

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176635 Admit Date : 20-Jul-2026 Admit Time : 11:09 AM UHID : BAH-00635029

Patient Details :

Patient Name	: Baby SYEDA GOHAR FATIMA	Age	: 4 Y 4 M 8 D
Guardian	: Mr SYED AZEEM UDDIN	DOB	: 12-03-2022
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H NO 14-1-129/101, padmavathi nagar, Borabanda Hyderabad Telangana INDIA 500018	Phone No	: 9989447886/ 9059329845
		E-mail	: SYEDAZEEMUDDIN5@GMAIL.COM

Admission Details :

Bed Type : SEMI PRIVATE Bed No : SPVT 101 Ward Name : 1F-VIBGYOR
Room No : SPVT 101 Admission Type : First Visit

Contact Details :

Name : Mr SYED AZEEM UDDIN Relationship : Father
Contact Address : H NO 14-1-129/101, padmayathi nagar,
Borabanda Hyderabad Telangana INDIA 500018 Phone No : 9989447886 /

Signature

Doctor Details :

Doctor Name : Dr. UJJWALA DESAI Specialisation : GENERAL PEDIATRICS
Referral Doctor : Self Phone No :
Co-Consultant : Dr. FAISAL B NAHDI

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : ICICI LOMBARD GENERAL INSURANCE CO LTD

BAH-00635029 IP5-00176635
Baby SYEDA GOHAR FATIMA
12-03-2022 4 Y 4 M 8 D (F)
Dr. UJJWALA DESAI




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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
20/7/26	11:45 AM	ER	(101) Ward	Pooja
20/7/26	8:30 PM	101	237	Pooja

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

[illegible]

Date _____

Name of Equipment

Connecting Time

Disconnecting Time

Order No.

Signature

no other

Infusion pump

12pm

240532-

8

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
20/07	iv placement	1	12255	Tsmf
20/07	NHA	1	24050	

ANY OTHER INFORMATION

a-ray- ①

Date : 23/7/26

Time : @10AM

Prepared By : ✓

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Rosnarns	2nd floor	—	—



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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Syeda Gohar fatima

UHID ID:

Department:

Consultant:

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12-03-2022 4 Y 4 M 8 D (F)
Dr. UJJWALA DESAI





Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Fever
cough / 3 days
cold

Headache / vomiting (Abd. pain)

History of present illness :

Child was apparently well 3 days back, later she developed fever. Sudden in onset, high grade, associated with chills. Subsiding with oral medication.

↓

Later, she developed cough - productive in nature, & cold.

After 2 days ↓

she developed headache more in frontal area due to vomiting - non bilious, non-projectile in nature associated with Abdominal pain.

No similar history in family
No known chronic illness

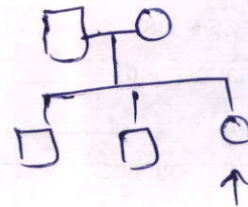


Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Term / LSCA / C/S / BW - 2.5 kg
No NICU admission



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

• Attend as per age

Immunization History :

Vaccinated till now as per MCI



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) 40 cm (Centile _____) Height (cms): 103 cm (Centile _____)

Weight (kgs) 13.15 kg (Centile _____)

On Examination :

Temperature : 99.5 F Pulse Rate : 131 bpm B.P. _____ SPO2 100% R

Resp. rate and type of breathing : _____

Br 22 bpm

Rash ⊖

Lymphadenopathy _____

Oedema : ⊖

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : RASG, No RD

Air entry & breath sounds : mild Rch

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : SIS, ⊕

Heart Sounds : _____

Any murmur : No murmur

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

Per Abdomen :

Inspection : Soft

Palpation : non Tender

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 : 5/15

Cranial Nerves : _____

Motor System:

Nutrition : _____

Tone: _____

Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : Regular

Clinical Summary & Diagnostic:

Acute febrile illness



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Secondary Infection

Desired goals of the treatment : Resolution of symptoms

Planned Labs:

CBP / CRP / Blood clt
Dengue NSI —
EBM —
LFT —
5 virus panel —
CNS —
Chest x-ray N/R
Trend

Planned Management

2x Ceftriaxone
AZS
Simvastatin
Nebulization
O2
2x fluids

DR. UJJWALA DESAI
Registration No: 90550

Signature of the Doctor: [Signature]

Name of the Doctor: Dr. Balaji

Date & Time: 20/3/22 11 AM

Signature of the Consultant: [Signature]

Name of the Consultant: Dr. Ujjwal

Date & Time: 21/3/22

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/3/22 2 PM	Seen by Resident ASis - Acute Febrile Illness (D3) Ongoing fever spikes 2 PM - 103°F. CUE - 6-8 pus cells. CXR - mild ↑ in Broncho - vascular markings, minimal @ paracardiac infiltrates. O/E Child asleep, febrile hemodynamically stable. Chest clear, abdomen mild congested soft hydration fair	Plan 1. Continue CEFTRIAXONE AZITHROMYCIN Neb. 2. Trace Viral panel, Dengue NS, IgM. 3. Monitor vitals, inform SOS. \$ Salinity Noted by Shanti 5 PM
21/7	Child c AFI c Afe gentle.	Send urine c/s.
21/7	CRP - 53	① More send panel
8:30	② 87%	
	CUE - 68 pus cells	
		DR. FAISAL B NAHDI Registration No: 66228 Cul

