

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176051

Admit Date : 06-Jul-2026

Admit Time : 06:39 PM UHID : BAH-00643224

Patient Details :

Patient Name : Master SHAIK MUHAMMAD

Age : 0 Y 6 M 24 D

Guardian : Mr SHAIK AHMED

DOB : 12-12-2025 09:43 AM

Gender : Male

Religion :

Occupation :

Marital Status : Single

Address (H) : H NO 18-7-426/116, BHAVANI NAGAR
Charminar Hyderabad Telangana INDIA
500002

Phone No : 6301775220/ 9398354030

E-mail : nomailid@gmail.com

Admission Details :

Bed Type : SEMI PRIVATE

Bed No : SPVT 105

Ward Name : 1F-VIBGYOR

Room No : SPVT 105

Admission Type : First Visit

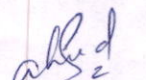
Contact Details :

Name : Mr SHAIK AHMED

Relationship : Father

Contact Address : H NO 18-7-426/116, BHAVANI NAGAR
Charminar Hyderabad Telangana INDIA 500002

Phone No : 6301775220 / 9398354030


Signature

Doctor Details :

Doctor Name : Dr. DR.V.V.R.SATYA PRASAD

Specialisation : PEDIATRIC NEPHROLOGY

Referral Doctor : Self

Phone No :

Co-Consultant : Dr. SRUTHI BALLA

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : CARE HEALTH INSURANCE LIMITED

BAH-00643224 IP5-00176051
Master SHAJK MUHAMMAD
12-12-2025 0 Y 6 M 24 D (M)
Dr. DR.V.V.R.SATYA PRASAD


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Children's
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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
12/12/25	7:10 pm	ER	105	

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
6/7/26	Iv placement	②	90626	
7/1/26	NHA	①	969126	

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00643224 IP5-00176051
Master SHAIK MUHAMMAD
12-12-2026 0 Y 6 M 24 D (M)
Dr. DR.V.V.R.SATYA PRASAD



Patient Name:

Muhammed Shaikh

UHID ID:

Department:

Consultant:

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: mother Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Loose stools x 7 days
Vomiting x 3 days
↓ oral intake x 7 days

History of present illness :

CHC: Loose stools x 7 days, watery in nature, no blood in stools

Vomiting x 3 days (1-2 episodes/day),
Vomiting out milk, non bilious.
also ↓ oral intake

- No fever
- passing urine well

K/C/O B/L cystic dysplastic kidneys.



Pediatric Multiorgan History & Physical Examination

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

K/c/o cystic dysplastic kidneys.

Birth & Neonatal History:



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

} upper middle class

Developmental History :

① development

Immunization History :

vaccination till date



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment: _____

Planned Labs:

CBP ~~at 10am~~

VBG _____

Complete stool examination

CRP _____

Blood c/s

N/R

1cm

6/2/26

Planned Management

- Ixj Ceftriaxone

- 1/2 DNS + 35 ml Bicarbonate @ 20m

- X 2 D drops

- Probiotics

- Esmoprazole

VBG tomorrow morning

Signature of the Doctor: Ramy

Name of the Doctor: Dr. RAMYA

Date & Time: 6/2/26, 6:50pm

Signature of the Consultant: [Signature]

Name of the Consultant: Dr. Sahar

Date & Time: 6/2/26 - 5:30pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2:30pm	C/S/B Resident	
	Δ cystic dysplasia of kidney	
	Acute gastritis	
	loose stools	Plan
	vomiting	
	↓ oral intake	① Inj ceftriaxone 450mg.
	hemodynamically stable	② 1/2 DNS + 35ml H ₂ O - @ 20ml/hr
	<u>OIE</u> child is alert active	③ 28D drops.
	vitals stable	④ Inj Esmoprazole
		<u>Trace</u> <u>SSch</u>
		CRP
		Bld c/s
		CSE
		CBP.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/2	U/S Resident of: Cystic dysplasia of kidney	
	No vomiting / loose stool.	Plan
	Passed urine (8:30am - 12:30pm) apparent)	- 2x ceftriaxone (P2)
		- 4 hyp nurodotil
	Wt → 6.220 kg.	- 4 iv fluids
	Sp = 91/49 (61).	- 801 discharge
	Temp - 98.5°F	- monitor vitals
		Prof
8/2 10:30 AM	Slb Dr. Lathaprasad	DIC today
		ECG NORM
		7 E/D
		NURODOTIL 5ml TID
		ROGALONE A/D
		0.25mg
		urine a day
		on after 1wk = RP2.

