BAH-00599200 IP5-00174570
Baby BAKKA RUDRAKSHI YADAV
05-12-2023 2 Y 5 M 26 D (F)
Dr. ANNAPOORNA TADAVARTHY

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ IP No : _____ Consultant: _____ Dept : _____

Date of Admission: _____ Time : _____ Date of Discharge : 2/6/26 Time: 11am

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
31/5/26	7pm	BB	118	Anju

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
31/05	CBP, CRP, Urea, Creat	55363.	Ismail
	S/E,		
	X-ray chest	27442	Ismail
1/6	Blood culture	55542	Aparanjidhia
1/6	5 viral panel	26532	Aparanjidhia
	D/C		

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
1/6	Infusion pump	[illegible]	Stop	962121	[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
31/05/26	iv placement	1	36671	Isreal
1/6/26	NAA	0	637540	APNY

Pragap 1/6/26

ANY OTHER INFORMATION

X-ray - (1)

Date : 2/6/26 Time : 11am Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00174570 **Admit Date** : 31-May-2026 **Admit Time** : 06:24 PM **UHID** : BAH-00599200

Patient Details :

Patient Name	: Baby BAKKA RUDRAKSHI YADAV	**Age**	: 2 Y 5 M 26 D
Guardian	: Mr BAKKA CHINTU	**DOB**	: 05-12-2023
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H NO 3-138/A , NEAR HANUMAN TEMPLE, Kokapet Hyderabad Telangana INDIA 500075	**Phone No**	: 9951951504/ 9948302659
		E-mail	: VATTELAMAHENDHERYADAV@GMAIL.COM

Admission Details :

Bed Type : GENERAL WARD **Bed No** : GW 118 **Ward Name** : 1F-GENERAL WARD I

Room No : GW 118 **Admission Type** : First Visit

Contact Details :

Name : Mr BAKKA CHINTU **Relationship** : Father

Contact Address : H NO 3-138/A , NEAR HANUMAN TEMPLE, Kokapet Hyderabad Telangana INDIA 500075 **Phone No** : 9951951504 / 9705149930

Sravani
Signature

Doctor Details :

Doctor Name : Dr. ANNAPOORNA TADAVARTHY **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : Self **Phone No** :

Co-Consultant : Dr. FAISAL B NAHDI

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : STAR HEALTH AND ALLIED INSURANCE CO LTD

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FICIENCY CHECK LIST OF CASE SHEET

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

Doc. No. : RCHBH/ FRM / GENERAL / 126

Signature and Date : Save 2/6/26

(P.T.O)

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU / 2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: Rudrakshi

UHID ID: _____

BAH-00599200 IP5-00174570
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Department: _____

Consultant: _____

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Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

cough : 2days
fever : 1day
↑ work of breating : yesterday night

History of present illness :

c/o cough : 2d, non productive,
no postural and diurnal variation.
no post tussive cough.
a/w fever : 1day
non documented
not a/w chills
no diurnal variations
increased work of breathing as fast breathing
since yesterday night
no c/o travel.
no c/o TB contact

K/C/O Chronic wheezer
recurrent LRTI
requiring 5 admissions
for wheeze over 2 yr.

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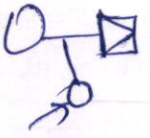
Pediatric Multiorgan History & Physical Examination

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

Ø

Birth & Neonatal History:

A / N perinatal transition



Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History :

Developed as per age

Immunization History :

Immunised as per age.

(P.T.O.)

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Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 8.9kg. (Centile _____)

On Examination :

Temperature : 98.5°F Pulse Rate : 138/min B.P. 95/56 mm Hg SPO2 99% / RA

Resp.rate and type of breathing : 40/min ↑work of breathing

Rash ⊖

Lymphadenopathy

Oedema :

Allergies (if any):

Respiratory System :

Inspection (any s/o distress) : tracheal Tug ⊕, ~~retract~~

Air entry & breath sounds : BAE ⊕, equal

Any addes sounds : wheeze ⊕

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1S2 ⊕

Any murmur : ⊖

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

Per Abdomen :

Inspection

Palpation : Soft, NT

Ausculation : BS ⊕

Spine : ⊖ External Genitelia : ⊖

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

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Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15/15

Cranial Nerves :

Motor System:

Nutriton : NAD

Tone: Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials:**

Plantars

Sensory System : Intact

Bladder / Bowel : Regular

Clinical Summary & Diagnostic:

Wheeze associated lower resp. infection

(P.T.O.)

