

EMERGENCY ROOM TRIAGE FORM

Patient's Name: Master Pradyumna Age: 6y 6M Gender: ☒ Male ☐ Female
Date: 6/7/20 Time of Arrival: 11:50 AM Triage Completion Time: 11:52 AM
Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): Nil ☐ Not known any drug Allergies
Source of Information: ☒ Parents ☐ Others (Specify): Nil
Mode of Arrival: ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance ☒ Normal ☐ Sick Looking	Work of Breathing ☒ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea	☒ Stable ☐ Unstable:
Circulation / Colour ☒ Normal ☐ Abnormal ☐ Bleeding		☐ Not - Life - Threatening ☐ Life -Threatening

Initial Vital Signs: Temp: 97.3°F PR: 105b/m BP: 101/64 RR: 24b/m SpO₂: 98% RA
Chief Complaints: Came for chemotherapy, KICLO - BAIL

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

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

* CTAS - Canadian Triage and Acuity Scale

Dr. Prashanti
Signature of Parent / Guardian

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse: NR Subnuw

Signature of Triage Nurse: [Signature]

Date & Time: 6/7/20 at 11:52 AM.



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 06/02/2020 Time of arrival: 11:53 AM

Chief Complaints: Came for Chemotherapy RBS: NA

Height: NA Weight: 20.87 kg BMI: NA Head Circumference (<2 years) NA

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

If yes, identify NA

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

☐ Character NA ☐ Location NA ☐ Frequency NA ☐ Duration NA

RISK FOR FALL:

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

- ☐ If Patient is > 6 years

Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

- ☐ Mobility Problem
- ☐ Walking Problem
- ☐ Developmental Delay
- ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

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

Social History: Lives With Parents @ Home

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

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

Time of Initial assessment completed by ER Nurse: 11:55 AM

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

Time	Nursing Notes
	Monitor Vitals
	Day Care Orders
	CBP Done in of BASS

Samples collected by:

MA

Time:

MA

Samples sent by:

Time:

Medication given in ER:

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

Condition of patient at time of shift - out:	Details of Shift - out
HR: 122b RR: 24 GCS: 4/5/6 Pain Score: 0 Repeat RBS (if applicable): 1/1	Shift - out from ER to: ONCO Time of Shift - out: 12:55 PM Handover given to: JAMUNA (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

line chart

Name of the Nurse:

T. Gentile

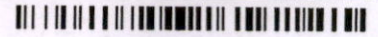
Signature of the Nurse:

[Signature]

Date & Time:

6/20/2020 @ 11:55 PM

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176025

Admit Date : 06-Jul-2026

Admit Time : 12:32 PM **UHID :** BAH-00645702

Patient Details :
Patient Name : Master PRADYUMNA AKONDI

Age : 6 Y 6 M 7 D

Guardian : Mr VISWANATH AKONDI

DOB : 29-12-2019

Gender : Male

Religion :
Occupation :
Martial Status : Single

Address (H) : FLAT NO 101, SURYA SAKETH PALACE ,
 ROAD NO 6, POOJITHA ENCLAVE , RAJEEV
 GANDHI NAGAR, Bachupally Hyderabad
 Telangana INDIA 500090

Phone No : 8688419576/ 9052550118

E-mail : A.VISWANATH1@GMAIL.COM

Admission Details :
Bed Type : GENERAL WARD

Bed No : GW 139

Ward Name : 1F-GENERAL WARD II

Room No : GW 139

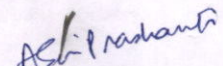
Admission Type : First Visit

Contact Details :
Name : Mr VISWANATH AKONDI

Relationship : Father

Contact Address : FLAT NO 101, SURYA SAKETH PALACE ,
 ROAD NO 6, POOJITHA ENCLAVE , RAJEEV
 GANDHI NAGAR, Bachupally Hyderabad
 Telangana INDIA 500090

Phone No : 9052550118


Signature
Doctor Details :
Doctor Name : Dr. SIRISHA RANI

Specialisation : HEMATO ONCOLOGY

Referral Doctor : Self

Phone No :
Co-Consultant :
Payment Details :
Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELFPAY



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Sirisha Rani

Date : 6/7/24

Type of Admission: ☒ OPD ☐ ER ☐ Referral (if referral, Doctor's Name: _____)

Start Time of Assessment: 12:40 pm Weight: 20.8 kg

Allergic History: _____

Chief Complaints:

B-AE / CALA he / i Amp 21 (1) / PPR
on readmission
came for chemotherapy
NO H/O fever, cold, cough, vomiting
fresh complaint