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/4 9am	CS/B Resident <u>Adenoviral illness</u> → 2 fever spikes post admission → cough/cold better → no vomiting → on & off abd pain → headache & fever → poor oral intake → not passed stools O/E: alert stable vitals Chest clear. S/E: NAD.	Adv. 1) R/v stop Azithromycin 2) Add Ribavirin 3) Use IVF to 1/2 maintenance 4) Encourage orally 5) Wff fever spikes
	Adenoviral infection.	While No more CS Repet CBP/CRP to know DR. UJJWALA DESAI Registration No: 90550 with Azithromycin make Ondaceron oral 9am 21/4/22



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/2/26	CLIN Resident	
3:30pm	Dr: Adenoviral illness.	
	episode of fever - 101.4°F (2:30 pm)	Plan
	Intermittent H/o Headache during high fever	- Send urine clg.
	Passing urine - dark yellow.	- ct in fluids
	↓ oral intake.	- ct by ceftriaxone (D2)
		Syrp Azithromycin (D2)
		Cep Ribavirin (D1)
		- Encourage oral intake
		- wif fever spikes
		- monitor vitals
		Ranj
	Repeat	c 13/2
	to monitor	1 c 12/2
		Doc
		Dr. Ujjwala
		5/1/26
		DR. UJJWALA DESAI
		Registration No: 90550

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/7 9am	<u>C/S/B Resident</u> <u>Δ: Adenoviral infection</u> - afebrile - doing well O/E : alert vitals stable chest clear. Review → 5/2/19	<u>Adv :</u> 1) (D) today Akhiile Ceftriaxone 1gm at 10am. f15 cefixim Bevon E Ribavirin Discharge Dr. Drijun ga

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Pati



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RESULT SHEET

Date	20/7	22/7/26			
Time		7pm			
Hb	11.9	11.9			
PCV	37	37.8			
RBC	4.9	4.93			
WBC	18.9K	6770			
N/L	87/7	356/55.8			
Platelets	3.21L	2.77 lakh			
CRP	53	23 ↓			
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP	154				
SGPT	14				
SGOT	32				
T.Bill/Conj	0.5/0.3				
T.Protein	7.2				
S.Albumin	4				
S.Globulin	3.2				
A/G Ratio	1.2				
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

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MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From:ER.....

Shifted to:ward.....

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature:Dr. Balaji.....

Date & Time:20/7/26 : 11 AM.....

Nurse Name & Signature:poorna.....

Date & Time:20/7/26 : 11:20 AM.....

Weight 13.15 kg Ward

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

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

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

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

VERIFIED BY : Name Signature



DRUG CHART

Date of Admission: 20/7/20 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 : Symp. CROCIN DS				Date Time															
Dose	Route	Frequency	Start Date	20/7/20	21/7														
3.5 ml	PO	SOS	20/7/20	21/7	23:30														
Doctor's Signature		Valid Period	Pharm.																
Dr. B. B. B.		48 hrs																	
Additional Instructions:																			
Max 6-8th hourly between 20/7																			

DRUG : Symp. MEFTAL (5/100)				Date Time															
Dose	Route	Frequency	Start Date	20/7	21/7														
6.5 ml	PO	SOS	20/7	21/7	21/7														
Doctor's Signature		Valid Period	Pharm.																
Sahit																			
Additional Instructions:																			
temp > 102 max 8th hourly																			

DRUG : Inj ONDANSETRON				Date Time															
Dose	Route	Frequency	Start Date	21/7															
3mg IV		SOS	21/7																
Doctor's Signature		Valid Period	Pharm.																
Sahit																			
Additional Instructions:																			
vomiting																			



REGULAR PRESCRIPTIONS

Weight. 13.15 kg Ward.

VERIFIED
Dr. Balaji

DRUG : <u>2nj. CEFTRIAXONE</u>				Date Time	20/7 18/7 22/7															
Dose	Route	Frequency	Start Date																	
600mg	ZV	BD	20/7/26																	
Name & Signature of the Doctor Starting the Drugs:																				
Dr. Balaji																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

10pm 12pm 12pm 12pm
10pm 12pm 12pm 12pm
10pm 12pm 12pm 12pm
10pm 12pm 12pm 12pm

STOP

DRUG : <u>2nj. ONDANSETRON</u>				Date Time	20/7 18/7 22/7															
Dose	Route	Frequency	Start Date																	
3mg	ZV	TID	20/7/26																	
Name & Signature of the Doctor Starting the Drugs:																				
Dr. Balaji																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

10pm 12pm 12pm 12pm
10pm 12pm 12pm 12pm
10pm 12pm 12pm 12pm
10pm 12pm 12pm 12pm

DO
stop

VERIFIED

DRUG : <u>2nj. ESMOPRAZOLE</u>				Date Time	20/7 21/7 22/7 23/7															
Dose	Route	Frequency	Start Date																	
15mg	ZV	OD	20/7/26																	
Name & Signature of the Doctor Starting the Drugs:																				
Dr. Balaji																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

