

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175785

Admit Date : 30-Jun-2026

Admit Time : 08:17 PM UHID : BAH-00660336

Patient Details :

Patient Name : Master MANCHIKALAPATI RITHWIK AYAN

Age : 5 Y 5 M 26 D

Guardian : Mr MANCHIKALAPATI NANI

DOB : 04-01-2021

Gender : Male

Religion :

Occupation :

Marital Status : Single

Address (H) : H.NO-1-25, NUKAVARAM, Pokuru Prakasam
Andhra Pradesh INDIA 523113

Phone No : 9959567457/ 8074646484

E-mail : NANIANIMATION@GMAIL.COM

Admission Details :

Bed Type : PRIVATE ROOM

Bed No : PVT 303

Ward Name : 3F-ZONE B

Room No : PVT 303

Admission Type : First Visit

Contact Details :

Name : Mr MANCHIKALAPATI NANI

Relationship : Father

Contact Address : H.NO-1-25, NUKAVARAM, Pokuru Prakasam
Andhra Pradesh INDIA 523113

Phone No : 9959567457 / 8074646484

Signature

Doctor Details :

Doctor Name : Dr. FAISAL B NAHDI

Specialisation : GENERAL PEDIATRICS

Referral Doctor : DAVID WILLIAMS

Phone No : 7799345465

Co-Consultant : Dr. ANNAPOORNA TADAVARTHY

Payment Details :

Payment Mode : DC/CC Card

Deposit Amount : 5000.00

Payor Name : CARE HEALTH INSURANCE LIMITED

BAH-00660336 IP5-00175785
Master MANCHIKALAPATI RITHWIK
04-01-2021 5 Y 5 M 26 D (M)
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 : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
30/6/26	9:30 pm	ea	303	Coetu

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Venkata Ramana			
2	Dr. Venkata Ram	1/7/26	9682874	Alexya
3	Dr Shirisha Ravi	2/7/26	9684478	Yamun
4	Dr. Shirisha Rami	4/7/26	9687185	Witchitha
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
30/6/26	CBP, CRP, ESR,	65898	Pant
	RP2, Blood cu,		
1/7/26	LFT	26065700	Lowh
1/7/26	CUF	26065706	Law
1/7/26	PCT, Ferritin, mycoplasma 16m		
	measles, Tdm, antibodies	26065713	Law
1/7/26	USG abdomen & big joint	32591	St
1/7/26	Doppler Study.		Law
1/7/26	PT / INR.	26065913	Law
1/7/26	SARS covid, EBV antibodies.		Alekhy
	LDH	26065941	
2/7/26	Triglyceride, widal, well tdx	26066776	Yamen
	Brucella		
02/07	Bone marrow Aspiration		
	and Biopsy	21066295	Prash
	Bone marrow c/s		
2/7/26	2D echo	265-032915	Yamen
4/7/26	CBP, CRP, LFT, renal profile	26066910	Cicisha
	ferritin & (PCT)	26067052	Cicish

[illegible]

[illegible]

Signature

Dan F

Palenik

Conscious sedation

[illegible]

Prepared By :

Billing Supervisor



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PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00660336 IP5-00175785
Master MANCHIKALAPATI RITHWIK
04-01-2021 5 Y 5 M 26 D (M)
Dr. ANNAPOORNA TADAVARTHY



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

clo fever - 8 days

rash - 7 days

periorbital edema - 2 days

abd pain - 8 days

low urine - 2 days, ↓ U/O - 2 days

History of present illness :

clo fever - 8 days, multiple spikes/day,
mod grade, reducing on medication.
Not a/w chills;

~~o H/O fall & sustained~~

H/O abd pain, epigastric on & off - 8 days.

clo rash, started on abd spread to whole
body in 2 days, ~~is~~ palpable, non blanching,
not a/w pruritus.

clo periorbital edema - 2 days
also ↓ urine output.

On IV & Oral Abx - 13 days.

~~cat~~ USG (29/6) → 5/19 - gb wall edema;

fever x 23/6 - 25/6
rash x 24/6

- Cefixime 500

- Ceftriaxone 27/6 - 28/6
Amikacin

- 28/6 - Mero / Amikacin
Azee



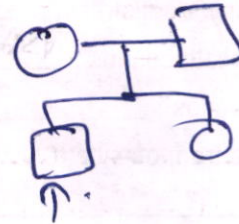
Pediatric Multiorgan History & Physical Examination

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

no
H/o fall, spiral fr of @ femur. on 17/6/21
sprained Tarsus.

Birth & Neonatal History:

term / Apgar / M



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

As per age

Immunization History :

As per age (Including measles)
MIS.



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 17 kg (Centile _____)

On Examination :

Temperature : 101.5°F Pulse Rate : 123/m B.P. 94/60 SPO2 100%

Resp. rate and type of breathing : 26/m

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : clear

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : SS

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : soft

Auscultation : _____

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____

Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Atypical depis



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Sepsis

Desired goals of the treatment: H. stability

Planned Labs:

CBP
CRP
ESR
R_P 2 extra plain
Blood cts.
CUE

RIN 2 DECHO the USA high
RIN Widal
RIN orthopedician opinion
for

NS
Shavari
30/6/26

Planned Management

IVF
IV Amox
Ataxarabon
allow orally
S/O chaiting
NIS
Sevan
30/6/26

Signature of the Doctor: Shankhar

Name of the Doctor: Shankhar

Date & Time: 20/6/26

Signature of the Consultant: Ch

Name of the Consultant: Ch

Date & Time: (9am)

Reg. No. 60228
FAISALABAD
ANNAPOORNA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/06/2021 12 AM	CSD Resident ? Atypical sepsis Ongoing unknown fever spikes (+) Vitals (N) U/O Delirious SLE → rash (+) periorbital edema (+) CNS MS / (N) PB / (N)	Adv 1) Bare Wks 2) Send LFT & urine sample. 3) manage orally. 4) (RTD) JSG High / Widal. Ortho opinion. 5) Inform SRS. Amanth noted by Vishu
Dr. FAISAL B NAHDI Reg. No: 66228	Cloud c AFI c Atypical sepsis c Iy lanahy Syn / sm: / Pu	* Plan: * USg Abdomen & Hip Joint Doppler of lower limb * Dr Venkatesh to see
17/06/2021 9 AM (CNS)	Cloud reduction / 17/06/2021 Nahy	* LFT / Feitin / PCT Measles Igm antibody * Mycoplasma Igm Co Noted by Alekhya



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/7 10pm	<u>C/S/B Resident</u> ↑ lactate dehydrogenase ↑ ferritin hepatomegaly fever. ↑ transaminases ? HLH. no continuous fever remittant O/E: dull. sick look (+) no shock.	<u>Adv.</u> ① R/v triglyceride fibrinogen. LFT. CBP. ② R/v hematocrit consult. ③ R/v BMA/Bx ④ Keep NPO from Fam. ⑤ Naprosyn to add Akhila noted by ciciks 020918 S



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7 8:30am	C/S/B Resident Δ: PUO	
	response to Naproxen (+) Adv:	
	O/E: alert dull. vitals stable on room air chest: BAT (+) abdomen soft hepatomegaly (+) generalised anasarca (+) rash (+)	1) Hematology consultation today, 2) Cont NPO plan BMA + Bx today 3) Continue all current medications & IVF 4) Temperature charting 2 July 5) Monitor vitals 6) Trace pending labs/c/s. Stehile
C/S/B 2/7 8:30am	C/S/B Dr. FAISAL B NAHDI Reg. No: 66228 c Atypical Seps c Secondary HCH: C/S/B	Hematology: C/S/B C/S/B mfw (P.T.O)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/1/21 12pm	CD/W Dr. Faisal	
		<u>Adv.</u>
		① Send Serum - triglycerides - Widal - Weil Felix - Brucella serology
		② 2D Echo today at RCH Banjara Rd no 2 today
		<u>Ahde</u>
2/1/21 2:30pm	<u>Procedure notes</u>	
	Under strict aseptic precautions, bone marrow aspiration & biopsy done. Samples sent for. Uneventful. Send BM culture	<u>Shankar</u>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/26	Seen by <u>Dr. Faris</u> sir	
	1 fever spike (+)	<u>Plan::</u>
	Hemodynamically stable	• Start Inj Methylprednisolone
	Hydration fair	2mg/kg/dose
		• Continue Prediceton as advised
		• Monitor vitals
		• Strict I/O charting
		• Trace Bone marrow biopsy reports.
		Dr. Ramez
		<u>noted by gannam</u>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7 8:30am	Cs/B Resident	
	A: Puro, suspected HLLT	Adv:
	→ fever: 5pm - 101°F	1) W/f fever temperature every 4hrly
	→ <u>u/o ↓ ed.</u>	
	O/E: alert stable vitals	2) Continue IVF ½ maintenance
	rash ⊕	Meropenam D3
	denudation ⊕	Vancomycin D3
	edema generalised pitting	Azithromycin P4
	chest clear.	Naproxen
	abdomen soft	MPS.
		3) Stop reg PCM.
		4) Labs:
		↳ CBP 4m Gar
		↳ CRP today
		↳ LFT
		↳ BFT. feritin
		Achilles
		5) Strict I/O charting daily weight

Dr. FAISAL B NAHDI
Reg. No: 66228

Anal
3/7
8:30am
(u/pw):



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 4:30pm	SIB Resident 2: PVO. no fever. itching (+) P.R. stable O/C. child alert vitals stable RU - BLAC (+) CUS - SIS2 (W) PIA - soft. Path (+) BNA 2 Reactive urethra O/C phagocytes	Plan 1) continue medication as per chart 2) monitor vitals 3) wif fever 4) strict NO claustrg Daily weight check. 5) Inform sos. 6) CBP CRP LFT RFT Ferritin } tomorrow 6 AM Noted by pooja
4/7	Dr. FAISAL B NAHDI Reg. No: 66228 Cutic AFI (P.V.O.) Atypical sepm Secondary HLT. 8cm Clug Acland Pain xine well	Plan Send Blood Inuylph to dy hematome consultation based on reports stop IV fluids



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/2/26 1:20 PM	Seen by Resident. ASIS - PVO ? 2° HLH	Plan
	Child Afebrile > 36 hrs. oral intake less.	1. continue
	child irritable, afebrile hemodynamically stable	AZITHROMYCIN DS Meropenem } Dr. Vancomycin }
	Chest clear	2. Methylprednisolone -
	abdomen soft	3. monitor vitals
	no meningeal signs	q inform SOS
	ALP - 536 → 1090.	
	CRP - 50.	\$ Santhi
4/2/26 2 PM	Seen by Dr. Faisal	1. Send PCT in same sample.
		2. Stop vancomycin q Azithromycin
		\$ Santhi
	Dr. FAISAL B NAHDI Reg. No. 06228	noted by <u>trish</u> 020913



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/1/21 5:30 PM	Seen by Resident ASis - PVO 2° HLH	Peau
	2 fever spikes yesterday 1 PM, 4 PM - 100; 100.8 F	1. Continue AZITHROMYCIN MEROPENEM NAPROSYN METHYLPREDNISOLONE
	oral intake less. O/E child asleep, afebrile & hemodynamically stable w/ further fever spikes chest clear abdomen soft hydration fair rashes ⊕ ACT - 3.23	monitor vitals, ↓ santi
		(Adv)
Child (11/11)	child i PVO	⊖ Continue same medich
(11/11)	Steady HLH	⊖ Augs the Camla
(5/1/21) (10:30 AM)	Child seen	
	Dr. FAISAL B NAHDI Reg. No: 66228	Noted by Rim



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7 8:30am	C/S/B Resident Δ: PUO - 2° HLH - afebrile since 36 hrs. no pain - rash resolving - good oral intake o/e: vitals stable chest ^{asleep} clear edema better no dehydration rash demolding chest: BAE ⊕ / ⊕ no murmur abd: no organomegaly	Adv: 1) Continue Meropenam D6 MPS 2mg/kg D4 Naproxen D5 2) change dressing today over Ⓚ knee 3) Plan labs on Flup
6/7	Curd c p.v.o. E Secndry HLH	Atkule (Plan:)
Curd (c/fn) (8:30am)	Curd solid	* Stop IV mtyl/pudm * Start oral amoxicil -



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7 5pm	C/S/B Dr. Faisal C/S/B Resident. <u>PUO - 2° HLH</u> afebrile good o/i o/e: alert adema to sing s/e: NAD.	<u>Adv.</u> 1-) Plan (D) t/m. 2-) Cont all current medications 3-) w/f fever spikes 4-) Dressing change Noted by Akshay 606820. Akhile
7/7	and c lvo- Secondary HLH	(Adv.)
(Puro).	Clay stand A/child:	① Insdy today ② Ho Ludy. Rept tabs C M FN nsandya.
		CBP / CRP / ESR / function / LFT. End.

IP5-00175785

04-01-2021

5Y6M2D

(M)

Dr. FAISAL B NAHDI



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



CROSS CONSULTATION FORM

Doctor Name : Dr. Nand Kumar Singh Date : _____ Time : _____

Diagnosis : _____

Hospital : _____

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

Signature: _____

Findings and Recommendations :

Ref of Dr. Nand Kumar Singh

Dr. Farid Khan

Dr. Upendra

Case of 1st term 2nd @ 2nd

1st 2nd entry point - oral exam

Trained & entry the age

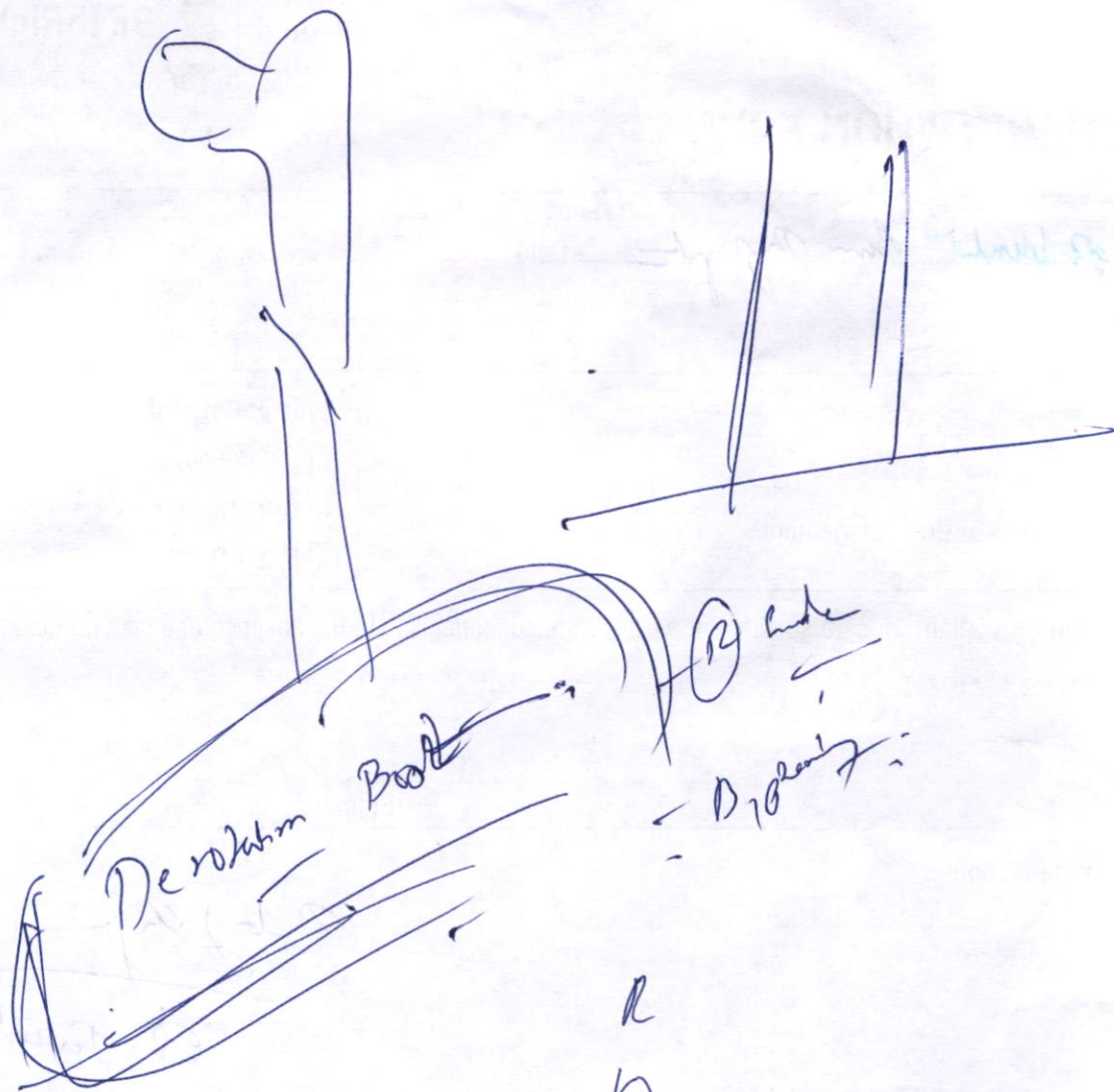
U36 - No Medici

with Leaky

also suggested about

Consultant :

