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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00175968 **Admit Date** : 04-Jul-2026 **Admit Time** : 01:10 PM **UHID** : BAH-00660682

Patient Details :

Patient Name	: Baby RAASHI SRIVASTAVA	**Age**	: 6 Y 11 M 6 D
Guardian	: Mr SUVEER SRIVASTAVA	**DOB**	: 28-07-2019
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: VILLA NO 48, PRANAV PRANEETH VALLEY Bachupally Hyderabad Telangana INDIA 500090	**Phone No**	: 9819806636/ 6393107328
		E-mail	: RUCHI291114@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 SUVEER SRIVASTAVA **Relationship** : Father

Contact Address : VILLA NO 48, PRANAV PRANEETH VALLEY Bachupally Hyderabad Telangana INDIA 500090 **Phone No** : 9819806636

Signature

Doctor Details :

Doctor Name : Dr. KAPIL BHAGWATRAO SACHANE **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD

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ACTIVITY RECORD FOR BILLING

Name :_____

BAH-00660682 IP5-00175968
Baby RAASHI SRIVASTAVA
28-07-2019 6 Y 11 M 6 D (F)
Dr. KAPIL BHAGWATRAO SACHANE

UHID No. : _____ nsultant: _____ Dept : _____

Date of Admission: ____ te of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
04/07/26	1:40 pm	ER	ward	
4/7/26	7pm	101	237	Neelima

Cross Consultation Visit

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

DIC

INVESTIGATIONS

Date	Investigations	Order No.	Signature
4/7/26	Blood c/s, CRP, Widal, Dengue NS,	7034	Charan
4/7/26	urine c/s	26421	Meelin
6/7/2	CBP, CRP	26067U17	Swathi
	D/C		

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
4/7	Infusion pump	2pm		93641	Merlin

DC

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
4/7/26	IV placement	(1)	7395	Charan
4/7	NHA	1	9604	Meeli

D/C

ANY OTHER INFORMATION

Nil

Date : 06/7/26 Time : @9AM Prepared By : —

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

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: RAASHI SRIVASTAVA

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Baby RAASHI SRIVASTAVA
28-07-2019 6 Y 11 M 6 D (F)
Dr. KAPIL BHAGWATRAO SACHANE

UHID ID:

Department:

Consultant:

BAH-00660682 IP5-00175968
Baby RAASHI SRIVASTAVA
28-07-2019 6 Y 11 M 6 D (F)
Dr. KAPIL BHAGWATRAO SACHANE

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Fever :- 4days
Decreased oral intake / 3days
Reduced urine output x 1day

History of present illness :

C/O fever x 4 day
↓
- Moderate - high grade
- 3 - 4 spikes / day
- Partially responding to antipyretics

Associated with poor oral intake, Decreased oral intake & excessive crying

No H/O cough, cold, vomitting, loose stools etc.

BAH-00660682 IP5-00175968
Baby RAASHI SRIVASTAVA
28-07-2019 6 Y 11 M 6 D (F)
Dr. KAPIL BHAGWATRAO SACHANE

Pediatric Multiorgan History & Physical Examination

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

Not significant.

Birth & Neonatal History:

Not significant.

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History :

Normal for age

Immunization History :

Immunized for age.

(P.T.O.)

BAH-00660682 IP5-00175968
Baby RAASHI SRIVASTAVA
28-07-2019 6 Y 11 M 6 D (F)
Dr. KAPIL BHAGWATRAO SACHANE

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs))__24.83__(Centile _____)

On Examination :

Temperature : 98.3°F Pulse Rate :106/min B.P. 91/47 (56) SPO2 98-1CR/A

Resp.rate and type of breathing : 22/min.

Rash —

Lymphadenopathy —

Oedema :

Allergies (if any):

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds : B/L AE(+)

Any addes sounds :

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1S2(+)

Any murmur :

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

Per Abdomen :

Inspection

Palpation :

Ausculation : Soft

Spine : External Genitelia :

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

BAH-00660682 IP5-00175968
Baby RAASHI SRIVASTAVA
28-07-2019 6 Y 11 M 6 D (F)
Dr. KAPIL BHAGWATRAO SACHANE

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Alert

Cranial Nerves : WNL

Motor System:

Nutriton : WNL

Tone: WNL Power WNL

Co-ordinator : WNL

Posture : WNL

Involuntary Movements : WNL

Reflexes :

DTR WNL **Superficials:** WNL

Plantars

Sensory System : WNL

Bladder / Bowel : WNL

Clinical Summary & Diagnostic: Dengue / Typhoid c mild dehydration

(P.T.O.)

BAH-00660682 IP5-00175968
Baby RAASHI SRIVASTAVA
28-07-2019 6 Y 11 M 6 D (F)
Dr. KAPIL BHAGWATRAO SACHANE

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Infection

Desired goals of the treatment : Resolution of Symptoms.