10pm 12pm 12pm 12pm
10pm 12pm 12pm 12pm
10pm 12pm 12pm 12pm
10pm 12pm 12pm 12pm

VERIFIED

DRUG : <u>Syrup. AZITHROMYCIN</u>				Date Time	20/7 21/7 22/7 23/7															
Dose	Route	Frequency	Start Date																	
3ml	PO	OD	20/7/26																	
Name & Signature of the Doctor Starting the Drugs:																				
Dr. Balaji																				
Additional Instructions:																				
(5ml = 200mg)																				
Daily Doctor's Endorsement by a Sign																				

10pm 12pm 12pm 12pm
10pm 12pm 12pm 12pm
10pm 12pm 12pm 12pm
10pm 12pm 12pm 12pm

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
23/7		Inj CEFTRIAZONE	1g	IV		



(F)

Weight. 13.15 kg Ward.

[illegible]

Signature _____

VERIFIED BY : Name

BAH-00635029
Baby SYEDA GOHAR FATIMA
12-03-2022
Dr. UJJWALA DESAI
IP5-00178635
4 Y 4 M 8 D
(F)

IN DISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Patient's Name: Hindi 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		
20/7/26	11:15 AM	7	Infection control measures	M	4	0	1	1	NA	Pooja
20/7/26	12 PM	9	soft diet	F	1	0	1	7	—	Nikita

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							

IP5-00176635
Baby SYEDA GOHAR FATIMA
12-03-2022 4 Y 4 M 8 D
Dr. UJJWALA DESAI (F)

MULTI-DISCIPLINARY PLAN OF CARE FORM



Diagnosis: APQ

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
20/7/26 11 AM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fever, Cough, Cold	Reduction of Symptoms	200 medication		☒ Nursing ☐ Others:
20/7/26 11:05 AM	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fever, cough, cold	1st - stability	200 medication		☒ Medical ☐ Others:
20/7/26 12 PM	☐ Medical ☐ Nursing ☒ Others: Dietician	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	AFI	soft diet	RDA:- E:- 1350 kcal/day P:- 23 g/d		☐ 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:

BAH-00635029
Baby SYEDA GOHAR FATIMA
12-03-2022 4 Y 4 M 8 D (F)
Dr. UJJWALA DESAI

(1.30 am - Metasp - Sm)

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Saida Johar Fathima Age : 4y Gender: ☐ Male ☒ Female
Date : 20/02/26 Time of Arrival : 9.40am Triage Completion Time : 9.42am
Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): NA ☐ Not known any drug Allergies
Source of Information : ☒ Parents ☐ Others (Specify): NA
Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

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

Initial Vital Signs: Temp: 103.1°F PR: 160b/m BP: 98/66 RR: 24b/m SpO₂: 98%
Chief Complaints: Fever x Since 3 days Cough, cold, headache, vomiting

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Ramya

Signature of Triage Nurse : Ramya

Date & Time : 20/02/26 @ 9.42am

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

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 20/7/26 Time of arrival : 9:43 am
Chief Complaints: Fever since 3 days, cough, cold, headache, vomiting since 3 days RBS: 110 mg/dl
Height : NA Weight : 13.80 kg BMI : NA Head Circumference (<2 years) : NA
Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: NA
If yes, identify : NA
Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 9/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker
☐ Character : Nil ☐ Location : Nil ☐ Frequency : Nil ☐ Duration : Nil

RISK FOR FALL:

- ☒ If patient is < 6 years
tick below fall risk intervention directly
☐ If Patient is > 6 years
Assess the below parameters
History of Falling: within past 3 months ☐ Yes ☐ No
Ambulatory Aids:
• Wheelchair ☐ Yes ☐ No
• Uses furniture for support ☐ Yes ☐ No
Gait/Transferring:
• Bedrest / immobile ☐ Yes ☐ No
• Weak ☐ Yes ☐ No
• Impaired ☐ Yes ☐ No
Mental Status: Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

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

Social History: Lives With : parents

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

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

Time of Initial assessment completed by ER Nurse : 9:45 am

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

Time	Nursing Notes
9:45 am	Assess the child condition
	- monitored vitals & recorded
	- seen by Dr. Balaji
	- shifted to ward

Samples collected by:

(NL Gasmin)

Time:

10:15 AM

Samples sent by:

Time:

Medication given in ER:

+Trepidspousing.

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
7:45 AM 20/7/20	Syr. mecliz-P	PO	6 ml	N. P. 2	Beethi
1:55 PM 20/7/20	T. (as a 20) Junior	PO	15 mg + 2ml DW give 2ml	N. P. 2	Beethi
1:55 PM 20/7/20	Syr. ondansetron	PO	5 ml	N. P. 2	Beethi

Condition of patient at time of shift - out :	Details of Shift - out
HR: 106 bpm BP: 98/66 CFT: 5 sec RR: 25 bpm SPO ₂ : 98% GCS: 4/5/6 Temperature: 103.7°F Pain Score: 0 Repeat RBS (if applicable): NA	Shift - out from ER to: ward Time of Shift - out: 11:45 AM Handover given to: Beethi (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

Ov placement done

Name of the Nurse: Pooja Signature of the Nurse: [Signature]

