

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

Date of Admission : _____

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

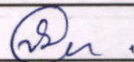
Consultant : _____ Dept : _____

Date of Discharge : _____ Time : _____

BAH-00514821 IP5-00175973
Master DULAM SRINARASIMHA
21-04-2014 12 Y 2 M 13 D (M)
Dr. SRISHA RANI



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
4/7/26		ER	Onco	

Cross Consultation Visit

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

[illegible]

Signature



[illegible]

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

$\frac{d}{dt} \left(\frac{1}{2} m v^2 + U(r) \right) = 0$

ANY OTHER INFORMATION
Don't change for NAA, - number

Don't change for NAA.

number

Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor

SUBHANKAR

Mang
ON LO

ADMISSION SHEET

Registration Details :

Admission No : IP5-00175973

Admit Date : 04-Jul-2026

Admit Time : 02:52 PM **UHID** : BAH-00514821

Patient Details :
Patient Name : Master DULAM SRINARASIMHA GOUD

Age : 12 Y 2 M 13 D

Guardian : Mr DULAM BALA BAIRIAH GOUD

DOB : 21-04-2014

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : H NO 5-10, GUDIKANDULA, THOWGTA (M),
Irkode Medak Telangana INDIA 502114

Phone No : 8309585455/ 9121931234

E-mail : dulambairagoud@gmail.com

Admission Details :
Bed Type : FOUR SHARING

Bed No : FSW 136

Ward Name : 1F-HEMATO-ONCOLOGY

Room No : FSW 136

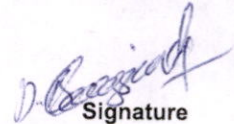
Admission Type : First Visit

Contact Details :
Name : Mr DULAM BALA BAIRIAH GOUD

Relationship : Father

Contact Address : H NO 5-10, GUDIKANDULA, THOWGTA (M),
Irkode Medak Telangana INDIA 502114

Phone No : 8790978339 / 9121931234


Signature
Doctor Details :
Doctor Name : Dr. SIRISHA RANI

Specialisation : HEMATO ONCOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant : Dr. NALLA ANURAAG REDDY

Payment Details :
Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

BAH-00514821 IP5-00175973
Master DULAM SRINARASIMHA
21-04-2014 12 Y 2 M 13 D (M)
Dr. SIRISHA RANI

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ADMISSION CRITERIA – ONCOLOGY

Admission / Transfer from:

☒ Emergency ☐ Outpatient (OPD) ☐ Ward ☐ Operation Theater ☐ Others:

Tick (✓) any of the following criteria requiring admission / transfer to ONCOLOGY

- ☒ For Chemotherapy-Day Care or IP Admission as per the Type of Chemotherapy
- ☐ Febrile Neutropenias (ANC <500 cells / mm³)
- ☐ Netropenic Enterocolitis
- ☐ Mucositis Induced Significant Diarrhea or Pain
- ☐ Neurological Complications (like Seizures, Bleeding, Thrombosis) that can arise while on Chemotherapy Treatment or at the Time of Presentation and also for other Systemic Problems like Pancreatitis during Chemotherapy
- ☐ Management of Oncological Emergencies
- ☐ Bleeding Problems (where it is indicated)
- ☐ Evaluation and Management of Severe Anemias
- ☐ Day Care Admissions for PRBC Transfusions
- ☐ Evaluation and Management of Sick Children who come with Hematological Problems like Severe Anemia like Autoimmune Hemolytic Anemia/ Bleeding/ Others
- ☐ Primary Immunodeficiency Disorders with Infections that Warrants Hospitalisation
- ☐ Management and Evaluation of Hemophagocytic Lymphohistocytosis
- ☐ Any Systemic Disorders with Significant Hematological issues like JRA / SLE with Secondary HLH

Signature of the Doctor:

Name of the Doctor:

Date & Time:

BAH-00514821 IP5-00175973
Master DULAM SRINARASIMHA
21-04-2014 12 Y 2 M 15 D (M)
Dr. SIRISHA RANI



DISCHARGE CRITERIA – ONCOLOGY

Discharge to:

- ☐ HDU / Step down ICU ☐ Ward ☐ Outside Facility ☐ Others:

Tick (✓) any of the following criteria requiring discharge / transfer from ONCOLOGY

- ☐ Completion of chemotherapy, with no debilitating side effects.
☐ Resolution of febrile episode, with no fever > 24hrs and Absolute Neutrophil count (ANC) > 500cells/mm3.
☐ Admitted patients - Once the admitting problem gets resolved or made a plan to manage further on out-patient basis.

Signature of the Doctor: *A*

Name of the Doctor : *Dr. Sarani*

Date & Time: *07/7/26 @ 10 Am*



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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

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Master DULAM SRINARASIMHA
21-04-2014 12 Y 2 M 13 D (M)
Dr. SRISHA RANI





Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

K/C/O Relapsed Bcell ALL / CNS -ve / Early relapse /
(Medullary +ve CNS) / Completed cycle A & cycle B of methotrexate CVAD +
MRD < 0.01% (Negative)

History of present illness :

Now came for chemotherapy

H/o Cold since 2-3 days

No H/o fever, cough, vomiting, loose stools, fresh complaints

CBP → Hb = 10.4 $\frac{3.77}{58} \frac{21}{413}$
30.6

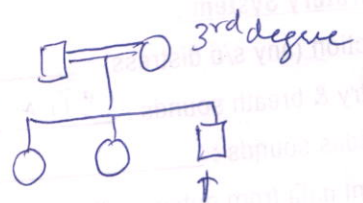


Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

3.5kg / LSC / NO H/O NEW STAY



Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

} upper middle class

Developmental History :

(N) developed

Vaccination History :

Vaccination till 5yr age given

(P.T.O.)

he / Early rupture / Mea / Hx CNS-ve.
motherly.

(P.T.O.)



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 30.54 kg (Centile _____)

On Examination :

BAH-00514821 IP5-00175973
Master DULAM SRINARASIMHA (M)
21-04-2014 12 Y 2 M 13 D
Dr. SIRISHA RANI

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

CRP on OPD basis

MRB after
3 weeks
21/7/26

Planned Management

Chemotherapy

Per Abt

Inspect

Palpation

Auscultation

Spine : _____

Relevant data

Signature of the Doctor: Ramya
Name of the Doctor: Dr. RAMYA
Date & Time: 4/7/26 : 2:30pm

Signature of the Consultant: _____

Name of the Consultant: _____

Date & Time: 4/7/26 @ 2:30

Dr. SANDHYA VADADI
Reg. No: 71604



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Date & Time	Progress Notes	Doctor's Order
5/7/26 9am	Relapsed B-AU / CAHA ⊕ Early relapse / (medullary + CNS) ⊕	mini type CVD cycle A. (2)
No complaints		Plan 1. ct chemotherapy 2. ct supportive care. DIC PTM POB LP / PTM.
		<u>Plan</u> Dr. SANDHYA VADDADI Reg. No: 71664
		NIB Gayathri 4/7/26 @ 2:30 5/7/26 IM