Planned Labs:

Blood cs
Urine cs.
~~[illegible]~~
CRP
Dengue NS-1
widal (tube test)

FBS, HbA1c, Lipid profile, LFT, Creat, BUN, Uric acid, TFT
CBP, ESR, CUE, Dengue IgM IgG
MP
→ Done at tenet today.

Planned Management

- Admission in ward
- IV Fluids
- inj. ceftriaxone
- inj. Pantop
- BP, spo2 monitoring.
- Trace Tenet lab reports

DR. KAPIL BHAGWATH RAO SACHANE
Registration No.: 2002/03/1356

Signature of the Doctor: .....
Name of the Doctor: N Sreelatha
Date & Time: 4/7/19, 2 PM.

Signature of the Consultant: .....
Name of the Consultant: .....
Date & Time: .....

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26 5pm	c/s/c	PICU Resident-
	Δ: Acute febrile illness	Plan
	Fever × 4 day	① Cont antibiotics.
	decreased urine output ×1 day	② Cont iv fluids
	Poor oral intake × 3days.	③ Encourage oral intake.
		④ Trend outputs
	No fever spike since admission.	⑤ Trend dengue.
	Hemodynamically stable on room air.	⑥ Trend LFTs.
	Chest: BIL clear	⑦ Monitor urine output.
	CVS: S1S2 (+)	Sd/-
	PA: Soft, NT.	
	CNS: GCS 15/15.	
	Pupil: 2+ 2+.	

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Baby RAASHI SRIVASTAVA
28-07-2019 6 Y 11 M 6 D (F)
Dr. KAPIL BHAGWATRAO SACHANE

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/2/26. 8 AM	C/S/B PICU fellow.	
	D/S:- Acute febrile illness	
	On room Air	plan.
	hemodynamically stable	1. w/f fever spikes.
	No fever spikes.	
	Chest - clear.	2. monitor vitals.
	CRP - 39.	3. encourage oral intake
	Dengue IgM, IgG } negative.	4. Trace widal, blood & urine culture reports.
	Thyroid - (N)	
	HbA1c - 5.7.	
		[signature] Dr Mathew
	Inj ceftriaxone - D2	

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Baby RAASHI SRIVASTAVA
28-07-2019 6 Y 11 M 6 D (F)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/26 12:40pm	C/S/B Dr kapil	
	Dx/s:- Acute febrile illness.	plan:
		1. Trace widal
	on room Adm	blood & urine culture
	hemodynamically stable	2. CBP, CRP — T/m.
	No fever spikes.	3. w/f feverspikes
	Chest-clear.	4. Monitor vitals.
		M Dr Mathew.
5/7/26 3pm.	C/S/B Resident	
	Dx/s:- Acute Febrile Illness (D5)	Plan
	No further fever spikes.	1) CBP, CRP — T/m 6 am
	child on roomair	
	Resp, P/A, CVS — (W)	2) Trace Blood c/s, Urine c/s
	Vitals-Stable.	3) w/f fever spikes
	Accepting — Orally.	4) Monitor Vitals.
		Dr-Jayalm.
	widal — Negative	Dr Mathew.

\H-00660682 IP5-00175968
by RAASHI SRIVASTAVA
-07-2019 6 Y 11 M 7 D (F)
KAPIL BHAGWATRAO SACHANE

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
06/07/26 8:00am	S/B Pun-fellow	
	Δ: AFI Evaluation	
	i) No fever	PLAN
	i) Oral intake improved	i) Trace Blood C/S
		urine C/S
	On P/A	
	No tachycardia	2) W/F fever
	Stable hemodynamically	3) Encourage orally,
	CRP ↓ing	4) Continue ceftriaxone
		[signature]
06/07/26	S/B Dr Kapil	
	Δ Acute febrile illness	Adv
	Viral pyrexia	(1)
	Afebrile	- Cefuroxime [illegible]
	alert active	
	Improved oral intake	- [illegible]
	hemodynamically stable	
	Chest BLAE equal	
	NVBS	DR. KAPIL BHAGWATH RAO SACHANE
	P/A Soft BS+	Registration No: 2002/03/1356
	CNS: Alert active	[signature]

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

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Baby RAASHI SRIVASTAVA
28-07-2019 6 Y 11 M 6 D (F)
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RESULT SHEET

(Outside)

Date	04/07/26	04/07/26.	6/7/26			
Time		2:00pm.	6:26Am			
Hb	13.4		12.0			
PCV	39.7		39.0			
RBC	4.96		4.61			
WBC	6920.		6250			
N/L	45/45		31/63			
Platelets	289K		327K			
CRP		39.0	18.0			
ESR	33					
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea	15.4					
Creatinine	0.5					
ALP	143					
SGPT	11					
SGOT	28					
T.Bill/Conj	0.16/0.09					
T.Protein	7.4					
S.Albumin	4.4					
S.Globulin	3					
A/G Ratio	1.47					
Uric Acid	3.2					
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells	2-3					
CUE - RBC Cells	No.					
CUE						
Epi	1-2					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
NS-1	Negative					
Dengue IgM	Negative					
IgG	Negative					
widal — negative.						
~~Dengue~~						

Culture and Sensitivities : HbA1c — 5.7.