Pediatric Assessment Triangle

A Appearance - TICLS _____

B _____ C Circulation ☒ Normal ☐ Abnormal

Breathing ☐ ↑ WOB ☐ ↓ WOB ☒ Normal ☐ Gasping / Apnea

☐ Pallor ☐ Cyanosis ☐ Mottling ☐ Bleeding

Initial Physiological Status: ☒ Stable ☐ Unstable

☐ Life Threatening ☐ Non Life Threatening

Any urgent interventions needed: ☐ Yes ☐ No

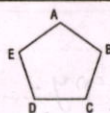
If Yes _____

Significant Past History: _____

Medication History: _____

Relevant Investigations: _____

Primary Assessment



Airway



☒ Open ☐ Maintainable ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____

Breathing



Rate: 24/min SpO₂ on FiO₂ 98% on RA

Rhythm: Regular

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: B/LAE (1)

Palpation Findings (If necessary) _____

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____



Circulation

HR: 105/min

CFT ☐ Central
☐ Peripheral

Any urgent interventions needed: ☐ Yes ☒ No

BP: 101/64 (73) mmHg

Pulse Volume: ☐ Central
☐ Peripheral

Murmurs: ☐ Yes ☒ No

Liver Span:

If in Shock: ☐ Compensated
☐ Hypotensive

ECG:

Any Signs of Heart Failure: ☐ Yes ☒ No

Muffled Heart Sound: ☐ Yes ☒ No

Engorged Neck Veins: ☐ Yes ☒ No



Disability

GCS: 15/15 AVPU:

Any urgent interventions needed: ☐ Yes ☐ No

Pupils: ☒ Responsive ☐ Non-Responsive
Size ☐ Right
☐ Left

If Yes

Active Seizures: ☐ Yes ☐ No Sugars:

Signs of Neurological compromise

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Exposure



Temp.: 97.3°F

Any urgent interventions needed: ☐ Yes ☒ No

Any Rash: ☐ Yes ☒ No,

If Yes

If yes describe the rash

Active bleed

Lacerations ☐ Abrasions ☐ bruises ☐

Describe:

.....

.....

.....

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest
☐ Shock - Compensated ☐ Hypotensive ☐
☐ Cardiopulmonary Arrest ☒ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings:

Labs Planned:

COP

Treatment Planned:

Chemotherapy.

Ty. ondans

Syp. Domstal.

N.B.
rept
06/07/21

Need for Oxygen: ☐ Yes ☒ No if yes Low Flow ☐ High Flow ☐ PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): B-cell ALL @

Assessment done by

Name of the Doctor: Dr. Ramya

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor:

Signature: [Signature]

Signature:

Date & Time: 6/7/21; 12:40 pm

Date & Time:

BAH-00645702
Master PRADYUMNA AKONDI
29-12-2019 8 Y 6 M 7 D (M)
Dr. SIRISHA RANI



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From: ICU

Shifted to: ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Voriconazole Tab	1Tab	PO	OD		☒ C ☐ DC
2	Syp. Bectrim	5ml	PO	BD	5/7/26	☒ C ☐ DC
3	Tab Lenzol	1Tab	PO	OD		☒ C ☐ DC
4	Tab Dena	1-1/2Tab	PO	BD		☒ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Romye

Date & Time: 6/7/26; 12:30pm

Nurse Name & Signature: T. Jenthina

Date & Time: 6/7/26 @ 12:30

DRUG CHART

Date of Admission: 6/2/26 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 :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature				Valid Period
Additional Instructions:				

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

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



REGULAR PRESCRIPTIONS

Weight. 20.87kg Ward.

DRUG : <i>Inj ONDANSETRON</i>				Date Time	<i>6/7</i>
Dose	Route	Frequency	Start Date		
<i>4mg</i>	<i>IV</i>	<i>TID</i>	<i>6/7/26</i>		
Name & Signature of the Doctor Starting the Drugs:				<i>GAM X</i>	
Additional Instructions:				<i>2PM 25/8</i>	
				<i>10PM</i>	
Daily Doctor's Endorsement by a Sign					

DRUG : <i>Syp DOMPERIDONE</i>				Date Time	<i>6/7</i>
Dose	Route	Frequency	Start Date		
<i>4ml</i>	<i>PO</i>	<i>BD</i>	<i>6/7/26</i>		
Name & Signature of the Doctor Starting the Drugs:				<i>10M 25/8</i>	
Additional Instructions:				<i>10P</i>	
Daily Doctor's Endorsement by a Sign					

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

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

Weight. 20.87 kg 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.

Signature

[illegible]

Weight. 20.87kg Ward.