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

(P.T.O)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/16 9PM	<u>Morning rounds</u> Relapsed Bell's palsy @ / Early relapse / Mickellany + WS @ / mini hypn WAD - 3. Aphasia, Ant V. 1.5 @ S @ → MURDER L3200 WS MS MS @	1) want chemo 2) ct. supp. care 3) monitor labs 4) (R/D) DL thn. <u>Amurkhan</u>
	Dr. Amurkhan 4/3/16 @ 10:15 AM Dr. Amurkhan Ready to go	Nursing 6/7/16 12PM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/24 9:00 AM	<u>CLB Resident</u> Relapsed Bcell ABL / CAHA ⊕ / early relapse / medullary + CN ⊕ / mini Hyper CRAD cycle A. No new issues. <u>O/S</u> child Alert & Active vitals stable CN ⊕ M. stable P/A: left CN: NAD.	<u>Plan</u> Continue chemotherapy. - monitor vitals - Inpt (for). - Plan for d/c today. R/M on 13/7 CCBP, LAT ct dexamethasone 120mg night shift ct supportive care Dr. SANDHYA VADDADI Reg. No: 71664 <i>[Handwritten signature: Sandhya Vaddadi]</i> <i>[Handwritten signature: K. A. M.]</i>

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00514821 IP5-00175973
Master DULAM SRINARASIMHA
21-04-2014 12 Y 2 M 13 D (M)
Dr. SIRISHA RANI



1

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RESULT SHEET

Date	4/7				
Time	5 PM				
Hb	10.4				
PCV	30.6				
RBC	3.66				
WBC	3.77				
N/L	58/31				
Platelets	413				
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					



Sheet No:

REGULAR PRESCRIPTIONS

Weight 20.54 kg Ward

DRUG : Symp. LEVIPIL				Date Time	4/7	5/7	6/7	7/7												
Dose	Route	Frequency	Start Dt.																	
3ml	PO	BD	4/7/26	Sam X	Sam X	Sam X	Sam X	Sam X												
Name & Signature of the Doctor Starting the Drugs: Dr. Rani																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : Zj ONDANSETRON				Date Time	4/7	5/7	6/7	7/7												
Dose	Route	Frequency	Start Dt.																	
6mg	IV	TID	4/7/26	Sam X	Sam X	Sam X	Sam X	Sam X												
Name & Signature of the Doctor Starting the Drugs: Dr. Rani																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : Symp. DOMPERIDONE				Date Time	4/7	5/7	6/7	7/7												
Dose	Route	Frequency	Start Dt.																	
6ml	PO	BD	4/7/26	Sam X	Sam X	Sam X	Sam X	Sam X												
Name & Signature of the Doctor Starting the Drugs: Dr. Rani																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : TAB Dexamethasone				Date Time	4/7	5/7	6/7	7/7												
Dose	Route	Frequency	Start Dt.																	
4mg	PO	1-1/2	4/7/26	Sam X	Sam X	Sam X	Sam X	Sam X												
Name & Signature of the Doctor Starting the Drugs: Dr. Rani																				
Additional Instructions: x 4 days (After food)																				
Daily Doctor's Endorsement by a Sign																				



Sheet No:

REGULAR PRESCRIPTIONS

Weight 30.54 kg Ward

DRUG : <u>MTAB CARZOL</u>				Date Time	<u>4/7/20</u>															
Dose <u>30mg</u>	Route <u>PO</u>	Frequency <u>Q24H</u>	Start Dt. <u>4/7/20</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Sirisha Rani</u>				<u>Dr. Sirisha Rani</u> <u>Dr. Sirisha Rani</u> <u>Dr. Sirisha Rani</u>																
Additional Instructions: <u>Before food</u>																				
Daily Doctor's Endorsement by a Sign				<u>Dr. Sirisha Rani</u>																
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																				

Date of Admission: 4/7/20 Drug Allergies: Not known any Drug Allergies

- 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.

Weight. 30.54 kg Ward.

Page: 2/4

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

(P.T.O)

Weight. 30.54 kg Ward.

[illegible]

Signature

VERIFIED BY: Name

BAH-00514821 IP5-00175973
Master DULAM SRINARASIMHA
21-04-2014 12 Y 2 M 13 D (M)
Dr. SRISHA RANI



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MEDICATION RECONCILIATION FORM

Drug Allergies: No

☒ Not known any Drug Allergies

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

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

Shifting From: ER

Shifted to: Ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Syp. Septoran	5mc	PO	OD	3/7/26	☒ C ☐ DC
2	Syp. Zimcont	5mc	PO	OD		☒ C ☐ DC
3	Syp. Celamox	5mc	PO	OD		☒ C ☐ DC
4	Teb Uditiv	1teb	PO	BD		☒ C ☐ DC
5	Syp. Deep Levipil	3mc	PO	BD		☒ 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. Remya

Date & Time: 4/7/26; 2:30pm

Nurse Name & Signature: Nes. Sushmita

Date & Time: 4/7/26 @ 4:15 3pm



CHEMOTHERAPY PRESCRIPTION

All the chemotherapy medications are high risk / high alert drugs.
While administering chemotherapy drugs watch for nausea, vomiting, rashes,
urine output and any local extravasation of the drug.

Sheet No. ①	Weight (kg) : 30.5 kg	Body Surface Area: 1.1 m ²	Diagnosis: Relapsed ALL / Refractory	Protocol: mini hyper CVAO cycle 3
-------------	-----------------------	---------------------------------------	--------------------------------------	-----------------------------------

DATE	TIME	Composition of Chemotherapy (if infusion, mention ml / hr = Mcg / kg / min. etc.)	DOSE	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
4/7/2024	11/10	INT VINORELBINE	1.6 mg	IV	stat	A	Sonam Anu	4/7	A	Sonam Anu
4/7/24	6pm	INT CYCLOPHOSPHAMIDE IN 100 ML NS	170 mg NS	IV	over 1 hour @ 100ml/h	A	pooja pivya	4/7	A	Sonam Anu
5/7/26	6AM	INT CYCLOPHOSPHAMIDE IN 100 ML NS	170 mg	IV	over 1 hour @ 100ml/h	A	Sonam Anu	5/7	A	Sonam Anu
5/7/26	6pm	inj CYCLOPHOSPHAMIDE in 100ml NS	150mg	IV	100ml/h	A	neeru pooja	5/7	A	Anu Soni
6/7/26	6AM	inj CYCLOPHOSPHAMIDE in 100ml NS.	150mg	IV	100ml/h	A	Anu Soni	6/7	A	Sonam Anu
6/7/26	6pm	inj CYCLOPHOSPHAMIDE in 100ml NS	150mg	IV	100ml/h	A	neeru Diger	6/7	A	Anu Mandira Diger