HDL — 36.

V.L.D.L — 17.6.

LDL — 87.6.

Triglycerides — 88.

Total cholesterol — 141.

Radiology : USG :

X-Ray :

ECHO :

CT : T3 — 1.24 (0.94—2.41)

MRI T4 — 8.3 (6.4—13.3)

Others (ECG, Contrast Studies etc.,) : TSH — 3.75 (0.7—6.4)

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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
						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : N. Prakash, M.D.

Date & Time : 04/7/26, 12:30 pm

Nurse Name & Signature: pooja

Date & Time : 4/7/26 @ 1P'm

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Baby RAASHI SRIVASTAVA
28-07-2019 6 Y 11 M 6 D (F)
Dr. KAPIL BHAGWATRAO SACHANE

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DRUG CHART

Date of Admission: 4/7/26 Drug Allergies: ..... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line I through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG : Syp-CROCIN DS

Dose	Route	Frequency	Start Date
8ml	PO	SOS	4/7

Doctor's Signature	Valid Period	Pharm.
N. Rms	48H	

Additional Instructions: (5ml/240 mg) If Temp 299.9°F max. 6th hourly

Date / Time

DRUG : Syp

Dose	Route	Frequency	Start Date

Doctor's Signature	Valid Period	Pharm.

Additional Instructions:

Date / Time

DRUG : Inj. PARACETAMOL

Dose	Route	Frequency	Start Date
400mg	IV	SOS	4/7

Doctor's Signature	Valid Period	Pharm.
N. Rms	48H	

Additional Instructions: If Temp ≥ 101°F (max 6th hourly)

Date / Time

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

Baby RAASHI SRIVASTAVA
28-07-2019 8 Y 11 M 6 D (F)
Dr. KAPIL BHAGWATRAO SACHANE

REGULAR PRESCRIPTIONS

Weight. 26.63 Kg Ward. ....

DRUG: Inj. CEFTRIAXONE				Date/Time	4/7	5/7	6/7
Dose	Route	Frequency	Start Date				
1300mg	IV	12H	04/7	6am	X	[illegible]	[illegible]
Name & Signature of the Doctor Starting the Drugs: N. Prakash							
Additional Instructions: 100mg/kg/day				6pm	4pm	[illegible]	
Daily Doctor's Endorsement by a Sign					[illegible]	[illegible]	[illegible]

DRUG: Inj. PANTOPRAZOLE				Date/Time	4/7	5/7	6/7
Dose	Route	Frequency	Start Date				
30mg	IV	24H	4/7				
Name & Signature of the Doctor Starting the Drugs: N. Prakash				6am	4pm	[illegible]	[illegible]
Additional Instructions:							
Daily Doctor's Endorsement by a Sign					[illegible]	[illegible]	[illegible]

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

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

Patient Sticker

Weight. 26-63kg Ward. .....

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

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

Signature .....

VERIFIED BY .....me

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

28-07-2019 8 Y 11 M 6 D (F)
Dr. KAPIL BHAGWATRAO SACHANE

I.V. FLUIDS CHART

Weight: 26.63 kg Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
04/7/19	8.30 2pm	DNS	IV	30			5/7		

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

BAH-00660682 IP5-00175968
Baby RAASHI SRIVASTAVA
28-07-2019 5 Y 11 M 6 D (F)
Dr. KAPIL BHAGWATRAO SACHANE

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I.

Patient's / Learner Language: Hindi Patient / Learner Literacy: ☒ Read ☐ Write ☐ Speak Willingness to Learn: ☒ Yes ☐ No Healthcare Literacy: ☒ Yes ☐ No

Identified Education Needs:

1. Diagnosis
2. Treatment and Care Plan
3. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights
13. Risk / Safety
14. Activity / Exercise
15. Social & Rehabilitation Needs
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		
04/07/16	1-25PM	7	Infection control measures	M	4	O	1	1	—	Renuka
4/7/16	2PM	9	Normal diet	M	1	O	1	1	—	monica

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
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify .....