Name : Dr. Nand Kumar Singh Signature : NKS Date & Time : 11/7/2021



R

(1) T. Chyng J

$\frac{1}{2} - \frac{1}{2} - \frac{1}{2} - (4) A$

(2) T. Lince (6) A

(3) G. Lince (1) m

(4) L. D. 1000 (1) m

(5) R. L. Lince (1) m

Der. 2 100 J

(1) Der

BAH-00660338 IP5-00175785
Master MANCHIKALAPATI RITHWIK
04-01-2021 5 Y 5 M 28 D (M)
Dr. FAISAL B NAHDI

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CONSULTATION FORM

Doctor Name : Dr. Bhargava Date : 31/7/26 Time :

Diagnosis :

Hospital : RCH

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

Signature: [Signature]

Findings and Recommendations :

→ c/o - fever since 7 days

→ c/o - Rashes x 7 days

→ c/o - skin peeling

Echo - Structurally Normal

- (M) cardiac chambers

LMCA - 2.2mm (Z score +0.01)

LAD - 1.5mm (Z score -0.94)

PCA - 1.5mm (Z score -1.04)

Aortic Sinus - 19mm (Z score +0.68)

30/6/26

46 - 118mm

TC - 44K

PLT - 1.92L

CRP - 50

Prescribed Form

- 28-6

Consultant : Dr. Bhargava

Name : Dr. Jambhavan Signature : [Signature] Date & Time : 31/7/26

1. *Quercus* (10-15%)
 2. *Pinus* (10-15%)
 3. *Juniperus* (10-15%)
 4. *Salix* (10-15%)
 5. *Betula* (10-15%)
 6. *Populus* (10-15%)
 7. *Alnus* (10-15%)
 8. *Corylus* (10-15%)
 9. *Fraxinus* (10-15%)
 10. *Ulmus* (10-15%)
 11. *Liriodendron* (10-15%)
 12. *Thuja* (10-15%)
 13. *Taxus* (10-15%)
 14. *Abies* (10-15%)
 15. *Sciurus* (10-15%)
 16. *Peromyscus* (10-15%)
 17. *Microtus* (10-15%)
 18. *Citellus* (10-15%)
 19. *Spermophilus* (10-15%)
 20. *Neotoma* (10-15%)
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 22. *Dipodomys* (10-15%)
 23. *Reithrodontomys* (10-15%)
 24. *Perognathus* (10-15%)
 25. *Spizella* (10-15%)
 26. *Junco* (10-15%)
 27. *Passer* (10-15%)
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 88. *Empidonax*
 89. *Protonotaria*
 90. *Regulus*
 91. *Polioptila*
 92. *Parus*
 93. *Geothlypis*
 94. *Chondestes*
 95. *Contopus*
 96. *Empidonax*
 97. *Protonotaria*
 98. *Regulus*
 99. *Polioptila*
 100. *Parus*

1. *Quercus*
 2. *Pinus*
 3. *Juniperus*
 4. *Salix*
 5. *Betula*
 6. *Populus*
 7. *Alnus*
 8. *Corylus*
 9. *Fraxinus*
 10. *Ulmus*
 11. *Liriodendron*
 12. *Thuja*
 13. *Taxus*
 14. *Abies*
 15. *Sciurus*
 16. *Peromyscus*
 17. *Microtus*
 18. *Citellus*
 19. *Spermophilus*
 20. *Neotoma*
 21. *Onychomys*
 22. *Dipodomys*
 23. *Reithrodontomys*
 24. *Perognathus*
 25. *Spizella*
 26. *Junco*
 27. *Passer*
 28. *Carpodacus*
 29. *Geothlypis*
 30. *Chondestes*
 31. *Contopus*
 32. *Empidonax*
 33. *Protonotaria*
 34. *Regulus*
 35. *Polioptila*
 36. *Parus*
 37. *Geothlypis*
 38. *Chondestes*
 39. *Contopus*
 40. *Empidonax*
 41. *Protonotaria*
 42. *Regulus*
 43. *Polioptila*
 44. *Parus*
 45. *Geothlypis*
 46. *Chondestes*
 47. *Contopus*
 48. *Empidonax*
 49. *Protonotaria*
 50. *Regulus*
 51. *Polioptila*
 52. *Parus*
 53. *Geothlypis*
 54. *Chondestes*
 55. *Contopus*
 56. *Empidonax*
 57. *Protonotaria*
 58. *Regulus*
 59. *Polioptila*
 60. *Parus*
 61. *Geothlypis*
 62. *Chondestes*
 63. *Contopus*
 64. *Empidonax*
 65. *Protonotaria*
 66. *Regulus*
 67. *Polioptila*
 68. *Parus*
 69. *Geothlypis*
 70. *Chondestes*
 71. *Contopus*
 72. *Empidonax*
 73. *Protonotaria*
 74. *Regulus*
 75. *Polioptila*
 76. *Parus*
 77. *Geothlypis*
 78. *Chondestes*
 79. *Contopus*
 80. *Empidonax*
 81. *Protonotaria*
 82. *Regulus*
 83. *Polioptila*
 84. *Parus*
 85. *Geothlypis*
 86. *Chondestes*
 87. *Contopus*
 88. *Empidonax*
 89. *Protonotaria*
 90. *Regulus*
 91. *Polioptila*
 92. *Parus*
 93. *Geothlypis*
 94. *Chondestes*
 95. *Contopus*
 96. *Empidonax*
 97. *Protonotaria*
 98. *Regulus*
 99. *Polioptila*
 100. *Parus*



CROSS CONSULTATION FORM

Doctor Name : Dr. Sirisha Rani Date : 2/7/26 Time : 12 pm

Diagnosis :

Hospital : RCH - B

Type of Referral :

☐ Emergency

☐ Urgent

☒ Non Urgent

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

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

Signature:

Findings and Recommendations :

5 yr old male with spiral # of left femur on 17/6/26
underwent surgery.
2 days post sx - child developed fever spikes
↓
2 days later developed rash.
rash started over nape of neck & progressed
caudally, non pruritic, blanching
c/o abdominal pain since 1 week.
labs: anemia, leukopenia, thrombocytopenia (resolved)
transaminitis (rising) @ RFT.
hypoalbuminemia,
CRP ↑, ESR @.
hyperferritinemia / ↑ LDH
D/E: dull, generalised erythematous papular rash,
anasarca ⊕, hepatomegaly ⊕ / NT.

Consultant :

Name : Dr. Sirisha Rani Signature : [Signature] Date & Time : 2/7/26

plan

- 1) To collect Measles IgM, ~~Mycoplasma~~
 - 2) To do BMA, Biopsy & also bone marrow culture
 - 3) 2D Echo Today
 - 4) To start steroids after Bone marrow.
 - 5) To send Weil Felix.
- To consider sending Brucella serology if all else negative

CROSS CONSULTATION FORM

Doctor Name : Dr. SIRISHA RANI Date : 4/6/26 Time : 11 am

Diagnosis : HLH

Hospital :	Type of Referral : ☐ Emergency ☐ Urgent ☐ Non Urgent
Referred for : ☐ Opinion ☐ Co-Management ☐ Transfer of care	

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

Signature: _____

Findings and Recommendations :

Referred child
afebrile x 1 day
rash ↓
steroid started on 2/7/26
1/1/10 ^{aggravate} rash, labs s/o HLH - to continue steroids
Imp: Secondary HLH (2° to infection)
Unlikely primary HLH
Plan
1) continue steroids by methyl pred x 2 more days
then oral steroid
2) at supportive care.
BMA (verbal report) - no atypical cells
flow cytometry - @
3 wks relapse
↑
fup on

Consultant :

Name : Dr. SIRISHA RANI Signature : _____ Date & Time : 4/6/26 11 am

7/6/26
10 AM

Dr. Sandhya

Revised child

afebrile x 24 hours.

fever - ↓.

Wt: 5.07 / PT ↓.

0/2 - child alert

peeling of skin

erythema ⊕.

Plan

1) Tab OMNACORTIL (10mg / 5mg (15mg))

1 — 1 — 1 x 5 days

then to taper

2) change dressing

3) skin care.

4) To repeat

CBP

LFT

fever

RBS

after 3 days

& decide on

steroid tapering

5) Continue IV antibiotics as planned.

Dr. Sandhya

Shari

BAH-00660336 IP5-00175785
Master MANCHIKALAPATI RITHWIK
04-01-2021 5 Y 6 M 0 D (M)
Dr. FAISAL B NAHDI



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CROSS CONSULTATION FORM

Doctor Name : Dr. Venkatesh Ch. Raghavulu Date : Time :

Diagnosis :

Hospital :

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

Signature: _____

Findings and Recommendations :

F/u of Hyaline MFL @ 12
operated noted c/o normal

OK. Healthy Dr.

Review in 6000 hrs.

F/u c/o Dr. Karthik

Healthy. Hyaline MFL.

already - previous Dr. Dr. Karthik.

OK. Healthy

R. Karthik

Consultant :

Name : Dr. Karthik Ch. Raghavulu Signature : [Signature] Date & Time : 1:05 PM

BAH-00660336 IP5-00175785
Master MANCHIKALAPATI RITHWIK
04-01-2021 5 Y 6 M 26 D (M)
Dr. ANNAPOORNA TADAVARTHY



OUTSIDE

RESULT SHEET

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

Denique → -ve
Sumb → -ve
Typhoid → -ve
BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery
Her nu J -ve

Date	22/7/6	26/6	22/6	27/6	26/6	28/6	29/6
Time							
Hb	9.3	10.4	10.8		10.4	10.0	10.8
PCV	30	31	33		31	30	30
RBC	4.01	4.07	4.28		4.01	4.01	4.08
WBC	14500	4800	10900		4800	3300	4000
N/L	60/30	55/40	50/40		55/40	60/30	62/33
Platelets	2.9	2.17	2.56		2.17	1.75	1.26
CRP		17			17	55	87
ESR							
PCT							
RBS	78		89				95
Na							145
K							5.1
Cl							9.9
Ca/Mg			8.1				
Phosphate				6.24			
Urea	16					18	
Creatinine	0.5		0.6			0.8	0.52
ALP		78	58		78	72	180
SGPT		112	16		112	222	69
SGOT		69	20		69	182	62
T.Bill/Conj		0.7-0.3	0.6-0.3		0.7-0.3	0.8-0.3	0.4-0.1
T.Protein		6.0	6		6.0	6.0	6.0
S.Albumin		3.2	3.2		3.2	3.2	2.0
S.Globulin		2.3	2.6		2.3	2.5	2.0
A/G Ratio							1.0
Uric Acid							
S.Amylase							
Sr.Lipase							
Blood Lactate							
S.Cholesterol							
PT/INR							
APTT							
CSF Protein / Sugar							
Cells							
N/L							24



0 positive
outside

RESULT SHEET

Date	17/6	22/6	26/6	28/6	29/6	29/6
Time					2am	7pm
Hb	9.3	10.8	10.4	10 ↓	10.8	9.8 ↓
PCV						
RBC						
WBC	14500	10,900	4880 ↓	3300 ↓	4000	3200 ↓
N/L	60/30	50/40	55/40	60/30	62/33	74/23
Platelets	2.9 L	2.56 L	2.17 L	1.75 L	1.26 L	1.42 L ↑
CRP			17	55 ↑	87 ↑	
ESR						
PCT						
RBS						
Na					145	
K					5.1	
Cl					99	
Ca/Mg		8.6				
Phosphate		6.2				
Urea	16			18		
Creatinine	0.5	0.6		0.6	0.5	
ALP		58	78	72		180
SGPT		16	112 ↑	221 ↑		69
SGOT		20	69 ↑	182 ↑		62
T.Bill/Conj		0.6/0.3	0.7/0.3	0.8/0.3		0.4/0.1
T.Protein		6	6	6		4
S.Albumin		3.2 ↓	3.2 ↓	3.2		2 ↓
S.Globulin		2.6	2.3	2.5		2
A/G Ratio						1
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date	26/6	29/6			
Time					
CUE - Alb	-				
CUE - Sugar	-				
CUE - Ketones	-				
CUE - PUS Cells	(N)				
CUE - RBC Cells					
CUE					
Stool Pus Cell					
OVA / Cyst					
Occult Blood					
BT / CT	(N)				

Culture and Sensitivities :

Serology - HIV - neg

HBsAg / HCV - neg

Dengue NSI / IgM / IgG - negative

Radiology :

USG :

29/6 - GB wall edema

X-Ray :

mesenteric lymphadenitis

ECHO :

CT :

MRI

Others (ECG, Contrast Studies etc.) :

3AH-00660336 IP5-00175785
Master MANCHIKALAPATI RITHWIK (M)
14-01-2021 5 Y 5 M 27 D
Dr. FAISAL S NAHDI

RESULT SHEET

Date	30/6/16	11/7/20	24/7/26			
Time						
Hb	11		8-8↓			
PCV	35.5		27.1↓			
RBC	8.4.5		3.53			
WBC	4,410		4.86			
N/L	48/39		72/16			
Platelets	1.92L		3.37L			
CRP	50		50			
ESR	16					
PCT		28.6	3.23			
RBS			3.23			
Na	133		135			
K	4.5		4.2			
Cl	103		103			
Ca/Mg						
Phosphate						
Urea	17		8			
Creatinine	0.8		0.3			
ALP		536↑	1070↑			
SGPT		502↑	230↑			
SGOT		746↑	180↓			
T.Bill/Conj		1.1<0.1	0.3<0.2↓			
T.Protein		4.9	5.5			
S.Albumin		2.5↓	2.9↑			
S.Globulin		2.4	2.6			
A/G Ratio		2.4	1.1			
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR		14/1.0				
APTT		60 VITK				
CSF Protein / Sugar						
Cells						
N/L						

TG - 368
ferretin - 9480/ 3450 (4/7)
LDH - 3088

PATIENT NAME: BAH-00680338 IP5-00175785
Master MANCHIKALAPATI RITHWIK
AGE: 04-01-2021 5 Y 5 M 28 D (M)
Dr. FAISAL B NAHDI
DONE BY: 

DATE: 2/7/2026

PEDIATRIC ECHOCARDIOGRAM REPORT

Situs	
Cardiac Position	
Systemic Veins	
Pulmonary Veins	
Atrio ventricular connection	
Ventricular arterial connection	
Great artery relationship	
Right atrium	
Left atrium	
Inter atrial septum	
Mitral Valve	
Tricuspid Valve	
Right ventricle	
Left ventricle	
Interventricular septum	
Aorta and aortic arch	(M)
Pulmonary artery and branch PA	Aortic Annulus - 15mm (Z Score +1.23)
Aortic Valve	Aortic Bicuspid - 25mm 19mm (Z Score +0.68)
Pulmonary valve	STJ - 15mm - (Z Score +0.03)
Coronaries	LCCA - 2.2mm (Z Score +0.01) LAD - 1.5 (Z score -0.54)
PDA	
Pericardium	RCA - 1.5mm
Others	(Z Score -1.09)

Doppler

	Gradients	Regurgitation
Mitral flow		
Tricuspid flow		
Aortic flow		
Pulmonary flow		

Mitral flow	E'	A'	S'
Medial LV	E'	A'	S'
Tricuspid flow	E'	A'	S'
Time Intervals	IVRT	IVCT	DT
Others			

MEASUREMENTS

Position	Absolute (cm)	Z Score	Position	Absolute (cm)	Z Score
AO			Tricuspid Annulus		
LA			Mitral Annulus		
IVSd	1.610		Aortic Annulus		
LVIDd	3.40		PA Annulus		
LVPWd	1.407		RPA		
IVSs	1.692		LPA		
IVIDS	2.46		MPA		
LVPWsMA	1.773		AO Isthmus		
EF	60%		LV Mass		
FS	30%		Others		

IMPRESSION :

Performed by :

CARDIOLOGY REQUISITION FORM

Name:	BAH-00660336 IP5-00175785 Master MANCHIKALAPATI RITHWIK 04-01-2021 5 Y 5 M 28 D (M) Dr. FAISAL B NAHDI	Age:	
Sex:		Date:	2/7/26
UHID No:		Weight:	

DIAGNOSIS:

PUR
suspected H+H

SILENT CLINICAL FINDINGS:

anasarca, generalised
hepatomegaly nontender rash
lip peeling

IMPORTANT LAB PARAMETERS:

transaminitis, ↑ CRP, ⊕ ESR.

