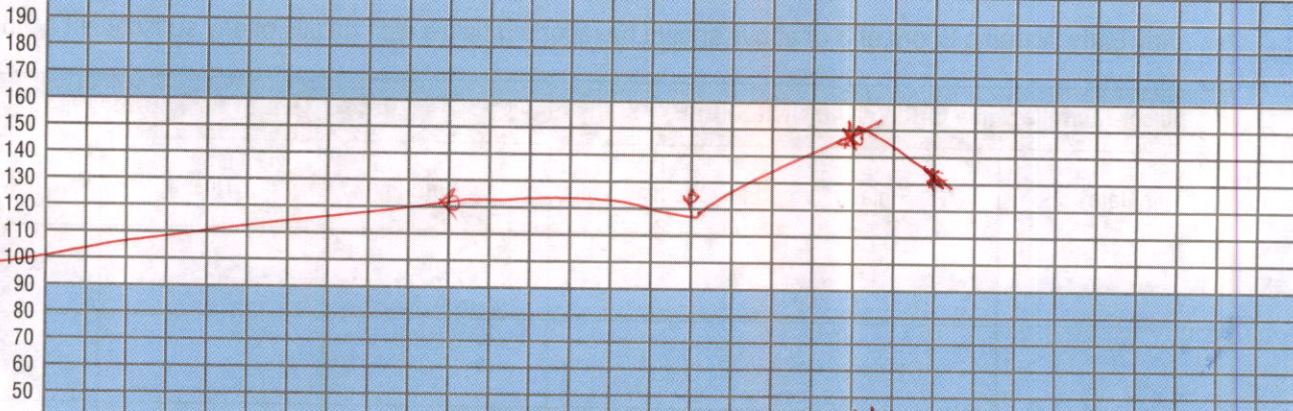


Heart Rate
(bpm)

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
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Normal Altered

GCS *

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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

BAH-00661676 IPS-00176410
Baby GOLI SRI TRISHIKA PRASANNA
28-05-2026 0 Y 1 M 22 D (F)
Dr. VIJAYANAND JAMALPURI



: RCH / FRM / CLINICAL / 124

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

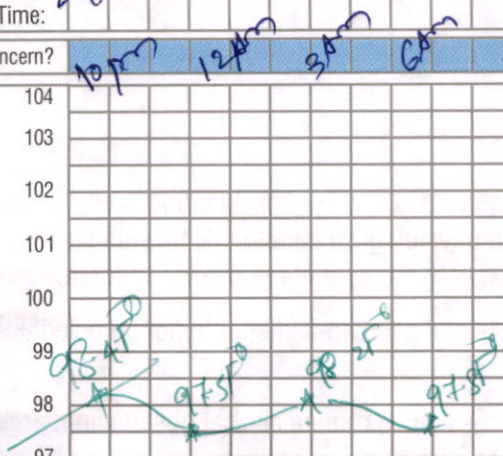
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time:

Doctor/Nurse/Family Concern?

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94

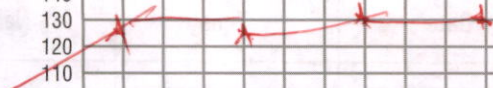


Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

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



Note:

BP does not score
in early
warning scoring

Heart Rate (Number)

70
60
50
40
30
20
10

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

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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.

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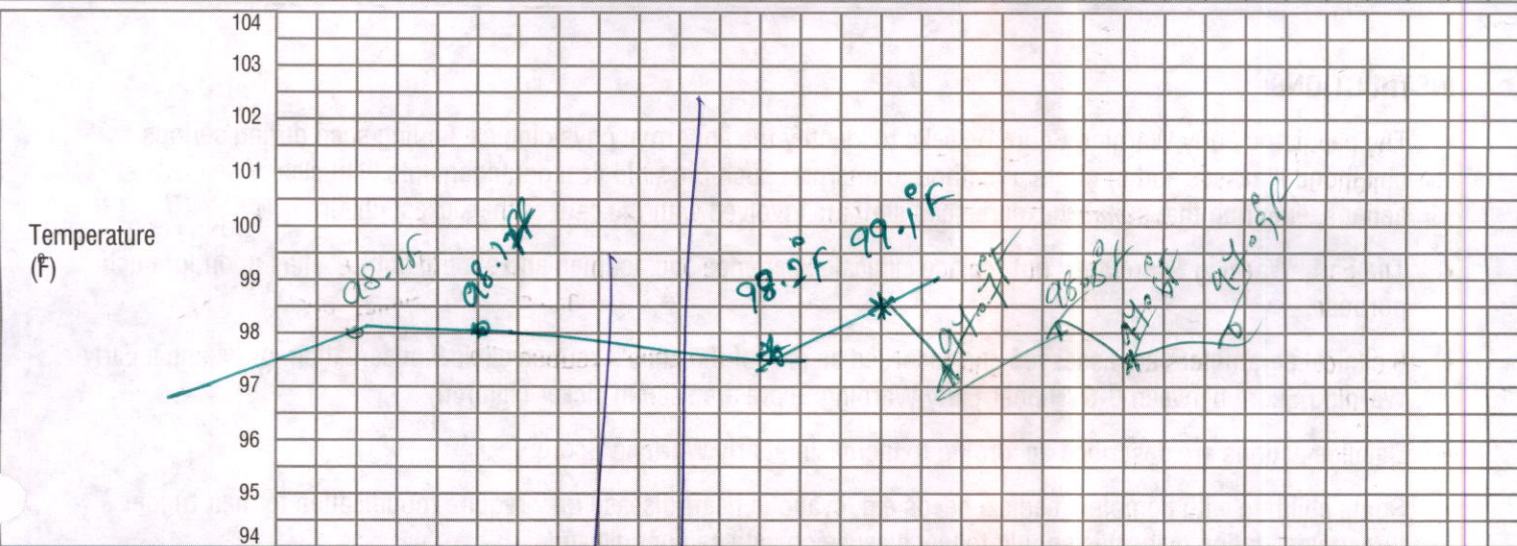


INFANT (<1 year)
Children's Observation &
Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 10AM 12PM 3PM 5PM 5:45PM 7:30PM 9PM 10:30PM 12AM 1PM

Doctor/Nurse/Family Concern?



Heart Rate (bpm)
and
Blood Pressure (mmHg) *

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

120b/h 100b/h 180b/h 160b/h

Refused Refused

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

Resp Rate (Number)

30b/h 35b/h 40b/h 40b/h

Resp Mod/ Severe Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

Conscious Level Normal Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

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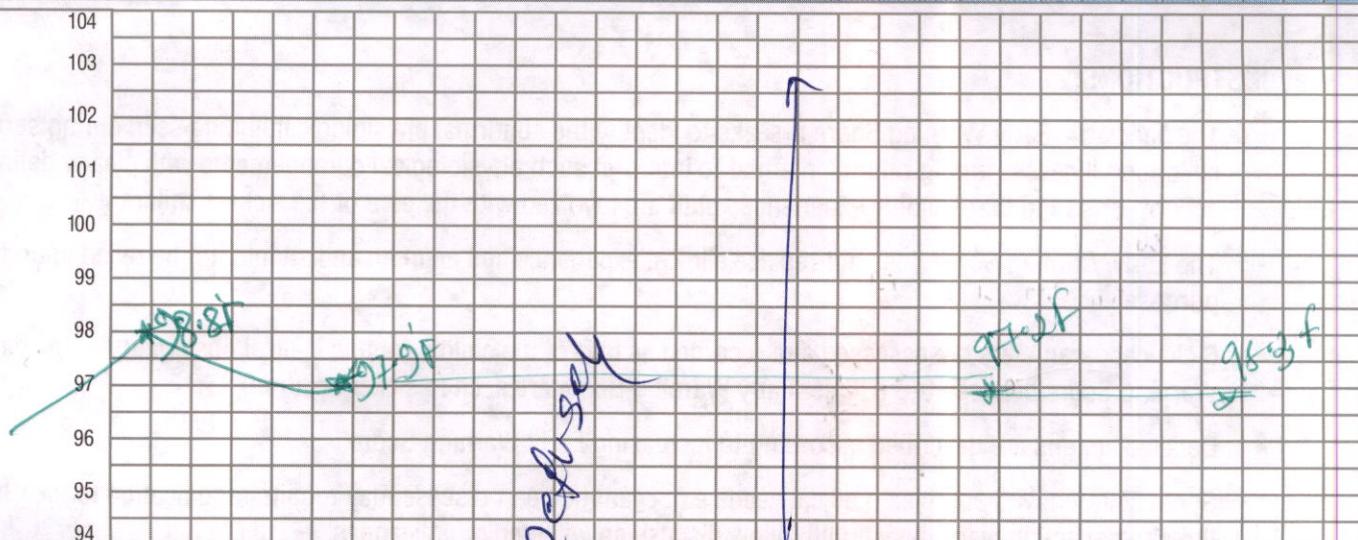
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 9AM 12PM 6PM 10PM 2AM 6AM