[illegible]

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RESULT SHEET

Smear: (2)

Date	6/7/26				
Time	7:00pm				
Hb	12.1				
PCV	37.3				
RBC	4.98				
WBC	16,660				
N/L	24/68				
Platelets	6.246				
CRP	5				
ESR					
PCT					
RBS					
Na	136				
K	4.6				
Cl	108				
Ca/Mg					
Phosphate					
Urea	59				
Creatinine	0.8				
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

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. Remya

Date & Time : 6/12/26 6:50pm

Nurse Name & Signature:

Date & Time :

Ward

DRUG : SYP. NODOSIS				Date Time
Dose	Route	Frequency	Start Dt.	
2.5ml	P.O	TID	7/7	6pm X 5pm
Name & Signature of the Doctor Starting the Drugs:				apm 5
Additional Instructions:				10pm 5pm
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				

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

Signature

VERIFIED BY : Name

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																					

DRUG CHART

Date of Admission: 12/2/25 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 :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature				Valid Period
Pharm.				
Additional Instructions:				

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

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

VERIFIED BY : Name Signature



REGULAR PRESCRIPTIONS

Weight. 6.1 kg Ward.

DRUG : Inj CEFTRIAXONE				Date/Time	6/7/25
Dose	Route	Frequency	Start Date		
450mg	IV	O.D	6/7		
Name & Signature of the Doctor Starting the Drugs: Dr. Remy				10pm Son / 5pm Son	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : INJ. ESMOPRAZOLE				Date/Time	6/7/25
Dose	Route	Frequency	Start Date		
5mg	IV	O.D	6/7		
Name & Signature of the Doctor Starting the Drugs: Dr. Remy				6am 9pm Son / 5pm Son	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : Z & D DROPS				Date/Time	6/7/25
Dose	Route	Frequency	Start Date		
0.5ml	ORAL	O.D	6/7		
Name & Signature of the Doctor Starting the Drugs: Dr. Remy				6pm 9pm Son / 5pm Son	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : ECONORM Sachet				Date/Time	6/7/25
Dose	Route	Frequency	Start Date		
1 Sachet	PO	BD	6/7/26		
Name & Signature of the Doctor Starting the Drugs: Dr. Remy				10am 12pm Son / 5pm Son	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					



Weight. Ward.

[illegible]

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Master SHAIK MUHAMMAD
12-12-2025 0 Y 6 M 26 D (M)
Dr. DR.V.V.R.SATYA PRASAD



D. : RCH / FRM / CLINICAL / 124

INFANT (<1 year)
**Children's Observation &
Early Warning Scoring Chart**

Pratiksha
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 8/7/26 Time:

Doctor/Nurse/Family Concern?

Temperature
(F)

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

Heart Rate (Number)

Resp. Rate (bpm)
(Over 1 Minute) *

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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

Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

Score 1 : Continue normal observation by staff nurse

Score 2 : Shift in charge nurse to be informed and continue hourly observations

Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see

Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

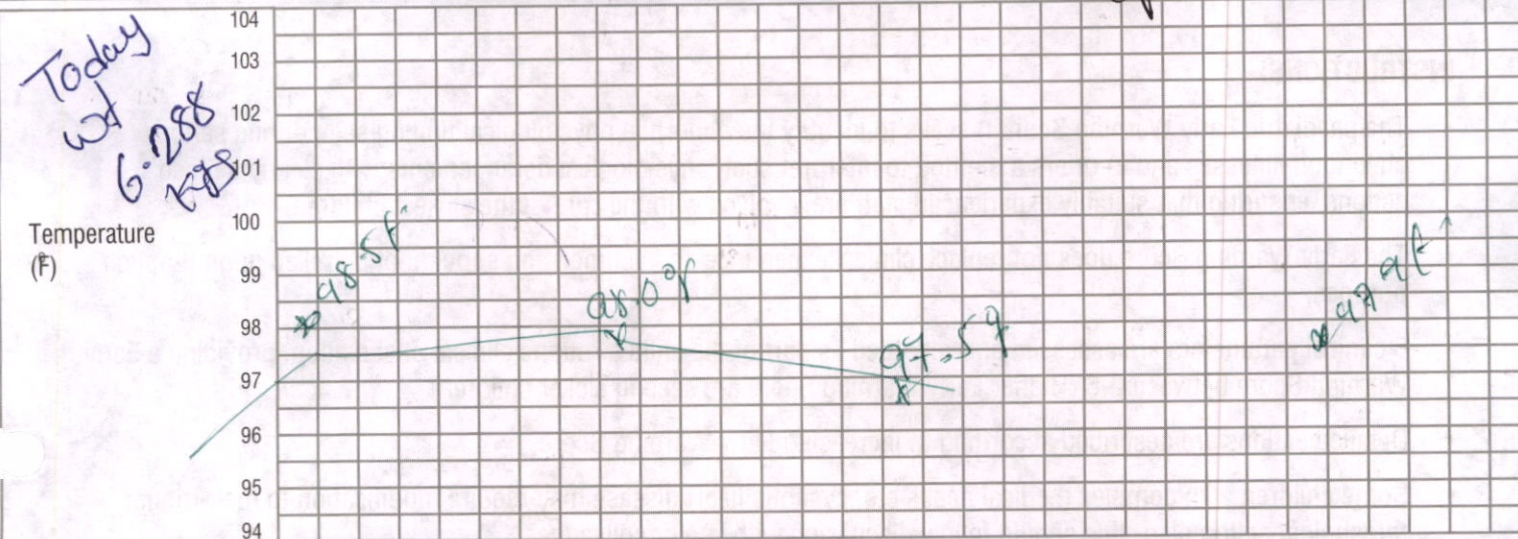


INFANT (<1 year) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 7/7/26 Time: 6AM

Doctor/Nurse/Family Concern? 10am 1P~ 6P 10P~



Heart Rate (bpm)	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50
and															
Blood Pressure (mmHg) *															
Note: BP does not score in early warning scoring															
Heart Rate (Number)	106/107	110/111	130/131	110/111	109/110	108/109	107/108	106/107	105/106	104/105	103/104	102/103	101/102	100/101	99/100

Resp. Rate (bpm) (Over 1 Minute) *	70	60	50	40	30	20	10
Resp Rate (Number)	28/29	28	26/27	28	28/29		

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

TOTAL SCORE					
Number of shaded boxes	1	1	1	1	1
Pain Score	2	2	2	2	2
Observer's Initials					

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.
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No. : RCH / FRM CLINICAL / 124

INFANT (<1 year)