Date & Time: 20/7/20 @ 10:30 AM



Nursing General Admission Assessment Form For Pediatrics

Diagnosis: AFJ
Arrival Time: 6:20 PM Mode of Arrival: on wheel chair Admitting From: ☒ ER ☐ OPD ☐ Direct
Allergy / Adverse Reaction: NA Body Weight: 13.1 Kg
Height: NA cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>NA</u>	<u>NA</u>	<u>NA</u>

Family History: no significant 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: 13.1 kg Length: 126 cm Head Circumference (< 2 years): 51 cm

Temp.: 99.0°F HR: 126 bpm RR: 21 bpm BP: 101/67

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

Fall Risk Assessment: ☒ Yes ☐ No Score: 28 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

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

Character of Pain: NA Location: NA Frequency: NA Duration: NA

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):

Social History: Lives With *family*

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 *Mother*

Nurse's Name: *Priyanka* Date: *20/7/26* Time: *3pm*

Signature *RB*

BAH-00635029 IP5-00176635
Baby SYEDA GOHAR FATIMA
12-03-2022 4 Y 4 M 9 D (F)
Dr. UJJWALA DESAI



No. : RCH/ FRM / CLINICAL / 125

22/7
PRESCHOOL (1-5 years)

Children's Observation &
Early Warning Scoring Chart

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	10AM	2PM	6PM	10PM	2PM	6AM
Doctor / Nurse / Family Concern?							
Temperature (F)	104						
	103						
	102						
	101						
	100						
	99	98.2	98.6	97.7	98.4	98.2	97.7
	98						
	97						
	96						
	95						
94							
Heart Rate (bpm)	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
	90						
	80						
	70						
	60						
	50						
Note: BP does not score in early warning scoring							
Heart Rate (Number)		126b/m	123b/m	126b/m	124b	120b	124b
Resp. Rate (bpm) (Over 1 Minute) *	70						
	60						
	50						
	40						
	30						
	20						
	10						
Resp Rate (Number)		23b/m	26b/m	23b/m	24b	23	25b
Resp Distress	Mod/ Severe None / Mild						
Receiving O ₂ (l/min) O ₂ Saturations (%)		100%	98%	100%	99%	99%	98%
Conscious Level	Normal Altered						
GCS *		15/15	15/15	15/15	15/15	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		UD	UD	UD	UD	UD	UD
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.					
NB: Scores 3 should be recorded overleaf							

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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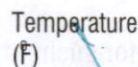
Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
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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)

FOREIGN BORN

[illegible]

Heart Rate (Number)

Resp Rate (Number)

GCS *

Observer's Initials

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

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20/7

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time: 10pm	2AM	6AM
Doctor / Nurse / Family Concern?			
Temperature (F)	104	103	102
	101	100	99
	98	97	96
	95	94	
Heart Rate (bpm)	190	180	170
	160	150	140
and	130	120	110
Blood Pressure (mmHg) *	100	90	80
	70	60	50
Note: BP does not score in early warning scoring			
Heart Rate (Number)	120	113	125
Resp. Rate (bpm) (Over 1 Minute) *	70	60	50
	40	30	20
	10		
Resp Rate (Number)	28	26	27
Resp	Mod/ Severe		
Distress	None / Mild		
Receiving O ₂ (l/min)			
O ₂ Saturations (%)	99%	98%	99%
Conscious Level	Normal		
	Altered		
GCS *	15/15	15/15	15/15
TOTAL SCORE	0	0	0
Number of shaded boxes			
Pain Score	0	0	0
Observer's Initials	A	S	J

ACTIONS

NB: Scores 3 should be
recorded overleaf

- Score 1 : Continue normal observation by staff nurse
Score 2 : Shift in charge nurse to be informed and continue hourly observations
Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 20/03/22	Time: 12:30 pm	2:20 pm	3:42 pm	4 pm	6:10 pm	7 pm
Doctor / Nurse / Family Concern?						
Temperature (F)	96.5	103.5	101.2	98.5	102.5	98.5
Heart Rate (bpm)	110	110	110	110	110	110
Blood Pressure (mmHg) *	110/60	110/60	110/60	110/60	110/60	110/60
Resp. Rate (bpm) over 1 Minute *	28	28	28	28	28	28
Conscious Level	Normal	Normal	Normal	Normal	Normal	Normal
GCS *	15	15	15	15	15	15
TOTAL SCORE	1	1	1	1	1	1
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	UJW	UJW	UJW	UJW	UJW	UJW

ACTIONS

NB: Scores 3 should be recorded overleaf

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		1.5.6			

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BAH-00635029 IP5-00176635
 Baby SYEDA GOHAR FATIMA (F)
 12-03-2022 4 Y 4 M 8 D
 Dr. UJJWALA DESAI



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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

FLUID CHART

Sheet No. :