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: 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		
4/7/26	3pm	7.	Infection control measures	M	4	0	1	1	—	<i>[Signature]</i>
5/7	12pm	7.	infection control measure	M	4	0	1	1	—	<i>[Signature]</i>
6/7/26	10Am	9	Normal High protein diet	M	1	0	1	1	—	<i>[Signature]</i>
7/7	9am	7	infection control measures	M	1	0	1	1	—	<i>[Signature]</i> Staff Nurse

Part - III: CODES

Who was taught:		PT: Patient	F: Father	M: Mother	S: Spouse	Sn: Son	D: Daughter	C: Caregiver	O: Other (Specify)
Learning Barriers:									
1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice					
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)					
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing						
Teaching Tools Used:									
A: Audio	D: Demonstration	V: Video	O: Oral	P: Printed					
Mechanism/s to overcome barrier/s:									
1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify						
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference							
Understanding:									
1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review							



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

Replaced B-ALL

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
4/7/26 3pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	B-cell ALL	H. Stable.	chemotherapy	<i>[Signature]</i>	☐ Nursing ☐ Others:
4/7/26 3pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	B-cell ALL	H. Stable.	chemo	<i>[Signature]</i>	☒ Medical ☐ Others:
6/7/26 10am	☐ Medical ☐ Nursing ☒ Others: <i>Dr. Sirisha Rani</i>	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	B-cell ALL	Normal High Protein diet	<u>RDA</u> E: 1750 kcal/d P: 31g/d	<i>[Signature]</i>	☐ 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:



TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/04/2014 Time: 9 AM
Doctor / Nurse / Family Concern?

Temperature (°F)

104	
103	
102	
101	
100	
99	98.5
98	
97	
96	
95	
94	

Heart Rate (bpm)

190	
180	
170	
160	
150	
140	
130	
120	
110	
100	103
90	
80	71
70	
60	
50	

and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring

Heart Rate (Number) 96 bpm

Resp. Rate (bpm) (Over 1 Minute)

70	
60	
50	
40	
30	
20	
10	

Resp Rate (Number) 22 bpm

Resp Distress	Mod/ Severe None / Mild	0
Receiving O ₂ (l/min)	O ₂ Saturations (%)	100%
Conscious Level	Normal / Altered	C
GCS *		15/15

TOTAL SCORE	0
Number of shaded boxes	0
Pain Score	0
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.

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

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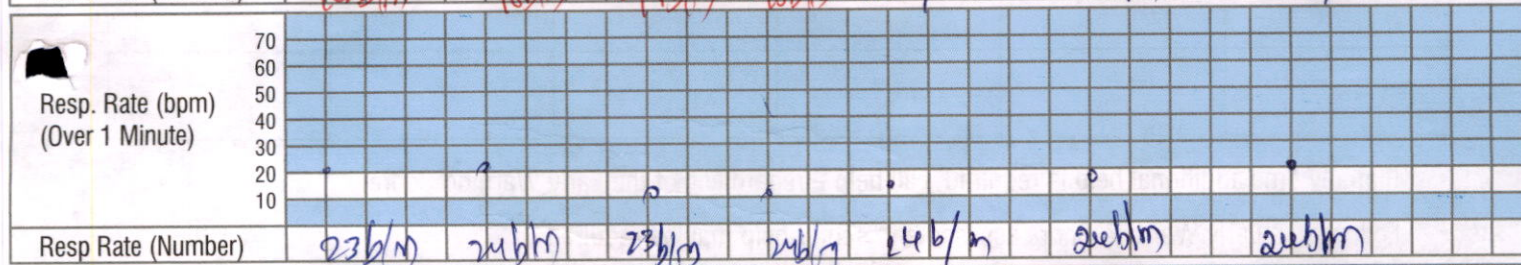
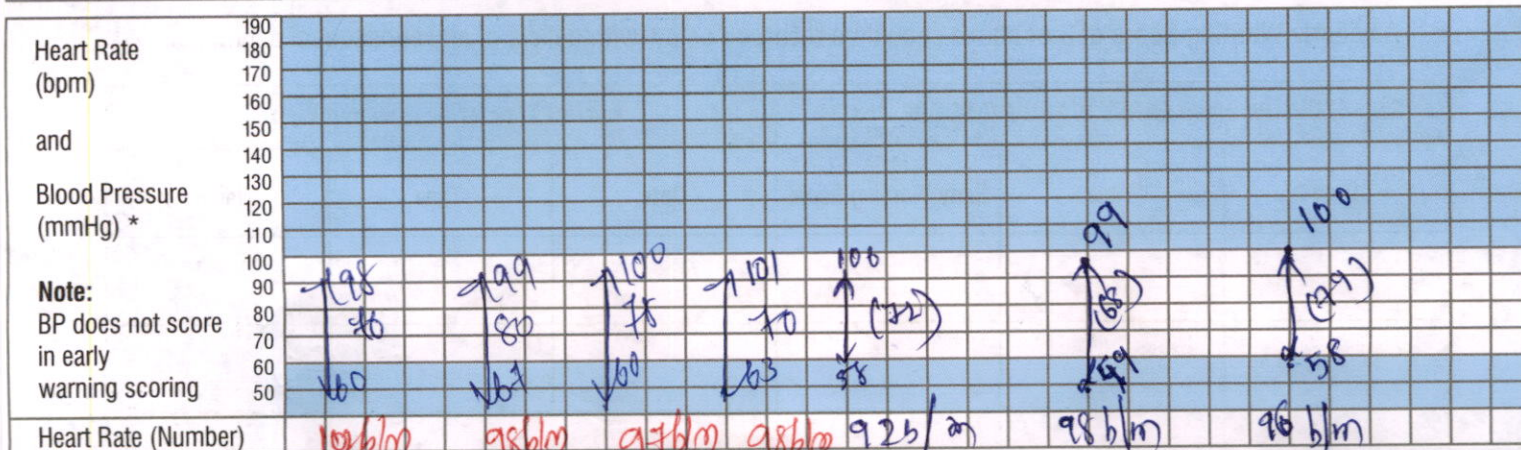
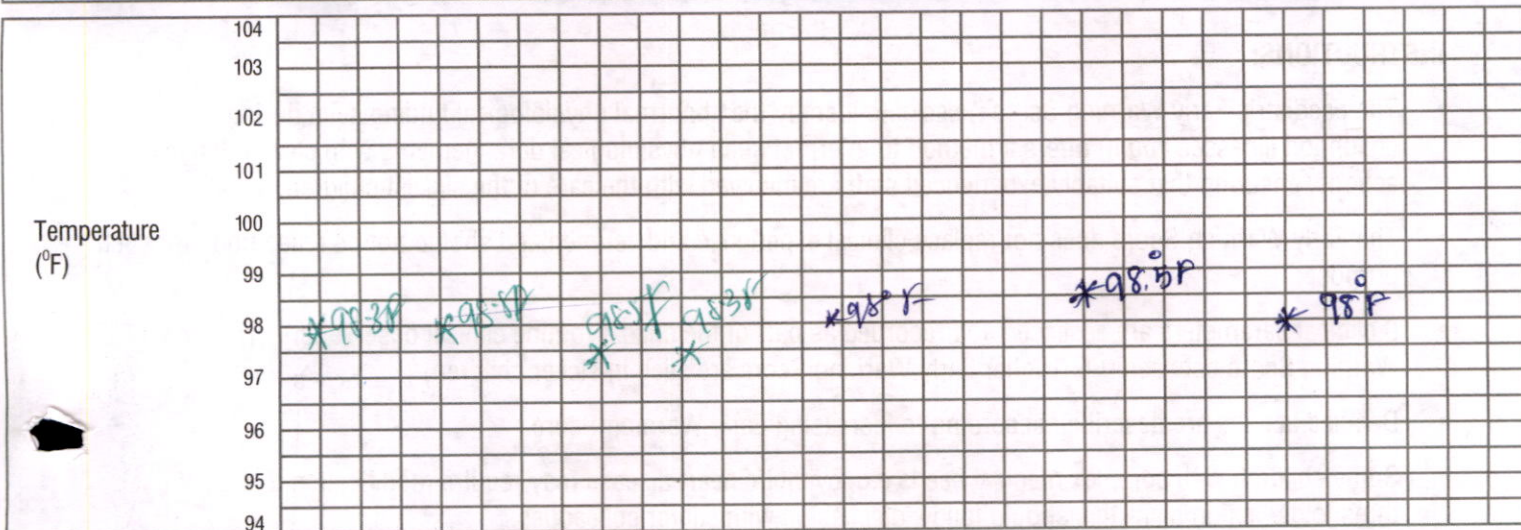