Doctor/Nurse/Family Concern?

Temperature
 (°F)

104
103
102
101
100
99
98
97
96
95
94



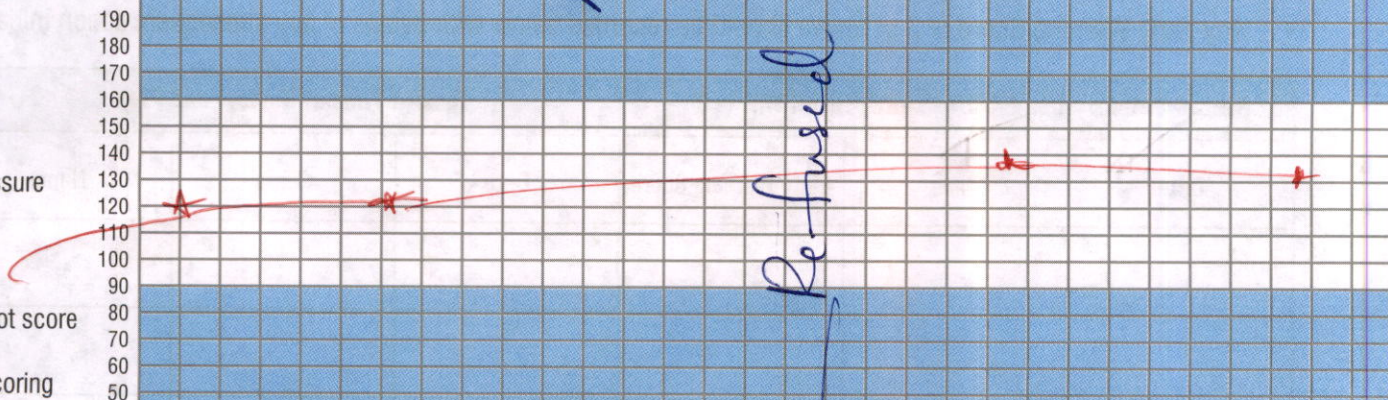
Heart Rate
 (bpm)

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

and

Blood Pressure
 (mmHg) *

Note:
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 warning scoring

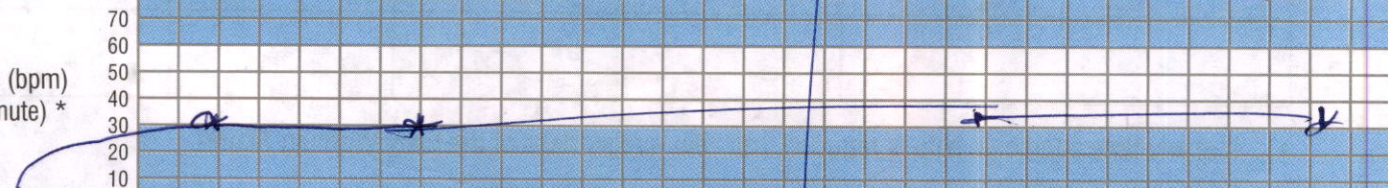


Heart Rate (Number)

124 124 124 129 bpm

Rate (bpm)
 (Over 1 Minute) *

70
60
50
40
30
20
10



Resp Rate (Number)

34 36 38 38

Resp Mod/ Severe
 Distress None / Mild

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

(100%) (100%) 99% 98%

Conscious Normal
 Level Altered

GCS *

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

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0 0 0 0

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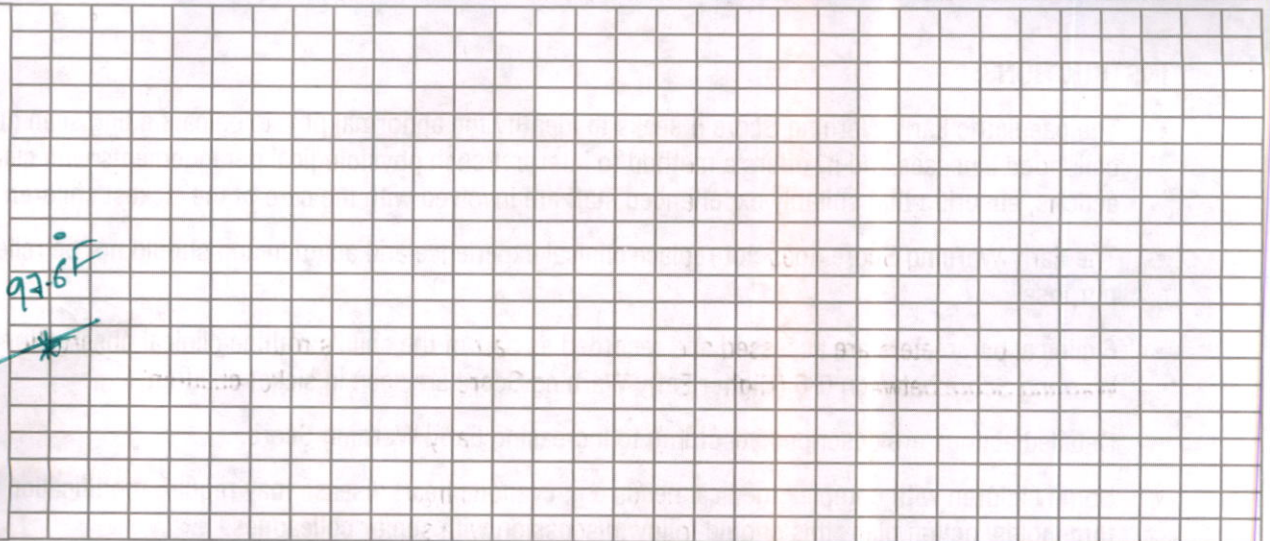
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 11am

Doctor/Nurse/Family Concern?