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

		Intake			Output					IV Site	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 :						
20/07/26	02:00 pm	1								0	✓
	03:00 pm			45ml						0	✓
	04:00 pm	ONS		45ml						0	✓
	05:00 pm			45ml						0	✓
	06:00 pm			45ml						0	✓
	07:00 pm	1								0	✓
Total Intake :					Total Output : M-0 0-2						
20/7/26	08:00 pm	1	neg swatch	45ml						0	Swab
	09:00 pm		swatch	45ml			NP		✓	0	Swab
	10:00 pm	ONS								0	Swab
	11:00 pm								✓	0	Swab
	12:00 am			45ml						0	Swab
	01:00 am			45ml						0	Swab
Total Intake :					Total Output : M-0 0-2						
21/7/26	02:00 am	1		45ml						0	Swab
	03:00 am			45ml						0	Swab
	04:00 am	ONS		45ml			NP			0	Swab
	05:00 am			45ml						0	Swab
	06:00 am			45ml					✓	0	Swab
	07:00 am									0	Swab
Total Intake :					Total Output : M-0 0-1						
Total 24 hrs. Intake		540ml.			Total 24 hrs. Output		M-0 0-5				



FLUID CHART

Sheet No. :

21/7

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

		Intake			Output						IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am	A DMS ↓	weeds nelen.	45ml							0	Rosny
	09:00 am			15 ml							0	Rosny
	10:00 am										0	Rosny
	11:00 am			45ml							0	Rosny
	12:00 pm			95ml							0	Rosny
	01:00 pm			95ml							0	Rosny
Total Intake :				285ml			Total Output : M-1 U-2					
	02:00 pm	A DMS ↓	Pocce any								0	Rosny
	03:00 pm			25ml							0	Rosny
	04:00 pm			25ml							0	Rosny
	05:00 pm			25ml							0	Rosny
	06:00 pm										0	Rosny
	07:00 pm										0	Rosny
Total Intake :				75ml			Total Output : M- U-3					
21/7	08:00 pm	DMS	Bred jam.	200							0	Sweet
	09:00 pm			200						0	Sweet	
	10:00 pm			200						0	Sweet	
	11:00 pm									0	Sweet	
	12:00 am									0	Sweet	
	01:00 am									0	Sweet	
Total Intake :				600			Total Output : M-0 U-3					
21/7	02:00 am	DMS	watz	200							0	Sweet
	03:00 am			200						0	Sweet	
	04:00 am			200						0	Sweet	
	05:00 am			200						0	Sweet	
	06:00 am									0	Sweet	
	07:00 am									0	Sweet	
Total Intake :				600			Total Output : M-0 U-2					
Total 24 hrs. Intake		435ml			Total 24 hrs. Output		M U-6					

FLUID CHART

Sheet No. : 22/7

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

		Intake			Output					IV Site	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	N.G						
22/7	08:00 am	I		✓						0	Mona
	09:00 am	I	Wght	✓					✓	0	
	10:00 am	No DVF	Wght	✓						0	
	11:00 am	No DVF		✓						0	
	12:00 pm	I		✓					✓	0	
	01:00 pm	I		✓						0	
Total Intake :					Total Output : U-2 W-0						
22/7	02:00 pm	I		✓						0	Mona
	03:00 pm	I	Piet	✓						0	
	04:00 pm	No DVF	Wght	✓					✓	0	
	05:00 pm	No DVF		✓						0	
	06:00 pm	I		✓						0	
	07:00 pm	I		✓					✓	0	
Total Intake :					Total Output : U-2 W-0						
	08:00 pm	I	Piet	✓						0	Sudat
	09:00 pm	I	Wght	✓					✓	0	
	10:00 pm	No DVF		✓						0	
	11:00 pm	No DVF		✓					✓	0	
	12:00 am	I		✓					✓	0	
	01:00 am	I		✓					✓	0	
Total Intake :					Total Output : N-0 U-3						
	02:00 am	I		✓						0	Sudat
	03:00 am	I		✓						0	
	04:00 am	No DVF		✓						0	
	05:00 am	No DVF		✓						0	
	06:00 am	I		✓					✓	0	
	07:00 am	I		✓						0	
Total Intake :					Total Output : N-0 U-1						
Total 24 hrs. Intake											
Total 24 hrs. Output		N-0 U-8									

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.
3. 24 hrs. total to be entered in the kardex in RED.

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

NURSING CARE RECORD



Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 20/07/26

Assessment: pt having some activity

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
1pm	*Assess the pt General condition.	2pm	*Assessed the pt General condition.	pt is stable
2:30pm	*check the pt all vitals	3pm	*checked the pt all vitals	
3:30pm	*maintain s/o chart	4pm	*maintained s/o chart	
5pm	*provide comfortable position	5:30pm	*provided comfortable position	
6pm	*administer all medication given by per doctor order	6pm	*administered all medication given by per doctor order	

Re-Assessment:

Special Notes: CUG sendd

Nurse Signature: [Signature] Nurse Name: Shanthi Date & Time: 20/07/26 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/7/26

Assessment: Patient having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8PM	* Assess The pt General condition	8:10PM	* Assessed The pt General condition	pt is stable
12AM	* Monitor vital signs	12:10AM	* Monitoring vital signs	
2AM	* Maintain fluid balance	2:10AM	* Maintained personal hygiene	
4AM	* Maintained personal hygiene	4:10AM	* Maintained fluid balance	
6AM	* Ensure safety	6:10AM	* provided side rails	
8AM	* Administer medication as per doctor order	8:10AM	* Administered medications per doctor order	