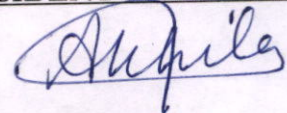
INDICATION FOR ECHO & REQUIRED INFORMATION:

to r/o Kawasaki, IE

CONSULTANT NAME:

Dr. Faisal

RESIDENT SIGNATURE:





DRUG CHART

Date of Admission: 30/6/21 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 : <u>SYP. CHOCOLATE PS</u>				Date Time																
Dose <u>5-5ml PO</u>	Route <u>PO</u>	Frequency <u>6th hly</u>	Start Date <u>30/6</u>																	
Doctor's Signature <u>Ashank</u>		Valid Period	Pharm.																	
Additional Instructions: <u>(Cough/sneezing T > 100° F)</u>																				

DRUG : <u>SYP. MEFENAL</u>				Date Time																
Dose <u>2ml PO</u>	Route <u>PO</u>	Frequency <u>8th hly</u>	Start Date <u>30/6</u>																	
Doctor's Signature <u>Ashank</u>		Valid Period	Pharm.																	
Additional Instructions: <u>T > 102° F</u>																				

DRUG : <u>IM PARACETAMOL</u>				Date Time																
Dose <u>250mg IM</u>	Route <u>IM</u>	Frequency <u>SOS</u>	Start Date <u>30/6</u>																	
Doctor's Signature <u>Ashank</u>		Valid Period	Pharm.																	
Additional Instructions: <u>T > 102° F</u>																				



REGULAR PRESCRIPTIONS

Weight. 17kg Ward.

DRUG : <u>Inj MEROPENEM</u>				Date Time																
Dose	Route	Frequency	Start Date																	
<u>680mg</u>	<u>IV</u>	<u>8thly</u>																		
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Inj CEFTRIAXONE</u>				Date Time	<u>30/6</u>															
Dose	Route	Frequency	Start Date																	
<u>800mg</u>	<u>IV</u>	<u>BD</u>	<u>30/6</u>																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Inj ESMOPRAXOLE</u>				Date Time	<u>30/6</u>	<u>1/7</u>	<u>2/7</u>	<u>3/7</u>	<u>4/7</u>	<u>5/7</u>	<u>6/7</u>	<u>7/7</u>								
Dose	Route	Frequency	Start Date																	
<u>20mg</u>	<u>IV</u>	<u>OD</u>	<u>30/6</u>																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>ATPRAX LOTION</u>				Date Time	<u>30/6</u>	<u>1/7</u>	<u>2/7</u>	<u>3/7</u>												
Dose	Route	Frequency	Start Date																	
	<u>UA</u>	<u>TID</u>	<u>30/6</u>																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

VERIFIED



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : <u>Syr. AZITHROMYCIN</u>				Date	Time															
Dose	Route	Frequency	Start Dt.	1/7	1/7	2/7	3/7													
4ML	PO	OD	30/6																	
Name & Signature of the Doctor Starting the Drugs:				Signature 11PM 2/7/28 STOP Signature																
Additional Instructions:				5ml = 20mg 11PM 2/7/28																
Daily Doctor's Endorsement by a Sign				Signature 11PM 2/7/28																

DRUG : <u>Inj MEROPENAM</u>				Date	Time															
Dose	Route	Frequency	Start Dt.	1/7	2/7	3/7	4/7	5/7	6/7	7/7										
650mg	IV	TID	30/6																	
Name & Signature of the Doctor Starting the Drugs:				Signature 11PM 2/7/28 STOP Signature																
Additional Instructions:				40mg/kg/dose 11PM 2/7/28																
Daily Doctor's Endorsement by a Sign				Signature 11PM 2/7/28																

DRUG : <u>Inj VANCOMYCIN</u>				Date	Time															
Dose	Route	Frequency	Start Dt.	1/7	2/7	3/7	4/7													
350mg	IV	8hrly	1/7																	
Name & Signature of the Doctor Starting the Drugs:				Signature 11PM 2/7/28 STOP Signature																
Additional Instructions:				20mg/kg/dose over 1 hour 11PM 2/7/28																
Daily Doctor's Endorsement by a Sign				Signature 11PM 2/7/28																

DRUG : <u>Inj PARACETAMOL</u>				Date	Time															
Dose	Route	Frequency	Start Dt.	1/7	2/7	3/7														
100mg	IV	q6h	1/7																	
Name & Signature of the Doctor Starting the Drugs:				Signature 11PM 2/7/28 STOP Signature																
Additional Instructions:				6pm 11PM 2/7/28																
Daily Doctor's Endorsement by a Sign				Signature 11PM 2/7/28																



FORTE REGULAR PRESCRIPTIONS

Weight 176g

Ward

Docu. No. : RCHBH /FRM / CLINICAL / 108

Sheet No:

REGULAR PRESCRIPTIONS

Weight 17kg Ward

DRUG : Symp NARROSYN				Date Time	2/7	3/7	4/7	5/7	6/7	7/7										
Dose	Route	Frequency	Start Dt.		8AM	8AM	8AM	8AM	8AM	8AM										
5ml	PO	TID	1/7																	
Name & Signature of the Doctor Starting the Drugs:				Dr. Hile																
Additional Instructions:				(5ml/125mg) Imp/kg/dose																
Daily Doctor's Endorsement by a Sign				8AM 8AM 8AM 8AM 8AM 8AM 8AM 8AM 8AM 8AM 8AM 8AM 8AM 8AM 8AM 8AM 8AM 8AM 8AM 8AM																
DRUG : Symp METHYLPREDONISOLONE				Date Time	2/7	3/7	4/7	5/7	6/7	7/7										
Dose	Route	Frequency	Start Dt.		9PM	9PM	9PM	9PM	9PM	9PM										
34mg	IV	OD	2/7																	
Name & Signature of the Doctor Starting the Drugs:				Dr. Salathur																
Additional Instructions:				@2mg/kg/dose																
Daily Doctor's Endorsement by a Sign				9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM																
DRUG : SYRUP ATARAX				Date Time	3/7	4/7	5/7	6/7	7/7											
Dose	Route	Frequency	Start Dt.		10AM	10AM	10AM	10AM	10AM	10AM										
5ml	PO	BD	3/7/26																	
Name & Signature of the Doctor Starting the Drugs:				Dr. Madhu																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				10AM 10AM 10AM 10AM 10AM 10AM 10AM 10AM 10AM 10AM 10AM 10AM 10AM 10AM 10AM 10AM 10AM 10AM 10AM 10AM																
DRUG : LIQUID PARAFFIN				Date Time	3/7	4/7	5/7	6/7	7/7											
Dose	Route	Frequency	Start Dt.		9PM	9PM	9PM	9PM	9PM	9PM										
-	4A	BD	3/7/26																	
Name & Signature of the Doctor Starting the Drugs:				Dr. Madhu																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM 9PM																



Sheet No: SYP FORTE **REGULAR PRESCRIPTIONS** Weight Ward

DRUG : <u>Tab OMNACORT</u>				Date Time	<u>6/7/20</u>
Dose	Route	Frequency	Start Dt.		
<u>305ml</u>	<u>PO</u>	<u>TID</u>	<u>6/7/20</u>		
Name & Signature of the Doctor Starting the Drugs:					
<u>[Signature]</u>					
Additional Instructions:					
<u>5ml / 15mg</u>					
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					



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
1/7	3AM	Inj. PAM (Paracetamol)	250 mg	IV	Al	Sumane
1/7	7:30pm	VITAMIN K	5 mg	IV	Al	Yamun
1/7	2:30pm	Inj. KETAMINE	20 mg	IV	Al	Alabhy
3/7/26	12:30pm	INJ. AVIL	8.5 mg	IV	Al	Palash
						Sadip
						Sumane
						Novel

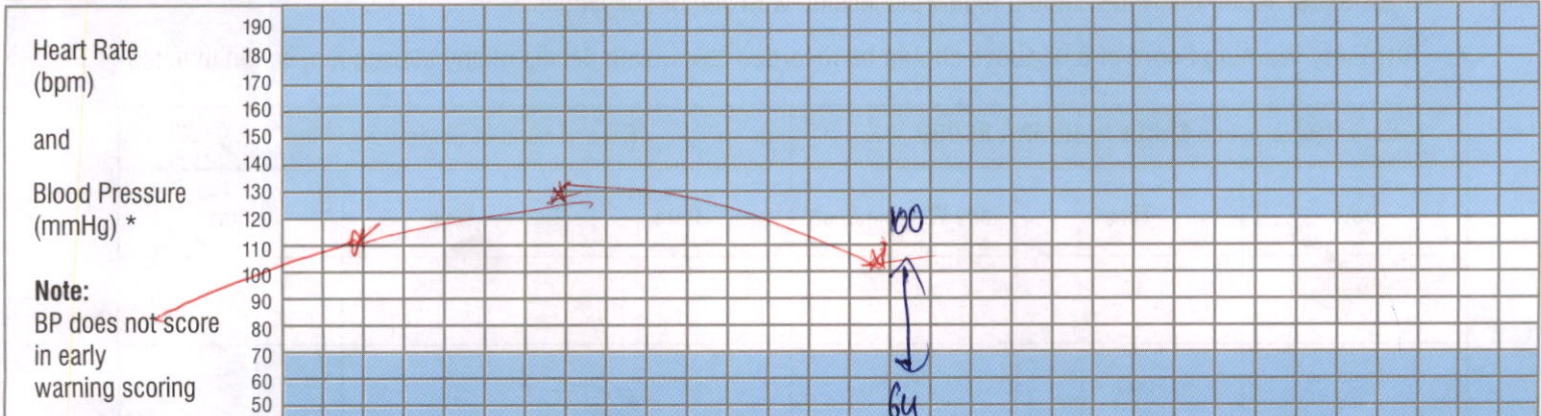
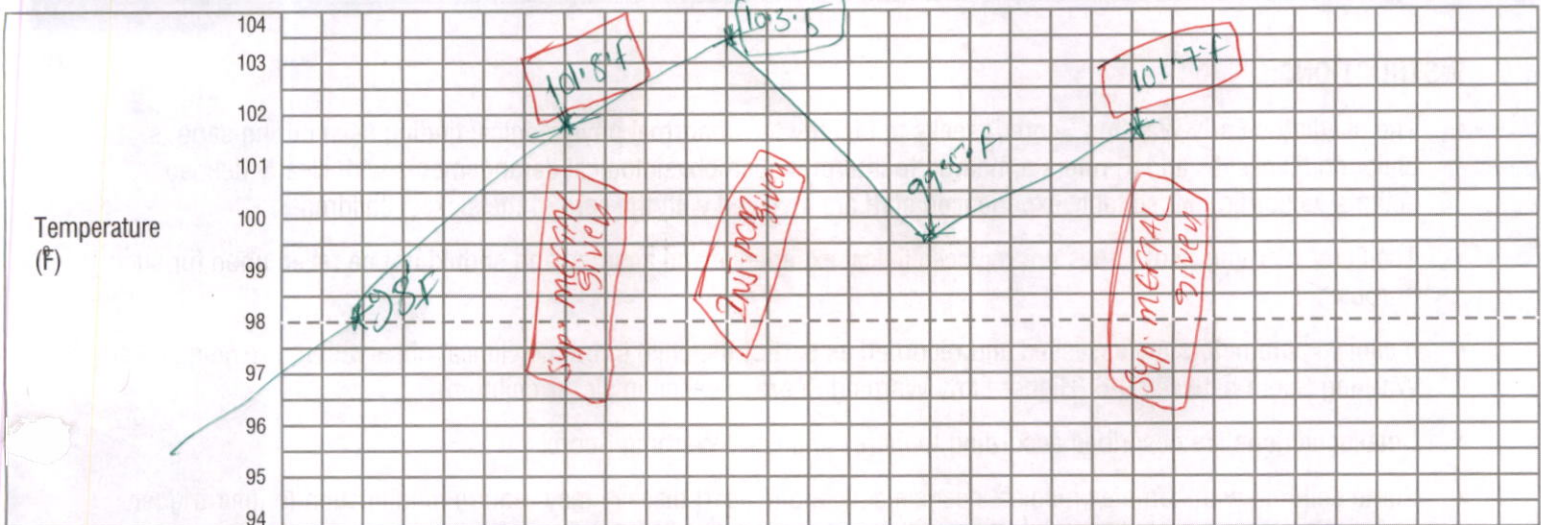
4:30 AM

Weight. 17kg Ward.

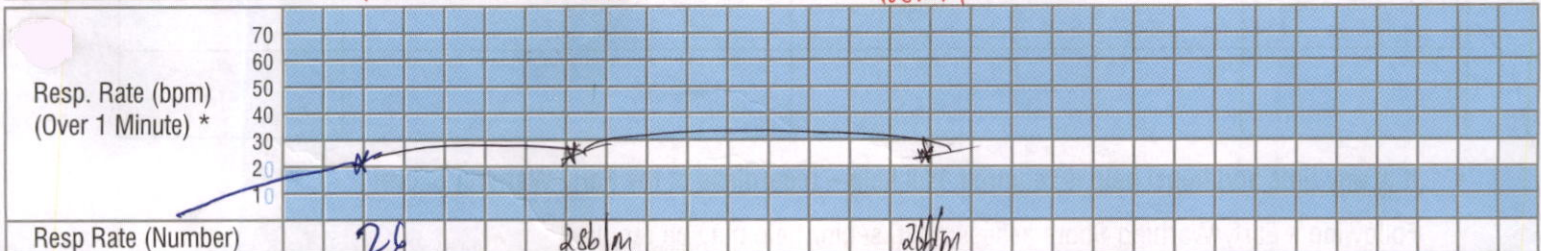
[illegible]

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 10PM 11AM 3AM 6AM 7:30AM
Doctor / Nurse / Family Concern?



Heart Rate (Number) 112 130 100



Resp Rate (Number) 26 28 26

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 99% 99% 99%

Conscious Level Normal Altered

GCS * (14/15) (14/15) (14/15)

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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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.
- 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

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- 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.

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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)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time: 9am	9:30am	10am	11am	12pm	1pm	2pm	3pm	4pm	4:30pm	5pm	6pm	7pm	8pm
Doctor / Nurse / Family Concern?														
Temperature (°F)	104													
	103													
Heart Rate (bpm)	190													
	180													
Blood Pressure (mmHg) *	170													
	160													
Note:	150													
	140													
BP does not score in early warning scoring	130													
	120													
Heart Rate (Number)	110													
	100													
Resp. Rate (bpm) (Over 1 Minute) *	90													
	80													
Resp Rate (Number)	70													
	60													
Resp Mod/ Severe Distress None / Mild	50													
	40													
Receiving O ₂ (l/min) O ₂ Saturations (%)	30													
	20													
Conscious Level Normal Altered	10													
GCS *														
TOTAL SCORE														
Number of shaded boxes														
Pain Score														
Observer's Initials														

ACTIONS

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BAH-00660336 IP5-00175785
Master MANCHIKALAPATI RITHWIK
04-01-2021 5 Y 5 M 27 D (M)
Dr. FAISAL B NAHDI



RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation &
Early Warning Scoring Chart