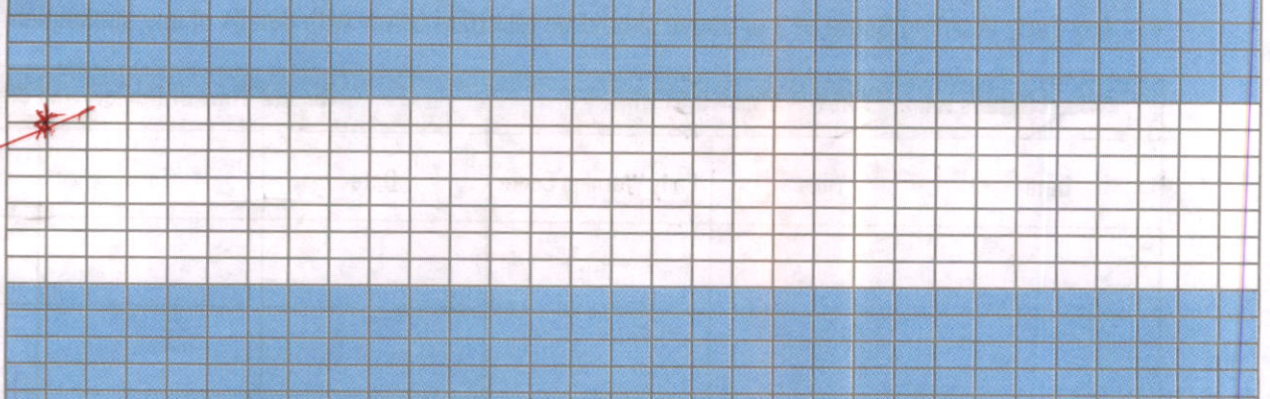
Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94



Heart Rate
(bpm)

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



and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

Respiratory Rate (Number)

70
60
50
40
30
20
10



Number)

Good/ Severe
None / Mild

(l/min)

is (%)

Normal

Altered

ORE

shaded boxes

Initials

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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		
15/7/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am									0	Such	
	12:00 pm	milk					✓			✓	0	Such
	01:00 pm						✓			✓	0	Such
Total Intake :			Total Output : M-2 U-2									
	02:00 pm									✓	0	Such
	03:00 pm	milk					✓			✓	0	Such
	04:00 pm										0	Such
	05:00 pm	water					✓			✓	0	Such
	06:00 pm										0	Such
	07:00 pm										0	Such
Total Intake :			Total Output : M-2 U-3									
	08:00 pm										0	Surge
	09:00 pm										0	Surge
	10:00 pm	no IVP	milk				✓			✓	0	Surge
	11:00 pm										0	Surge
	12:00 am										0	Surge
	01:00 am										0	Surge
Total Intake :			Total Output : U-1 M-1									
	02:00 am		milk								0	Surge
	03:00 am									✓	0	Surge
	04:00 am		milk								0	Surge
	05:00 am	no IVP					NP				0	Surge
	06:00 am	no IVP	milk	20ml						✓	0	Surge
	07:00 am			20ml							0	Surge
Total Intake : 20ml			Total Output : U-2 M-0									
Total 24 hrs. Intake			Total 24 hrs. Output									
20ml			U-8 M-5									



FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am	FF + 60ml									0	Jessie
	09:00 am			10ml							0	Jessie
	10:00 am			10ml			✓			✓	0	Jessie
	11:00 am	FF + 60ml		10ml							0	Jessie
	12:00 pm			10ml			✓			✓	0	Jessie
	01:00 pm										0	Jessie
Total Intake :			120ml + 40ml			Total Output : U - 3 M - 2						
	02:00 pm			10ml							0	Jessie
	03:00 pm			10ml							0	Jessie
	04:00 pm	mix		10ml			✓			✓	0	Jessie
	05:00 pm	mix.		10ml			✓			✓	0	Jessie
	06:00 pm			10ml			✓			✓	0	Jessie
	07:00 pm			10ml							0	Jessie
Total Intake :			11 - 60ml			Total Output : U - 2 M - 2						
	08:00 pm										0	Durga
	09:00 pm										0	Durga
	10:00 pm										0	Durga
	11:00 pm			10ml			✓			✓	0	Durga
	12:00 am			10ml							0	Durga
	01:00 am			10ml							0	Durga
Total Intake :			30ml			Total Output : U - 1 M - 1						
	02:00 am			10ml			✓			✓	0	Durga
	03:00 am			10ml			✓			✓	0	Durga
	04:00 am										0	Durga
	05:00 am						✓			✓	0	Durga
	06:00 am										0	Durga
	07:00 am										0	Durga
Total Intake :			20ml			Total Output : U - 2 M - 2						
Total 24 hrs. Intake			180ml			Total 24 hrs. Output			U - 8 M - 7			



FLUID CHART

Sheet No. : 12/7

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am			10 ml							0	Rim
	09:00 am	Milk		10 ml			✓			✓	0	Rim
	10:00 am	DNS		10 ml							0	Rim
	11:00 am			10 ml							0	Rim
	12:00 pm	Milk		10 ml			✓			✓	0	Rim
	01:00 pm										0	
Total Intake :			T - 50 ml			Total Output :					U - 2 M - 2	
	02:00 pm										0	Rim
	03:00 pm	1/2					✓			✓	0	Rim
	04:00 pm	DNS		10 ml							0	Rim
	05:00 pm			10 ml							0	Rim
	06:00 pm			10 ml			✓			✓	0	Rim
	07:00 pm			10 ml							0	Rim
Total Intake :			T - 40 ml			Total Output :					U - 2 M - 2	
	08:00 pm										0	suman
	09:00 pm	Milk									0	suman
	10:00 pm	DNS		10 ml			✓			✓	0	suman
	11:00 pm			10 ml						✓	0	suman
	12:00 am	Milk		10 ml							0	suman
	01:00 am			10 ml							0	suman
Total Intake :						Total Output :					U - 2 M - 1	
	02:00 am			10 ml							0	suman
	03:00 am	Milk		10 ml							0	suman
	04:00 am	DNS		10 ml			✓			✓	0	suman
	05:00 am			10 ml			✓				0	suman
	06:00 am	Milk					✓				0	suman
	07:00 am										0	suman
Total Intake :						Total Output :					U - 1 M - 3	
Total 24 hrs. Intake						Total 24 hrs. Output					U - 7 M - 8	



FLUID CHART

Sheet No. : *17/4/21*

- All measurements in ml.
- 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			
											0	Surge	
	08:00 am	Milk									0	Surge	
	09:00 am						✓			✓	0	Surge	
	10:00 am	Milk									0	Surge	
	11:00 am						✓			✓	0	Surge	
	12:00 pm	Milk					✓			✓	0	Surge	
	01:00 pm										0	Surge	
Total Intake :						Total Output : 0-3 M-3							
	02:00 pm	Milk								✓	0	Surge	
	03:00 pm						✓			✓	0	Surge	
	04:00 pm	Milk					✓				0	Surge	
	05:00 pm						✓			✓	0	Surge	
	06:00 pm	Milk					✓			✓	0	Surge	
	07:00 pm										0	Surge	
Total Intake :						Total Output : 0-4 M-4							
	08:00 pm										0	Surge	
	09:00 pm	Milk									0	Surge	
	10:00 pm						✓				0	Surge	
	11:00 pm	Milk					✓			✓	0	Surge	
	12:00 am									✓	0	Surge	
	01:00 am	Milk									0	Surge	
Total Intake :						Total Output : 0-2 M-2							
	02:00 am	Milk									0	Surge	
	03:00 am						✓				0	Surge	
	04:00 am						✓			✓	0	Surge	
	05:00 am	Milk					✓			✓	0	Surge	
	06:00 am										0	Surge	
	07:00 am	Milk									0	Surge	
Total Intake :						Total Output : 0-2 M-3							
Total 24 hrs. Intake						Total 24 hrs. Output							



FLUID CHART

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Your Right to a Safe Delivery

Sheet No. :