Re-Assessment: Re-Assessment was done pt is stable

Special Notes: w/ fever spikes

Nurse Signature: [Signature]

Nurse Name: Latho

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

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 21/4/26

Assessment: Baby having Good Activity.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8Am	Assess the baby general condition	8:10Am	Assessed the baby general condition	Baby vital stable.
10Am	Maintain Fluid Balance.	10:15Am	Maintained Fluid Balance.	
12pm	Ensure baby safety	12:15pm	Explained about Hand Hygiene.	
4pm	Maintain personal Hygiene.	4:20pm	Explained about Hand Hyg.	
6pm	provide comfortable position	6:30pm	provided comfortable position.	
7pm	Administer Medication as per doctor advice.	7:30pm	Administered Medication as per drug chart.	

Re-Assessment: Baby full comfortable.

Special Notes: W/P fever spike. CBC, CRP.

Nurse Signature:

Rosary

Nurse Name:

Rosary

Date & Time:

21/4/26 @ 8pm

BAH-00635029 IP5-00176635
 Baby SYEDA GOHAR FATIMA
 12-03-2022 4 Y 4 M 8 D (F)
 Dr. UJJWALA DESAI



NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 21/7/20

Assessment: Patient having weakness of dull

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 General condition	8:10pm	* Assessed The pt General condition	Patient is feel better
12AM	* Monitor vital signs	12:10AM	* Monitoring vital signs	
2AM	* Ensure safety	2:10AM	* provided side rails	
4AM	* Maintain fluid balance	4:10AM	* maintained fluid balance	
8AM	* Administer medication as per doctor order	6:10AM	* Administered medication as per doctor order	

Re-Assessment: Re-assessment was done.

Special Notes: w/p fever spikes

Nurse Signature: [Signature]

Nurse Name: Swathi

Date & Time: 22/7/20 8AM

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 22/7/26

Assessment: BABY having is dull

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the Baby General Condition.	8am	→ Assessed the Baby General Condition.	BABY vitals stable
10am	→ monitor the Baby vitals.	10am	→ monitored the Baby vitals.	
12pm	→ maintain I/O chart	12pm	→ maintain I/O chart.	
4pm	→ Administer the medication given by doctor order.	4pm	→ maintain I/O chart.	
8pm	→ provide comfortable position.	8pm	→ Administer the medication given by doctor.	

Re-Assessment: Reduce the Pain

Special Notes: at same medication.

Nurse Signature: [Signature] Nurse Name: Mounika Date & Time: 22/7/26 08pm

BAH-00635029 IP5-00176635
 Baby SYEDA GOHAR FATIMA
 12-03-2022 4 Y 4 M 10 D (F)
 Dr. UJJWALA DESAI



NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 22/7/20

Assessment: Patient having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess The baby General condition	8:10am	* Assessed The baby General condition	Patient is stable
10AM	* Monitor vital signs	12:10AM	* Monitoring vital signs	
2AM	* Ensure safety	2:10AM	* provided side rails	
4AM	* Maintain fluid balance	4:10AM	* Maintained fluid balance	
6AM	* Maintained personal hygiene	6:10AM	* Maintained personal hygiene	
8AM	* Administer medication as per doctor order.	8:10AM	* Administer medication as per doctor order.	