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

Mechanism/s to overcome barrier/s:

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

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

SAH-00660662 IPS-00175968
Baby RAASHI SRIVASTAVA
28-07-2019 6 Y 11 M 6 D (F)
Dr. KAPIL BHAGWATRAO SACHANE

MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis: APD

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
4/9/26 1 pm	☑ Medical ☐ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	APD	hemodynamic stability	IV fluids		☑ Nursing ☐ Others:
4/7/26 1pm	☐ Medical ☑ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fever	Ht- stability	IV fluids		☑ Medical ☐ Others:
4/9/26 2pm	☐ Medical ☐ Nursing ☑ Others: Dietitian	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Dengue/Typhoid c mild dehydration	Normal diet	RDA:- E:-1450kcal/d P:-25g/d	monica	☐ 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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Baby RAASHI SRIVASTAVA
28-07-2019 6 Y 11 M 6 D (F)
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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Baby. Rashi Srivastava. Age : 6y 11M. Gender: ☐ Male ☑ Female

Date : 4/7/26 Time of Arrival : 12:40 Pm Triage Completion Time : 12:42pm

Allergies: ☐ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify) : Nil ☐ Not known any drug Allergies

Source of Information : ☑ Parents ☐ Others (Specify) .....

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance: ☐ Normal ☐ Sick Looking

Work of Breathing: ☐ Normal ☐ Decreased ☐ Increased ☐ Gasping / Apnea

Circulation / Colour: ☐ Normal ☐ Abnormal ☐ Bleeding

INITIAL PHYSIOLOGICAL STATUS

☑ Stable

☐ Unstable :
- ☐ Not – Life - Threatening
- ☐ Life – Threatening

Initial Vital Signs: Temp: 98.3°F PR: 106 b/m BP: 91/47(56) RR: 22 b/m SpO2: 97% RA.

Chief Complaints: Fever x4 days, Poor oral Intake x 3 days.

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:

1. Have you had fever (elevated temperature) in the past 2 weeks ☑ Yes ☐ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☑ No
3. 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

1. 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: .....
2. 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

Name of Triage Nurse : NR Subnur

Date & Time : 4/7/26 at 12:42pm

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

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 E
d Cough

☐ Any patient with fever and respiratory symptoms who answ
YES" to any of the questions on epidemiologic risk factors
"PART B" of the triage screening above.

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

Patients should be immediately isolated in a negative press
room or a single room (as appropriate) for pending evaluati

The patient should be given a surgical mask immediately, if n
already waring one.

Both patient and triage staff should perform hand hygiene.

The staff should use PPE (as appropriate).

Signature of Triage Nurse :

RISK FO
☐ If pa
tick b
☐ If Patie
Assess
History of Falli
Ambulatory Aid
• Wheelchair
• Uses furniture
Gait/Transferring:
• Bedrest / immo
• Weak
• Impaired
Mental Status: Forget
IF YES FOR ANY CATE
Fall Risk Intervention:
☐ Escort while ambul
☐ Assist Patient
☐ Educate patient and f
Psychological Screening:
nusual concerns about patien
Yes Consultant Notified: .....
cial History: Lives With .....
lings in household ☐ Yes
tural & Spiritual Needs: ☐ Yes
ime of Initial assessment comp
Pain
Docu. No. : RCHBH /FRM / CLINICAL / 120

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

Time	Nursing Notes
12:45 pm	- Assess the child condition
	- monitored vitals & recorded
	- seen Dr. prathiba
	- shifted to ward
[illegible]	tab. paracetamol 500

Time: 1 pm

Time:

Samples collected by: NR. karthik

Samples sent by :

Medication given in ER:

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

Condition of patient at time of shift - out :

HR: 106 bpm BP: 91/47 CFT: <3 sec

RR: 24 bpm SPO$_2$: 97%

GCS: 4/5/6 Temperature : 98.3 F

Pain Score: 0

Repeat RBS (if applicable): NA

Details of Shift - out

Shift - out from ER to: ward

Time of Shift - out: 1:40 pm

Handover given to: (Nurse's Name) Merlin.

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV placement done

Name of the Nurse : pooja

Signature of the Nurse :

Date & Time : 4/2/26 @ 1 pm

IAH-00660682 IP5-00175968
Baby RAASHI SRIVASTAVA
28-07-2019 6 Y 11 M 6 D (F)
Dr. KAPIL BHAGWATRAO SACHANE

CH/ FRM / CLINICAL / 125

5/7

PRESCHOOL (~~1-5~~ 5-12 years)