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Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: respiratory distress

Desired goals of the treatment : hemodynamic stability

Planned Labs:

- CBP
- CRP
- urea
- creatinine
- S. electrolytes.
- Chest Xray. → N/B
  Tinaal
  31/05/26

Planned Management

- Neb. c̄ DUOLIN - 6hrly
  LEVOLIN - 6hrly
- BUDECORT MDI
- OMNACORTIL Syrup
- monitor SpO_2, RR 4hrly
- watch for distress.

Signature of the Doctor: ....

Name of the Doctor: Savithri

Date & Time: 31/5/26 6 pm

Signature of the Consultant: ....

Name of the Consultant: Anup T.

Date & Time: 1/6/26 9:30 AM

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
31/5/26 8PM	Seen by Resident : Dr Sahithi WALRI. labs reviewed chest xray - B/L perihilar infiltrates + BL↑ bronchovascular markings O/E Child on Room air Hemodynamically stable no distress CRP - 27 S/B Resident (Dr. Nandan)	R/V Plan 1. Add Antibiotics. 2. Continue medications as charted. Sahithi.
01/06/2026 8AM	S : WALRI On Room Air Hemodynamically stable No fresh issues No fever spikes No RD	P/Plan - Start Inj. Ceftriaxone - send blood cls - continue medications as charted (OMNACORTIL-D2) - ~~R/v~~ to do 5 viral panel - W/S fever spikes/RD - Monitor vitals q 4hrly (Dr. Nandan)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/6/26	P/S/B Dr. Annapoorna.	P)
9:30 Dr	NALRI.	Send 5 viral panel,
		blood c/s
	Hemodynamically	IV fluids 20%
	stable	Contd IV Abx
	Chest - Clear.	
		A.T
		ord By AP/PY
1/6	C/I/B resident	
	WALRI	
	c/o: No fresh complaints	Adv
	O/E	- Trace Blood c/s
	RS - BAE (+), wheeze (+)	- ct medications as per chart
	P/A - (N)	- Trace Adenovirus
	CVS S1, S2 (+)	- monitor vitals
	Viral panel - Neg	
	4 viruses - Negative	
4pm	chest - wheeze ↓.	P) Contd same

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

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B/ Resident (Dr. Nanda)	
02/06/2026 9AM = D: WALRI		Plan =
	On Room Air Hemodynamically stable No fresh issues Oral intake fair No respiratory distress RS- B/L wheeze (+) Blood c/s -> awaited	R/v discharge today
		Dr. Nanda
2/6/26 10.30 AM	Seen by Dr. Annapoorna B/L wheeze (+).	Plan 6Am 2pm 10pm Neb = DUOLIN - 8hrly Neb = LEVOLIN - 8hrly 10Am 6pm 2Am Syp OMNACORTIL. 5 ml - . BUDECORT puff - 100mcg BD Syp ZIPRAX .2 ml 1d 10 days SOS LEVOLIN 4 puffs SOS for respiratory distress

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

(P.T.O)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☑ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER Shifted to: ward (118)

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Sahitini

Date & Time : 31/5/26 6 PM.

Nurse Name & Signature: Jyoti

Date & Time : 31/5/26 8pm

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RESULT SHEET

Date	31/5					
Time	7pm.					
Hb	9.7					
PCV	32.4					
RBC	4.98					
WBC	13.95k					
N/L	44/42.					
Platelets	4'8L					
CRP	27					
ESR						
PCT						
RBS						
Na	138					
K	4.2					
Cl	108					
Ca/Mg						
Phosphate						
Urea	20					
Creatinine	0.3					
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 : 5 viral panel - Negative
Adeno -> Negative

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

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DRUG CHART

Date of Admission: 31/5/26 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 : Syp PARACETAMOL				Date / Time
Dose: 3ml	Route: PO	Frequency: 6th hourly	Start Date: 31/5	
Doctor's Signature: Sahithi	Valid Period: 48 hrs	Pharm.		
Additional Instructions: temp > 100°F (5ml/240mg)				

DRUG : Syp MEFTAL				Date / Time
Dose: 4.5ml	Route: PO	Frequency: 8th hourly	Start Date: 31/5	
Doctor's Signature: Sahithi	Valid Period: 48hrs	Pharm.		
Additional Instructions: temp > 102°F (5ml/100mg)				

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

VERIFIED BY : Name ..... Sig ..... re

BAH-00599200 IP...
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REGULAR PRESCRIPTIONS

Weight. 9 kg Ward.