Children's Observation &
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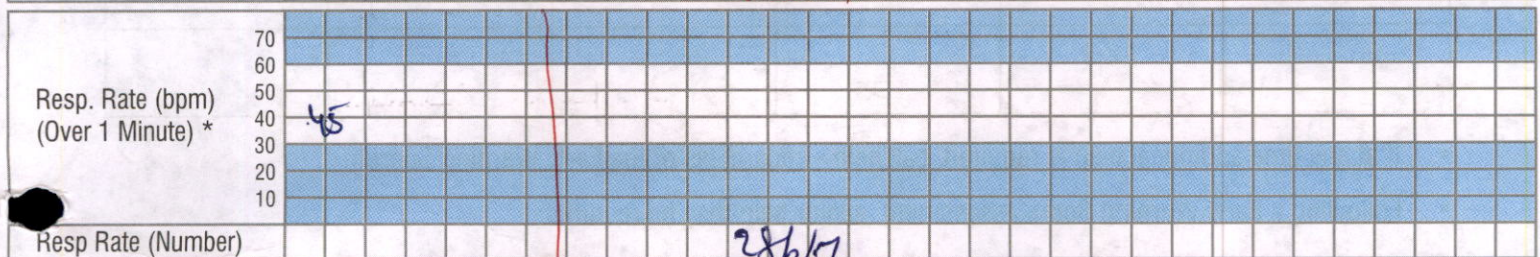
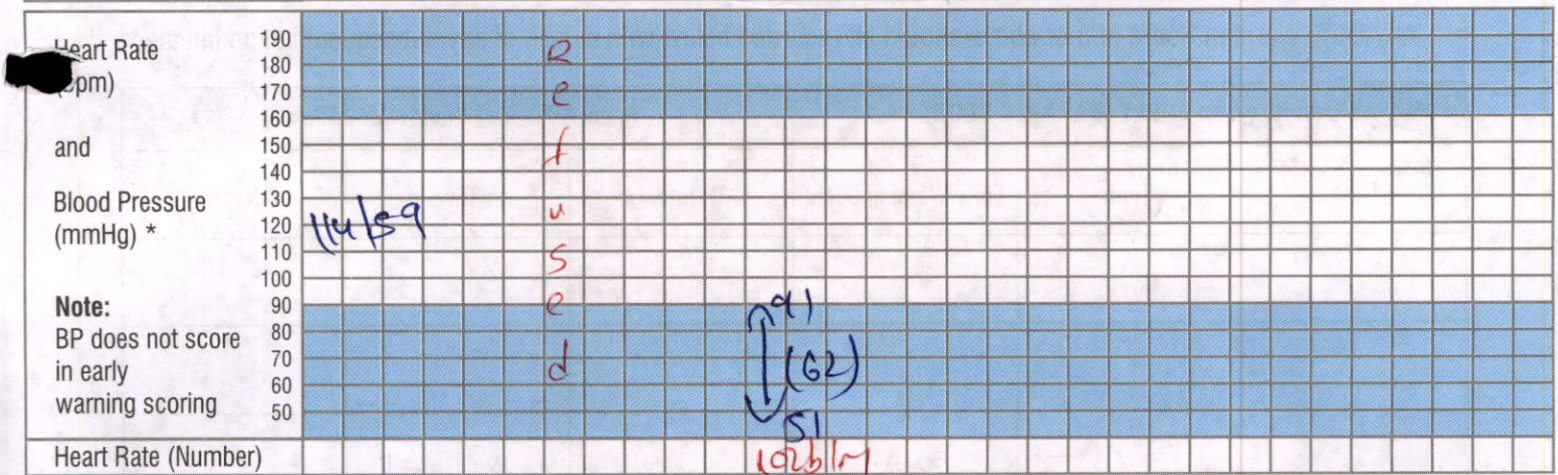
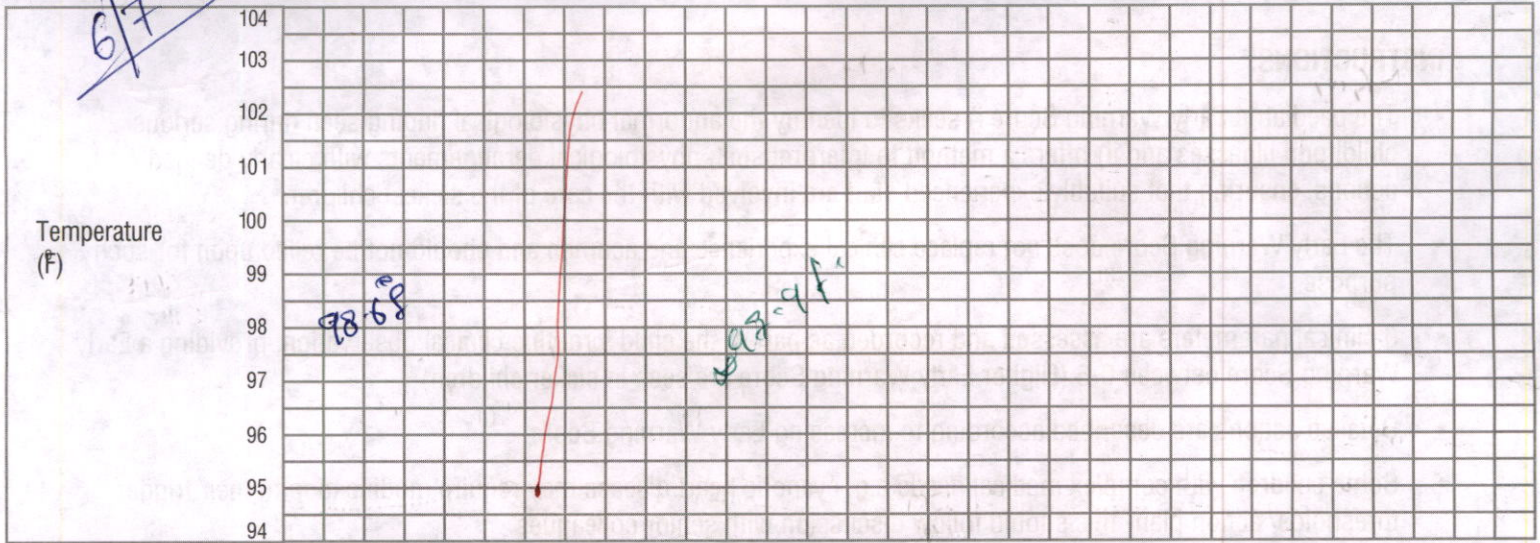
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 7:30pm 10pm 9AM 6AM

Doctor/Nurse/Family Concern?



Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)		100%
O ₂ Saturations (%)		100%
Conscious Level	Normal	
	Altered	5/15
GCS *		5/15
TOTAL SCORE		
Number of shaded boxes		1
Pain Score		1
Observer's Initials		2

ACTIONS

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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 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	↑		20ml							0	Swarna	
	09:00 pm	1/2 Dist		20ml							0		
	10:00 pm	Dist		—							0	Swarna	
	11:00 pm	35ml		—							0		
	12:00 am	NaHCO ₃		20ml							0	Swarna	
	01:00 am	↓		20ml							0		
Total Intake :						Total Output :							
	02:00 am	↑		20ml							0	Swarna	
	03:00 am	1/2 Dist		20ml							0		
	04:00 am	35ml		20ml							0	Swarna	
	05:00 am	Sodium		20ml							0		
	06:00 am	Bi carb.		—							0	Swarna	
	07:00 am	↓		—							0		
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							



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								
12/12/26	08:00 am	↑		I.V	N.G	/	✓	/	/	Emotion	0	/	
	09:00 am	1/2 DMS		20ml							0		
	10:00 am	+35ml	Milk	20ml							0		
	11:00 am	20ml		20ml							0		
	12:00 pm	breast		-							0		
	01:00 pm	↓		-							0		
Total Intake :						Total Output :							
12/12/26	02:00 pm	↓		20ml	/	/	/	/	/	150ml	0	/	
	03:00 pm	1/2 DMS		20ml							0		
	04:00 pm			20ml							0		
	05:00 pm	+35ml		20ml							0		
	06:00 pm	breast		20ml							0		
	07:00 pm	↓		-							0		
Total Intake :						Total Output :							
7/7/26	08:00 pm	↓		20ML	/	/	/	/	/	0	Arana		
	09:00 pm			20ML							0	Arana	
	10:00 pm	1/2 DMS		-							0	Arana	
	11:00 pm	+35ml		2-							0	Arana	
	12:00 am	BICARB		20ML							0	Arana	
	01:00 am			20ML							0		
Total Intake :						Total Output :							
8/7	02:00 am	↓		20ML	/	/	/	/	/	0	Arana		
	03:00 am	1/2 DMS		20ML							0	Arana	
	04:00 am	+35ml		20ML							0	Arana	
	05:00 am	BICARB		20ML							0	Arana	
	06:00 am	↓		-							0	Arana	
	07:00 am			-							0		
Total Intake :						Total Output :							

Total 24 hrs. Intake	
-----------------------------	--

Total 24 hrs. Output	
-----------------------------	--



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						

Patient Sticker

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 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: 6/7/26

Assessment: poor oral intake

- 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 general condition of the patient.	8:10 PM	Assessed general condition of the patient.	p/z condition is normal
10PM	Monitor vital signs.	10:5 PM	Monitored vital signs.	
12AM	Administer I.V Fluids.	12:10 AM	Administered I.V Fluids 1/2 DNS + NatHCO ₃ 20ml/hr.	
6AM	Administer medication as per doctor's order.	6:10 AM	Administered medication as per doctor's order.	
7AM	Maintain I/O chart.	7:30 AM	Maintained I/O chart.	

Re-Assessment: Re-Assessment done by checking vitals.

Special Notes: w/f Dehydration.

Nurse Signature: 

Nurse Name: Swarna

Date & Time: 7/7/26 8AM



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 2/1/26

Assessment: baby condition slightly normal

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
8a	Assess the pt general condition	8:10a	Assessed pt general condition	dy doing above all the care pt condition is normal
10a	provide comfortable position		provided comfortable position	
	monitor vitals signs	10:10a	monitored vitals and recorded	
	maintain 1/2 clut		maintained 1/2 clut (fluid	
12a	do day morning rounds done	12:10a	C1/2 DNS + 35ml bicarbonate) going	
	doctor said VBA tomorrow		Ensured safety	
2a	see plan d/c tomorrow	9:10a	Administered medication as	
	Administer medications as per chart		per chart	

Re-Assessment: monitor vitals & maintain 1/2 clut

Special Notes: VBA tomorrow (plan d/c tomorrow) so

Nurse Signature: [Signature]

Nurse Name: Anitha

Date & Time: 2/1/26 2a

BAH-00643224 IP5-00176051
 Master SHAIK MUHAMMAD
 12-12-2025 0 Y 6 M 24 D (M)
 Dr. DR.V.V.R.SATYA PRASAD

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: 21/12/25

Assessment:

Goals

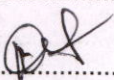
- ☐ Maintain Airway and Oxygenation ☐ Relieve Pain & Discomfort ☐ Maintain Fluid Balance ☐ Improve Activity Tolerance ☐ Maintain Good Nutritional Status ☐ Maintain Skin Integrity
☐ Maintain Personal Hygiene ☐ Prevent Infection ☒ Meet Elimination Needs ☒ Ensure Safety ☐ Early Ambulation Reduce Anxiety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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	* Assess the general condition of the patient.	2pm	* Assessed the general condition of the patient.	By above all the procedures the patient can be stable.
4pm	* maintain personal hygiene.	4pm	* maintain personal hygiene.	
8pm	* monitor vitals.	8pm	* monitored vitals.	
6pm	* maintain OR fluid. * maintain good nutrition.	6pm	* maintained OR fluid. * maintained good nutrition.	