3

19/7/26

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

Date	Time	Nature of Fluid	Intake			Output						IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am		Milk				✓			✓	0	Durge	
	09:00 am										0	Durge	
	10:00 am		Milk				✓			✓	0	Durge	
	11:00 am						✓			✓	0	Durge	
	12:00 pm		milk				✓			✓	0	Durge	
	01:00 pm										0	Durge	
Total Intake :						Total Output : 0-4 M-4							
	02:00 pm		Milk								0	Durge	
	03:00 pm						✓			✓	0	Durge	
	04:00 pm		Milk				✓			✓	0	Durge	
	05:00 pm						✓			✓	0	Durge	
	06:00 pm		Milk				✓			✓	0	Durge	
	07:00 pm										0	Durge	
Total Intake :						Total Output : 0-4 M-4							
	08:00 pm										0	Suck	
	09:00 pm		Milk				✓			✓	0	Suck	
	10:00 pm										0	Suck	
	11:00 pm		Milk				✓			✓	0	Suck	
	12:00 am									✓	0	Suck	
	01:00 am		Milk							✓	0	Suck	
Total Intake :						Total Output : M-2 0-3							
	02:00 am		NPO	20ml							0	Suck	
	03:00 am		Milk	20ml			✓				0	Suck	
	04:00 am		NPO	20ml						✓	0	Suck	
	05:00 am		Milk	20ml							0	Suck	
	06:00 am		NPO							✓	0	Suck	
	07:00 am		Milk							✓	0	Suck	
Total Intake :						Total Output : M-1 0-3							
Total 24 hrs. Intake		7											
Total 24 hrs. Output		M-12 0-14											



FLUID CHART

Sheet No. : (K) 20/7/26

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		
20/7/26	08:00 am			90ml							0	Jyoth
	09:00 am			80ml							0	Jyoth
	10:00 am	D	milk								0	Jyoth
	11:00 am	N									0	Jyoth
	12:00 pm	S	milk	20ml							0	Jyoth
	01:00 pm	I		20ml							0	Jyoth
Total Intake :			90ml			Total Output :					0-2 m-1	
20/7/26	02:00 pm			20ml							0	Jessie
	03:00 pm		milk	90ml							0	Jessie
	04:00 pm										0	Jessie
	05:00 pm	D	milk	20ml							0	Jessie
	06:00 pm	N		20ml							0	Jessie
	07:00 pm	I	milk	20ml							0	Jessie
Total Intake :			60ml			Total Output :					0-7 m-2	
20/7/26	08:00 pm			20ml							0	Suh
	09:00 pm		milk	20ml							0	Suh
	10:00 pm										0	Suh
	11:00 pm	D	milk	20ml							0	Suh
	12:00 am	/		20ml							0	Suh
	01:00 am			20ml							0	Suh
Total Intake :						Total Output :					M-2 U-3	
20/7/26	02:00 am			20ml							0	Suh
	03:00 am		milk	20ml							0	Suh
	04:00 am										0	Suh
	05:00 am	D	milk	20ml							0	Suh
	06:00 am	/		20ml							0	Suh
	07:00 am			20ml							0	Suh
Total Intake :						Total Output :					M-1 U-2	

Total 24 hrs. Intake

Total - 320ml

Total 24 hrs. Output

M-6 U-1

BAH-00661676
Baby GOLI SRI TRISHIKA PRASANNA
28-05-2026 0 Y 1 M 22 D (F)
Dr. VIJAYANAND JAMALPURI



IPS-00176410

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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		milk 60ml							✓	0	Syathi
	09:00 am						✓				0	Syathi
	10:00 am		milk 60ml							✓	0	Syathi
	11:00 am										0	Syathi
	12:00 pm		milk 60ml							✓	0	Syathi
	01:00 pm						✓				0	Syathi

Total Intake : 180ml

Total Output : 0-3 m-2

	02:00 pm		milk 60ml							✓	0	Jessie
	03:00 pm						✓			✓	0	Jessie
	04:00 pm										0	Jessie
	05:00 pm		milk 60ml				✓			✓	0	Jessie
	06:00 pm										0	Jessie
	07:00 pm		milk 60ml							✓	0	Jessie

Total Intake : 180ml

Total Output : 0-3 m-2

	08:00 pm	1	milk 20ml							✓	0	Yamuna
	09:00 pm	1	milk 20ml				✓			✓	0	Yamuna
	10:00 pm	1	milk 20ml								0	Yamuna
	11:00 pm	1									0	Yamuna
	12:00 am	1	milk 20ml				✓			✓	0	Yamuna
	01:00 am	1	milk 20ml								0	Yamuna

Total Intake : 80ml

Total Output : 0-2 m-2

	02:00 am		milk 60ml								0	Yamuna
	03:00 am						✓			✓	0	Yamuna
	04:00 am		milk 60ml								0	Yamuna
	05:00 am										0	Yamuna
	06:00 am						✓			✓	0	Yamuna
	07:00 am		milk 60ml								0	Yamuna

Total Intake :

Total Output : 0-2 m-2

Total 24 hrs. Intake

milk 580ml + DMS 80ml

Total 24 hrs. Output

0-10 m-8



FLUID CHART

Sheet No. : 214 ⑥

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am										0	smk
	09:00 am	milk									0	smk
	10:00 am						✓			✓	0	smk
	11:00 am	milk								✓	0	smk
	12:00 pm						✓			✓	0	smk
	01:00 pm	milk									0	smk
Total Intake :						Total Output : U - 2 M - 2						
	02:00 pm										0	smk
	03:00 pm	milk	bow				✓				0	smk
	04:00 pm	bow					✓			✓	0	smk
	05:00 pm	milk	bow				✓			✓	0	smk
	06:00 pm										0	smk
	07:00 pm										0	smk
Total Intake :						Total Output : U - 2 M - 3						
	08:00 pm										0	smk
	09:00 pm	milk	bow								0	smk
	10:00 pm									✓	0	smk
	11:00 pm	milk	bow				✓			✓	0	smk
	12:00 am										0	smk
	01:00 am	milk	bow								0	smk
Total Intake :						Total Output : U - 2 M - 1						
	02:00 am										0	smk
	03:00 am	milk	bow				✓				0	smk
	04:00 am										0	smk
	05:00 am	milk	bow							✓	0	smk
	06:00 am										0	smk
	07:00 am	milk	bow							✓	0	smk
Total Intake :						Total Output : U - 2 M - 1						
Total 24 hrs. Intake			2 bowl			Total 24 hrs. Output			U - 8 M - 7			



23/8

FLUID CHART

Sheet No. : 2

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

		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	↓	Milk	20ml			✓			✓	0	Jessie
	09:00 am	↓	Milk	60ml							0	Jessie
	10:00 am	↓	Milk	20ml			✓			✓	0	Jessie
	11:00 am	↓	Milk	60ml							0	Jessie
	12:00 pm	↓								✓	0	Jessie
	01:00 pm	↓	Milk	60ml			✓			✓	0	Jessie
Total Intake :			120ml			Total Output :			U-4 m-3			
	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

Patient Sticker

FLUID CHART

Sheet No. :

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

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine				
			Mouth	I.V	N.G									
	08:00 am													
	09:00 am													
	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: 15/07/26

Assessment: patient is having discomfort

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

Time	Plan of Care	Time	Implementation	Evaluation
11:30 AM	* Assess the Baby Condition and vitals check	11:30 AM	* Assessed the baby Condition and vitals checked	* now baby Condition is stable
1 PM	* monitor the Pb chart	1:30 PM	* monitored the Pb chart	
3 PM	* every hourly check the fever spikes	3:30 PM	* every hourly checked the fever spikes	
6 PM	* Administer medicine as per chart	6:30 PM	* Administered medicines per chart	
7 PM	* Ensure Safety	7:30 PM	* Ensured Safety	

Re-Assessment: Assess the baby Condition now Condition is stable

Special Notes:

Nurse Signature: Sushu

Nurse Name: Sushu - 607635

Date & Time: 15/07/26 @ 8pm

BAH-00661676 IPS-00176410
 Baby GOLI SRI TRISHIKA PRASANNA
 28-05-2026 0 Y 1 M 18 D (F)
 Dr. VIJAYANAND JAMALPURI

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 15/7/26

Assessment: Pt having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the general condition of the Pt	9pm	* Assessed the general condition of the Pt	* Now Pt is stable
10pm	* Monitor the vital's	11pm	* monitored the vital's	
12pm	* Administer medication as per chart	1pm	* Administer medication as per chart	
2pm	* maintain I/O chart	3pm	* maintained I/O chart	
4pm	* Prevent infection	5pm	* Prevented infection	
6pm	* ensure safety	7pm	* ensured safety	
			re assessment done	