DRUG : DUOLIN

Dose	Route	Frequency	Start Date
250 mcg	Neb	6 hrly	31/5

Name & Signature of the Doctor Starting the Drugs: Sahithi

Additional Instructions:

Date/Time	31/5	1/6	2/6
9 am	X	Appu	
3 PM	X	Niki	
9 PM	Swarna		
3 AM	Swarna	SW	SW
Daily Doctor's Endorsement by a Sign	✓	✓	✓

DRUG : LEVOLIN

Dose	Route	Frequency	Start Date
1 resp	Neb	6 hrly	31/5

Name & Signature of the Doctor Starting the Drugs: Sahithi

Additional Instructions: 1 resp = 1.2mg.

Date/Time	31/5	1/6	2/6
12 Am	X	Swarna	SW
6 Am	X	Swarna	SW
12 Pm	X	Appu	
6 Pm	4pm Ramesh	Niki	
Daily Doctor's Endorsement by a Sign	✓	✓	✓

DRUG : BUDECORT MDI

Dose	Route	Frequency	Start Date
2 puff	MDI	12 hrly	31/5

Name & Signature of the Doctor Starting the Drugs: Sahithi

Additional Instructions: MDI c̄ Spacer. (100 mcg)

Date/Time	31/5	1/6
10 AM	X	Sona Niki
10 PM	Sushma Swarna	
Daily Doctor's Endorsement by a Sign	✓	✓

DRUG : OMNACORTIL Syrup

Dose	Route	Frequency	Start Date
5 ml	PO	8 hrly	31/5

Name & Signature of the Doctor Starting the Drugs: Sahithi

Additional Instructions: (5 ml/5 mg)

Date/Time	31/5	1/6	2/6.
6 AM	X	Sushma Swarna	Pranali Sujatha
2 pm	X	Sona Niki	
10 PM	Sushma Swarna	Pranali Sujatha	
Daily Doctor's Endorsement by a Sign	✓	✓	✓

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Sheet No: .... **REGULAR PRESCRIPTIONS** Weight .... Ward ....

DRUG : INJ. CEFTRIAXONE

Dose	Route	Frequency	Start Dt.
450mg	IV	q12hrly	01/06

Date ▸ 1/6, 2/6

10am 500mg
10pm

Name & Signature of the Doctor Starting the Drugs: Dr. Nandan.

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

VERIFIED BY : Name .... Signature ....

Patient Sticker

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Sheet No: .... **REGULAR PRESCRIPTIONS** Weight .... Ward ....

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾

VERIFIED BY : Name .... Signature ....

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Weight. 9 kg Ward. .....

	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

BAH-00599200 IP5-00174570
Baby BAKKA RUDRAKSHI YADAV
05-12-2023 2 Y 5 M 26 D (F)
Dr. ANNAPOORNA TADAVARTHY

I.V. FLUIDS CHART

Weight. 9kg. Ward. ....

		...sition of I.V. Fluid (...tion ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
1/6	11am	Inf DNS (70%)	i.v	26	[signature]	Nikhita. / Anupa	2/6	[signature]	[signature]

VERIFIED BY : Name .... Signature ....

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NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
31/5	00.00	Levolin 0.63 :- 7PM & 12am		
	01.00		(4)	9637884
1/6	02.00	Duluvin- 6pm 2am	Swarna	
	03.00			
1/6	04.00	Duluvin - 9am,	Appu	6375647
	05.00	Levolin - 12pm		
	06.00			
	07.00			
	08.00			
	09.00			
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

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Doc. No. : RCH/ FRM / CLINICAL / 125

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : ...16..... Time:					
Doctor / Nurse / Family Concern?	1pm	5pm	10pm	2Am 21/12/26	6Am
Temperature (F)	99.4F	98.6F	98.1F	98.9F	98.3F
Heart Rate (bpm) and Blood Pressure (mmHg) * **Note:** BP does not score in early warning scoring	197 (113) 61	100 (86) 64	98 56 50	96 59 51	93 62 50
Heart Rate (Number)	98b/m	110b/m	112b/m	120b/m	129
Resp. Rate (bpm) (Over 1 Minute) *					
Resp Rate (Number)	38b/m	29b/m	28b/m	29b/m	28b/m
Resp Distress: Mod/ Severe / None / Mild					
Receiving O_2(l/min) O_2Saturations (%)	96%	99%	92%	98%	96%
Conscious Level: Normal / Altered					
GCS *	15/15	15/15	15/15	14/15	14/15
TOTAL SCORE Number of shaded boxes	1	1	1	1	1
Pain Score	0	0	0	0	0
Observer's Initials	S	S	S	S	S

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.