3

TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 6/4 Time: 9AM 1PM 4PM 7PM 10PM 3AM 6AM
Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe	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
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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- 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.
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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

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BAH-00514821 IP5-00175973
Master DULAM SRINARASIMHA
21-04-2014 12 Y 2 M 13 D (M)
Dr. SIRISHA RANI



Doc. No. : RCHB/ FRM / CLINICAL / 127

TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

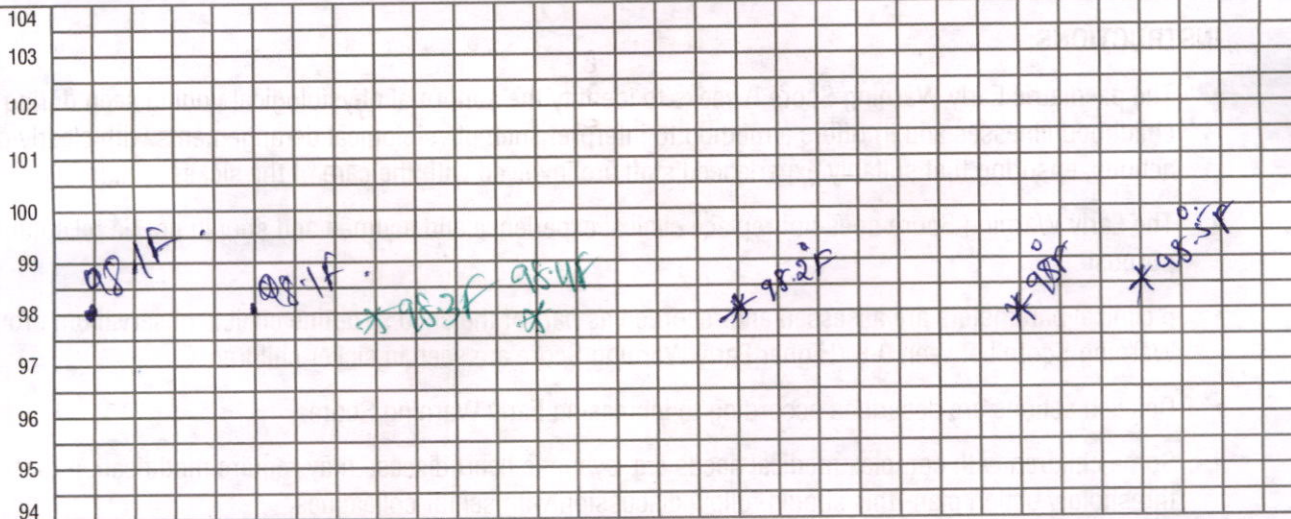
Rainbow
Children's
Hospital
It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 5/4 Time: 9 AM 1 PM 4 PM 7 PM 10 PM 3 AM 6 AM
Doctor / Nurse / Family Concern?

Temperature
(°F)



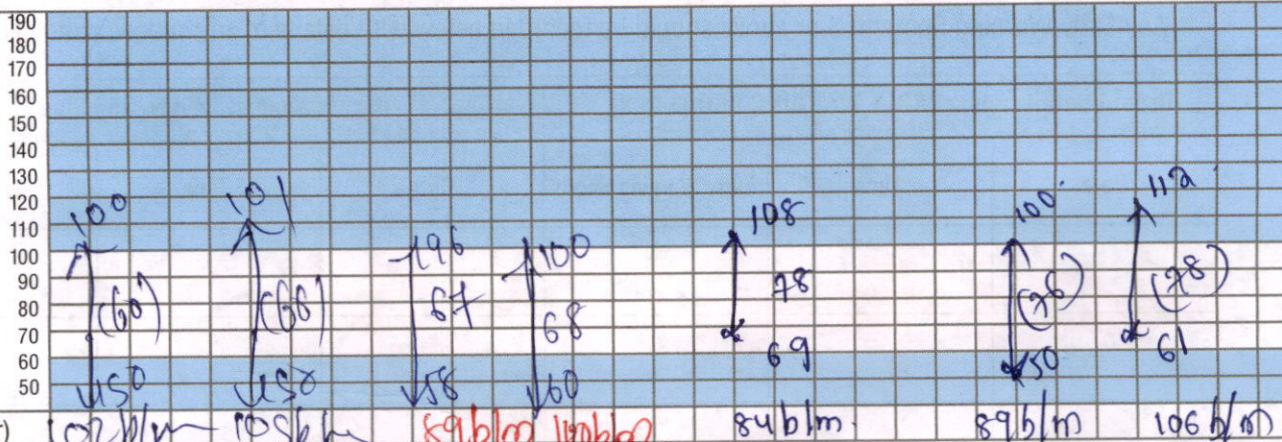
Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