Re-Assessment:

monitor vitals.

Special Notes:

Nurse Signature: 

Nurse Name: Durga [018165]

Date & Time: 21/12/25 @ 8pm

BAH-00643224 IP5-00176051
Master SHAIK MUHAMMAD
12-12-2025 0 Y 6 M 24 D (M)
Dr. DR.V.V.R.SATYA PRASAD



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: 31/7/25

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	Assess the general condition of the baby	8AM	Assessed the general condition of the baby	by done all these to improve baby condition
10AM	monitor vital signs & record	10AM	monitored vital signs & record	
	provide comfortable position		provided comfortable position	
	1/2 DNS + 35 mL HCO ₃ 20 mL/hr ongoing		1/2 DNS + 35 mL HCO ₃ 20 mL/hr ongoing	
6AM	Administer medication as per doctor orders.	6AM	Administered medication as per doctor orders.	

Re-Assessment:

Special Notes: VBG film

Nurse Signature: Aruna

Nurse Name: Aruna

Date & Time: 31/7/25



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature: Nurse Name: Date & Time:

BAH-00643224 IP5-00176051
 Master SHAIK MUHAMMAD
 12-12-2025 0 Y 6 M 24 D (M)
 Dr. DR.V.V.R.SATYA PRASAD



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

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

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



THE HUMPTY DUMPTY SCALE

06/7 7/7 8/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4		
	3 to less than 7 years old	3		1			
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2		
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1		
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2	2	2	2		
	Oriented to own Ability	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			13	13	13		

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		NO	NO	NO		
Other Intervention(s) Specify		NO	NO	NO		
Nurse's Name :		Susmita	Aranya	Aruna		
Signature :		Bu	Aranya	Aruna		
Date :		6/7/25	7/7	8/7		
Time :		4:25 PM	6 AM	6 AM		



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Prashant Department: Pediatric Date of Admission: 06/7/26

SITUATION	Diagnosis: <u>Acute gastritis</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area	Shift Time	<u>CR</u> <u>7:10pm</u>	<u>1st Floor</u> <u>8PM-8AM</u>	<u>1st floor</u> <u>8:30am</u>	<u>1st</u> <u>8-8pm</u>	<u>1st</u> <u>8-8am</u>
	Medical Condition (Any special condition to be noted):		<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
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>98°F</u>	<u>98.4°F</u>	<u>97.5°F</u>	<u>98.2°F</u>	<u>97°F</u>
	Res:	<u>26b/m</u>	<u>21b/m</u>	<u>26</u>	<u>28</u>	<u>27b/m</u>	
	SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>99%</u>	<u>98%</u>	
	Pulse:	<u>125b/m</u>	<u>116b/m</u>	<u>124</u>	<u>128</u>	<u>119</u>	
	BP:	<u>110/59</u>	<u>90/64</u>	<u>101/50</u>	<u>101/62</u>	<u>95/59</u>	
Fall Risk Score:	<u>13</u>	<u>13</u>	<u>13</u>	<u>10</u>	<u>10</u>		
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>		
Recommendations	Safety Needs:		<u>✓</u>	<u>side rails</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:			<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Reethi</u>	<u>Swarna</u>	<u>Anish</u>	<u>Dingy</u>	<u>Aruna</u>	
Signature :		<u>Ki</u>	<u>Swarna</u>	<u>Anish</u>	<u>Dingy</u>	<u>Aruna</u>	
Date:		<u>06/7/26</u>	<u>7/7</u>	<u>7/7</u>	<u>7/7</u>	<u>8/7</u>	
Time:		<u>7:10pm</u>	<u>8AM</u>	<u>8:30am</u>	<u>8pm</u>	<u>8pm</u>	
Taken Over By Name :		<u>Swarna</u>	<u>Anish</u>	<u>Dingy</u>	<u>Aruna</u>	<u>Dingy</u>	
Signature :		<u>Swarna</u>	<u>Anish</u>	<u>Dingy</u>	<u>Aruna</u>	<u>Dingy</u>	
Date:		<u>6/7</u>	<u>7/7</u>	<u>7/7</u>	<u>7/7</u>	<u>8/7</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	