Re-Assessment: Re-assessment was done

Special Notes: Patient is a w/f fever

Nurse Signature: [Signature] Nurse Name: Swathi Date & Time: 23/7/20 @ 8AM



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Ujjwala Department: ER Date of Admission: 20/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known					
	<u>ARO</u>		If Yes Specify:					
BACKGROUND	Area	Shift Time	<u>ER</u> 11:45 am	<u>ER</u> 11:45 am	<u>ER</u> 11:45 am	<u>ER</u> 11:45 am	<u>ER</u> 11:45 am	<u>ER</u> 11:45 am
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>92.9°F</u>	<u>98.2°F</u>	<u>98.4°F</u>	<u>98.1°F</u>	<u>98.1°F</u>	<u>98.0°F</u>
		Res:	<u>28 bpm</u>	<u>18 bpm</u>	<u>26 bpm</u>	<u>25 bpm</u>	<u>28 bpm</u>	<u>27 bpm</u>
		SpO ₂ :	<u>99%</u>	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>	<u>99%</u>
		Pulse:	<u>111 bpm</u>	<u>110 bpm</u>	<u>101 bpm</u>	<u>102 bpm</u>	<u>106 bpm</u>	<u>102 bpm</u>
		BP:	<u>99/56</u>	<u>100/60</u>	<u>106/71</u>	<u>107/72</u>	<u>101/62</u>	<u>102/61</u>
	Fall Risk Score:	<u>7</u>	<u>7</u>	<u>7</u>	<u>7</u>	<u>7</u>	<u>7</u>	
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>		
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>
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>Pooja</u>	<u>Shanthi</u>	<u>Priyanka</u>	<u>Swathi</u>	<u>Rosmary</u>	<u>Swathi</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>20/7/26</u>	<u>20/7/26</u>	<u>20/7</u>	<u>21/7/26</u>	<u>21/7/26</u>	<u>21/7/26</u>	
Time:		<u>11:45 am</u>	<u>8 AM</u>	<u>9 AM</u>	<u>8 AM</u>	<u>8 AM</u>	<u>8 AM</u>	
Taken Over By Name :		<u>Shanthi</u>	<u>Priyanka</u>	<u>Swathi</u>	<u>Rosmary</u>	<u>Swathi</u>	<u>Manika</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>20/7/26</u>	<u>20/7</u>	<u>20/7/26</u>	<u>21/7/26</u>	<u>21/7/26</u>	<u>22/7/26</u>	
Time:		<u>11:45 am</u>	<u>8 AM</u>	<u>9 AM</u>	<u>8:15 am</u>	<u>8 PM</u>	<u>8 AM</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Ujjwala Desai Department: H01 Date of Admission: 20/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify: <u>NA</u>			
	Area	Shift Time				
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>H01</u> <u>8am-8pm</u> <u>NA</u>	<u>H01</u> <u>8pm-8am</u> <u>NA</u>		
ASSESSMENT	Allergy:		☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:	<u>98.6°F</u>	<u>98.4°F</u>		
		Res:	<u>26b/m</u>	<u>27b</u>		
		SpO ₂ :	<u>100%</u>	<u>98%</u>		
		Pulse:	<u>126b/m</u>	<u>120b</u>		
		BP:	<u>104/60</u>	<u>102/64</u>		
		Fall Risk Score:	<u>7</u>	<u>7</u>		
Pain Score:		<u>0/10</u>	<u>0/10</u>			
Recommendations	Safety Needs:		<u>yes</u>	<u>yes</u>		
	Physiotherapy		☐ 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
	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>Mounib</u>	<u>Beatty</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>22/7/26</u>	<u>22/7/26</u>			
Time:		<u>28pm</u>	<u>28am</u>			
Taken Over By Name :		<u>Beatty</u>	<u>Rosmar</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>22/7/26</u>	<u>23/7/26</u>			
Time:		<u>07pm</u>	<u>08:00am</u>			



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/7/26	11:15 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Pooja
20/7	7 PM	0/10	PA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Swab
21/7	3 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Swab
21/7/26	11 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Rosy
21/7/26	7 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Rosy
22/7/26	3 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Swab
22/7/26	11 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	mountain
22/7/26	7 PM	0/10	PA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	mountain
23/7	3 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Swab
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

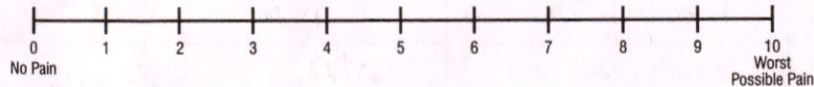
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 min after pain relief intervention.

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

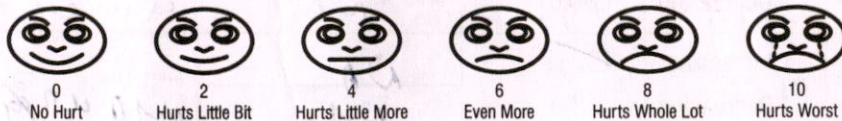
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



BAH-00635029 IP5-00176635
 Baby SYEDA GOHAR FATIMA
 12-03-2022 4 Y 4 M 8 D (F)
 Dr. UJJWALA DESAI



BRADEN 'Q' SCALE

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

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

					Date :	20/03/2022	22/03/2022	23/03/2022
					Time :	11:30 AM	2:30 PM	6:30 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e. extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of 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 F 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	28
Docu. No. : RCHB/FRM / CLINICAL / 119					Evaluator's Name	poorja	Subh	Subh

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



CHECKLIST FOR THROMBOPHLEBITIS

20/7 21/7 22/7

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	—	—	—	—	—	—	—	—	—	
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				[Signatures]									

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 : [Signature] Name : Prigme

Signature of Ward In Charge :

Signature : [Signature] Name : Poraj Dew

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0									
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	—									
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				Rosny									

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 : Nasim Name : Nasim

Signature of Ward In Charge :

Signature : _____ Name : _____

BAH-00635029
Baby SYEDA GOHAR FATIMA
12-03-2022 4 Y 4 M 8 D (F)
Dr. UJJWALA DESAI



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

20/7 21/7 22/7 23/7

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	
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	
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			10	10	10	10	

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		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		no	no	no	no	
Other Intervention(s) Specify		no	no	no	no	
Nurse's Name :		Pooja	Shub	Shub	Shub	
Signature :		R	Q	Q	Q	
Date :		20/7	21/7	22/7	23/7	
Time :		11:15 AM	8A	6A	6AM	

BAH-00635029
Baby SYEDA GOHAR FATIMA
12-03-2022 4 Y 4 M 8 D
Dr. UJJWALA DESAI (F)

Rainbow
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It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: as per doctor order