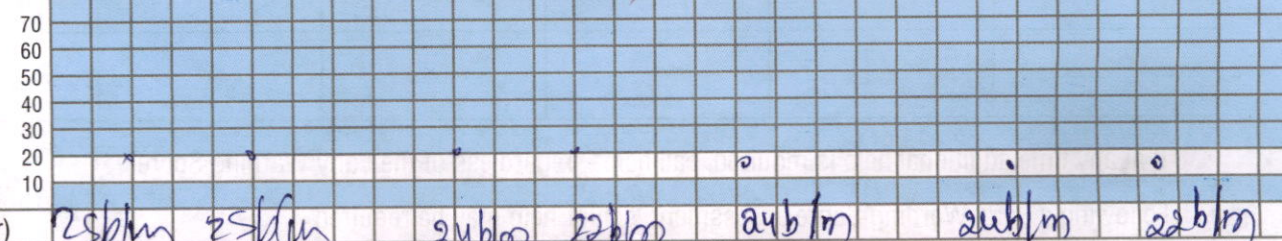
Note:
BP does not score
in early
warning scoring

Heart Rate (Number)



Resp. Rate (bpm)
(Over 1 Minute)

Resp Rate (Number)

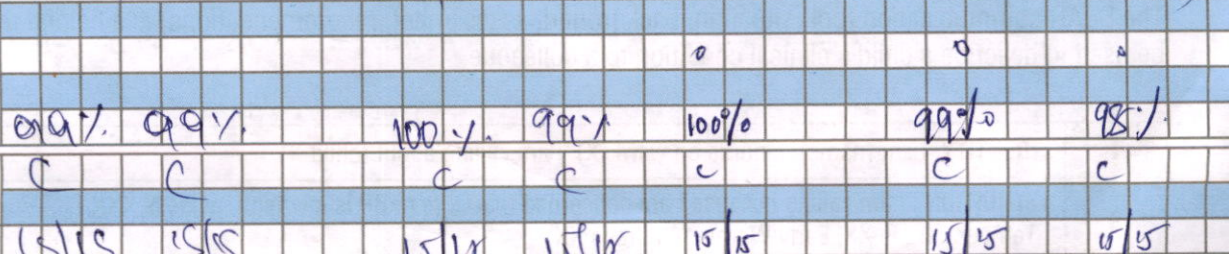


Resp Mod/ Severe
Distress None / Mild

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

Conscious
Level Normal
Altered

GCS *

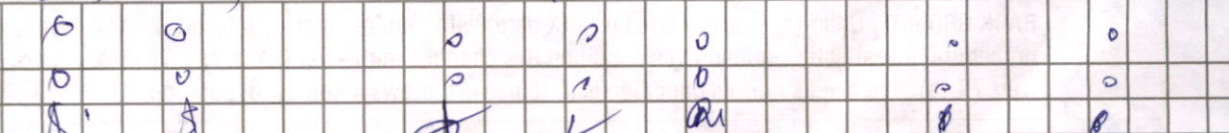


TOTAL SCORE

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 fellow or PICU consultant to be informed.

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:

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SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9/2 Time: 7pm 10pm 3am 6am
Doctor / Nurse / Family Concern?

Temperature (°F)	104				
	103				
	102				
	101				
	100				
	99				
	98	98.2	*98.5F	*98.5F	*98F
	97				
	96				
	95				
	94				

Heart Rate (bpm)	190				
	180				
	170				
	160				
and Blood Pressure (mmHg) *	150				
	140				
	130				
	120				
Note: BP does not score in early warning scoring	110				
	100				
	90				
	80				
	70				
	60				
	50				
Heart Rate (Number)		110b/m	110b/m	119b/m	110b/m

Resp. Rate (bpm) (Over 1 Minute) *	70				
	60				
	50				
	40				
	30				
	20				
	10				
Resp Rate (Number)		26b/m	26b/m	26b/m	25b/m

Resp Distress	Mod/ Severe				
	None / Mild				
Receiving O ₂ (l/min)					
O ₂ Saturations (%)		100%	99%	100%	99%
Conscious Level	Normal	c	c	c	c
	Altered				
GCS *		15/15	15/15	15/15	15/15

TOTAL SCORE				
Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	S	A	A	A

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
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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								
2/4	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							

FLUID CHART

Sheet No. : 2

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

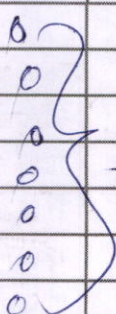
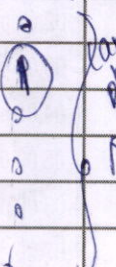
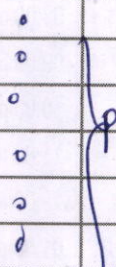
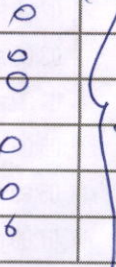
		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	
			Mouth	I.V	N.G						
6/4	08:00 am	Water		50ml						200ml	New
	09:00 am	Water		50ml							
	10:00 am	Water		50ml							
	11:00 am			50ml						100ml	
	12:00 pm			50ml							
	01:00 pm	Water		100ml							
Total Intake :			450ml			Total Output : 300ml					
6/8	02:00 pm	Rice		50ml							Pooja
	03:00 pm	Water		50ml						300ml	
	04:00 pm			50ml							
	05:00 pm			50ml							
	06:00 pm			100ml						100ml	
	07:00 pm			50ml							
Total Intake :			450ml			Total Output : 400ml					
	08:00 pm			40ml							Pooja
	09:00 pm	Rice		40ml						200ml	
	10:00 pm	Water	100ml	40ml							
	11:00 pm			40ml							
	12:00 am			40ml						100ml	
	01:00 am			40ml							
Total Intake :			340ml			Total Output : 300ml					
	02:00 am			40ml							Pooja
	03:00 am			40ml						250ml	
	04:00 am			40ml							
	05:00 am			40ml							
	06:00 am			40ml						100ml	
	07:00 am			40ml							
Total Intake :			240ml			Total Output : 350ml					

Total 24 hrs. Intake 1480 ÷ 48.9 cc/kg/day

Total 24 hrs. Output 1430 ÷ 1.9 cc/kg/hr

Sheet No. : 2

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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								
5/1/20	08:00 am	Saline		40ml						200ml	0		
	09:00 am			40ml			✓				0		
	10:00 am			100ml	40ml		✓				0		
	11:00 am			40ml							0		
	12:00 pm	H ₂ O		100ml	40ml					100ml	0		
	01:00 pm			40ml							0		
	Total Intake : 400ml					Total Output : 300ml							
5/1/20	02:00 pm	Rice		40ml							0		
	03:00 pm	Azo	100ml	40ml						150ml	0		
	04:00 pm			40ml							0		
	05:00 pm			40ml							0		
	06:00 pm	Saline		100ml						200ml	0		
	07:00 pm	H ₂ O	50ml	40ml							0		
	Total Intake : 390ml					Total Output : 350ml							
5/1/20	08:00 pm			40ml							0		
	09:00 pm	Rice		40ml						200ml	0		
	10:00 pm	H ₂ O	80ml	40ml							0		
	11:00 pm			40ml							0		
	12:00 am			40ml						250ml	0		
	01:00 am			40ml							0		
	Total Intake : 320ml					Total Output : 450ml							
5/1/20	02:00 am			40ml							0		
	03:00 am			40ml						150ml	0		
	04:00 am			40ml							0		
	05:00 am			40ml							0		
	06:00 am			40ml						250ml	0		
	07:00 am			40ml							0		
	Total Intake : 240ml					Total Output : 400ml							
Total 24 hrs. Intake		1,390 ; 45 cc/kg				Total 24 hrs. Output		1,500 ; 2.05 cc/kg					