Children's Observation & Early Warning Scoring Chart

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : .... Time:	10AM	2PM	6PM	10pm	2AM	6AM
Doctor / Nurse / Family Concern?						
Temperature (°F) (104–94)	98.7°F	98.8°F	97.7°F	98.2°F	98.1°F	98.4°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (190–50)	102/60 (80)	104/63 (85)	100/58 (80)	90/49 (69)	92/52 (65)	99/57 (71)
Heart Rate (Number)	126 b/m	123 b/m	126 b/m	95	95	100
Resp. Rate (bpm) (Over 1 Minute) * (70–10)						
Resp Rate (Number)	23 b/m	26 b/m	23 b/m	23	24	26
Resp Distress: Mod/ Severe						
Resp Distress: None / Mild						
Receiving O_2(l/min)						
O_2Saturations (%)	99%	100%	99%	99%	99%	98%
Conscious Level: Normal				C	C	C
Conscious Level: 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	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Note: BP does not score in early warning scoring

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00660682 IP5-00175968
Baby RAASHI SRIVASTAVA
28-07-2019 6 Y 11 M 6 D (F)
Dr. KAPIL BHAGWATRAO SACHANE

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

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

Rainbow® Children's Hospital
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 4/7 Time:	3pm	6.30pm	10pm	2AM	6AM
Doctor / Nurse / Family Concern?					
Temperature (F)	98F	99.1F	99.0F	98.2F	98.0F
Heart Rate (bpm) and Blood Pressure (mmHg) *	96/78	86/57	96/(70)	101/60	96/(75)
Note: BP does not score in early warning scoring	78	51	52	52	53
Heart Rate (Number)	110bpm	120bpm	110	108	110
Resp. Rate (bpm) (Over 1 Minute) *					
Resp Rate (Number)	24bpm	26bpm	22	20	20
Resp Distress: Mod/ Severe / None / Mild					
Receiving O_2(l/min) O_2Saturations (%)	98%	99%	99%	99%	98%
Conscious Level: Normal / Altered			C	C	C
GCS *	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0
Pain Score	0	0	0	0	0
Observer's Initials	M	M			

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

Patient Sticker

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Date	Time	Early Warning Score	Date	Time	Name

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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 I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

BAH-00660682 IP5-00175968
Baby RAASHI SRIVASTAVA
28-07-2019 6 Y 11 M 6 D (F)
Dr. KAPIL BHAGWATRAO SACHANE

Patient Sticker

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FLUID CHART

Sheet No. : 1

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

Date	Time	Intake: Nature of Fluid	Intake: Route: Mouth	Intake: Route: I.V	Intake: Route: N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: 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 :**						
1/7	02:00 pm		water	30ml							0	
	03:00 pm			30ml							0	
	04:00 pm	DNS		-							0	
	05:00 pm			30ml							0	
	06:00 pm			30ml						200ml	0	
	07:00 pm			-							0	
Total Intake :				120ml		**Total Output :**						
	08:00 pm			30ml							0	
	09:00 pm			30ml						100ml	0	
	10:00 pm			-							0	
	11:00 pm	DNS		30ml			PP				0	
	12:00 am			30						200ml	0	
	01:00 am			30ml							0	
Total Intake :				160ml		**Total Output :**						H-0 U-32
	02:00 am			30ml							0	
	03:00 am			30ml			PP				0	
	04:00 am	DNS		30ml							0	
	05:00 am			30ml							0	
	06:00 am			30ml							0	
	07:00 am			30ml						90ml	0	
Total Intake :				100ml		**Total Output :**						H-0 U-190

Total 24 hrs. Intake	420ml	Total 24 hrs. Output	H-0 U-471ml.

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FLUID CHART

5/7

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BirthRight BY RAINBOW HOSPITALS
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Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
5/7	08:00 am			—							0	
	09:00 am		Ichyt	—						100ml	0	
	10:00 am		Hue.	30ml			✓				0	
	11:00 am	DNS		30ml							0	
	12:00 pm			30ml							0	
	01:00 pm			30ml						100ml		
Total Intake :				120ml		Total Output :						
	02:00 pm			—							0	
	03:00 pm		Rice + Hue	—							0	
5/7	04:00 pm			—			✓			✓	0	
	05:00 pm	NO IVF		—							0	
	06:00 pm			—							0	
	07:00 pm			—						✓	0	
Total Intake :						Total Output :						
	08:00 pm		Rice	—							0	
	09:00 pm		water	—						✓	0	
6/7	10:00 pm	NO IVF		—			✓				0	
	11:00 pm			—							0	
	12:00 am			—						✓	0	
	01:00 am			—							0	
Total Intake :						Total Output :						
	02:00 am			—							0	
	03:00 am	NO	water	—						✓	0	
6/7	04:00 am	IVF		—							0	
	05:00 am			—			✓				0	
	06:00 am			—						✓	0	
	07:00 am			✓							0	
Total Intake :		Good				Total Output :						

Total 24 hrs. Intake	Good	Total 24 hrs. Output	11-20-8

BAH-00650682 IP5-00175968
Baby RAASHI SRIVASTAVA
28-07-2019 6 Y 11 M 6 D (F)
Dr. KAPIL BHAGWATRAO SACHANE

NURSING CARE RECORD

Rainbow® Children's Hospital — It takes a lot to treat the little.
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Shift: ☐ Morning ☑ Afternoon ☐ Night