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 31/5/2023 Time: 7:30pm

Doctor / Nurse / Family Concern?	10pm	2am	6am	10am
Temperature (F)	97.2°F	98.1°F	96.3°F	98.1°F
Heart Rate (bpm) and Blood Pressure (mmHg) *	100 (65) 70	103 (73) 59	101 (67) 50	99 (60) 48	113 (85) 72
Note: BP does not score in early warning scoring				
Pulse Rate (Number)	120b/m	125b/m	110b/m	116b/m	104b/m
Resp. Rate (bpm) (Over 1 Minute) *					
Resp Rate (Number)	22brt/mt	28b/m	29b/m	28b/m	24b/m
Resp Distress: Mod/ Severe / None / Mild					
Receiving O_2(l/min) O_2Saturations (%)	100%	100%	100%	97%	98%
Conscious Level: Normal / Altered					
GCS *	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	1	1	1	1	1
Pain Score	0	0	0	0	0
Observer's Initials	D				

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.
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	Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

...ow 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

Patient Sticker

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

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FLUID CHART

Sheet No. : 1

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	Intake: Nature of Fluid	Route: Mouth	Route: I.V	Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm				ER							
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
3/5	06:00 pm	NO IV	milk								0	Rama devi
	07:00 pm									✓	0	
Total Intake :						**Total Output :**						
	08:00 pm										0	
	09:00 pm									✓	0	Swa
	10:00 pm	NO	DBM								0	
3/5	11:00 pm	IVF									0	SU
	12:00 am		DBL									
	01:00 am										0	
Total Intake :						**Total Output :**						
	02:00 am										0	
	03:00 am	NO	DBM								0	Swarn
	04:00 am									✓	0	
4/6	05:00 am	IVF	DBL								0	Swarn
	06:00 am									✓	0	
	07:00 am											Swarn
Total Intake :						**Total Output :**						

Total 24 hrs. Intake	

Total 24 hrs. Output	

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FLUID CHART

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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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
1/6	08:00 am		Idly								0	
	09:00 am	10	Milk								0	
	10:00 am	WT						NA			0	
	11:00 am		Milk		NA						0	
	12:00 pm										0	
	01:00 pm										0	
Total Intake :						**Total Output :**						
1/6	02:00 pm			25ml							0	
	03:00 pm			25ml							0	
	04:00 pm	NBS		—			NS				0	
	05:00 pm	DNS		—							0	
	06:00 pm			—							0	
	07:00 pm			—							0	
Total Intake :						**Total Output :**						
1/6	08:00 pm										0	
	09:00 pm										0	
	10:00 pm	DNS		25ml	NA						0	
	11:00 pm			25ml							0	
	12:00 am			25ml							0	
	01:00 am			25ml							0	
Total Intake :						**Total Output :**						
2/6	02:00 am			25ml							0	
	03:00 am			25ml							0	
	04:00 am	DNS		25ml	NA						0	
	05:00 am			—							0	
	06:00 am			—							0	
	07:00 am			✓							0	
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 1/6/26 Time: 9Am