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	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm	fluo	100ml	50ml								
	07:00 pm			50ml					200ml			
Total Intake :			300ml			Total Output :					200ml	
	08:00 pm			40ml								
	09:00 pm	fluo	100ml	40ml					150ml			
	10:00 pm			40ml								
	11:00 pm			40ml								
	12:00 am			40ml					200ml			
	01:00 am			40ml								
Total Intake :			340ml			Total Output :					350ml	
	02:00 am			40ml								
	03:00 am			40ml								
	04:00 am			40ml					150ml			
	05:00 am			100ml								
	06:00 am			100ml								
	07:00 am			40ml					250ml			
Total Intake :			360ml			Total Output :					400ml	

Total 24 hrs. Intake

1,000 ; 33.3cc/kg

Total 24 hrs. Output

950 ; 3.7cc/kg/hr



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 3:30 pm. Mode of Arrival: by parents Admitting From: ☐ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Body Weight: 30 Kg

..... na Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>na</u>	<u>na</u>	<u>YES</u>

Family History: Healthy Family

Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☒ No

If yes please list,

Was the child's birth normal? ☒ Yes ☐ No If No, please describe problems:

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

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

Observations: Weight: 30 kg Length: Head Circumference (< 2 years):

Temp.: 98.2 HR: 104 bpm RR: 26 bpm BP: 100/60

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

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

Risk of Pressure Sore (Braden Q Score 29) (Document in the Braden Q Assessment Sheet)

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

Character of Pain Location Frequency Duration

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

Inform consultant for positive criteria

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

Inform consultant for positive criteria

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

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify Inform consultant for positive criteria.**Social History:** Lives With *Parents*Siblings in household ☐ Yes ☒ No (if yes How Many?)All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach : ☒ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump : ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ NoInformation given to *mother*Nurse Signature: *[Signature]*Nurse Name: *Pooja*Date: *4/7/26*Time: *3:40 pm*

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 7/7/26

Assessment: patient having weakness

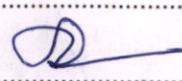
Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	Assess the Patient condition	8:30AM	Assess the Patient condition	patient is stable.
9AM	monitor vital	9:30AM	monitored vital	
9:30AM	maintain IV fluids	10AM	maintained IV fluids	
10AM	Administer medication	11AM	Administered medication	
11AM	provide personal hygiene	11:30AM	Provided personal hygiene	
11:30AM	provide supportive care	12PM	provided supportive care	

Re-Assessment: patient is stable

Special Notes: D/L today.

Nurse Signature: 

Nurse Name: SUBHANKAR

Date & Time: 7/7/26 8:18 PM

4

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6/2/26

Assessment: patient having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the general condition of the patient.	9pm	→ Assessed the general condition of the patient.	Patient felt better
10pm	→ Monitored vital signs.	11pm	→ Monitored vital signs.	
12am	→ Provided side rails.	1am	→ Provided side rails.	
2am	→ Maintained hand hygiene.	3am	→ Monitored hand hygiene.	
5am	→ Administered medications.	6am	→ Administered medications.	
7am	→ Maintained I/O chart.	8am	→ Maintained I/O chart.	

Re-Assessment: patient felt better

Special Notes: 4/ Sonam

Nurse Signature: \$

Nurse Name: Sonam

Date & Time: 4/2 @ 8am

BAH-00514821 IP5-00175973
Master DULAM SRINARASIMHA
21-04-2014 12 Y 2 M 14 D (M)
Dr. SIRISHA RANI



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: 6/7/20

Assessment:

patient having weakness

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
8:40 AM	Assess the patient's general condition	9:15 AM	Assessed the patient's general condition	Pt was stable
10:10 AM	Monitor for the vital and keep	10:25 AM	monitored the vital and	
11:45 AM	maintain fluid balance	12:30 PM	maintained fluid balance	
3 PM	provide sugar safety	3:18 PM	provided side rail	
5:25 PM	provide personal hygiene	6 PM	provided personal hygiene	
6:45 PM	provide patient & family education	7 PM	provided patient & family education	

Re-Assessment:

patient was stable

Special Notes:

continue chemotherapy

Nurse Signature: Alexia

Nurse Name: Alexia

Date & Time: 6/7/20 @ 8 PM

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7

Assessment: patient hearing weakness

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 patient general condition	9pm	Assessed the patient general condition	patient feels better.
10pm	monitor vitals	10:45pm	monitored vitals	
12Am	maintains personal hygiene.	1Am	TO explained personal hygiene.	
2Am	Ensure safety.	3Am	provided side rails	
4Am	Administer medications.	5Am	Administered medications	
6Am	Maintains I/O chart.	8Am	Maintained I/O chart.	

Re-Assessment: patient is stable

Special Notes:

Nurse Signature: 

Nurse Name: pooja

Date & Time: 6/7/20 @ 8Am



4

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/1/14

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				
	Patient having nausea					

Time	Plan of Care	Time	Implementation	Evaluation
2:10pm	Assess the patient general condition	2:10pm	Assessed the patient general condition	It was stable
3:20pm	monitor the vital and rail	3:55pm	monitored the vital and rail	
4pm	provide secure safety	4:12pm	provided side rail	
5:5pm	provide IV fluid	5:40pm	provided IV fluid DMS	
5:28pm	monitor the I/O chart	6:28pm	provided medication as per doctor order	
6pm	provide medication	7:40pm	provided patient & family education	
7:8pm	provide patient & family education			

Re-Assessment:

Patient was stable

Special Notes:

continue chemo for 4 Thos

Nurse Signature: Alauini

Nurse Name: Alauini

Date & Time: 5/1/14 8pm



3

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/7/20

Assessment: patient having measles.