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 Tubes/Drains/Catheter: ☐ Yes ☐ No Vital Signs: Temp: ☐ Yes ☐ No Res: ☐ Yes ☐ No SpO ₂ : ☐ Yes ☐ No Pulse: ☐ Yes ☐ No BP: ☐ Yes ☐ No Fall Risk Score: ☐ Yes ☐ No Pain Score: ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Recommendations	Safety Needs: ☐ Yes ☐ No Physiotherapy: ☐ Yes ☐ No Others Specify: ☐ Yes ☐ No Special Diet: ☐ Yes ☐ No Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Post Operative Procedure Special Orders:					
	Handed Over By Name :					
	Signature :					
	Date:					
	Time:					
	Taken Over By Name :					
	Signature :					
	Date:					
	Time:					



BRADEN 'Q' SCALE

					Date :	06/7	7/7	8/7	
					Time :	8pm	6 AM	6am	
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:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		1	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.		1	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.		1	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.		1	4	4	
FRICITION-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."		1	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.		1	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.		1	4	4	
TOTAL SCORE						28	28	28	
Evaluator's Name						Keeth	P. Ravi	Arav	

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
06/12/26	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Reethi
7/12	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Swarna
7/12	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
8/12	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Aruna
				☐ 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		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

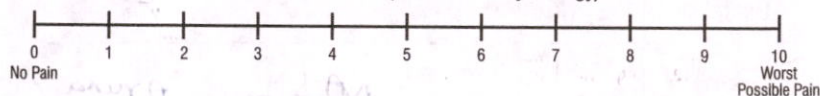
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams 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





CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 6/7			DAY-2 9/1/20			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				
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			-	-	-	-				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			-	-	-	-				
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			-	-	-	-				
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			-	-	-	-				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-	-	-				
Signature of the Nurse						Sudhakar			Aruna				

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 : A Name : Anishan

Signature of Ward In Charge :

Signature : N Name : Neeraja

BAH-00643224 IP5-00176051

Master SHAJK MUHAMMAD

12-12-2025 0 Y 6 M 24 D (M)

Dr. DR.V.V.R.SATYA PRASAD

**INTERDISCIPLINARY PATIENT
/ FAMILY EDUCATION RECORD**Rainbow®
Children's
Hospital
It takes a lot to treat the little.BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Par

Patient's / Learner Language: 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		
06/7	6pm	2	Treatment & care plan	M	1	1	1	0	—	Beeth
7/7	9am	9	DBM feeds + Lactogen 1:30 ml dilution	m	1	0	1	1	—	Nicitha

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:	<table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								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	
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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:	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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Understanding:	1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review																				

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
6/7/26 6PM	☒ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	B/L Cystic dysplastic kidney	H-dynamic stability	IV medication	[Signature]	☐ Nursing ☐ Others:
6/7/26 6PM	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fever & loose stools	H. stability	IV fluids	[Signature]	☐ Medical ☒ Others:
7/7/26 am	☐ Medical ☐ Nursing ☒ Others: dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	B/L cystic dysplastic kidney c Acute Gastritis	OBm feeds + lactogen (1:30ml) c stage feeding fndc + free ading	RDA:- E:-108 kcal/kg/d P:-2.1 g/kg/d	[Signature]	☐ 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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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 7/7/26 Time: 9am