Re-Assessment:

Special Notes:

Nurse Signature: 

Nurse Name: Durga

Date & Time: 15/7/26 @ 8pm

BAH-00661676 IP5-00176410
 Baby GOLI SRI TRISHIKA PRASANNA
 28-05-2026 0 Y 1 M 18 D (F)
 Dr. VIJAYANAND JAMALPURI



NURSING CARE RECORD

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Shift: ☒ Day ☐ Night

Date: 16/7/28

Assessment: Baby having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the Baby general Condition	8:30 am	Assessed the baby general Condition	Baby is stable
10:30 am		4am		
12pm	Assess the Baby vitals	1:30 pm	Assessed the baby vitals	
2:15 pm	Assess the baby in a Comfortal. position	3pm	Assessed the baby in a Comfortable position	
5pm		6pm		
8pm	Check the baby temp	7pm	Checked the baby vitals	

Re-Assessment: Baby is stable now

Special Notes: Q/V - PCR of CSF

Nurse Signature: [Signature] Nurse Name: (605575) J. J. Date & Time: 16/7/28 @ 8pm

BAH-00661676 IP5-00176410
 Baby GOLI SRI TRISHIKA PRASANNA
 28-05-2026 0 Y 1 M 18 D (F)
 Dr. VIJAYANAND JAMALPURI



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 17/7/20

Assessment: pt having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the general condition of the Pt	9pm	* Assessed the general condition of the Pt	* Now Pt is stable
10pm	* monitor the vital's	11pm	* monitored the vital's	
12am	* Administer medication as per chart	1am	* Administered medication as per chart	
2am	* Maintain I/O chart	3am	* maintained I/O chart	
4am	* Prevent infection	5am	* prevented infection	
6am	* ensure safety	7am	* ensured safety	

Re-Assessment: re-assessment done

Special Notes:

Nurse Signature:

Nurse Name: Durga

Date & Time: 17/7 @ 8am



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 17/7/26

Assessment: Baby is having Discomfort.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8Am	Assess the general condition of the Baby.	8:30pm	Assessed the general condition of the Baby.	
10Am	Administer the medication as per Drug chart.	10:30Am	Administered the medication as per Drug chart.	
12pm	Monitor the vitals.	12:30pm	vital checked and recorded.	
3pm	Maintain the fluids.	3:30pm	continued the fluid 10ml/hr	
7pm	Ensure the safety.	7:30pm	Provided the side rails up.	

Now is the Patient Stable.

Re-Assessment: Re-Assessment Done y th only Done

Special Notes: cannula Removed. and new ~~cannula~~ cannula placement Done 3:30pm

Nurse Signature:

Nurse Name: Rini

Date & Time: 17/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 17/7/26

Assessment: PT having Discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8PM	→ Assess the PT condition	8PM	→ Assessed the PT condition.	PT is stable
11PM	→ vital chart maintain	11PM	→ vital chart maintain	
12AM	→ Ensure safety	12AM	→ Ensured safety	
6AM	→ continue IV fluid	4AM	→ continue IV fluid	
8AM		8AM		

Re-Assessment: PT is stable

Special Notes: - Nil -

Nurse Signature: S

Nurse Name: sumana

Date & Time: 18/7/26

BAH-00661676 IP5-00176410
 Baby GOLI SRI TRISHIKA PRASANNA
 28-05-2026 0 Y 1 M 19 D (F)
 Dr. VIJAYANAND JAMALPURI

NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 18/7/26

Assessment: Pt having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	* Assess the general condition of the Pt	9am	* Assessed the general condition of the Pt	* Now Pt is stable
10am	* Monitor the vital's	11am	* monitored the vital's	
12pm	* Administer medication as per chart	1pm	* Administered medication as per chart	
2pm	* maintain - 2/0 chart	3pm	* maintained 2/0 chart	
4pm	* Relieve pain & discomfort	5pm	* Relieved pain & discomfort	
6pm	* ensure safety	7pm	* ensured safety	

Re-Assessment: re-assessment done

Special Notes:

Nurse Signature:  Nurse Name: Purge Date & Time: 18/7/26 @ 8pm

BAH-00661676 IP5-00176410
 Baby GOLI SRI TRISHIKA PRASANNA
 28-05-2026 0 Y 1 M 19 D (F)
 Dr. VIJAYANAND JAMALPURI



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 18/7/26

Assessment: PT having fever

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8PM	→ Assess the PT condition.	8PM	→ Assessed the PT condition.	PT is stable
11PM	→ vital chart maintain	11PM	→ vital chart maintain	
12AM	→ Given erocin drop	12AM	→ Ensured safety	
4AM	→ Stopped IV fluid	6AM	→ Stopped IV fluid	
8AM		8AM		

Re-Assessment: PT is stable

Special Notes: NA

Nurse Signature:

Nurse Name: Sumanet

Date & Time: 19/7/26 @ 8AM

BAH-00661676 IP5-00176410
 Baby GOLI SRI TRISHIKA PRASANNA
 28-05-2026 0 Y 1 M 20 D (F)
 Dr. VIJAYANAND JAMALPURI



NURSING CARE RECORD

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Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 19/7/26

Assessment: PT having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	* Assess the general condition of the PT	9Am	* Assessed the general condition of the PT	* now PT is stable
11Am	* Monitor the vital's	11Am	* monitored the vital's	
12Pm	* Administer medication as per chart	3Pm	* Administered medication as per chart	
4Pm	* Maintain D/o chart	5Pm	* Maintained D/o chart	
6Pm	* Ensure safety	7Pm	* ensured safety	

Re-Assessment: re-assessment done

Special Notes:

Nurse Signature: Nurse Name: Durga Date & Time: 19/7/26 @ 8:30

BAH-00661676 IP5-00176410
 Baby GOLI SRI TRISHIKA PRASANNA
 28-05-2026 0 Y 1 M 21 D (F)
 Dr. VIJAYANAND JAMALPURI



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 19/7/26

Assessment: Baby having fever

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8PM	→ Assess the Baby's condition.	8PM	→ Assessed the Baby's condition.	Baby is stable
11PM	→ vital chart maintain	11PM	→ vital chart maint	
12AM	→ Ensure safety	12AM	→ continue IV fluids	
9AM	→ continue IV antibiotic	9AM	→ maintained good nutrition	
8M		8AM		

Re-Assessment:

Special Notes: Mrs - brain - Tammaru @ 8:30 AM

Nurse Signature: Nurse Name: snehel Date & Time: 20/7/26 @ 8AM



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 20/7/26

Assessment: patient having fever

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	→ Assess the pt condition	8:10	→ Assessed the pt condition	now pt is stable
10AM	→ maintain vital signs	10:30	→ maintained vital signs	
11AM	→ maintain Iv fluid	11:20	→ maintained Iv fluid	
12pm	→ 2nd hourly feeding	12:30	→ provided 2nd hourly feeding	
1pm	→ administer medication	1:30	→ administered medication	
2pm	→ ensure safety	2pm	→ provided ensure safety	

Re-Assessment: Re-assessment done

Special Notes:

Nurse Signature: [Signature] Nurse Name: Jyothi (A010532) Date & Time: 20/7/26 @ 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 20/7/26

Assessment: Baby having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the baby General Condition	2:30 pm	Assessed the baby general Condition	Baby is stable now
3:30 pm	Assessed the baby vitals	4pm	Assessed the baby vitals	
4:30 pm	Assessed the baby in a Comfortable position	5:30 pm	Assessed the baby in a Comfortable position	
6pm	Assess the baby hygiene	6:30 pm	Assessed the baby hygiene	
7:15 pm		7:30 pm		

Re-Assessment: Baby is stable now

Special Notes: NA

Nurse Signature:

Nurse Name: Jessie @ 9010577

Date & Time: 20/7/26 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/4/26

Assessment: Baby is having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	7 Assess the Baby	8:30pm	7 Assess the Baby	Also Baby is Stable
	7 Assess condition		7 Assess condition	
10pm	7 monitor vitals	10:30pm	7 monitor vitals	
12pm	7 Administer medication as per chart	12:30pm	7 Administer medication as per chart	
3am	7 monitor fluid Balance	3:30am	7 monitor fluid Balance	
4am	7 ensure safety	4:30am	7 Ensure safety	

Re-Assessment:

Re-Assessment done every 30 min.