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
8 Am	Assess the patient general condition	9 Am	Assessed the patient general condition	patient feels better
9 Am	check vital	10:30	checked vital	
11 Am	provide sick rest	11:30	provided sick rest	
12 m	Maintain S/O chart	12:30	Maintained S/O chart	
1 p	Administer medication	2 p	Administered medication	

Re-Assessment: N/A

Special Notes: N/A

Nurse Signature: [Signature]

Nurse Name: Gayathri

Date & Time: 5/7/20 @ 3p



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/20

Assessment: Patient having hearing

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 patients	9am	→ Assessed the general condition of the patient.	Patient felt better
10am	→ Monitor vital signs.	11am	→ Monitored vital signs.	
12am	→ Provided side rails.	1pm	→ Provided side rails.	
2am	→ Maintain hygiene	3am	→ Maintained hygiene.	
5am	→ Administer medication	6am	→ Administered medication.	
7am	→ Maintain I/O chart.	8am	→ Maintained I/O chart	

Re-Assessment: Patient felt better

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Sonam

Date & Time: 7/7 @ 8am



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 4/2/16

Assessment: The Patient having Intubation

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
3pm	Monitor Vitals	4:30 PM	Monitored Vitals	
4:30 PM	Administer medication as per doctor advice	5pm	Administered medication as per doctor advice	Pz felt better
5pm	Provide Hydration	5:30 PM	Provided Hydration	
6pm	Provide Supportive Care	6:30 PM	Provided Supportive Care	

Re-Assessment: Pz felt better

Special Notes:

Nurse Signature: In

Nurse Name: Pooja

Date & Time: 4/2/16 8pm

1

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Sirisha Rani Department: Onco Date of Admission: 4/7/20

SITUATION	Diagnosis: <u>B. cell ALL</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time	ER 3:40 pm	Onco 8pm	Onco 8AM	Onco 2pm	Onco 8AM	
	Medical Condition (Any special condition to be noted):		Nil	na	NA	NA	na	na
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:	98.2°F	98.2°F	98.6°F	98.6°F	97.8°F	98.5°F
		Res:	22b/m	20b/m	21b/m	21b/m	22b/m	22b/m
		SpO ₂ :	98.1%	100%	100%	100%	99%	100%
		Pulse:	100b/m	100b/m	97b/m	97b/m	98b/m	98b/m
		BP:	94/60(68)	96/60	100/63(29)	100/63	101/60	100/61
Fall Risk Score:	10	10	10	10	10	10		
Pain Score:	0	0	0	0	0	0		
Recommendations	Safety Needs:	yes	side rail	side rail	side rail	side rail	side rail	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	Nil	na	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	Nil	na	NA	NA	NA	na	
Post Operative Procedure Special Orders:		Nil	na	NA	NA	NA	na	
Handed Over By Name :		Susmita	Pooja	Sareem	Gaya	Nandini	Pooja	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		4/7/20	4/7	4/7	4/7	4/7	4/7	
Time:		3:40 pm	8pm	8AM	2pm	8pm	8AM	
Taken Over By Name :		Pooja	Sareem	Gaya	Nandini	Pooja	Nandini	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		4/7	4/7	4/7	4/7	4/7	4/7	
Time:		4pm	8AM	2AM	2pm	8pm	8AM	



2

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Sirisha Rani Department: Oncology Date of Admission: 4/7

SITUATION	Diagnosis: <u>B-ALL</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:			
	Area	Shift Time	0700 8AM	0700 8AM to 12PM	0700 8AM	0700 12PM
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:	<u>98.6°F</u>	<u>98.3°F</u>	<u>98.3°F</u>	<u>98.5°F</u>
		Res:	<u>22b/m</u>	<u>23b/m</u>	<u>22b/m</u>	<u>20b/m</u>
		SpO ₂ :	<u>100%</u>	<u>99%</u>	<u>98%</u>	<u>97%</u>
		Pulse:	<u>97b/m</u>	<u>98b/m</u>	<u>97b/m</u>	<u>100b/m</u>
		BP:	<u>100/60/64</u>	<u>100/63</u>	<u>100/63</u>	<u>96/66/76</u>
Fall Risk Score:		<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	
Pain Score:		<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	
Recommendations	Safety Needs:		<u>side rail</u>	<u>side rail</u>	<u>side rail</u>	<u>side rail</u>
	Physiotherapy		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Special Diet:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☒ No
	Other Special Orders / Medications:		<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>	
Handed Over By Name :		<u>Anu M</u>	<u>Navee</u>	<u>pooja</u>	<u>subhanur</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>6/7</u>	<u>6/7</u>	<u>6/7</u>	<u>7/7</u>	
Time:		<u>8AM</u>	<u>8AM</u>	<u>8AM</u>	<u>12PM</u>	
Taken Over By Name :		<u>Navee</u>	<u>Anu M</u>	<u>subhanur</u>	<u>DC</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>6/7</u>	<u>6/7</u>	<u>6/7</u>	<u>6/7</u>	
Time:		<u>8AM</u>	<u>8AM</u>	<u>8AM</u>	<u>8AM</u>	



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
4/5/20	3pm	0	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil nil	
4/7	11pm	0	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	N/A	Am m
5/7	7am	0	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	N/A	Am m
5/7	3pm	0	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	N/A	
5/7	10pm	0	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
6/7	6am	0	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
6/7	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Wce
6/7	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
7/7	6am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

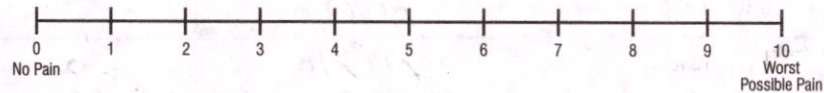
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, 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



BAH-00514821 IP5-00175973
Master DULAM SRINARASIMHA
21-04-2014 12 Y 2 M 13 D (M)
Dr. SRISHA RANI



BRADEN 'Q' SCALE

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

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

					Date :	4/7/28	5/7	6/7	7/7
					Time :	3 PM	8 AM	8 AM	8 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e. 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	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings 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	
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	28	28	28
Docu. No. : RCHBH / FRM / CLINICAL / 119					Evaluator's Name	Dr. SRISHA RANI	Dr. SRISHA RANI	Dr. SRISHA RANI	Dr. SRISHA RANI

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



THE HUMPTY DUMPTY SCALE

4/7 5/7 6/7 7/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	✓	2	
	13 years old and above	1					
Gender	Male	2	2	2	✓	✓	
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1	1	
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	✓	2	
	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	
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	
TOTAL			10	10	10	10	

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		1	yes	yes	yes	
Call device within reach		1	yes	yes	yes	
Wheels Locked		1	yes	yes	yes	
Room free of clutter		1	yes	yes	yes	
Adequate Lighting		1	yes	yes	yes	
Wheel Chair Support		NO	NO	NO	NO	
Other Intervention(s) Specify		NO	NO	NO	NO	
Nurse's Name :		Sushika	Sonam	pooja	pooja	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	
Date :		4/7/20	5/7	6/7	7/7	
Time :		3 PM	8 AM	8 AM	8 AM	



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	cannula bit pins removed
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		NA	-	-	-	-	-	-	-	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		NA	-	-	-	-	-	-	-	
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		NA	-	-	-	-	-	-	-	
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		NA	-	-	-	-	-	-	-	
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		NA	-	-	-	-	-	-	-	
Signature of the Nurse													

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

Signature of Shift In Charge :

Signature : Pooja Name : Pooja

Signature of Ward In Charge :

Signature : Sandeep Name : Sandeep

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									
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	NA									
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	NA									
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	NA									
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	NA									
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	NA									
Signature of the Nurse													

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

Signature of Shift In Charge :

Signature : DIVA Name : DIVA

Signature of Ward In Charge :

Signature : Saritha Name : Saritha



CONSENT FOR CHEMOTHERAPY

Patient Name : Srinivasimha Age : 12Y Gender : Male ☒ Female ☐
UHID No : BAH-00514821 Department : Oncology Date : 4/7/26
Type of Chemotherapy : intravenous

The type of reactions, nature of the major risks and complications arising from the treatment despite precautions has been explained to me. These can include Bone Marrow depression with subsequent infections, bleeding, nausea, vomiting, diarrhea, mouth ulcers, alopecia, fever, phlebitis, ulceration at the site of injection organ injuries etc.