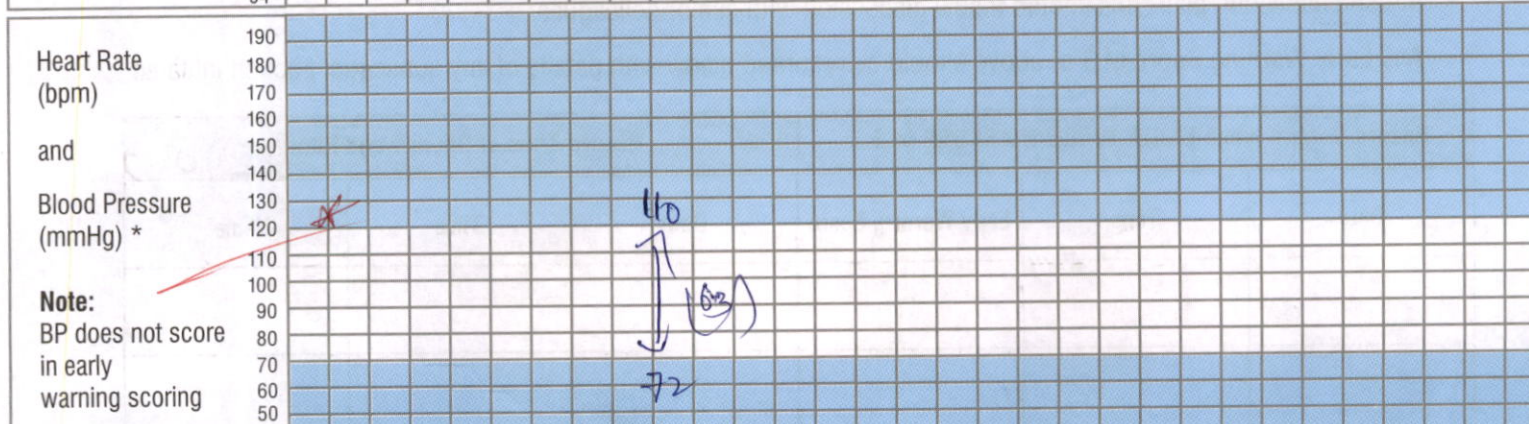
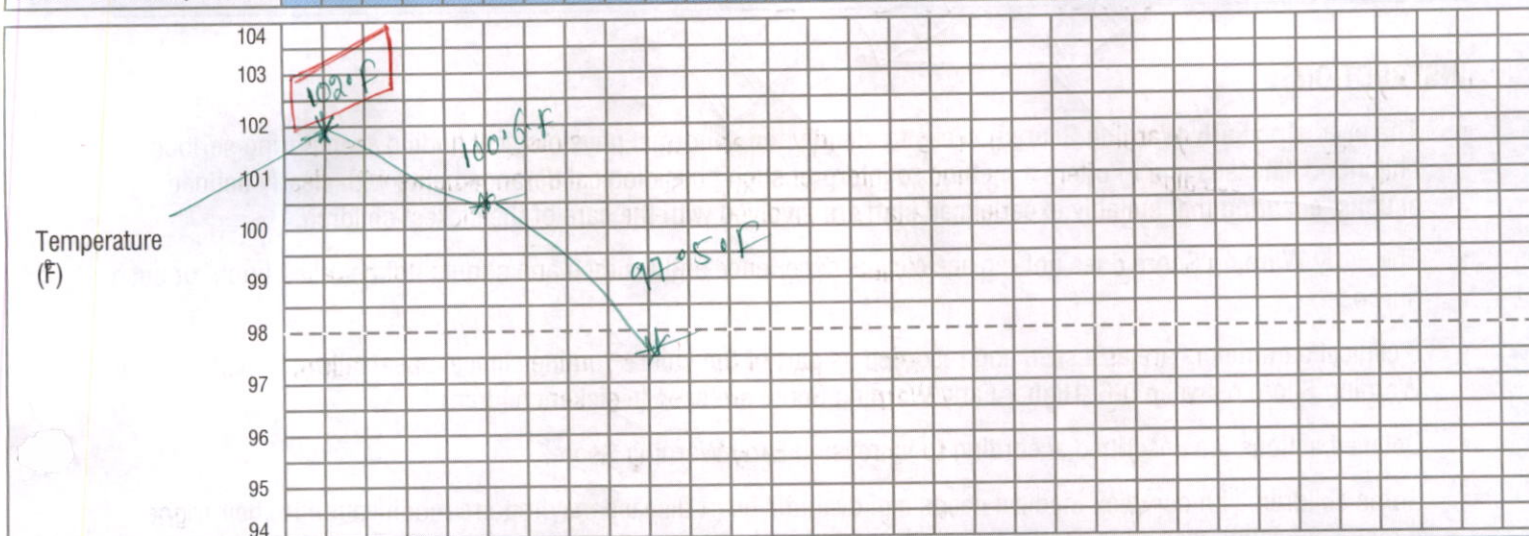
Rainbow
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BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

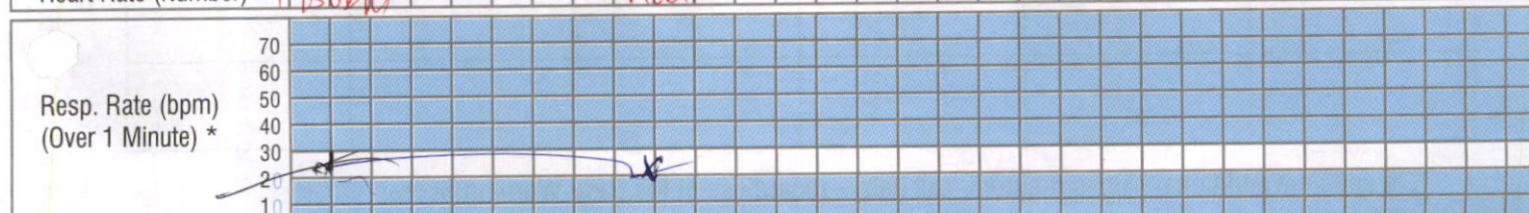
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 2AM 4AM 6:15AM

Doctor / Nurse / Family Concern?



Heart Rate (Number) 130bpm 110bpm



Resp Rate (Number) 20bpm 20bpm

Resp Mod/ Severe Distress None / Mild

Receiving O₂(l/min) O₂Saturations (%) 99% 99%

Conscious Level Normal Altered

GCS * (14/15) (14/15)

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

ACTIONS
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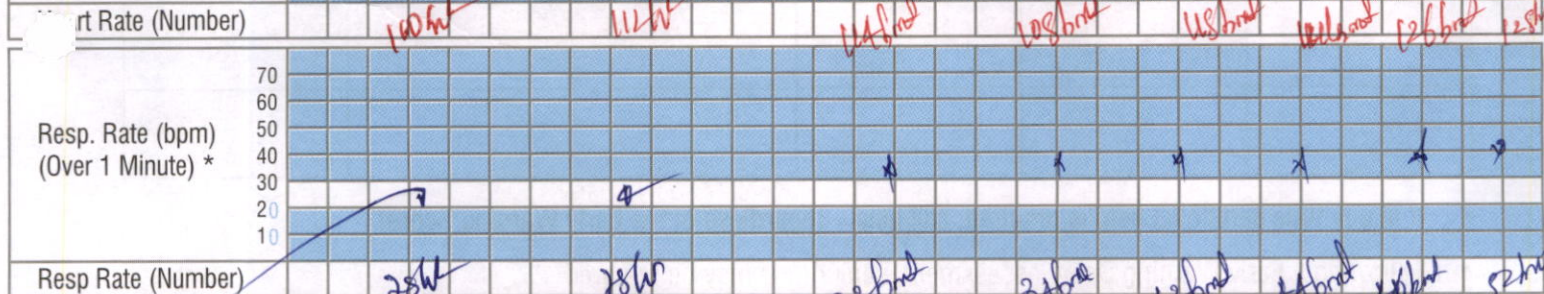
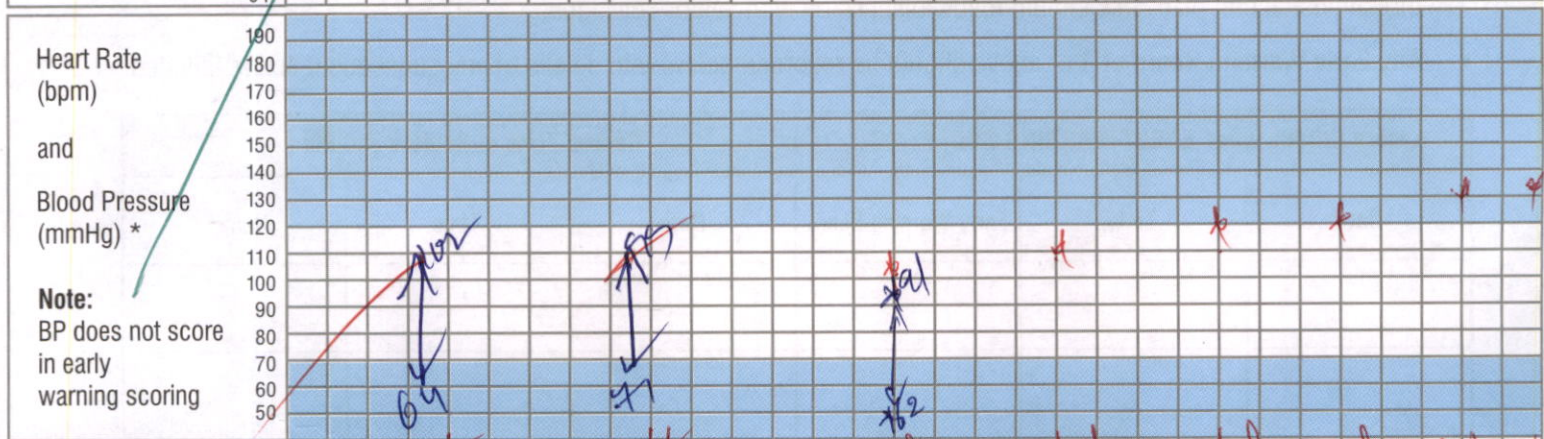
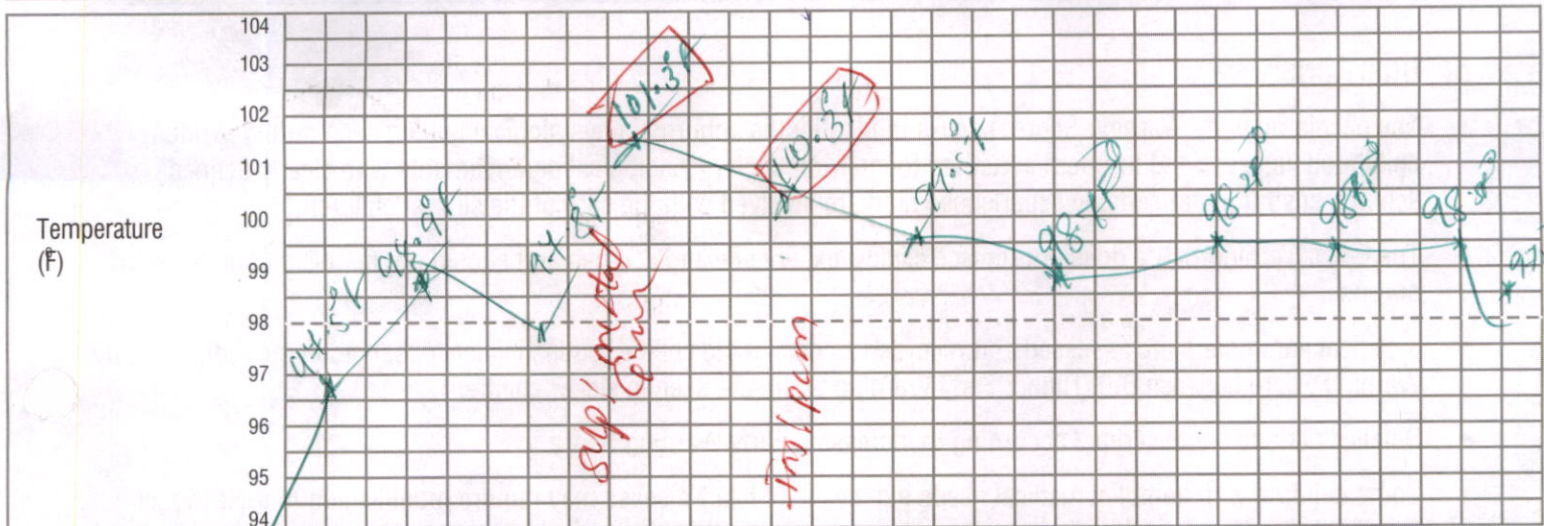
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 9:45 AM 10:30 AM 11:00 AM 5 PM 6:30 PM 7:45 PM 8 PM 10 PM 12 AM 3 AM 6 AM
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	Score 1 : Continue normal observation by staff nurse
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Patient Stick



ICAL / 126

3/7/26

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

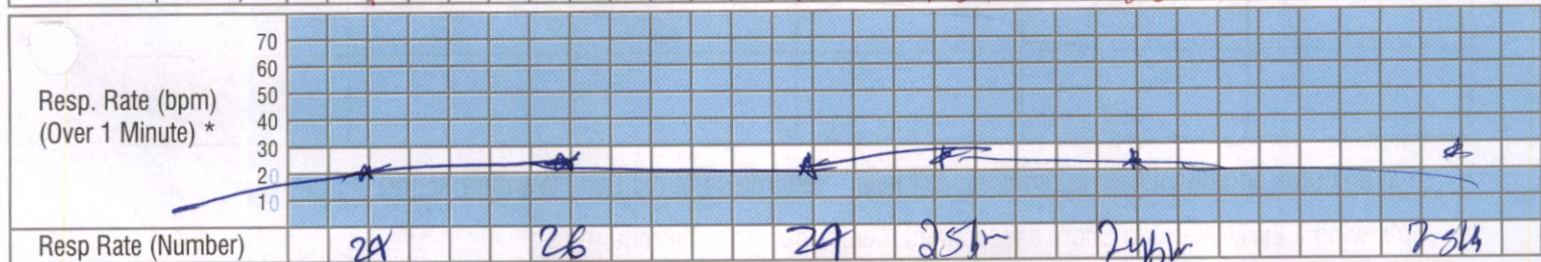
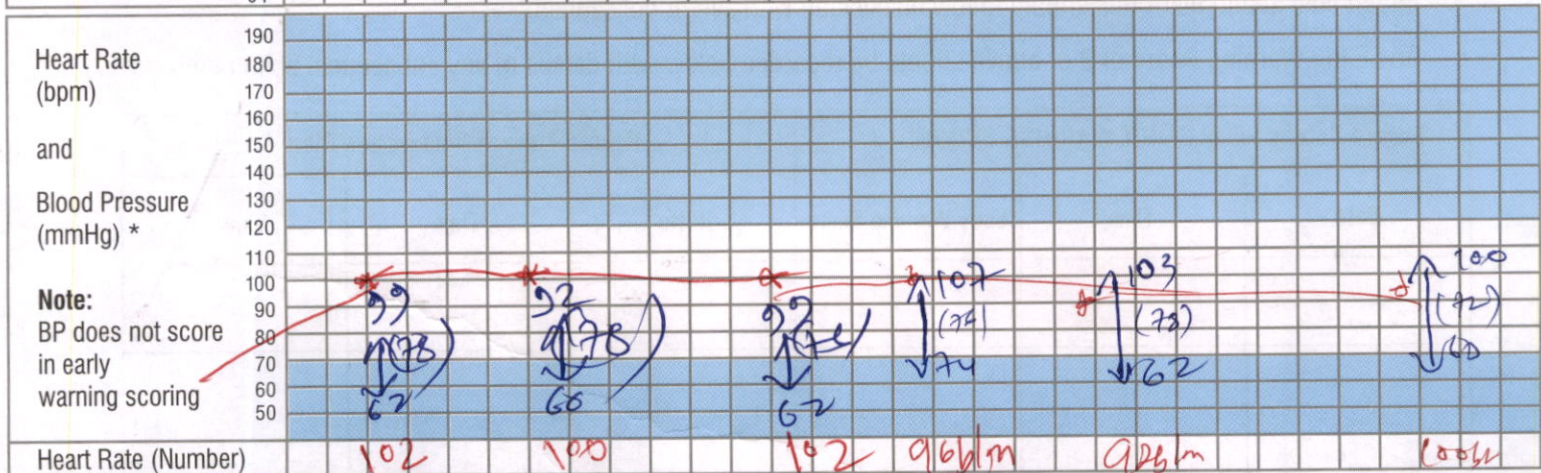
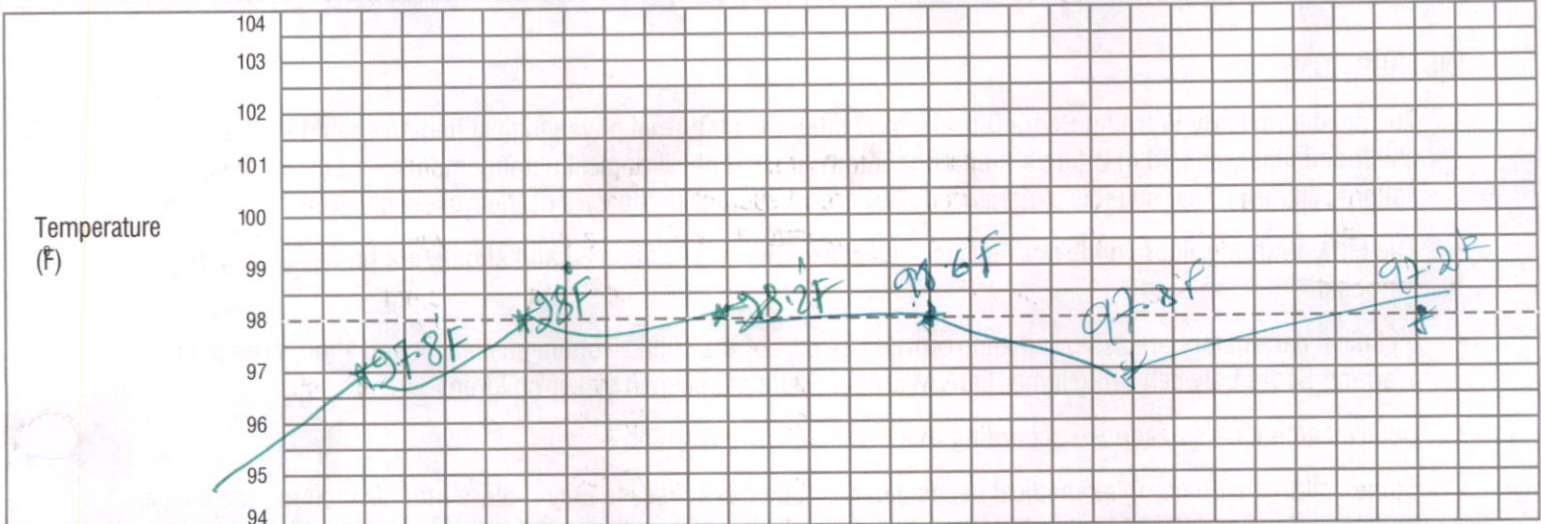
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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

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

Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)		
O ₂ Saturations (%)	99%	99%
Conscious Level	Normal	Altered
GCS *	(15/15)	(15/15)
TOTAL SCORE		
Number of shaded boxes	0	0
Pain Score	0	0
Observer's Initials		

ACTIONS

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5/7/26

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time: 10 AM	2 PM	6 PM	10 PM	2 AM	6 AM
Doctor / Nurse / Family Concern?						
Temperature (°F)						
Heart Rate (bpm) and Blood Pressure (mmHg) *						
Heart Rate (Number)	100	106	104	110	94 bpm	100 bpm
Resp. Rate (bpm) (Over 1 Minute) *						
Resp Rate (Number)	22	29	26	26	22	29
Resp Mod/ Severe Distress None / Mild						
Receiving O ₂ (l/min) O ₂ Saturations (%)	99% 99% 99% 99% 98% 98%					
Conscious Level Normal Altered						
GCS *	14/15	(14/15)	(14/15)	15	15	15
TOTAL SCORE						
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	FA	FA	FA	FA	FA	FA
ACTIONS	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.					