Weight: 6.12 kgs Centile: 25th

Height: 62 cms Centile: 25th

Inference: underweight child

RDA: Calories: 108 kcal/kg/d Protein: 2.1 g/kg/d

Diet Recommendations: DBM feeds + Lactogen (1:30ml) dilution

Re-Assessment: Stage I weaning foods + ICE advised

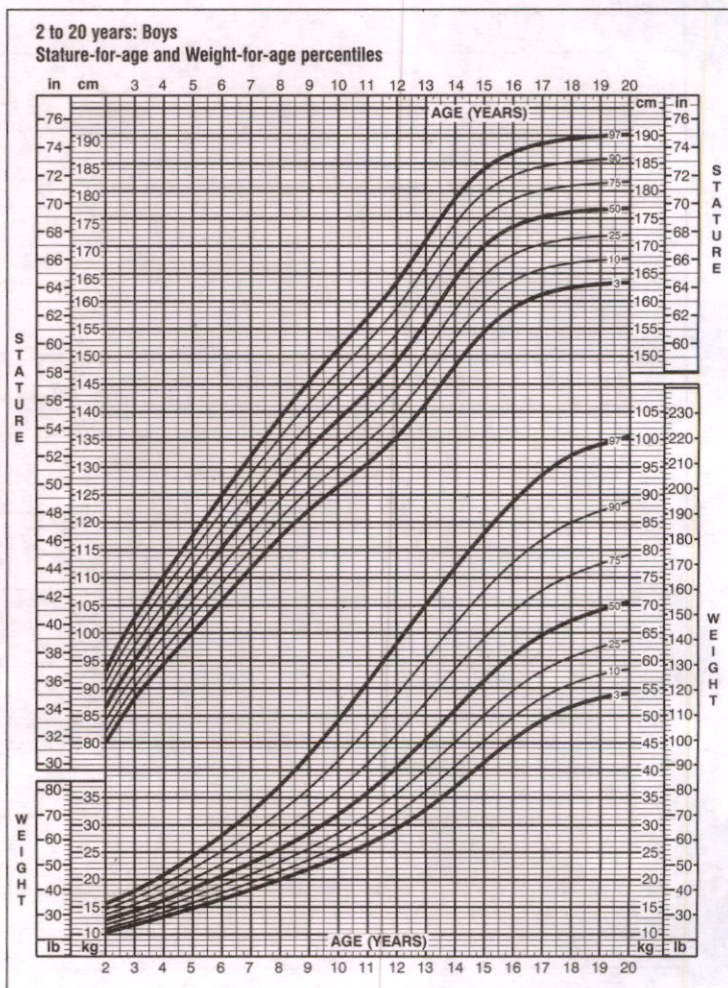
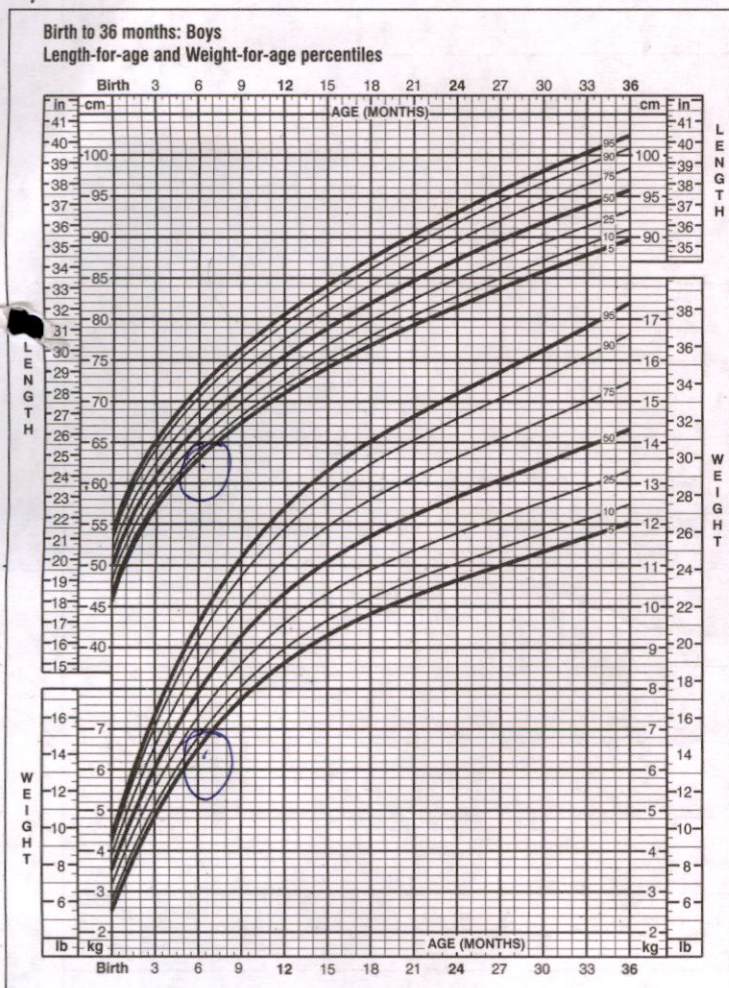
Food Allergies: Yes, Banana Veg/Non-veg: Veg

Diagnosis: B/L cystic dysplastic kidneys - Acute Gastritis

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha

Daily Notes:

~~8/1/26~~
9:45 am child is stable. oral intake is fair.

continue to stage I weaning foods & DBM feeds monies