Date: 4/7/26

Assessment: Baby having poor oral intake

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
4pm	Assess the general condition of the baby.	4pm	Assessed the general condition of the baby.	pt condition is normal.
	Monitor vital signs		Monitored vital signs	
6pm	Continue iv fluids	6.10pm	Continued iv fluids	
	Send urine cls		Sended urine cls	
7pm	Administer medication as per doctor order.	7.10pm	Administered medication as per doctor order.	
8pm	Encourage to take orally.	8pm	Encouraged to take orally	

Re-Assessment: Nil

Special Notes: Nil

Nurse Signature: Merlin Nurse Name: Merlin Date & Time: 4/7/26 @ 8pm

Docu. No: RCHBH /FRM / CLINICAL / 148

BAH-00660682 IP5-00175968
Baby RAASHI SRIVASTAVA
28-07-2019 6 Y 11 M 6 D (F)
Dr. KAPIL BHAGWATRAO SACHANE

NURSING CARE RECORD

Rainbow® Children's Hospital
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Shift: ☐ Morning ☐ Afternoon ☑ Night

Date: 4/7/26

Assessment: Patient having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	× Assess the baby General condition	8:10pm	× Assessed the baby General condition	Patient is comfortable
12AM	× Monitor vital sign	12:10AM	× Monitoring vital sign	
2AM	× Maintain fluid balance	2:10AM	× Maintained fluid balance	
4AM	× Maintain personal hygiene	4:10AM	× Maintained personal hygiene	
6AM	× Maintain I/O chart	6:10AM	× Maintained I/O charting	
8AM	× Administer medication as per doctor order	8:10A	× Administered medication as per doctor order	

Re-Assessment: Re-Assessment was done

Special Notes: w/r fever spikes

Nurse Signature: Nurse Name: Swati Date & Time: 5/7/26 @ 8AM

BAH-00660682 IP5-00175968
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28-07-2019 6 Y 11 M 6 D (F)
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NURSING CARE RECORD

Shift: ☑ Morning ☑ Afternoon ☐ Night   Date: 5/7/26

Assessment: BABY having is pain

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 BABY general condition.	8Am	→ Assessed the BABY general condition.	→ Patient vital stable
10Am	→ monitor the BABY vitals	10Am	→ monitored the BABY vitals	
12Pm	→ maintain I/O chart	12Pm	→ maintain hand hygiene	
4Pm	→ provid comfortable position	4Pm	→ Provideded Comfortable position	
8Pm	→ Administer the medication given by doctor order	8Pm	→ Administer the medication, given by doctor order,	

Re-Assessment: Reduce the pain.

Special Notes: c/ same medication
CBP, CRP. T/M 6Am

Nurse Signature: [signature]   Nurse Name: Mounika   Date & Time: 5/7/26 @ 8Pm

H-00660682 IP5-00175968
By RAASHI SRIVASTAVA
07-2019 6 Y 11 M 7 D (F)
KAPIL BHAGWATRAO SACHANE

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NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☑ Night Date: 5/7/2026

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	All plans are Implemented
12AM	* Monitor the vital signs	12:10AM	* Monitoring the vital signs	
4AM	* Ensure safety	4:10AM	* provided side rails	
6AM	* Maintain personal Hygiene	6:10AM	* Maintained personal Hygiene	
8AM	* Administer medication as per doctor orders	8:10AM	* Administer medication as per doctor orders	

Re-Assessment: Re-Assessment was done

Special Notes: W/F fever spikes

Nurse Signature: [signature] Nurse Name: Swati Date & Time: 5/7/26 @

Docu. No: RCHBH /FRM / CLINICAL / 148

Patient Sticker

BAH-00660682 IP5-00175968
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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Kapil Department: ward Date of Admission: 04/07/26