Special Notes:

Nurse Signature:  Nurse Name: Sneha Date & Time: 21/4/26 @ 8am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 21/7/26

Assessment: baby having is Discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the baby condition	8:20	→ Assessed the baby condition	now baby's stable
10am	→ maintain vital sign	10:20	→ maintained vital sign	
11am	→ maintain Iv fluid	11:30	→ maintained Iv fluid	
1pm	→ administer medication	1:20	→ administered medication	
2pm	→ ensure safety	2pm	→ provide ensure safety	

Re-Assessment:

Re-assessment done

Special Notes:

Nurse Signature: A

Nurse Name: SVATHI C0010321

Date & Time: 21/7/26 @ 2pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 21/7/26

Assessment: Baby having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the baby general Condition	2:30 pm	Assessed the baby general Condition	Baby is stable now
3:30 pm	Assess the baby vitals	4pm		
5:30 pm	Assess the baby in a Comfortable position	6:30 pm	Assessed the baby vitals	
7pm	Administer the baby Medication	7:30 pm	Assessed the baby in a Comfortable position	
7:45 pm		8pm	Administered the baby medication	

Re-Assessment: baby is stable Now

Special Notes: NA

Nurse Signature: [Signature]

Nurse Name: jessie @ 9010577

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

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 21/7/26

Assessment: Baby is having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the patient's condition	8:45pm	Assessed the patient's condition	Now Baby is stable
10pm	Administer medication as per chart	11:15pm	Administered medication as per chart	
12am	Maintain fluid balance	12:15am	Maintained fluid balance	
4am	Monitor vital signs	4:15am	Monitored vital signs	
7am	Ensure safety	7:15am	Ensured safety	

Re-Assessment: Re-Assessment done every 3rd hourly

Special Notes: 2D @ 11m

Nurse Signature: [Signature]

Nurse Name: Yamuna @ 60622

Date & Time: 22/7/26 @ 8am

BAH-00661676 IP5-00176410
 Baby GOLI SRI TRISHIKA PRASANNA
 28-05-2026 0 Y 1 M 23 D (F)
 Dr. VIJAYANAND JAMALPURI

NURSING CARE RECORD

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Shift: ☒ Morning ☐ Night

Date: 22/7/26

Assessment: Pt having Di'scomf

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 Pt condition	8AM	→ Assessed the Pt condition	Pt is stable
11AM	→ cannula changed Desc	11AM	→ vital chart maintained	
12PM	→ continue IV antibiotic	12PM	→ Ensured safety	
		PM	→ continue IV antibiotic	
		8PM		

Re-Assessment: Pt is stable

Special Notes: - Nil

Nurse Signature: S

Nurse Name: schman

Date & Time: 22/7/26

B4H-006616/B IP5-00176410

Baby GOLI SRI TRISHIKA PRASANNA

28-05-2026 0 Y 1 M 23 D (F)

Dr. VIJAYANAND JAMALPURI



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 22/5

Assessment: Patient is having Discomfort

Goals

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

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

- ☒ Maintain Fluid Balance
- ☐ Meet Elimination Needs

- ☐ Improve Activity Tolerance
- ☐ Ensure Safety

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

- ☐ Maintain Skin Integrity
- ☐ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assessed the patient's current condition.	8:20pm	Assessed the patient's current condition.	
10pm	Monitor vitals	10:20pm	Monitor vitals.	
12Am	Administer medication as per chart	12:30Am	Administer the medication as per chart	pt is stable
3Am	Do chart monitoring	3:30Am	Do chart monitoring	
6Am	Ensure safety	6:20Am	Ensure safety	

Re-Assessment: pt is stable

Special Notes: nil

Nurse Signature: [Signature]

Nurse Name: Sangeetha C 605728

Date & Time: 22/5/26 @ 8AM

BAH-00081676 IP5-00176410
 Baby GOLI SRI TRISHIKA PRASANNA
 28-05-2026 0 Y 1 M 28 D (F)
 Dr. VIJAYANAND JAMALPURI



NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 23/7/26

Assessment: Baby having di's comfort

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	8:30 am	Assessed the baby general condition	Baby is stable now
10:30 am	Assess the baby vitals	11am	Assessed baby vitals	
12pm	Assess the baby in a comfortable position	1:30 pm	Assessed the baby in a comfortable position	
2pm	Administer medication Assess the baby temperature		Administered the Baby medication	

Re-Assessment: Baby is stable now

Special Notes: NA

Nurse Signature:

Nurse Name: jessie @ 9/05/27

Date & Time: 23/7/26



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Vijayanand Jamalpur Department: ER Date of Admission: 15/7/26

SITUATION	Diagnosis: <u>AFB</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:			
	Area	Shift Time	10:20a 10:20a-2pm	2pm-8pm	8pm-8am	8am-8pm
BACKGROUND	Medical Condition (Any special condition to be noted):		NA	NA	NA	NA
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	98.2°F	97.8°F	98.0°F	98.1°F
	Res:	24 b/m	32 b/m	30 b/m	38 b/m	
	SpO ₂ :	100%	100%	99%	99%	
	Pulse:	156 b/m	146 b/m	145 b/m	145 b/m	
	BP:	83/69	81/65	8	84/61	
	Fall Risk Score:	12	12	12	12	
Pain Score:	0/10	0/10	0/10	0		
Recommendations	Safety Needs:		yes	yes	yes	yes
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		yes	yes	yes	NA
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		NA	NA	NA	NA
Post Operative Procedure Special Orders:			NA	NA	NA	NA
Handed Over By Name :			Shavani	Sukh	Durga	Tamara
Signature :			[Signature]	[Signature]	[Signature]	[Signature]
Date:			15/7	15/7/26	16/7	16/7
Time:			10:20a	8pm	8am	8am
Taken Over By Name :			Sukh	Durga	Senie	Durga
Signature :			[Signature]	[Signature]	[Signature]	[Signature]
Date:			15/7/26	15/7	16/7	16/7
Time:			10:30am	8pm	8am	8am



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. VIJAYANAND Department: 3rd floor Date of Admission: 18/7/26

SITUATION		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:						
BACKGROUND	Area	3rd floor	3rd floor	3rd floor	3rd floor	3rd floor	3rd floor	
	Shift Time	8PM-8AM	2PM-11PM	8PM-8AM	2PM-11PM	8PM-8AM	2PM-11PM	
ASSESSMENT	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	NA	NA	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
RECOMMENDATIONS	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	98°F	98.1°F	98°F	98.2°F	98°F	98.1°F
		Res:	26b/m	27b/m	28b/m	28b/m	26b/m	26b/m
		SpO ₂ :	99%	98%	99%	98%	99%	100%
		Pulse:	130b/m	125b/m	122b/m	125b/m	122b/m	130b/m
		BP:	-	-	-	-	-	-
	Fall Risk Score:	0	0	0	0	0	0	
	Pain Score:	1/10	0/10	0/10	0/10	0/10	0/10	
Safety Needs:	Yes	Yes	Yes	Yes	Yes	Yes		
Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No		
Others Specify:	NA	NA	NA	NA	NA	NA		
Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No		
Other Special Orders / Medications:	NA	NA	NA	NA	NA	NA		
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Suman	Durg	Suman	Durg	Sneha	Syoth	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		18/7/26	18/7	19/7/26	19/7/26	20/7/26	20/7	
Time:		8AM	9AM	8AM	8PM	8AM	2PM	
Taken Over By Name :		Durg	Suman	Durg	Sneha	Suman	Jessie	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		18/7	18/7/26	19/7	19/7/26	20/7/26	20/7	
Time:		8PM	8PM	8PM	8PM	8AM	2PM	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. VIJAYANAND Department: 3rd floor Date of Admission: 16/7/20