Weight: 8.9 kgs Centile: <5th

Height: 78 cms Centile: <5th

Inference: underweight d/t d

RDA: Calories: 1250 kcals/d Protein: 21g/d

Diet Recommendations: Soft diet

Re-Assesment: Avoid spicy, chilled and outside foods

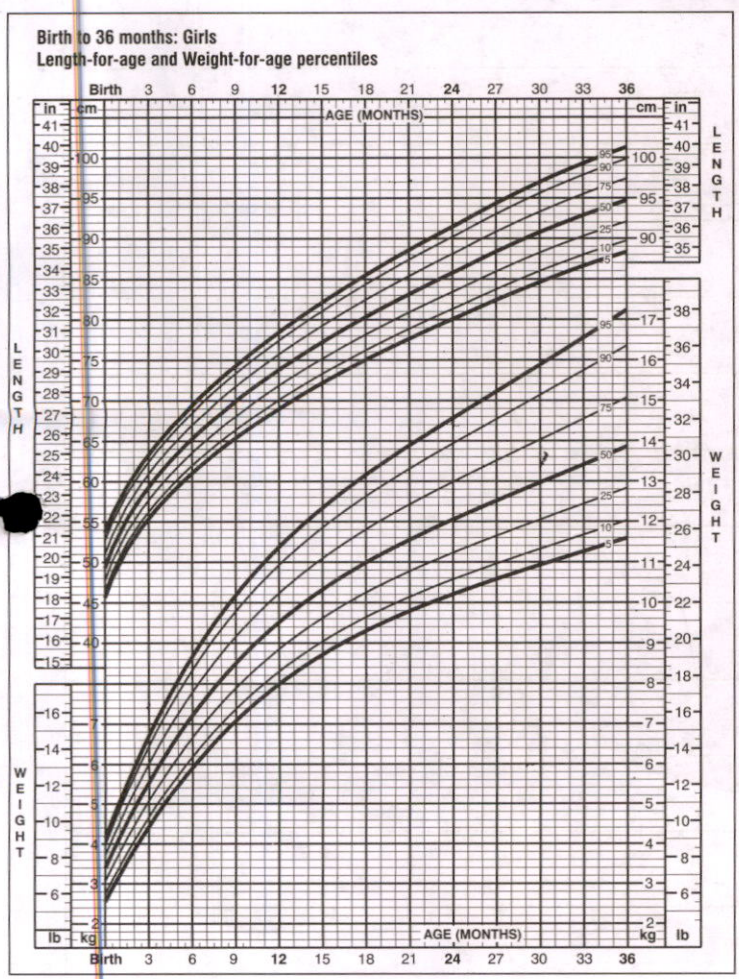
Food Allergies: NO Veg/Non-veg Non-veg

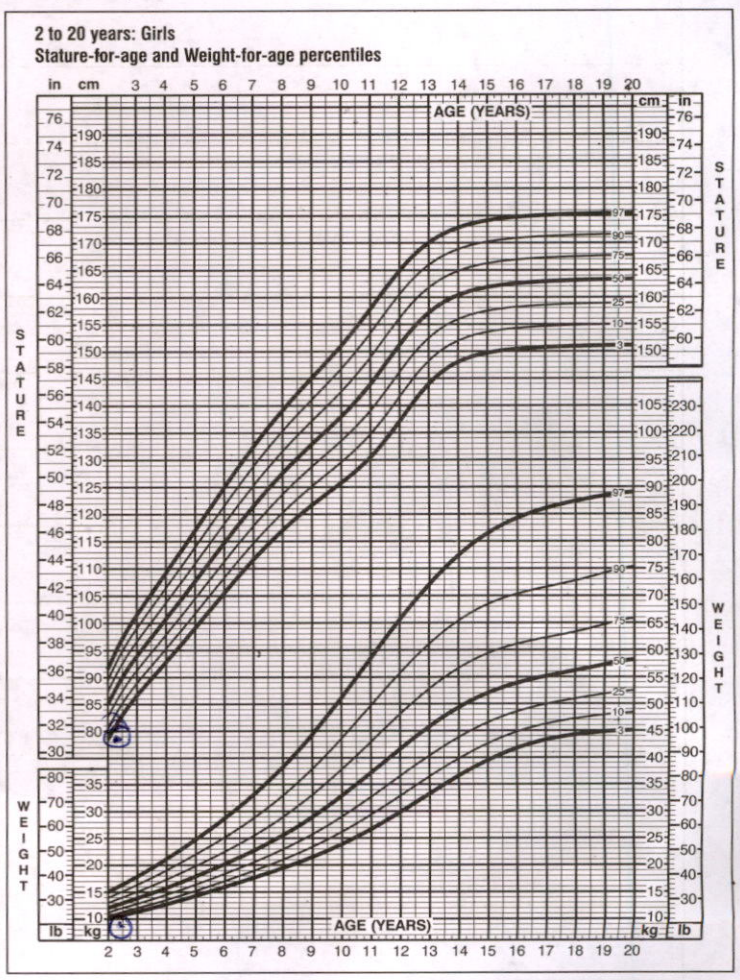
Diagnosis: Wheeze Associated lower respiratory infection

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Sravani

GROWTH CHART (GIRLS)





Dietician's Name Nikitha Dietician's Signature Nikitha

Docu. No. : RCHBH / FRM / CLINICAL / 161

(P.T.O.)

Daily Notes:

9/6/26 10:30AM	Child is stable Oral intake is fair.
	Continue c̄ soft diet. — Mounika