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

6/7/26

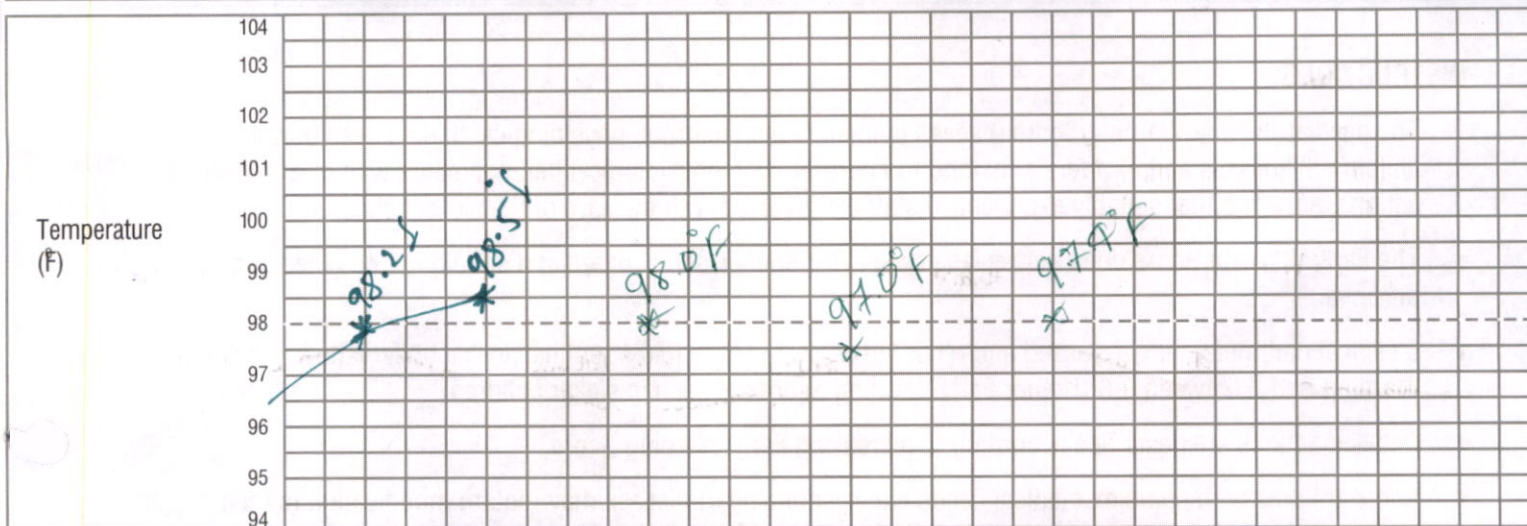


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Children's
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It takes a lot to treat the little.



BirthRight
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Date :	Time:									
Doctor / Nurse / Family Concern?		<i>6pm</i>	<i>9pm</i>	<i>10pm</i>	<i>2pm</i>	<i>6pm</i>				



Heart Rate (Number)

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

[illegible]

Resp Rate (Number)

70
60
50
40
30
20
10

366W	386/m	286Pm
------	-------	-------

GCS *

ere
ild

(10/10) (10/10)

Observer's Initials

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



FLUID CHART

30/6/26

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.

		Intake				Output					IV Site	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm	↓	H ₂ O	30ml						1	0	Urem.
	10:00 pm			30ml						1	0	Likely
	11:00 pm	DNS	H ₂ O	30ml						NP	0	Likely
	12:00 am	↑		30ml						1	0	Likely
	01:00 am		H ₂ O								0	Likely
Total Intake :						Total Output : U-0 M-0						
	02:00 am	1		30ml							0	Likely
	03:00 am	1	H ₂ O	30ml							0	Likely
	04:00 am	DNS		30ml						✓	0	Likely
	05:00 am		H ₂ O	30ml							0	Likely
	06:00 am	1		30ml							0	Likely
	07:00 am		H ₂ O								0	Likely
Total Intake :						Total Output : U-1 M-0						
Total 24 hrs. Intake		9-20 ml Kelly										
Total 24 hrs. Output		U-1 M-0										



FLUID CHART

Sheet No. : 9

1/7/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am	DMS		30 ml							0	AKB
	09:00 am		H ₂ O	30 ml						0	AKB	
	10:00 am			30 ml						0	AKB	
	11:00 am			30 ml						0	AKB	
	12:00 pm		H ₂ O	-						0	AKB	
	01:00 pm			-						0	AKB	
Total Intake :						Total Output : M-0 U-2						
	02:00 pm	DMS									0	AKB
	03:00 pm		H ₂ O							0	AKB	
	04:00 pm									0	AKB	
	05:00 pm		H ₂ O							0	AKB	
	06:00 pm									0	AKB	
	07:00 pm		H ₂ O							0	AKB	
Total Intake :						Total Output : M-0 U-1						
	08:00 pm	DMS									0	AKB
	09:00 pm		H ₂ O	30 ml						0	AKB	
	10:00 pm			30 ml						0	AKB	
	11:00 pm		H ₂ O	-						0	AKB	
	12:00 am			-						0	AKB	
	01:00 am			30 ml						0	AKB	
Total Intake :						Total Output : U-1 M-0						
	02:00 am	DMS		30 ml							0	AKB
	03:00 am		H ₂ O	30 ml						0	AKB	
	04:00 am			30 ml						0	AKB	
	05:00 am		H ₂ O	30 ml						0	AKB	
	06:00 am			30 ml						0	AKB	
	07:00 am		H ₂ O	30 ml						0	AKB	
Total Intake :						Total Output : U-4 M-0						

Total 24 hrs. Intake

7-360 ml

Total 24 hrs. Output

U-4 M-2



2/7/26

FLUID CHART

Sheet No. : (3)

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			30ml							0	Yam	
	09:00 am										0	Yam	
	10:00 am	only	0								0	Yam	
	11:00 am		0				✓			✓	0	Yam	
	12:00 pm		0								0	Yam	
	01:00 pm		0								0	Yam	
Total Intake : 30ml						Total Output : 0							
	02:00 pm		NPO	30ml							0	Yam	
	03:00 pm		NPO	30ml							0	Yam	
	04:00 pm	only	NPO	30ml							0	Yam	
	05:00 pm	only	NPO								0	Yam	
	06:00 pm		NPO								0	Yam	
	07:00 pm		NPO								0	Yam	
Total Intake : 90ml						Total Output : 0							
	08:00 pm			30ml							0	Subh	
	09:00 pm	only	H ₂ O	30ml						✓	0	Subh	
	10:00 pm	only	H ₂ O	30ml			✓				0	Subh	
	11:00 pm		H ₂ O	30ml							0	Subh	
	12:00 am		H ₂ O	30ml						✓	0	Subh	
	01:00 am		H ₂ O	30ml							0	Subh	
Total Intake :						Total Output : M-1							
	02:00 am			30ml							0	Subh	
	03:00 am		H ₂ O	30ml						✓	0	Subh	
	04:00 am	only	H ₂ O	30ml							0	Subh	
	05:00 am		H ₂ O	30ml							0	Subh	
	06:00 am		H ₂ O	30ml						✓	0	Subh	
	07:00 am		H ₂ O	30ml							0	Subh	
Total Intake :						Total Output : M-2							
Total 24 hrs. Intake			Total 24 hrs. Output			M-2			U-2				
Total 24 hrs. Intake			Total 24 hrs. Output			M-2			U-2				



FLUID CHART

Sheet No. : (4)

3/7/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am										0	on
	09:00 am	ONS	H ₂ O				✓			100ml	0	on
	10:00 am										0	Y
	11:00 am		H ₂ O	30ml							0	sumana
	12:00 pm			30ml							0	sumana
	01:00 pm			30ml						150ml	0	sum
Total Intake :						Total Output : V - 250 ml						
	02:00 pm										0	su
	03:00 pm	ONS	H ₂ O							250ml	0	sum
	04:00 pm										0	sum
	05:00 pm										0	su
	06:00 pm		H ₂ O							200ml	0	su
	07:00 pm										0	m
Total Intake :						Total Output : V - 950 ml						
	08:00 pm										0	poor
	09:00 pm		H ₂ O							300ml	0	poor
	10:00 pm										0	poor
	11:00 pm										0	poor
	12:00 am		H ₂ O							200ml	0	poor
	01:00 am										0	poor
Total Intake :						Total Output : V - 800 ml						
	02:00 am										0	poor
	03:00 am		H ₂ O								0	poor
	04:00 am										0	poor
	05:00 am									200ml	0	poor
	06:00 am		H ₂ O								0	poor
	07:00 am										0	poor
Total Intake :						Total Output : V - 200 ml						
Total 24 hrs. Intake												
Total 24 hrs. Output			V - 1,300 ml									



FLUID CHART

Sheet No. : 5

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
											0	Good
	08:00 am										0	Good
	09:00 am	↓ NORV Fruit	H2O						300ml		0	Good
	10:00 am										0	Good
	11:00 am		H2O								0	Good
	12:00 pm	↑									0	Good
	01:00 pm		H2O								0	Good
Total Intake :						Total Output : U: 300ml. m: 1						
	02:00 pm	↓	H2O								0	Good
	03:00 pm	↓									0	Good
	04:00 pm		H2O								0	Good
	05:00 pm	NORV Fruit							300ml		0	Good
	06:00 pm		H2O								0	Good
	07:00 pm	↑									0	Good
Total Intake :						Total Output : U: 300ml m: 1						
	08:00 pm										0	Good
	09:00 pm		H2O								0	Good
	10:00 pm								150ml		0	Good
	11:00 pm										0	Good
	12:00 am										0	Good
	01:00 am										0	Good
Total Intake :						Total Output : U- 150ml m- 0						
	02:00 am										0	Good
	03:00 am		H2O								0	Good
	04:00 am								150ml		0	Good
	05:00 am										0	Good
	06:00 am		H2O								0	Good
	07:00 am										0	Good
Total Intake :						Total Output : U- 150ml m- 0						
Total 24 hrs. Intake			Total 24 hrs. Output									
			U- 800ml m- 2									



FLUID CHART

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Sheet No. : 6

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

Date	Time	Nature of Fluid	Intake			Output						IV Site Thrombophlebitis Score	Sign. Nurse		
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine					
	08:00 am											0	Sum		
	09:00 am	H2O										0	Sum		
	10:00 am											0	Sum		
	11:00 am	H2O					✓			✓		0	Sum		
	12:00 pm											0	Sum		
	01:00 pm									200ml		0	Sum		
Total Intake :						Total Output : U - 200ml									
	02:00 pm											0	Sum		
	03:00 pm	H2O										0	Sum		
	04:00 pm						✓					0	Sum		
	05:00 pm									150		0	Sum		
	06:00 pm	H2O										0	Sum		
	07:00 pm											0	Sum		
Total Intake :						Total Output : U - 150ml									
	08:00 pm											0	Sum		
	09:00 pm	H2O								200ml		0	Sum		
	10:00 pm											0	Sum		
	11:00 pm						NP					0	Sum		
	12:00 am	H2O								200ml		0	Sum		
	01:00 am											0	Sum		
Total Intake :						Total Output : U - 400ml									
	02:00 am											0	Sum		
	03:00 am	H2O								200ml		0	Sum		
	04:00 am											0	Sum		
	05:00 am						NP					0	Sum		
	06:00 am	H2O								200ml		0	Sum		
	07:00 am											0	Sum		
Total Intake :						Total Output : U - 400ml									
Total 24 hrs. Intake															
Total 24 hrs. Output			U - 1150ml												



FLUID CHART

Sheet No. : F

6/7/26

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

Date	Time	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am	No 216 H ₂ O									0	Alanya
	09:00 am										0	Alanya
	10:00 am								200 ml		0	Alanya
	11:00 am										0	Alanya
	12:00 pm										0	Alanya
	01:00 pm										0	Alanya
Total Intake :					Total Output : M - 0 U - 200							
	02:00 pm	No 216 H ₂ O									0	Alanya
	03:00 pm										0	Alanya
	04:00 pm										0	Alanya
	05:00 pm								200		0	Alanya
	06:00 pm										0	Alanya
	07:00 pm								200			
Total Intake :					Total Output : M - 0 U - 400							
	08:00 pm	No 216 H ₂ O									0	Surge
	09:00 pm										0	Surge
	10:00 pm								200 ml		0	Surge
	11:00 pm										0	Surge
	12:00 am										0	Surge
	01:00 am										0	Surge
Total Intake :					Total Output : U - 200 ml M - 0							
	02:00 am	No 216 H ₂ O							200 ml		0	Surge
	03:00 am										0	Surge
	04:00 am										0	Surge
	05:00 am										0	Surge
	06:00 am								200 ml		0	Surge
	07:00 am										0	Surge
Total Intake :					Total Output : U - 200 ml M - 0							

Total 24 hrs. Intake

Total 24 hrs. Output U - 200 ml M - 0

FLUID CHART

Sheet No. :

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

		Intake				Output							
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake													
Total 24 hrs. Output													



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

PT having pain

Date: 30/6/20

Assessment:

Goals

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

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

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name: Likitha

Date & Time: 1/7/20 @ 8AM

BAH-00660336 IP5-00175785
 Master MANCHIKALAPATI RITHWIK
 14-01-2021 5 Y 5 M 27 D (M)
 Dr. FAISAL B NAHDI



NURSING CARE RECORD

Rainbow Children's Hospital
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BirthRight
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 Your Right to a Safe Delivery

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 11/7/26

Assessment: patient having fever's

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 patient General Condition.	9Am	=> Assessed The patient General condition.	patient Now Normal
10Am	=> plan for monitor patient-vitals.	12Am	=> monitoring patient vitals	
1pm	=> patient having fever	2pm	=> medications sister's given Inj. PCM, (or) Zyp. methyl. daz	
3pm	=> plan for medication.	4pm	=> PCM. 6 th Holy medication given as per	
5pm	=> plan for USG, Abdomine	6pm	=> check USG Abdomine done	
7pm	=> plan for monitor I/O chart	7:30pm	=> monitoring Baby I/O chart.	