SITUATION	Diagnosis: <u>AFI</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time	<u>3rd floor</u> <u>2pm-8pm</u>	<u>3rd floor</u> <u>8pm-2am</u>	<u>3rd floor</u> <u>2am-8am</u>	<u>5th floor</u> <u>2pm-8pm</u>	<u>3rd floor</u> <u>8pm-2am</u>	<u>5th floor</u> <u>8am-8pm</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:		Temp: <u>98.2°F</u>	<u>98.1°F</u>	<u>98.1°F</u>	<u>98.2°F</u>	<u>98.1°F</u>	<u>98°F</u>
	Res:		<u>20b/m</u>	<u>20b/m</u>	<u>20b/m</u>	<u>20b/m</u>	<u>20b/m</u>	<u>20b/m</u>
	SpO ₂ :		<u>98%</u>	<u>98%</u>	<u>98%</u>	<u>98%</u>	<u>98%</u>	<u>98%</u>
	Pulse:		<u>132b/m</u>	<u>114b/m</u>	<u>140b/m</u>	<u>140b/m</u>	<u>142b/m</u>	<u>138b/m</u>
	BP:		<u>110/70</u>	<u>110/70</u>	<u>110/70</u>	<u>110/70</u>	<u>110/70</u>	<u>110/70</u>
	Fall Risk 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	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>
	Safety Needs:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:			<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Handed Over By Name :			<u>Jessie</u>	<u>Jyoti</u>	<u>Jyoti</u>	<u>Jessie</u>	<u>Jyoti</u>	<u>Jyoti</u>
Signature :			<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:			<u>20/7</u>	<u>20/7</u>	<u>21/7</u>	<u>21/7</u>	<u>22/7</u>	<u>22/7</u>
Time:			<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>8pm</u>
Taken Over By Name :			<u>Jyoti</u>	<u>Jyoti</u>	<u>Jessie</u>	<u>Jyoti</u>	<u>Jyoti</u>	<u>Jyoti</u>
Signature :			<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:			<u>20/7</u>	<u>21/7</u>	<u>21/7</u>	<u>21/7</u>	<u>22/7</u>	<u>22/7</u>
Time:			<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>8pm</u>

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. vijayande Department: 3rd floor Date of Admission: 16/5

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	<u>Aff</u>							
BACKGROUND	Area	Shift Time	<u>3rd floor</u>	<u>8pm-11pm</u>	<u>2am-8am</u>			
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>				
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	<u>98.2F</u>	<u>98.2F</u>				
	Res:	<u>26bpm</u>	<u>26bpm</u>					
	SpO ₂ :	<u>99</u>	<u>99</u>					
	Pulse:	<u>84bpm</u>	<u>84bpm</u>					
	BP:	<u>-</u>	<u>-</u>					
	Fall Risk Score:	<u>-</u>	<u>-</u>					
Pain Score:	<u>yes</u>	<u>0/10</u>						
Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>					
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	<u>NA</u>	<u>NA</u>					
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>					
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>					
Handed Over By Name :		<u>Sangee</u>						
Signature :		<u>[Signature]</u>						
Date:		<u>23/5</u>						
Time:		<u>8 AM</u>						
Taken Over By Name :		<u>Jessie</u>						
Signature :		<u>[Signature]</u>						
Date:		<u>23/5</u>						
Time:		<u>8 AM</u>						



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	15/7	16/7	16/7	17/7	18/7
	3 to less than 7 years old	3	4	4	4	4	4
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	1
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2	2	2	2	2	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	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	1
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3		1	1	1	1
	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	1
TOTAL			12	12	12	12	12

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	✓	✓	✓	✓
Call device within reach	yes	✓	✓	✓	✓
Wheels Locked	yes	✓	✓	✓	✓
Room free of clutter	yes	✓	✓	✓	✓
Adequate Lighting	yes	✓	✓	✓	✓
Wheel Chair Support	no	no	no	x	no
Other Intervention(s) Specify	no	no	no	x	no
Nurse's Name :	Bhavi	Durga	Jane	Durga	Shweta
Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :	15/7	16/7	16/7	17/7	18/7
Time :	9:40 AM	8 AM	8 PM	8 AM	8 PM

BAH-00661676 IP5-00176410
 Baby GOLI SRI TRISHIKA PRASANNA
 28-05-2026 0 Y 1 M 20 D (F)
 Dr. VIJAYANAND JAMALPURI



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THE HUMPTY DUMPTY SCALE

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

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		Yes	Yes	Yes	Yes	Yes
Call device within reach		Yes	Yes	Yes	Yes	Yes
Wheels Locked		Yes	Yes	Yes	Yes	Yes
Room free of clutter		Yes	Yes	Yes	Yes	Yes
Adequate lighting		Yes	Yes	Yes	Yes	Yes
Wheel chair support		NA	NA	NA	NA	NA
Other Intervention(s) Specify		NA	NA	NA	NA	NA
Nurse's Name:		Sund	Sund	Sund	Sund	Sund
Signature:		S	S	S	S	S
Date:		19/11	20/11	21/11	22/11	23/11
Time:		8PM	8PM	8PM	8PM	8PM

BAH-00661676 IP5-00176410
Baby GOLI SRI TRISHIKA PRASANNA
28-05-2026 0 Y 1 M 17 D (F)
Dr. VIJAYANAND JAMALPURI

BRADEN 'Q' SCALE

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					Date :	15/7	16/7	17/7	18/7
					Time :	9:40 AM	8 PM	8 PM	8 PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	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	
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	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	
TOTAL SCORE					28	28	28	28	
Evaluator's Name					Shavai	Durg	Durg		

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

BAH-00661676 IP5-00176410
 Baby GOLI SRI TRISHIKA PRASANNA
 28-05-2026 0 Y 1 M 20 D (F)
 Dr. VIJAYANAND JAMALPURI



BRADEN 'Q' SCALE

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					Date :	10/7/26	20/7/26	21/7/26	22/7/26
					Time :	8AM	8AM	8AM	8AM
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:xtremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		9	7	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.		9	7	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.		9	7	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		9	7	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."		9	7	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		9	7	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.		9	7	4	4
					TOTAL SCORE	38	38	28	28
					Evaluator's Name	S	Shree	Shree	Shree

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

BAH-00661676 IP5-00176410
 Baby GOLI SRI TRISHIKA PRASANNA
 12-05-2026 0 Y 1 M 23 D (F)
 Dr. VIJAYANAND JAMALPURI



BRADEN 'Q' SCALE

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					Date :	23/5		
					Time :	5:47		
Mobility	Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4			
"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			
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			
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			
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4			
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4			
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.	9			
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28		
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Singh		

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
15/7/26	9:40 AM	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Shavani
15/7/26	12 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suehi
15/7/26	3 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suehi
15/7/26	6 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suehi
16/7/26	12 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Durga
16/7	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Durga
16/7	12 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Jessie
16/7	6 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Jessie
17/7	12 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Durga
17/7	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Durga

Re-assessment Frequency:

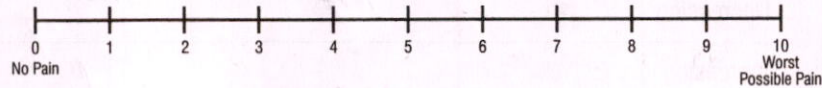
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

Date	Time	(0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
17/7	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NIL	Rino
17/7	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NIL	Rino
18/7	12AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Surge
18/7	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	Surge
18/7	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	Surge
18/7	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	Surge
18/7/2	12pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Surge
19/7/26	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Surge
20/7/26	12AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Surge
20/7/26	8AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Surge

Re-assessment Frequency:

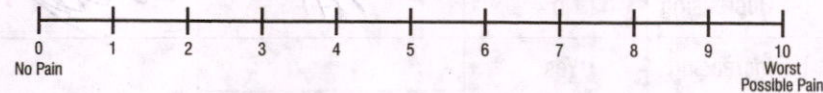
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- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
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Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/7	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Yunus
20/7	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Jessie
20/7	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sulim
20/7	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		Sulim
20/7	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Jessie
21/7	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Jessie
21/7	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Yunus
22/7	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Yunus
22/7	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	snare
22/7	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	cap

Re-assessment Frequency:

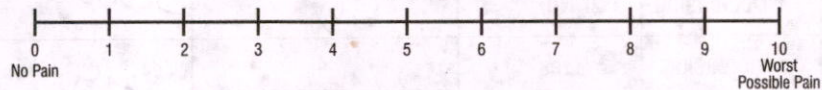
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 - Prior to pain relieving intervention.
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PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

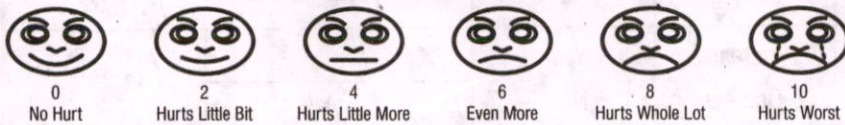
Numerical Pain Scale (Obstetric and Gynecology)



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

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Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
23/7	12 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sarge
23/7	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sarge
23/7	12 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Jessie
23/7				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

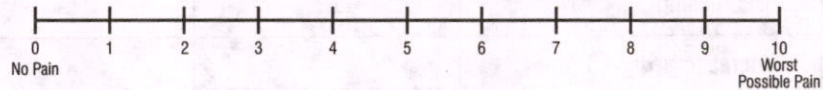
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PAIN ASSESSMENT TOOLS

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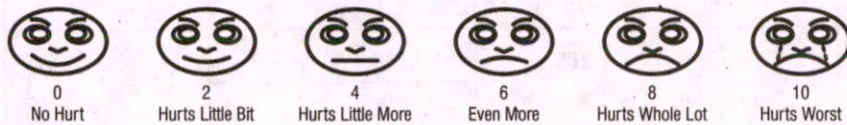
Numerical Pain Scale (Obstetric and Gynecology)



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

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Wong - Baker (Pediatrics) Above 7 Years



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	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	-	-	-	-	-	-	-	-	-	Cannula removed 2:30pm and new cannula placed
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				Sueh Sueh	Durg J	TC	J	Durg	Rim	Rim	Rim	Rim	

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 :

Sujatha

Signature of Ward In Charge :

Anitha

Signature : Sujatha Name : Sujatha

Signature : Anitha Name : Anitha

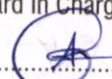
Signature : Name :

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				Remove Cannula
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	-	-	-	-	-	-				
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Signature of the Nurse				Syothi	Sessie	P	gum	gum	gum				

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

Signature of Shift In Charge :
 Signature :  Name : Naumitha

Signature of Ward In Charge :
 Signature :  Name : Naitha

BAH-00661876 IPS-00176410
Baby GOLI SRI TRISHIKA PRASANNA
28-05-2026 0 Y 1 M 22 D (F)
Dr. VIJAYANAND JAMALPURI

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CROSS CONSULTATION FORM

Doctor Name : Dr. Abhishek Date : 20/7 Time : 6:30 pm

Diagnosis :

Hospital :

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

Signature:

Findings and Recommendations :

Case reviewed

- No fever spikes since yesterday night
- accepting feeds well, 100%

OK - Baby sleeping, AF flat
@ Home / power / reflexes

MRE Bicus
- upto base edema of
splenium of corpus
callus

At

① Continue Mergonem + Colistin

shall R/W

Consultant :

Name : Dr. Abhishek R. Jain Signature : Dr. Abhishek R. Jain Date & Time :

BAH-00661676 IP5-00176410
Baby GOLI SRI TRISHIKA PRASANNA
28-05-2026 0 Y 1 M 21 D (F)
Dr. VIJAYANAND JAMALPURI



CROSS CONSULTATION FORM

Doctor Name : Dr. Mannu Chaudhary Date : 20/7 Time : 4:15pm

Diagnosis : Meningitis

Hospital : RCH - B

Type of Referral :

☐ Emergency

☐ Urgent

☒ Non Urgent

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

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

Signature: _____

Findings and Recommendations :

Consultant :

Name : _____ Signature : _____ Date & Time : _____



CROSS CONSULTATION FORM

Doctor Name : Dr. Abhishek R. Jain Date : 16/7/26 Time : 9:30 AM

Diagnosis :

Hospital : RCH, BH

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

MENINGITIS

2 Meningoencephalitis

Signature:

Findings and Recommendations :

Thanks for Referral.

Fever :: 6 days

History Noted

Issues: 1) Fever :: 9 days.

2) Encephalopathy (+) → Accepting feeds normally.

CSF

prot - 111 mg/dl.

Sugar - 42 mg/dl.

Cells - 330 cells/mm³

P 22% L 78%

O/E: HC: 36 cms.

No neurocutaneous markers.

Child conscious

EOM - full.

Tone - (N)

B/L symmetrical antigravity movements (+).

AF ≈ 0.5 cm, open.

Adv

1) Comprehensive PCR panel - CSF.

2) NSG

3) continue IV antibiotics

4) Trace B/C/S and CSF C/S report.

5) CSF - Gene Xpert to send.

Attendant :

Dr. Abhishek R. Jain

Signature :

Dr. Abhishek R. Jain

Date & Time :

Job Nuroteam

21/4/26
10 AM

Dr. Ramesh K.
Divinet

Case Reviewed.

MAI → COCC-MERS.

Obs. - vitals → stable

MAI → COCC-MERS.

- ALL CN intact

⊗ motor examination.

EN BS - done in
outside hospital
↓

To trace ⊗.

Top: - prolonged pyrexia
with exanthematous
rash resolved with

COCC-infections
? Rickettsial
? Bacterial
? Enteroviral

Dr. Ramesh K.
Divinet

UG

Adv.

points corrected
regarding the
pregnancy of
rhinoceros

continue need be
admission for
another 7 days.

Trace ENBS ⊗
- weight is next
period.

BAH-00661676 IP5-00176410
Baby GOLI SRI TRISHIKA PRASANNA
28-05-2026 0 Y 1 M 23 D (F)
Dr. VIJAYANAND JAMALPURI



CARDIOLOGY REQUISITION FORM

Name: GOLI SRI TRISHIKA PRASANNA

Age: 1 month 17 day

Sex: Female

Date: 22-07-2026

UHID No: BAH-00661676

Weight: 4.73 Kgs

DIAGNOSIS:

meningitis

SILENT CLINICAL FINDINGS:

had 40 fever for since 6 days
rash

15/7/26

CSF → Glu - 42

Protein - III

cells - 330 P - 22-1.
L - 787.

IMPORTANT LAB PARAMETERS:

malaria → negative
negative for
mycoplasma

INDICATION FOR ECHO & REQUIRED INFORMATION:

CONSULTANT NAME:

Dr. vijayanand
jamalpur.

RESIDENT SIGNATURE:

Madhus