[illegible]

Signature

BAH-00645702 IP5-00176025
 Master PRADYUMNA AKONDI
 29-12-2019 6 Y 6 M 7 D (M)
 Dr. SIRISHA RANI



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RESULT SHEET

Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
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						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI

 Others (ECG, Contrast Studies etc.,) :

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29-12-2019 6 Y 6 M 7 D (M)
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FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	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												

Patient Sticker

FLUID CHART

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Sheet No. :

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

		Intake				Output					IV Site 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			

10

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

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

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

BAH-00645702
Master PRADYUMNA AKONDI
29-12-2019 6 Y 6 M 7 D (M)
Dr. SIRISHA RANI



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/2/2022	1pm	ER	Ward	[Signature]

Cross Consultation Visit

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

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Date : 6/7/26

Time : 4pm

Prepared By : meel

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
meel	CW-TT		

Patient



THE HUMPTY DUMPTY SCALE

6/2

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3				
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2				
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1				
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1				
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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				
TOTAL			11				

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		YES				
Other Intervention(s) Specify		YES				
Nurse's Name :		Thompson				
Signature :		[Signature]				
Date :		6/2/20				
Time :		1:00				

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 6/7 Time: 4 PM		
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	
and Blood Pressure (mmHg) *	90	
	80	
	70	
	60	
	50	
	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 O ₂ (l/min) O ₂ 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 fellow or PICU consultant to be informed.		

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Srisha Department: PEDIATRICS Date of Admission: 06/01/2020

SITUATION	Diagnosis: <u>klclo - B-cell ALL</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:			
	Area	Shift Time				
BACKGROUND	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
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp: <u>98.4</u>	<u>98.5</u>			
	Res:	<u>24</u>	<u>25</u>			
	SpO ₂ :	<u>98%</u>	<u>99%</u>			
	Pulse:	<u>112</u>	<u>107</u>			
	BP:	<u>98/61/44</u>	<u>99/65</u>			
	Fall Risk Score:	<u>1</u>	<u>1</u>			
Recommendations	Safety Needs:	<u>-</u>	<u>-</u>			
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	<u>-</u>	<u>-</u>			
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	<u>ALL</u>	<u>NA</u>			
Post Operative Procedure Special Orders:		<u>ALL</u>	<u>NA</u>			
Handed Over By Name :		<u>T. Paul</u>	<u>Samu</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>6/1/20</u>	<u>6/1/20</u>			
Time:		<u>1 PM</u>	<u>4 PM</u>			
Taken Over By Name :		<u>Samu</u>	<u>[Signature]</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>6/1/20</u>	<u>6/1/20</u>			
Time:		<u>1 PM</u>	<u>4 PM</u>			

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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



BRADEN 'Q' SCALE

					Date : 29/12/2019			
					Time : 10:00 AM			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or 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			
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			
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 mean 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.	4			
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	24		
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	FAK		

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
6/6/20	1pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	RA RA	
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

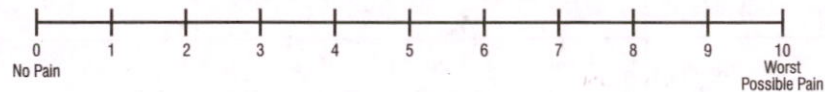
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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





INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.
Patient's / Learner Language: English / Telugu Patient / Learner Literacy: ☒ Read ☐ Write ☐ Speak Willingness to Learn: ☒ Yes ☐ No Healthcare Literacy: ☒ Yes ☐ No

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
6/6/20	1 pm	7	Infection Control Measures	M	4	0	1	1	None	Further

Part - III: CODES

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

Learning Barriers:

1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	

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

Mechanism/s to overcome barrier/s:

1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference	

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review



MULTI-DISCIPLINARY PLAN OF CARE FORM

6/10- B-cell All

Diagnosis:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
6/7/2020 1:10 AM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	MONITOR VITALS	H. STABLE	CHEMOTHERAPY	Dr. Ranga	☒ Nursing ☐ Others:
6/7/2020 1:10 AM	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	B-cell All	H. Stability	Chemotherapy	Dr. Ranga	☒ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 8/7/25

Assessment: Contin. Baby born - clear

- | | | | | | | |
|--------------|---|--|---|---|---|---|
| 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	⇒ Pt general cont'd	6pm	⇒ Pt general cont'd	Baby born
4pm	⇒ comfortable position	4pm	⇒ Observation cont'd	
5pm	⇒ Observation cont'd	5pm	⇒ Pt cont'd	
	⇒ Clear lungs		⇒ Same skin	

Re-Assessment:

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Sameer

Date & Time: 8/7/25 6:50pm

Patient Sticker

NURSING CARE RECORD


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


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00645702 IP5-00176025 Master PRADYUMNA AKONDI 29-12-2019 6 Y 6 M 7 D (M) Dr. SIRISHA RANI 		Date & Time of Admission 6/07/2020 @ 12:32 pm	Date & Time of Transfer Order 6/07/2020 @ 1 pm
		Transfer Ordered by Dr. Ranjya	Reason for Transfer Day Care
From Unit ER	To Unit Day Care - 139	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File T. sheets (20)	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	/		
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐ Dr. Ranjya			
Name & Signature of Person who is Transferring nr. pongs		Name of Person Ordered Transfer Dr. Ranjya	
Patient & Clinical Records Received by : Savarant			
Date & Time of Patient Received : 6/7/20 @ 1 pm			

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

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