Re-Assessment:

Re-assess ment done 2nd Holy

Special Notes:

Temperature monitoring

Nurse Signature: Alekhyo

Nurse Name: Alekhyo / 606822

Date & Time: 11/7/26 8Am



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/26

Assessment: Patient is irritable

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the pt condition	8:10pm	Assessed the pt condition	
10pm	Plan for monitor vitals	10:30pm	monitored vitals	Now the
11am	Plan for maintain I/O chart	11:30am	maintained I/O chart & recorded	Pt is
12pm	Plan for Administer medication as per drug chart	3:20pm	Administered medication as per drug chart	stable
1pm	Plan for continue IV fluids	5:30pm	Continuing IV fluids	
2pm	Plan for send labs	7:50am	Sended labs	

Re-Assessment: Re-assessment done, pt is stable

Special Notes: Trace Labs

Nurse Signature: Pooja

Nurse Name: Pooja (018504)

Date & Time: 4/7/26 @ 8am

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 4/7/26

Assessment: pt having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8: PM	=> Assess for pt condition	8:30 PM	=> Assessed for pt condition	
10: PM	=> plan for vitals	10:30 PM	=> vitals checked & record	
12: PM	=> Administer medication as per doctor orders	12:30 PM	=> Administered medication as per doctor order	=> now pt looks better
3: PM	=> maintain ELO chart	3:30 PM	=> maintained ELO chart	
6: PM	=> plan for vitals	6:30 PM	=> vitals checked & record	
8: PM	=> Assess pt safety	8:10 PM	=> provided side rails	

Re-Assessment: Re-assessed

Special Notes:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 4/7/26



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/20

Assessment: Patient is crying.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the patient condition	8:10pm	Assessed the pt condition	now 4 pt is stable
10pm	Plan for monitor vitals	10:30pm	monitored vitals	
12am	plan for maintain I/O chart	1:30am	maintained I/O chart & recorded	
2am	plan for Administer medication as per drug chart	3:30am	Administered medication as per drug chart	
4am	plan for provide comfortable position	5:30am	provided comfortable position	
8am	Ensure Safety	6:10pm	Ensured safety	

Re-Assessment:

Re-assessment done. Patient is sleeping.

Special Notes:

Nurse Signature: Pooja

Nurse Name: Pooja (018504)

Date & Time: 5/7/26 @ 8AM

BAH-00660336 IP5-00175785
Master MANCHIKALAPATI RITHWIK
04-01-2021 5 Y 5 M 29 D (M)
Dr. FAISAL B NAHDI



NURSING CARE RECORD

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BirthRight
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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 15/11/26

Assessment: patient is crying

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 PT condition.	8AM	→ Assessed the PT condition	PT is stable
11AM	→ vital chart maintain	11AM	→ vital chart maintain	
12PM	→ Ensure safety	12PM	→ continued IV anti	
4PM	→ continue IV fluid	4PM	→ maintain good nutrit	
8PM		8PM		

Re-Assessment: PT is stable

Special Notes: -nil-

Nurse Signature: S

Nurse Name: Simana

Date & Time: 15/11/26 @ 8PM

JAF-00000330
Master MANCHIKALAPATI RITHWIK
04-01-2021 SY 6 M 1 D
Dr. FAISAL B NAHDI (M)

NURSING CARE RECORD

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BirthRight™
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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: Patient is having Discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the general condition of the patient.	8:30pm	Assessed the general condition of the patient.	Now is the patient stable
10pm	Monitor the vitals.	10:30pm	Monitoring the vitals.	
11pm	Administer the medication as per Drug Chart.	11:30pm	Administered the medication as per Drug Chart.	
5Am	maintain I/O chart.	5:30Am	maintaining the I/O chart.	
7Am	Ensure the Safety.	7:30Am	Ensure the Safety.	

Re-Assessment: Reassessment done 4th hourly vital

Special Notes: NIL

Nurse Signature: Rim

Nurse Name: Rima

Date & Time: 6/7/26 @ 8Am

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 5/7/26

Assessment: patient having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8A	⇒ Assess the patient General Condition.	10 PM	⇒ Assessed the patient General Condition	
11 AM	⇒ plan for monitor patient vitals.	12 PM	⇒ monitoring patient.	patient
2 PM	⇒ plan for monitor patient I/O chart	4 PM	⇒ Vitals TO monitoring patient I/O chart	Now stable
5 PM	⇒ plan for medication.	6 PM	⇒ medication given as per chart	
7 PM	⇒ plan for patient safety.	7:30 PM	⇒ ensure said daily	

Re-Assessment:

Special Notes: Regression ment done

Nurse Signature: Alekhya Nurse Name: Alekhya / 60020 Date & Time: 5/7/26 8 PM



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6/7/26

Assessment: Pt having discomfort

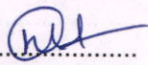
Goals

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

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

Re-Assessment: re-assessment done

Special Notes:

Nurse Signature:  Nurse Name: Nurse (607539) Date & Time: 7/7/26 @ 8am



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Date:

Assessment:

☐ 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
12:15	1. Assess patient's vital signs and level of consciousness. 2. Administer 100% oxygen via non-rebreather mask. 3. Establish IV access and administer 1L of 0.9% NS. 4. Monitor patient's oxygen saturation and vital signs. 5. Prepare for possible intubation.	12:30	1. Patient's vital signs are stable. 2. Oxygen saturation is 98% on 100% oxygen. 3. IV access is established and 1L of 0.9% NS is administered. 4. Patient is alert and oriented. 5. No further action is required.	1. Patient's vital signs are stable. 2. Oxygen saturation is 98% on 100% oxygen. 3. IV access is established and 1L of 0.9% NS is administered. 4. Patient is alert and oriented. 5. No further action is required.

Re-Assessment:

Special Notes:

Nurse Signature: _____ Nurse Name: _____ Date & Time: _____

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Annapoorna Department: pediatric Date of Admission: 30/6/26

SITUATION		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:						
BACKGROUND	Area	ER	3rd floor	3rd floor	3rd floor	3rd floor	3rd floor	
	Shift Time	9:30 pm	10PM-8AM	8am-8pm	8pm-8am	8am-8pm	8pm-8am	
ASSESSMENT	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	NA	NA	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ASSESSMENT	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	98.5	98.5	100.4	97.6	98.1	98.4
		Res:	24b/m	26b/m	20b/m	28b/m	28b/m	22b/m
		SpO ₂ :	100%	99%	98%	99%	100%	99%
		Pulse:	125b/m	126b/m	100b/m	130b/m	117b/m	102b/m
		BP:	100/59	100/60	86/52	100/66	100/72	111/71
		Fall Risk Score:	11	11	11	11	11	11
	Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10	
	Recommendations	Safety Needs:	✓	yes	yes	yes	yes	yes
		Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Others Specify:		NA	NA	NA	NA	NA	NA	
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:		NA	NA	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Keethi	Zikitha	Aleegy	Leeth	Yamun	Sukh	
Signature :		Ki	A	A	B	C	Sukh	
Date:		30/6	1/7/26	1/7/26	2/7/26	2/7/26	3/7/26	
Time:		9:30 pm	8AM	8pm	8AM	8pm	8AM	
Taken Over By Name :		Lixitha	Aleegy	Leeth	Yamun	Sukh	Sukh	
Signature :		A	A	B	C	Sukh	Sukh	
Date:		30/6/26	1/7/26	1/7/26	2/7/26	2/7/26	3/7/26	
Time:		10PM	8AM	8pm	8AM	8pm	8AM	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. F. N. Department: 3rd floor Date of Admission: 30/6/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	<u>Physical sepsis.</u>							
BACKGROUND	Area	Shift Time	<u>3rd floor</u> <u>8PM-8AM</u>	<u>3rd floor</u> <u>8PM-8AM</u>	<u>3rd floor</u> <u>8PM-8AM</u>	<u>3rd floor</u> <u>8PM-8AM</u>	<u>3rd floor</u> <u>8PM-8AM</u>	<u>3rd floor</u> <u>8PM-8AM</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>Physical sepsis</u>	<u>NA</u>	<u>Physical sepsis</u>	<u>Physical sepsis</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>98°F</u>	<u>97.6°F</u>	<u>97.6°F</u>	<u>97.8°F</u>	<u>98°F</u>	<u>98.8°F</u>
		Res:	<u>22b</u>	<u>23b/m</u>	<u>24b/m</u>	<u>25b/m</u>	<u>24b/m</u>	<u>24b/m</u>
		SpO ₂ :	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>
		Pulse:	<u>118b</u>	<u>109b</u>	<u>117b/m</u>	<u>92b/m</u>	<u>110</u>	<u>109</u>
		BP:	<u>100/62</u>	<u>92/62</u>	<u>90/70</u>	<u>98/72</u>	<u>99/82</u>	<u>94/64</u>
	Fall Risk Score:	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	
Pain Score:	<u>2/5</u>	<u>4/5</u>	<u>NA</u>	<u>4/5</u>	<u>2/5</u>	<u>2/5</u>		
Recommendations	Safety Needs:	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Smay</u>	<u>Pooja</u>	<u>Wick</u>	<u>Pooja</u>	<u>Smay</u>	<u>Rim</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>3/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>5/7/26</u>	<u>5/7/26</u>	<u>6/7/26</u>	
Time:		<u>8PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8AM</u>	
Taken Over By Name :		<u>Pooja</u>	<u>Wick</u>	<u>Pooja</u>	<u>Smay</u>	<u>Rim</u>	<u>Alucky</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>3/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>5/7/26</u>	<u>5/7/26</u>	<u>6/7/26</u>	
Time:		<u>8PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8AM</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Faisal Sandhu Department: Srd Floor Date of Admission: 30/6/26

SITUATION	Diagnosis: <u>Abapru seps</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	Area	Shift Time	30/6/26 8am-12pm	30/6/26 12pm-3pm				
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>				
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:	<u>97.75</u>	<u>98.2°F</u>				
		Res:	<u>26b/m</u>	<u>21b/m</u>				
		SpO ₂ :	<u>98%</u>	<u>98%</u>				
		Pulse:	<u>96b/m</u>	<u>45b/m</u>				
		BP:	<u>96/74</u>	<u>100/82</u>				
	Fall Risk Score:		<u>11</u>	<u>21</u>				
Pain Score:		<u>4/5</u>	<u>0/10</u>					
Recommendations	Safety Needs:		<u>NA</u>	<u>NA</u>				
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:		<u>NA</u>	<u>NA</u>				
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>				
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>					
Handed Over By Name :		<u>Abapru</u>	<u>Durga</u>					
Signature :		<u>A</u>	<u>De</u>					
Date:		<u>30/6/26</u>	<u>30/6/26</u>					
Time:		<u>8pm</u>	<u>8pm</u>					
Taken Over By Name :		<u>Durga</u>	<u>Wicuh</u>					
Signature :		<u>D</u>	<u>B</u>					
Date:		<u>30/6/26</u>	<u>30/6/26</u>					
Time:		<u>8pm</u>	<u>8pm</u>					

Patie



THE HUMPTY DUMPTY SCALE

30/6 1/7 1/7-2/7 2/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	3	3	3
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	✓
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	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	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	1
Medication sage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
TOTAL			11	4	1	4	4

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	✓	yes	yes	yes	✓
Call device within reach	✓	yes	yes	yes	✓
Wheels Locked	✓	yes	yes	yes	✓
Room free of clutter	✓	yes	yes	yes	✓
Adequate Lighting	✓	yes	yes	yes	✓
Wheel Chair Support	✓	yes	yes	yes	✓
Other Intervention(s) Specify	✓	yes	yes	yes	✓
Nurse's Name :		Keethy	Abhy	Abhy	Abhy
Signature :		KL	AB	AB	AB
Date :		30/6	1/7	1/7	2/7
Time :		1pm	6am	2pm	8pm



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	3	3	
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	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	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			11	11	11	11	

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		yes	yes	yes	yes
Call device within reach		yes	yes	yes	yes
Wheels Locked		yes	yes	yes	yes
Room free of clutter		yes	yes	yes	yes
Adequate lighting		yes	yes	yes	yes
Wheel chair support		NA	NA	NA	NA
Other Intervention(s) Specify		NA	NA	NA	NA
Nurse's Name:		Pooja	Raja	Ram	Arun
Signature:		[Signature]	[Signature]	[Signature]	[Signature]
Date:		4/1/21	5/1/21	6/1/21	6/1/21
Time:		6:00	6:00	8:00	8:00

THE HUMPTY DUMPTY SCALE

DATE	TIME	SCORE	CRITERIA	PARAMETER
1/1/00	10:00	1	1. 10 years old and above	General
1/1/00	10:00	2	2. 9-10 years old	General
1/1/00	10:00	3	3. 8-9 years old	General
1/1/00	10:00	4	4. 7-8 years old	General
1/1/00	10:00	5	5. 6-7 years old	General
1/1/00	10:00	6	6. 5-6 years old	General
1/1/00	10:00	7	7. 4-5 years old	General
1/1/00	10:00	8	8. 3-4 years old	General
1/1/00	10:00	9	9. 2-3 years old	General
1/1/00	10:00	10	10. 1-2 years old	General
1/1/00	10:00	11	11. 18 months and below	General
1/1/00	10:00	12	12. 15 months and below	General
1/1/00	10:00	13	13. 12 months and below	General
1/1/00	10:00	14	14. 9 months and below	General
1/1/00	10:00	15	15. 6 months and below	General
1/1/00	10:00	16	16. 3 months and below	General
1/1/00	10:00	17	17. 18 months and below	General
1/1/00	10:00	18	18. 15 months and below	General
1/1/00	10:00	19	19. 12 months and below	General
1/1/00	10:00	20	20. 9 months and below	General
1/1/00	10:00	21	21. 6 months and below	General
1/1/00	10:00	22	22. 3 months and below	General
1/1/00	10:00	23	23. 18 months and below	General
1/1/00	10:00	24	24. 15 months and below	General
1/1/00	10:00	25	25. 12 months and below	General
1/1/00	10:00	26	26. 9 months and below	General
1/1/00	10:00	27	27. 6 months and below	General
1/1/00	10:00	28	28. 3 months and below	General
1/1/00	10:00	29	29. 18 months and below	General
1/1/00	10:00	30	30. 15 months and below	General
1/1/00	10:00	31	31. 12 months and below	General
1/1/00	10:00	32	32. 9 months and below	General
1/1/00	10:00	33	33. 6 months and below	General
1/1/00	10:00	34	34. 3 months and below	General
1/1/00	10:00	35	35. 18 months and below	General
1/1/00	10:00	36	36. 15 months and below	General
1/1/00	10:00	37	37. 12 months and below	General
1/1/00	10:00	38	38. 9 months and below	General
1/1/00	10:00	39	39. 6 months and below	General
1/1/00	10:00	40	40. 3 months and below	General
1/1/00	10:00	41	41. 18 months and below	General
1/1/00	10:00	42	42. 15 months and below	General
1/1/00	10:00	43	43. 12 months and below	General
1/1/00	10:00	44	44. 9 months and below	General
1/1/00	10:00	45	45. 6 months and below	General
1/1/00	10:00	46	46. 3 months and below	General
1/1/00	10:00	47	47. 18 months and below	General
1/1/00	10:00	48	48. 15 months and below	General
1/1/00	10:00	49	49. 12 months and below	General
1/1/00	10:00	50	50. 9 months and below	General
1/1/00	10:00	51	51. 6 months and below	General
1/1/00	10:00	52	52. 3 months and below	General
1/1/00	10:00	53	53. 18 months and below	General
1/1/00	10:00	54	54. 15 months and below	General
1/1/00	10:00	55	55. 12 months and below	General
1/1/00	10:00	56	56. 9 months and below	General
1/1/00	10:00	57	57. 6 months and below	General
1/1/00	10:00	58	58. 3 months and below	General
1/1/00	10:00	59	59. 18 months and below	General
1/1/00	10:00	60	60. 15 months and below	General
1/1/00	10:00	61	61. 12 months and below	General
1/1/00	10:00	62	62. 9 months and below	General
1/1/00	10:00	63	63. 6 months and below	General
1/1/00	10:00	64	64. 3 months and below	General
1/1/00	10:00	65	65. 18 months and below	General
1/1/00	10:00	66	66. 15 months and below	General
1/1/00	10:00	67	67. 12 months and below	General
1/1/00	10:00	68	68. 9 months and below	General
1/1/00	10:00	69	69. 6 months and below	General
1/1/00	10:00	70	70. 3 months and below	General
1/1/00	10:00	71	71. 18 months and below	General
1/1/00	10:00	72	72. 15 months and below	General
1/1/00	10:00	73	73. 12 months and below	General
1/1/00	10:00	74	74. 9 months and below	General
1/1/00	10:00	75	75. 6 months and below	General
1/1/00	10:00	76	76. 3 months and below	General
1/1/00	10:00	77	77. 18 months and below	General
1/1/00	10:00	78	78. 15 months and below	General
1/1/00	10:00	79	79. 12 months and below	General
1/1/00	10:00	80	80. 9 months and below	General
1/1/00	10:00	81	81. 6 months and below	General
1/1/00	10:00	82	82. 3 months and below	General
1/1/00	10:00	83	83. 18 months and below	General
1/1/00	10:00	84	84. 15 months and below	General
1/1/00	10:00	85	85. 12 months and below	General
1/1/00	10:00	86	86. 9 months and below	General
1/1/00	10:00	87	87. 6 months and below	General
1/1/00	10:00	88	88. 3 months and below	General
1/1/00	10:00	89	89. 18 months and below	General
1/1/00	10:00	90	90. 15 months and below	General
1/1/00	10:00	91	91. 12 months and below	General
1/1/00	10:00	92	92. 9 months and below	General
1/1/00	10:00	93	93. 6 months and below	General
1/1/00	10:00	94	94. 3 months and below	General
1/1/00	10:00	95	95. 18 months and below	General
1/1/00	10:00	96	96. 15 months and below	General
1/1/00	10:00	97	97. 12 months and below	General
1/1/00	10:00	98	98. 9 months and below	General
1/1/00	10:00	99	99. 6 months and below	General
1/1/00	10:00	100	100. 3 months and below	General