SITUATION	Diagnosis: AFI			Any Infection: ☐ Yes ☐ No ☑ Not Known			
				If Yes Specify:			
BACKGROUND	Area / Shift Time	ER 1:40 pm	1st floor 2pm-8pm	HDU 8pm-8AM	HDU 8AM-8pm	HDU 8pm-8AM	
	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	NA	
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.3°F	98.1°F	98.4F	98.7F	98.4F	
	Res:	24bpm	26b/m	23b/m	26b/m	27b/m	
	SpO_2:	100%	100%	99%	100%	99%	
	Pulse:	106bpm	112b/m	110b/m	113b/m	114b/m	
	BP:	91/47	98/62	92/58	90/60	96/50	
	Fall Risk Score:	0/10	10	10	10	10	
	Pain Score:	0/10	0/10	0/10	0/10	0/10	
Recommendations	Safety Needs:	Side rails	Side rails	side rails	side rails	side rails	
	Physiotherapy	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
	Others Specify:	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	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	
Handed Over By Name :		Renuka	Merlin	Swathi	Mounika	Swathi	
Signature :		[signature]	[signature]	[signature]	[signature]	[signature]	
Date:		04/07/26	4/7	5/7/26	5/7/26	6/7/26	
Time:		1:45 pm	@ 8pm	@ 8AM	@ 8pm	@ 8AM	
Taken Over By Name :		Merlin	Swathi	Mounika	Swathi	Haritha	
Signature :		Merlin	[signature]	[signature]	[signature]	[signature]	
Date:		4/7/26	4/07	5/7/26	5/7/26	06/7/26	
Time:		@ 2pm	@ 8pm	@ 8AM	8pm	@ 8AM	

Docu. No. : RCHBH /FRM / CLINICAL / 097

BAH-00660682 IP5-00175968
Baby RAASHI SRIVASTAVA
28-07-2019 6 Y 11 M 6 D (F)
Dr. KAPIL BHAGWATRAO SACHANE

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

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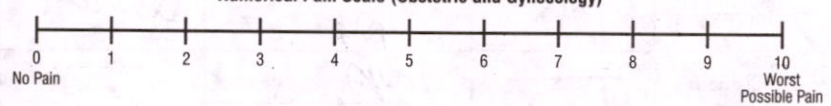
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
04/07/26	1:25pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	Renuka
4/7	9pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA NA	Swati
5/7	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA NA	Swathi
5/7	4PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA NA	Mouni
6/7	12AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA NA	Swathi
6/7	8AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA NA	Swathi
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

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

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, SaO_2	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

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BRADEN 'Q' SCALE

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					Date : 04/09/19	5/7	6/7	
					Time : 1:25PM	6PM	6PM	
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	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	
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	
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	
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	
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	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	
				TOTAL SCORE	28	28	28	
				Evaluator's Name	Renuka	Sini	Nirmal	

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

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

Patient Sticker

BAH-00650682 IP5-00175968
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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 4/7	DATE 5/7	DATE 6/7	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	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		
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		
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1		
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2		
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1		
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		
	TOTAL		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		
	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	No	No		
	Other Intervention(s) Specify		Yes	No	No		
	Nurse's Name :		Ronita				
	Signature :						
	Date :		4/7/19	5/7	6/7		
	Time :		1:22Pm		6Am		

Docu. No. RCHBH / FRM / CLINICAL / 005

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
BAH-00660682 IP5-00175968 Baby RAASHI SRIVASTAVA 28-07-2019 5 Y 11 M 6 D (F) Dr. KAPIL BHAGWATRAO SACHANE	4/07/2026 @ 1.10pm	4/7/26 @
	Transfer Ordered by Dr. K.B.S	Reason for Transfer Shifting
From Unit 101	To Unit 237	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 ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	DNS	1
2.	Intrafix	1
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Merlin	DR Kapil

Patient & Clinical Records Received by : Hanlay

Date & Time of Patient Received : 4/7/26 @ 7:30 pm

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

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

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
BAH-00660682 IP5-00175968 Baby RAASHI SRIVASTAVA 28-07-2019 6 Y 11 M 6 D (F) Dr. KAPIL BHAGWATRAO SACHANE	04/7/26 & 1:10PM	4/7/26 & 1:40 pm
	Transfer Ordered by Dr-prathibha	Reason for Transfer Admission.
From Unit ER	To Unit ward.	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 20	Number of Imaging Films No.	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☐ If yes, what ? file

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.	Nill	
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
NR-Renuka	Dr-prathibha.

Patient & Clinical Records Received by : Merlin.

Date & Time of Patient Received : 4/7/26 @ 2pm

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

101 → 237

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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 4/7/26 Time: 2 PM