The doctor have explained to me about the benefits and alternative for this procedure that

NA

I understand that no promise of cure or freedom from risk can be given. During the course of treatment I will report any symptoms if they become bothersome.

I have read the above and have no further questions about the treatment to be given.

Patient Attendant :

Signature : D. Kavitha
Name : D. Kavitha
Relationship with Patient : mother
Date & Time : 5/7/26 8pm

Witness :

Signature : Nandini
Name : Nandini
Date & Time : 5/7/26 8pm

Doctor (who is taking the consent):

Signature : Ahankeha
Name : Ahankeha
Date & Time : 5/7/26 8pm



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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 6/7/26 Time: 10 AM

Weight: 30.54 kg Centile: 75th

Height: 142 cm Centile: 71st

Inference: underweight child

RDA: — Calories: 1750 kcal/d Protein: 31g/d

Diet Recommendations: Normal High protein diet

Re-Assessment: Avoid spicy, chilled and outside foods.

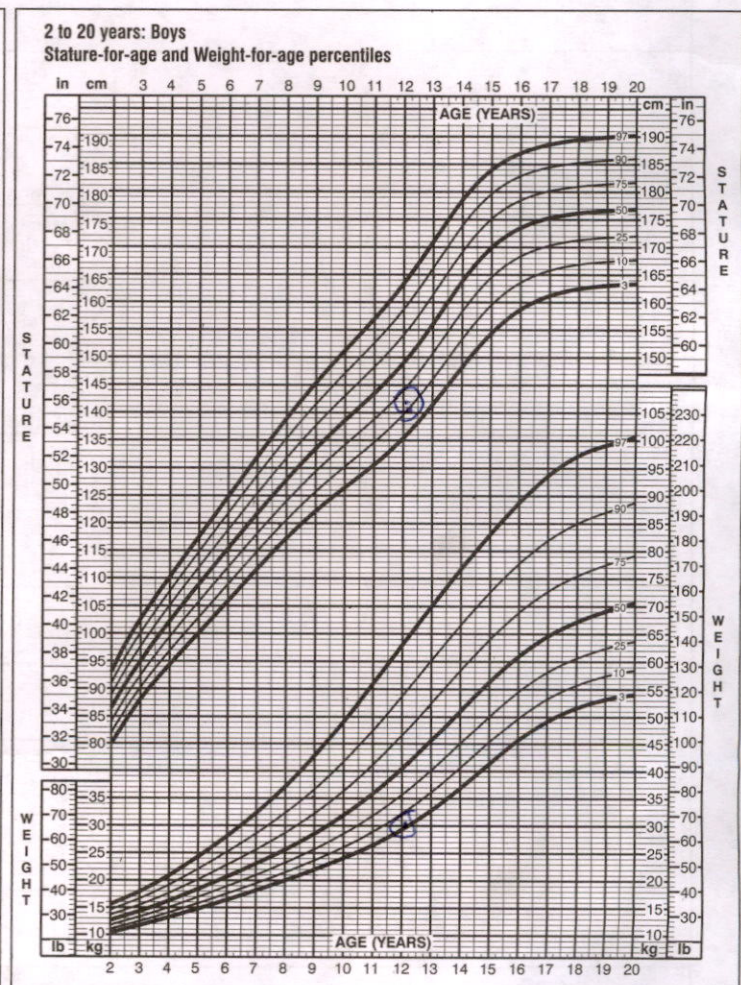
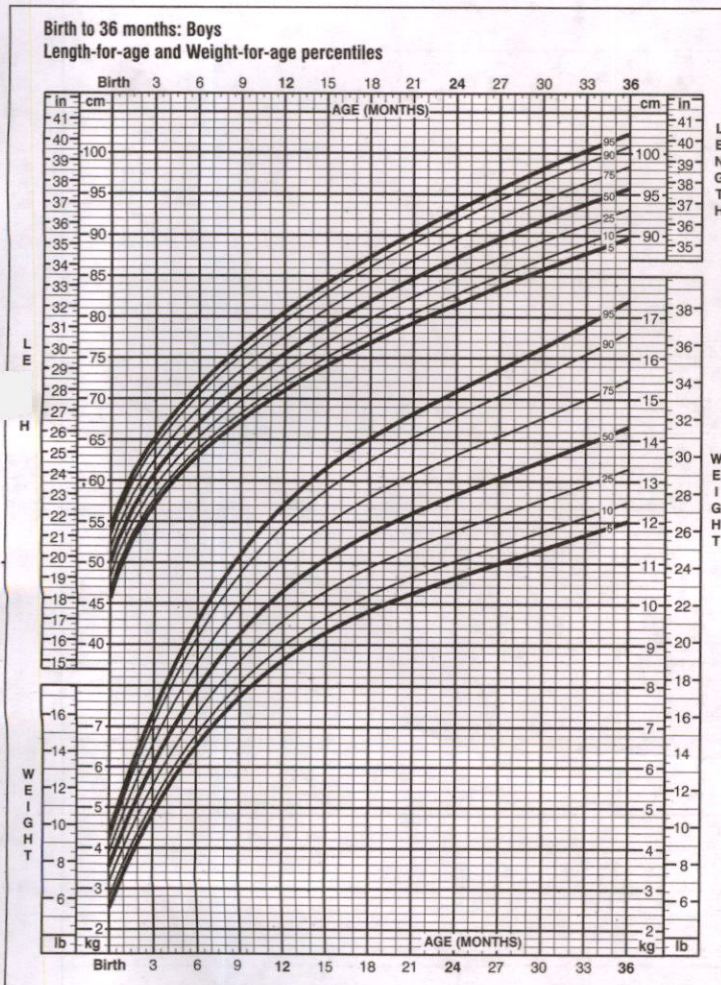
Food Allergies: No Veg/Non-veg: non veg

Diagnosis: BAC / CNS tied / relapse / CNS on for chemotherapy

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Parents Don't feed Hettelan. Don't charge for NHA

GROWTH CHART (BOYS)



Dietician's Name: Manjula

Dietician's Signature: Manjula

Daily Notes:

[illegible]