BAH-00660336 IP5-00175785
Master MANCHIKALAPATI RITHWIK
04-01-2021 5 Y 5 M 26 D (M)
Dr. ANNAPOORNA TADAVARTHY



BRADEN 'Q' SCALE

					Date : 30/6/2021	Time : 7:15 PM		
Mobility	1. Completely immobile: Patient is unable to make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	9	9	9	9
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	9	9	9	9
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	9	9	9	9
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	9	9	9	9
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	9	9	9	9
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	9	9	9	9
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	9	9	9	9
					TOTAL SCORE			
					28			
					Evaluator's Name			
					Keerthi			

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

Docu. No. : RCHBH /FRM / CLINICAL / 119

Risk	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

BRADEN 'Q' SCALE

					Date :	2/4-3/21	4/1/21	5/2/21
					Time :	8pm	8am	8am
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:xtremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	3	3	3	3
"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.	2	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
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	27
					Evaluator's Name	EC	SK	Pooja Bama

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



BRADEN 'Q' SCALE

					Date :	Time :		
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:tremitry position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	6/8	8:17	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 insic'e 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	20
					Evaluator's Name		Rin	Ala

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
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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

Patient ID: IP5-00175785
 BAH-00660336
 Master MANCHIKALAPATI RITHWIK (M)
 04-01-2021
 Dr. ANNAPOORNA TADAVARTHY

PAIN ASSESSMENT FORM

Time	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
30/6 7pm 0110	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Curtis
1/7/26 1am 0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Wright
1/7/26 6am 0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Curtis
1/7/26 10am 0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shly
1/7/26 12pm 1/10	Surge of pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	APC	Shly
1/7/26 2pm 0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shly
1/7/26 7pm 0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shly
2/7/26 1AM 0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Wright
2/7/26 6am 0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Curtis
2/7/26 11Am 0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Yann

Re-assessment Frequency:

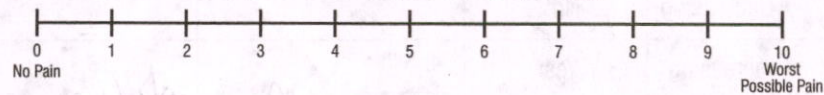
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

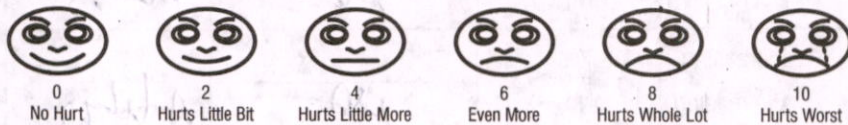
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
2/1/26	3pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Young
2/1/26	9pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sueh
2/1/26	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sueh
2/1/26	3am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sueh
2/1/26	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sueh
2/1/26	10am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pooja
2/1/26	11am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pooja
4/1/26	10Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Ullu
4/1/26	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Ullu
4/1/26	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pooja

Re-assessment Frequency:

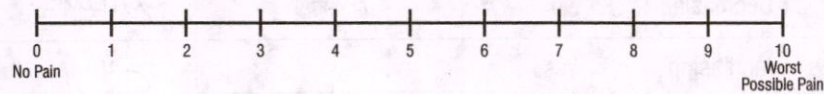
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

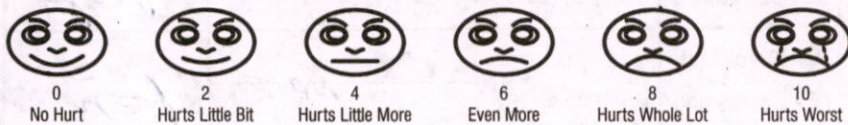
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
5/7/26	5pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pooja
5/7/26	12AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rbm
6/7/26	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rbm
6/7/26	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Alexy
6/7/26	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Alexy
7/7	12PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Durga
7/7	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Durga
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

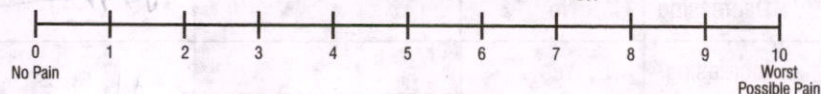
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

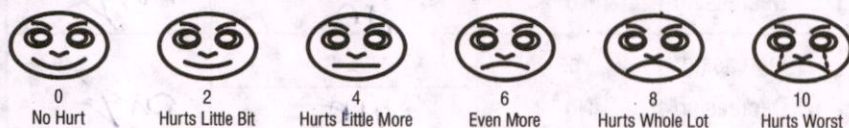
Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
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Wong - Baker (Pediatrics) Above 7 Years





CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0	0	0		
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			-	-	-	-	-	-		
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			-	-	2	-	-	-		
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			-	-	-	-	-	-		
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			-	-	-	-	-	-		
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-	-	-	-	-		
Signature of the Nurse						Likpen			Uka	Yan	Yan	Sucha	

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

Signature of Shift In Charge :

Signature : Name : Lovely

Signature of Ward In Charge :

Signature : Name : Anitha

BAH-00660336 IP5-00175785
Master MANCHIKALAPATI RITHWIK
04-01-2021 5 Y 5 M 29 D (M)
Dr. FAISAL B NAHDI



CHECKLIST FOR THROMBOPHLEBITIS

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

3/2/26 / 1/7/20 5/2/22

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-	-	-	-	1	-	-	Remove cannula
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-	-	-	-	-	-	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-	-	-	-	-	-	-	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-	-	-	-	-	-	-	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-	-	-	-	-	
Signature of the Nurse				Suman	Sun	Pos	Ula	Adin	Popi	Suz	Suz	Rim	

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

Signature of Shift In Charge :

Signature : Lovely Name : Lovely

Signature of Ward In Charge :

Signature : Anshu Name : Anshu



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

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 : Sugatha Name : Sugatha

Signature of Ward In Charge :

Signature : Anitha Name : Anitha



Moderate Sedation Flow-Sheet

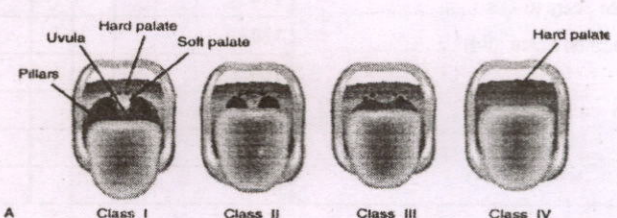
Immediate Pre-Sedation Assessment

B.P	PR	R.R	Temp	SPO ₂	Pain Score	Weight
108/76	145/min	28/min		100%		17 kgs.

Diagnosis: Suspected HLL

Procedure: DMA & biopsy

Comorbidities: _____

☒ Risk, benefits & alternatives discussed; ☒ Patient understand & elects to proceed ☒ Consents for procedure and sedation signed and dated ASA Physical Status ☒ ASA PS 1: Healthy Patient ☐ ASA PS 2: Mild Systemic Disease, no functional limitations ☐ ASA PS 3: Severe Systemic Disease, functional limitations ☐ ASA PS 4: Severe Systemic Disease, constant threat to life ☐ ASA PS 5: Moribund Patient unlikely to survive 24 hrs. ☐ ASA PS 6: A declared braindead patient whose organs are being removed for donor purposes ☐ E: Emergency procedure GCS: E M V ☒ IV Site: <u>lt. hand</u> Gauge: <u>20G</u> Sedation Plan: <u>short</u> Allergies: _____	AIRWAY EVALUATION Mouth: ☒ Normal ☐ Loose Teeth ☐ Small Mouth ☐ Protruding Incisors ☐ Receding Lower Jaw ☐ Dentures Neck: ☒ Normal ☐ Decreased ROM ☐ Thyromental Distance Less Than 6 cm ☐ Short Neck  Mallampati Class: ☐ I ☐ II ☐ III ☐ IV
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Monitoring of Patient Intra – Procedure

Procedure Monitoring

Heart Rate (HR), Respiratory Rate (RR), Oxygen Saturation (O₂ Sat) continuously monitored, and Level of Consciousness (LoC) to be monitored and recorded minimally every 15 minutes until 15 minutes after the last administration of any sedation, then every 30 minutes, then every 1 hour until stable. Respiratory status to be monitored continuously.

Level of Consciousness (LOC):

- ☒ A - Alert
☐ V - Verbally Responsive
☐ P - Painfully Responsive
☐ U - Unresponsive

Observation to be documented every 15 mins

TIME	BP	PR	RR	O ₂ Sat%	O ₂ Supplementation	Comments / Initials
Baseline 3pm	108/76	150	24	99%	—	
2:15 pm	113/78	145	48	94%	started O ₂ @ 5L/min	
3:30 pm	93/63 (68)	130	43	96%	O ₂ @ 5L/min	

DRUG & IV Fluid: (including Nitrous Oxide)	ROUTE	DOSE	TIME GIVEN	SUBSEQUENT DOSES AND TIME
2yr. KETAMINE	IV	20mg	3pm	-

Doctor Notes: Unremarkable

Time of transportation to post sedation care room: LOC:

Doctor Name: Shankar

Signature: Shankar

Post Sedation Care Room

[illegible]

TOTAL ALDRETTE SCORE AT DISCHARGE =
(If 9 and more patient can discharge from post Sedation care unit)

Activity :	Consciousness:	Respiration:	Oxygen Saturation:	Circulation:
Four extremities = 2	Fully awake = 2	Breathe Deep= 2	Sat O ₂ >92 % on room air = 2	BP +/- 20 mm hg of pre-op = 2
Two extremities = 1	Arousal on calling=1	Dyspnea, limited breathing = 1	Needs oxygen to maintain Sat O ₂ >90% = 1	BP +/- 20-50 mm hg of pre-op = 1
No extremities = 0	Unresponsive=0	Apnea = 0	Saturation <90% with oxygen = 0	Bp +/-50 mm hg of Pre-Op = 0

Patient Discharge Time:

Nurse Name:

Signature:

Date: Time:

Signature:

Stamp

PROCEDURE SAFETY CHECK LIST (TIMEOUT OUTSIDE OT)

Patient Name: MANCHI KALAPATI WITH WIFE Gender: ☒ Male ☐ Female UHID. No: BAH-00660336 Age: 54Y 5M
Date: 2/7/26 In-Time: 3pm Out-Time: 3:15 pm
Doctor Performing Procedure: Dr. Sravani Doctor Giving Sedation: Dr. prabhu Assisting Nurse: Brother Sadip

SIGN IN		TIME OUT		SIGN OUT	
Time: <u>3pm</u>		Time: <u>3:05 pm</u>		Time: <u>3:15 pm</u>	
	Yes No NA		Yes No NA		Yes No NA
Patient is verified using two identifiers (Name & UHID)	☒ ☐ ☐	Correct Patient	☒ ☐ ☐	Name of the Surgical / Invasive Procedure is recorded	☒ ☐ ☐
All required documents, images, studies are available	☒ ☐ ☐	Correct Site	☒ ☐ ☐	Instrument, Sponge and Needle Count Completed	☒ ☐ ☐
NPO Status Checked from Patient / Patient Attendant	☒ ☐ ☐	Correct Procedure	☒ ☐ ☐	Specimens are labeled	☒ ☐ ☐
Consent is Signed	☒ ☐ ☐	All the team members introduced	☒ ☐ ☐	Any equipment problems are addressed	☒ ☐ ☐
Any need for blood products	☐ ☒ ☐				
If Yes Comment:					
Any Risk of Hemodynamic Compromise	☐ ☒ ☐				
If Yes Comment:					
Any drug or food allergy	☐ ☒ ☐				
If Yes Comment:					
Correct Site of Procedure Marked	☒ ☐ ☐				
All resources required are correct, available and functioning	☒ ☐ ☐				
Signature of the Doctor: <u>[Signature]</u>		Signature of the Nurse: <u>Sadip</u>		Signature of the Nurse: <u>Sadip</u>	
Name of the Doctor: <u>Dr. prabhu</u>		Name of the Nurse: <u>Sadip</u>		Name of the Nurse: <u>Sadip</u>	

Any Adverse / Unexpected Events

procedure uneventful.

CONSENT FOR PROCEDURAL SEDATION

Authorization By: ☐ Patient ☒ Patient Attendant

I, the undersigned do hereby acknowledge the following:

- I have been made aware by the doctors in language known to me the details of sedation planned for the procedure
short sedation
- I have been made aware of the possible complications from the procedure of sedation as follows:
- Changes in heart rate, blood pressure, need for oxygen supplementation, allergic reactions, upper airway obstruction, laryngospasm, conversion to general anaesthesia
- I have been made aware that the sedation is being advised to relieve pain and anxiety during the procedure. It will help me remain calm, comfortable, and cooperative, allowing the procedure to be performed smoothly and safely.
- I have been clearly explained about the benefits, risk, and alternative of the sedation which is General Anaesthesia.
- I authorize Dr. Sirisha Rani and his / her team to perform the procedural sedation upon the patient / myself.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: [Signature]
Name: Nani
Relationship with patient: Father
Date & Time: 2/7/26 @ 3PM

Witness:

Signature: [Signature]
Name: Likitha
Date & Time: 2/7/26 @ 4PM

Doctor (who is taking consent):

Signature: [Signature] Name: Ahanisha Date: 2/7/26 Time: 3P

ప్రాసీజర్ల సెడేషన్కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, క్రింది విషయాలను అంగీకరిస్తున్నాను:

నాకు తెలిసిన భాషలో, వైద్యులు ఈ క్రింది ప్రాసీజర్కు ఇచ్చే సెడేషన్ గురించి పూర్తి వివరాలు నాకు తెలిపారు:

- సెడేషన్ వల్ల సంభవించగల సాధ్యమైన క్రింది సమస్యలు/ప్రమాదాలు గురించి నాకు తెలిపారు: గుండె వేగం మారడం, రక్తపోటు మారడం, ఆక్సిజన్ అవసరం, అలర్జిక్ ప్రతిచర్యలు, ఎగువ శ్వాసనాళ అడ్డంకి, లారింజోస్పాస్మ్, జనరల్ అనస్థీషియాగా మారాల్సిన అవకాశం.
- ప్రాసీజర్ సమయంలో నొప్పి, భయం, ఆందోళన తగ్గించేందుకు సెడేషన్ ఇవ్వడం అవసరం అని నాకు వివరించారు. ఇది ప్రాసీజర్ సజావుగా, సురక్షితంగా జరగడానికి సహాయపడుతుంది.
- సెడేషన్కు సంబంధించిన ప్రయోజనాలు, ప్రమాదాలు, ప్రత్యామ్నాయం (జనరల్ అనస్థీషియా) గురించి నాకు స్పష్టంగా వివరించారు.
- డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ ప్రాసీజర్ సెడేషన్ చేయడానికి నేను అనుమతిస్తున్నాను.
- పై సమాచారాన్ని నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ఉన్న ప్రశ్నలన్నీ, నాకు అర్థమయ్యే భాషలో సమాధానమిచ్చారు. ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

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CONSENT FOR SPECIAL PROCEDURES

Patient Name : Rithwik Gender: ☐ Male ☒ Female

UHID No : 660336 Department : Hematology Date : 2/7/26

I Nani S/D/W/O Rithwik

Here by give consent for procedure of : BMT & Mopay

For my patient, Named : Rithwik

The doctors have clearly explained to me that the procedure has following possible complications:

nausea, vomiting, infection

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

none

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr. Bravani

Patient Attendant :

Signature : Nani

Name : Nani

Relationship with Patient: Father

Date & Time : 2/7/26 @ 3PM

Witness :

Signature : Sneha

Name : Sneha

Date & Time : 2/7/26 @ 3PM

Doctor (who is taking the consent) :

Signature : Shankar

Name : Shankar

Date & Time : 2/7/26 @ 3PM

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు (అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

Patient ID: BAH-00660336 IP5-00175785
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PROCEDURE SAFETY CHECK LIST (TIMEOUT OUTSIDE OT)

Procedure Name: BMA & biopsy Date: 2/8/27 In-Time: Out-Time:
Doctor Performing Procedure: Dr. Shrawan Doctor Giving Sedation: Assisting Nurse:

SIGN IN		TIME OUT		SIGN OUT	
Time:		Time:		Time:	
	Yes No NA		Yes No NA		Yes No NA
Patient is verified using two identifiers (Name & UHID)	☒ ☐ ☐	Correct Patient	☒ ☐ ☐	Name of the Surgical / Invasive Procedure is recorded	☐ ☐ ☐
All required documents, images, studies are available	☒ ☐ ☐	Correct Site	☒ ☐ ☐	Instrument, Sponge and Needle Count Completed	☐ ☐ ☐
NPO Status Checked from Patient / Patient Attendant	☒ ☐ ☐	Correct Procedure	☐ ☐ ☐	Specimens are labeled	☐ ☐ ☐
Consent is Signed	☒ ☐ ☐	All the team members introduced	☒ ☐ ☐	Any equipment problems are addressed	☐ ☐ ☐
Any need for blood products	☐ ☒ ☐				
If Yes Comment:					
Any Risk of Hemodynamic Compromise	☐ ☒ ☐				
If Yes Comment:					
Any drug or food allergy	☐ ☐ ☒				
If Yes Comment:					
Correct Site of Procedure Marked	☒ ☐ ☐				
All resources required are correct, available and functioning	☒ ☐ ☐				
Signature of the Doctor: <u>Shanishas</u>		Signature of the Nurse: <u>Shrawan</u>		Signature of the Nurse: <u>Shrawan</u>	
Name of the Doctor: <u>Shanishas</u>		Name of the Nurse: <u>Shrawan</u>		Name of the Nurse: <u>Shrawan</u>	

Any Adverse / Unexpected Events

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 Dr. ANNAPOORNA TADAVARTHY

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD



Plugu

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		
30/6	7pm	2	Treatment & care plan	F	1	1	1	0	—	Keel/ta
1/7/26	8am	9	soft diet	f/m	1	0	1	1	—	same

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: BAH-00660336 IP5-00175785
 Master MANCHIKALAPATI RITHWIK
 04-01-2021 5 Y 5 M 26 D (M)
 Dr. ANNAPOORNA TADAVARTHY



Atypical sepsis

Date Time	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
30/6/26 @ 7pm	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fever x random H. stability	Iv fluids & Antibiotics	☐ Nursing ☒ Others:
30/6/26 @ 7pm	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fever x 5 days H. stability	Iv fluids & Antibiotics	☒ Medical ☐ Others:
1/7/26 8am	☐ Medical ☐ Nursing ☒ Others: <i>hydration</i>	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	sepsis Soft diet Atypical sepsis	RbA E- 1400 kcal/d P- 24g/dl	☐ 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:

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DISCHARGE PLANNING FORM

Nationality: INDIAN

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

1. Anticipated Date of Discharge: 21/7/26

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☒ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication ☒ Yes ☐ No

☐ Bathing ☐ Yes ☒ No

☐ Eating ☐ Yes ☒ No

☐ Walking ☐ Yes ☒ No

☐ Dressing ☐ Yes ☒ No

☐ Toileting ☐ Yes ☒ No

→ Assistance needed

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s:

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

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: LIRITHA

Date and Time: 30/6/26



nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 10 PM Mode of Arrival: Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: nil Body Weight: 17 Kg
Height: 52 cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>nil</u>	<u>Leg amputa</u>	<u>yes</u>

Family History:

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: 17 kg Length: Head Circumference (< 2 years):
Temp.: 98° F HR: 110 bpm RR: 22 bpm BP: 100/60

Pain Score: 13 Specify Site: 8-7 (Follow Pain Assessment Sheet & Document)

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

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

Pain Screening: ☐ Yes ☒ No If Yes, Pain Score: 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 Findings

Unusual 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

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 ☐ No Waste Disposal Explained: ☒ Yes ☐ No
- Infusion Pump : ☒ Yes ☐ No Hand hygiene Explained: ☒ Yes ☐ No ☐ Others
- Patient Rights & Responsibilities: ☒ Yes ☐ No
- Information given to parent(s)

Nurse Signature: [Signature]

Nurse Name: Likitha

Date: 30/6/26

Time: 10pm



EMERGENCY ROOM TRIAGE FORM

Patient's Name : R. Rithwik Age : 6 yrs Gender: ☒ Male ☐ Female
Date : 30/6/26 Time of Arrival : 7:46 pm Triage Completion Time : 7:48 pm
Allergies: ☐ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): ☐ Not known any drug Allergies

Source of Information: ☒ Parents ☐ Others (Specify): ☐ Stretcher ☐ Ambulance
Mode of Arrival: ☒ Ambulatory ☐ Wheelchair

INITIAL PHYSIOLOGICAL STATUS

☒ Stable
☐ Unstable:
☐ Not - Life - Threatening
☐ Life - Threatening

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance

☒ Normal
☐ Sick Looking

Circulation / Colour

☒ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing

☒ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

Initial Vital Signs: Temp: 101.5° PR: 123 b/m BP: 94/60 RR: 26 b/m SpO₂: 100%
Chief Complaints: C/O Fever x 5 days, Rash over body x 5 days

Triage Classification

- ☐ Level 1: Resuscitation
☐ Level 2: EMERGENT: Life or limb threatening
☐ Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening
☐ Level 4: LESS URGENT: Significant illness but not life threatening
☐ Level 5: NON - URGENT: May receive care when convenient

CTAS

- ☐ Immediate
☐ < 15 min
☒ 30 min
☐ 60 min
☐ 120 min

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Shavani

Date & Time : 30/6/26 @ 7:48 pm

Docu. No. : RCHBH / FRM / CLINICAL / 085

Signature of Triage Nurse : B

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

Time	Nursing Notes
7:20 pm	metformin p given at home (101-10)
	- assessed the pt condition
	- monitor the vitals
	- IV placement done
	- sample collected.
	- shifted to ward.

Samples collected by: / NR. John

Samples sent by :

Time:

Time:

8:10 pm

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
7:50 pm	Syr Bupropion	PO	5ml	[Signature]	Shavani

Condition of patient at time of shift - out :

HR: 132 / min BP: 94/60 CFT: 2.5 sec
 RR: 26 / min SPO₂: 100%
 GCS: 15/15 Temperature: 98.2°F
 Pain Score: 0/10
 Repeat RBS (if applicable): NA

Details of Shift - out

Shift - out from ER to: 303
 Time of Shift - out: 9:30 pm
 Handover given to: [Signature]
 (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

IV placement

Name of the Nurse :

Shavani

Signature of the Nurse :

[Signature]

Date & Time :

30/6/26

7:52 pm

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00660336 IP5-00175785 Master MANCHIKALAPATI RITHWIK 04-01-2021 5 Y 6 M 26 D (M) Dr. ANNAPOORNA TADAVARTHY 		Date & Time of Admission 30/6/26 at 8:15 pm	Date & Time of Transfer Order 30/6/26 @ 9:30 pm
		Transfer Ordered by Dr. Nandhan	Reason for Transfer Admission
From Unit CC	To Unit 303	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ op files If yes, what?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Nil		
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Mr. Bhavan		Name of Person Ordered Transfer Dr. Nandhan	
Patient & Clinical Records Received by : Likhitha			
Date & Time of Patient Received : 9:40 pm 30/6/26			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

303

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 11/7/26 Time: 8am

Weight: 17kg Centile: 25th

Height: 100cm Centile: 25th

Inference: 100% child

RDA: — Calories: 1400kcal/d Protein: 24gm/d

Diet Recommendations: Soft diet

Re-Assessment: Avoid Spicy, chilled & outside foods

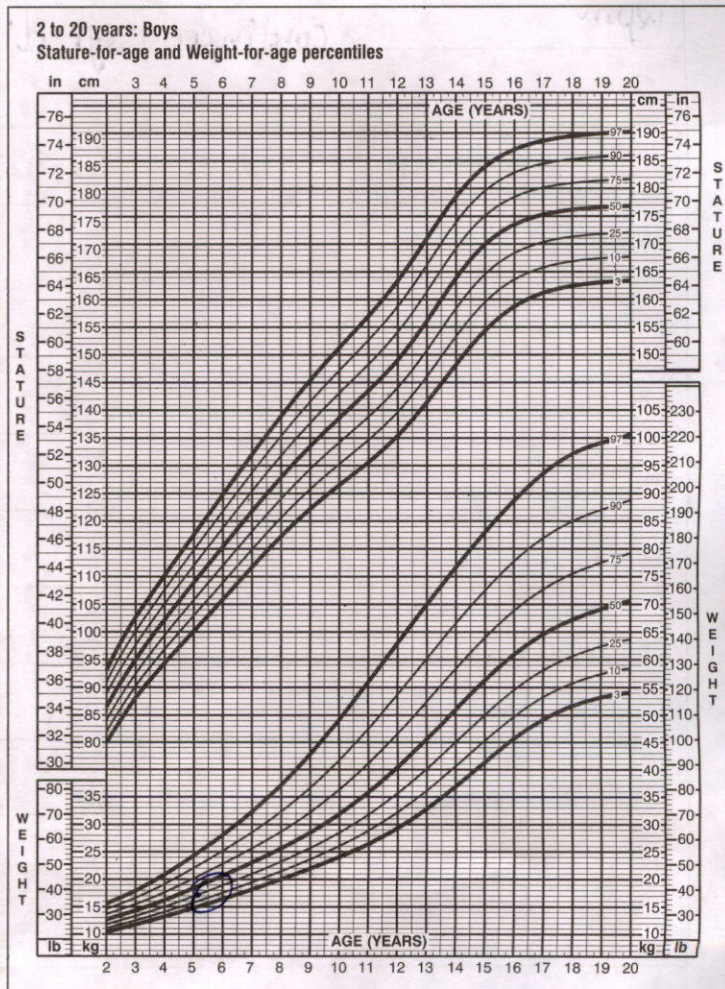
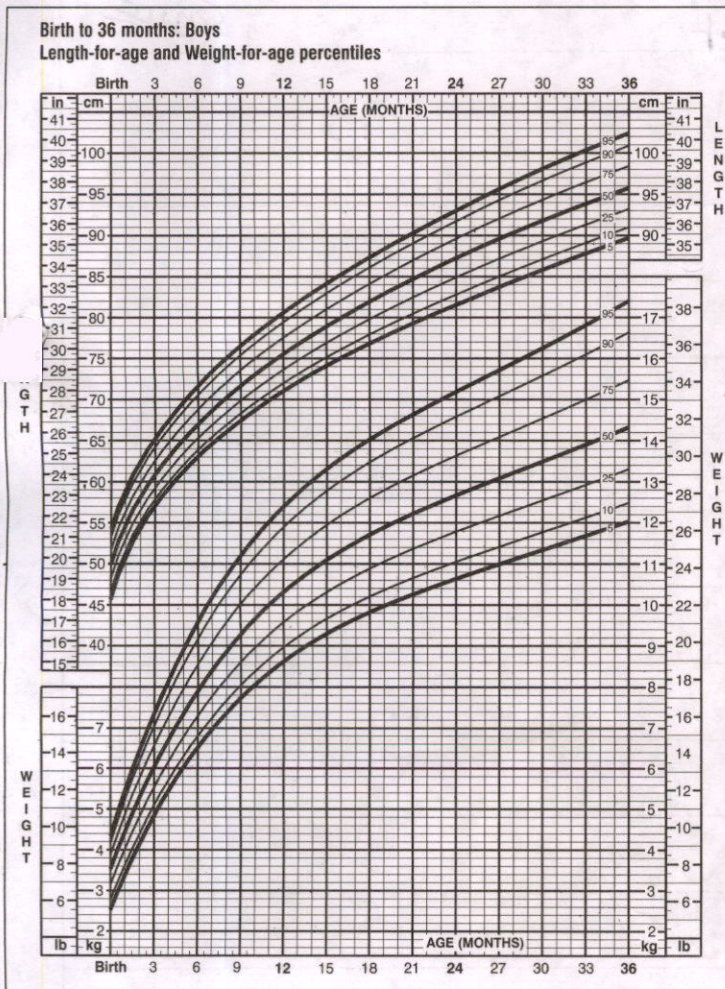
Food Allergies: No Veg/Non-veg: NON-veg

Diagnosis: Atypical Ep's

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: Sarma

Dietician's Signature: [Signature]

Daily Notes:

child is stable, on NPO until further orders

3/7/26 - child is stable, oral intake is optimal
9:45 am continue soft diet Saima

4/7/26 child is stable, oral intake is good.
11:40 am continue soft diet Seizure

5/3/26 child is stable, oral intake is better
12pm continue soft diet Scione



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/06/2021 12 AM	<u>CSD Resident</u> ? Atypical sepsis. Ongoing subnormal fever spikes ⊕ Vitals ⊖ U/O Delirious SLE → rash ⊕ pericardial effusion ⊕ CNS MS / ⊖ PB / ⊖	<u>Adv</u> 1) Eare Wks 2) Send LFT & urine sample. 3) manage wally. 4) (RTV) JSG High / Widal. Ortho opinion. 5) Inform SRS.
		<u>Atankhan</u> noted by Wishu
		* <u>Plan 3</u> .
	Cloud c AFI	* Usq Abdomen & Hip Joint Doppler of lower limb
	c Atypical sym. c ± ylamah. Syn / sm. /	* Dr Venkatesh to see.
	Cloud Reduction / 17/06/2021 Nahy	* <u>LFT</u> / <u>Ferritin</u> / <u>PCT</u> <u>Measles IgM</u> antibody.
		* <u>Mycoplasma IgM</u> Co
		Noted by Alankhan

Date & Time	Progress Notes	Doctor's Order
01/7 2pm 01/7 2pm	01/7 2pm 01/7 2pm	01/7 2pm 01/7 2pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
01/7 4:30pm	q/s/B Resident	
	<u>Δ: Sepsis / hepatitis</u>	<u>Adv:</u>
	fenetris - 9480 PCT - 28.6	1) Trace PT/INR/ap TT.
	- continuous fever	2) Inj Meropenam D1
	- poor intake	Inj Vancomycin D1
	- passed urine 2 times	Syp Azithromycin
	stools - ✓	3) R/V LDH, triglyceride
	O/E: dull / febrile	Calcium
	sick look.	
	generalised	
	macular rash ⊕	4) Send: EBV tetrapanel
	blanching	LDH
	CRT < 2s. ? flash.	5 viral panel
	peripheral pulse	SARS COVID antibodies
	⊕ / low volume.	
	not bounding	
	Atypical sepsis.	Temp control 000
	Rach no arthralgia	Drugman
	no lymphadenopathy	SPM
	no pruritus.	
	spleen not palpable	

Dr. UJJWALA DESAI
Reg. No: 90550



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/7 10pm	<u>C/S/B Resident</u> ↑ lactate dehydrogenase ↑ ferritin hepatomegaly fever. ↑ transaminases ? HLL. no continuous fever remittant O/E: dull. sick look no shock.	<u>Adv.</u> ① R/v triglyceride fibrinogen. LFT. CBP. ② R/v hematocrit consult. ③ R/v BMA/Bx ④ Keep NPO from Fam. ⑤ Naprosyn to add Akhila noted by cicris 080918



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7 8:30am	C/S/B Resident A: PUO	
	response to Naproxen (+)	Adv:
	O/E: alert dull. vitals stable on room air chest: BAT (+) abdomen soft hepatomegaly (+) generalised anasarca (+) oed (+)	1) Hematology consultation today, 2) Cont NPO plan BMA + Bx today 3) Continue all current medications & IVF 4) Temperature charting 2hly. 5) Monitor vitals 6) Trace pending labs/c/s. Akhile
2/7 8:30am	C/S/B Dr. FAISAL B NAHDI Reg. No: 66228	7) Hematology: Consult

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/21 12pm	C/D/W Dr. Faizal	
		<u>Adv.</u>
		① Send Serum - triglycerides - Widal - Weil Felix - Brucella serology
		② 2D Echo today at RCH Banjara Rd no 2 today
		Akhde
2/7/21 2:30pm	<u>Procedure notes</u>	
	Under strict aseptic precautions, bone marrow aspiration & biopsy done, samples sent for. Unremarkable. Send BM culture	
		<u>Shankar</u>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7 8:30am	Cs/B Resident A: PUO, suspected HLL → fever: 5pm - 101°F → <u>u/o ↓ feed.</u> O/E: alert stable vitals rash (+) denudation (+) edema generalised pitting chest clear. abdomen soft	Adv: 1) W/f fever temperature every 4hrly 2) Continue IVF ½ maintenance Meropenam D3 Vancomycin D3 Azithromycin P4 Naproxen MPS. 3) Stop reg PCM. 4) Labs: ↳ CBP Hm Gam ↳ CRP today ↳ LFT ↳ B.P.T. ferritin Achilles

Dr. FAISAL B NAHDI
Reg. No. 66228

Anal
3/7
8:30am
(u/o):

5) Strict I/O charting
daily weight