Weight: 26.6 kgs Centile: >75th

Height: 123 cms Centile: 750th

Inference: overweight child

RDA: — Calories: 1450 kcal/d Protein: 25 g/d

Diet Recommendations: Normal diet

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

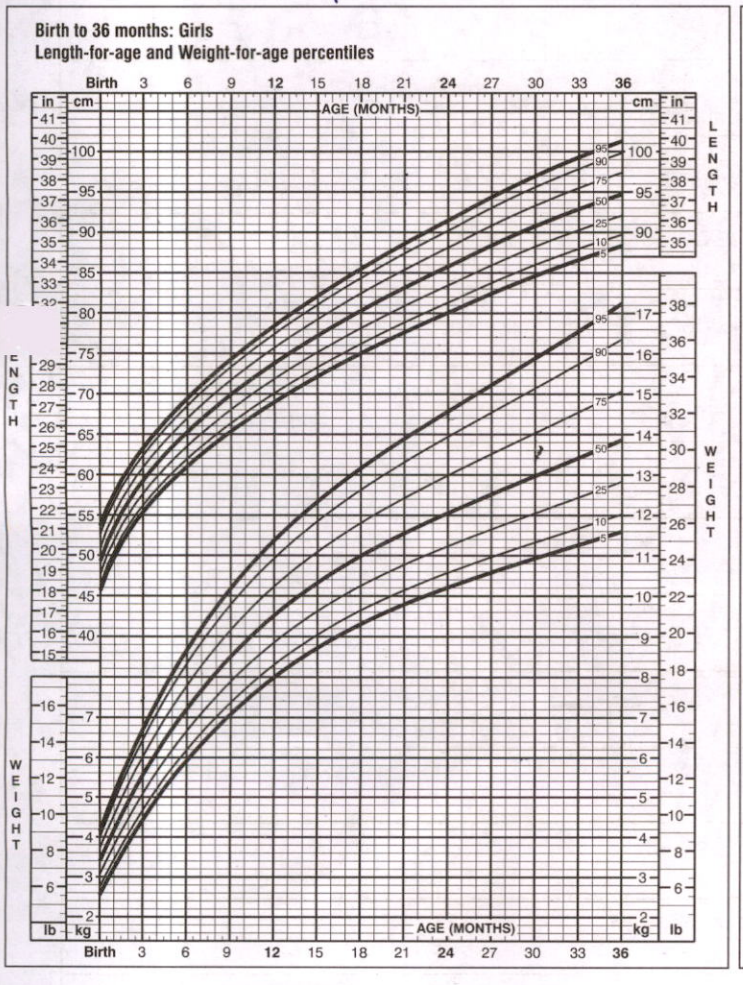
Food Allergies: No Veg/Non-veg Non-veg

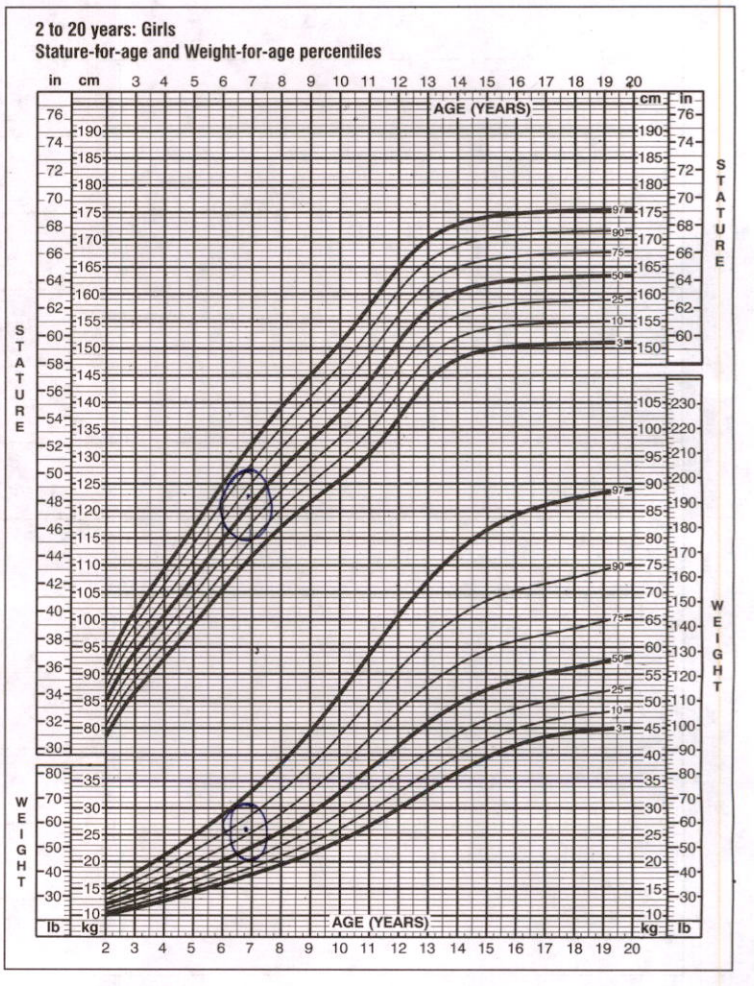
Diagnosis: Dengue / Typhoid & mild dehydration

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Jully

GROWTH CHART (GIRLS)





Dietician's Name Mounica Dietician's Signature Mounica

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

(P.T.O.)

Daily Notes:

5/7/26
9:15 Am — Child is stable, Intake is fair
continue normal diet & plenty
of oral liquids
saima

6/7/26
10 am — Child is stable. Intake is improving.
Continue normal diet
Monica