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

explain to mother

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: hand hygiene

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

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: Shanthi

Nurse Name: Shanthi

Date and Time: 11:45 AM

Docu. No. : RCHBH / FRM / CLINICAL / 191

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 20/7/26 Time: 12 PM

Weight: 13.8 kgs Centile: >5th

Height: 103 cms Centile: 50th

Inference: underweight child

RDA: — Calories: 1350 kcal/day Protein: 23 g/day

Diet Recommendations: soft diet

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

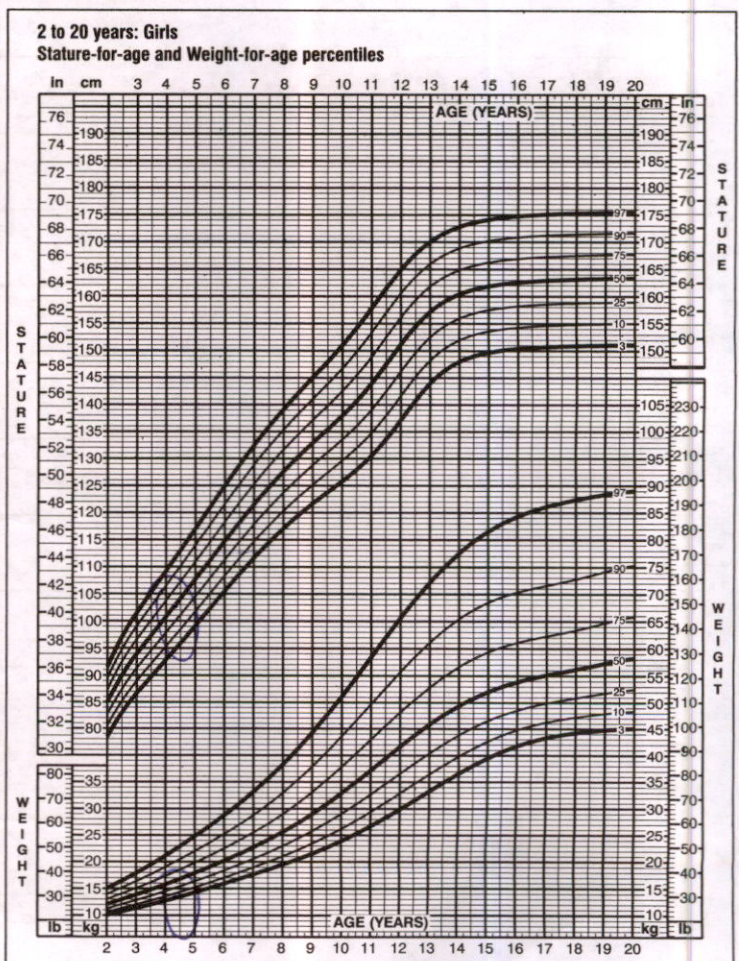
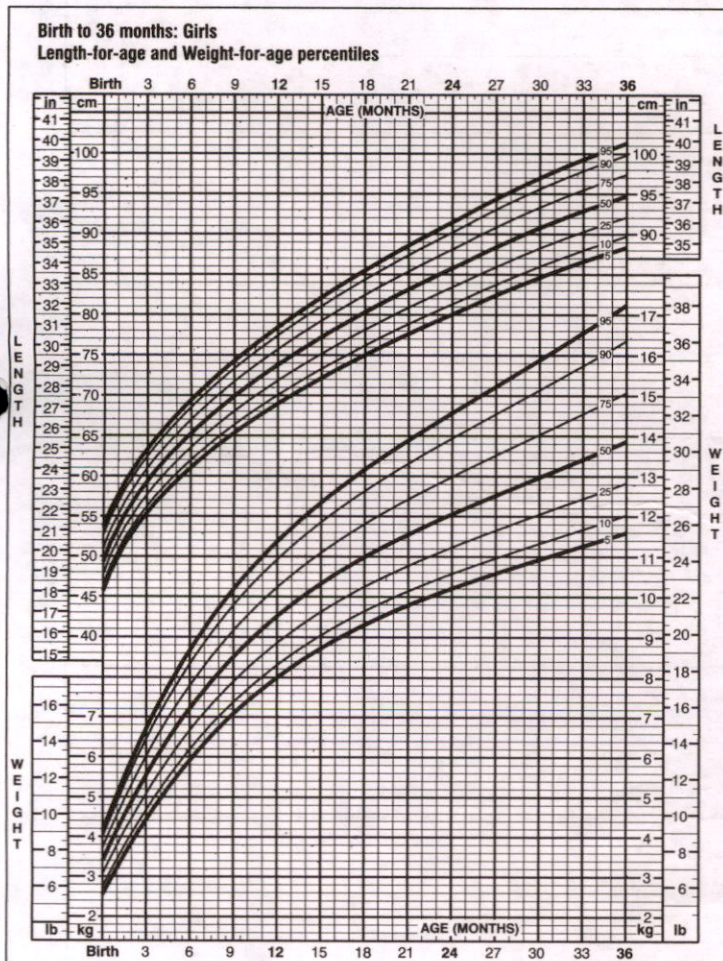
Food Allergies: No Veg/Non-veg Non-veg

Diagnosis: AFI

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (GIRLS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha

Daily Notes:

21/7/22 8am child is stable. Intake is fair
Continue on soft diet Nisha

22/7/26
9am

Child is stable. Intake is poor
continue c soft diet

Nickells

23/9/26 9:30am	Child is stable. Intake is good. Continue soft diet	Mojica
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