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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ACTIVITY RECORD FOR BILLING

Name :_____

BAH-00661076 IP5-00176152
Master ABDUL HUNAIN
01-03-2026 0 Y 4 M 8 D (M)
Dr. NALLA ANURAAG REDDY

UHID No. : _____ IP N _____ nt: _____ Dept : _____

Date of Admission: _____ Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
9/7/26	2:35 pm	ER	135	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
9/7	CBP, Reticulocyte count; Ferritin, Creat	68665	[illegible signature]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
9/7	Syringe Pump	4:30pm	10/7 hrs 12pm	9694959	[signature]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
9/7	IV placement.	(1)	4649	Samply
9/7	Blood Transfusion	(1)	9694963	

ANY OTHER INFORMATION

Date : 10/7/16 Time : 1:30 pm Prepared By : Pooja.

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Pooja.	Morning Shift Onco		

BAH-00661076 IP5-00176152
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01-03-2026 0 Y 4 M 8 D (M)
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ADMISSION CRITERIA – ONCOLOGY

Admission / Transfer from:

☑ Emergency ☐ Outpatient (OPD) ☐ Ward ☐ Operation Theater ☐ Others: .....

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

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

Signature of the Doctor: .....

Name of the Doctor: .....

Date & Time: 9/7/26 @ 2:40pm

Patient Sticker

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DISCHARGE CRITERIA – ONCOLOGY

Discharge to:

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

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

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

Signature of the Doctor: .....

Name of the Doctor : Bhavani

Date & Time: 10/Feb - 12pm

Rainbow Children's Hospital

BirthRight by Rainbow

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 : IP5-00176152 **Admit Date** : 09-Jul-2026 **Admit Time** : 01:50 PM **UHID** : BAH-00661076

Patient Details :

Patient Name	: Master ABDUL HUNAIN	**Age**	: 0 Y 4 M 8 D
Guardian	: Mr ABDUL FAHAD	**DOB**	: 01-03-2026 01:00 AM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H.NO 2-122/1, POUKAL VILLAGE, SS AUTO MOBILES, Bhainsa Adilabad Telangana INDIA 504103	**Phone No**	: 6309595330/ 6302307940
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : FOUR SHARING **Bed No** : FSW 135 **Ward Name** : 1F-HEMATO-ONCOLOGY

Room No : FSW 135 **Admission Type** : First Visit

Contact Details :

Name : Mr ABDUL FAHAD **Relationship** : Father

Contact Address : H.NO 2-122/1, POUKAL VILLAGE, SS AUTO MOBILES, Bhainsa Adilabad Telangana INDIA 504103 **Phone No** : 6309595330 / 6302307940

Ad. Fahad.
Signature

Doctor Details :

Doctor Name : Dr. NALLA ANURAAG REDDY **Specialisation** : HEMATO ONCOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant : Dr. SIRISHA RANI

Payment Details :

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

Payor Name : SELFPAY

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PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00661076 IP5-00176152
Master ABDUL HUNAIN
01-03-2026 0 Y 4 M 8 D (M)
Dr. NALLA ANURAAG REDDY

Patient Name: Abdul Hunain.

UHID ID:

Department:

Consultant:

BAH-00661076 IP5-00176152
Master ABDUL HUNAIN
01-03-2026 0 Y 4 M 8 D (M)
Dr. NALLA ANURAAG REDDY

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

c/o pallor
decreased oral intake } :: 1m.

History of present illness :

Pre morbidly well child.
c/o pallor noticed by parents :: 1m.
c/o decreased feeding :: 1m
c/o Rhinorrhoea :: 4m.
No. malena,

CBP - 8/7 -
5.4 / 17.8k / 3L
32/59

HbF - 65.1%.
HbA2 - 0.8.

BAH-00661076 IP5-00176152
Master ABDUL HUNAIN
01-03-2026 0 Y 4 M 8 D (M)
Dr. NALLA ANURAAG REDDY

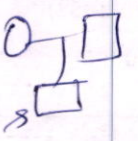
Pediatric Multiorgan History & Physical Examination

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

⊖

Birth & Neonatal History:

FT / LSCS / ⊖ perinatal transition



Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History :

rolling ⊕.

Immunization History :

Immunised

(P.T.O.)

BAH-00661076 IP5-00176152
Master ABDUL HUNAIN
01-03-2026 0 Y 4 M 8 D (M)
Dr. NALLA ANURAAG REDDY

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 5.9 kg (Centile ________)

On Examination :

Temperature : 98.4°F Pulse Rate : ________ B.P. ________ SPO2 ________

Resp.rate and type of breathing : 32/min Pallor ⊕. Af at level. no icterus

Rash ⊖

Lymphadenopathy ⊖

Oedema : ⊖

Allergies (if any): ________

Respiratory System :

Inspection (any s/o distress) : ________

Air entry & breath sounds : BAE ⊕

Any addes sounds : ________

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

Cardiovascular System :

Inspection of procordium : ________

Heart Sounds : $S_1 S_2$ ⊕

Any murmur : ⊖

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

Per Abdomen :

Inspection ________

Palpation : Soft, NT, no splenomegaly

Ausculation : BS ⊕

Spine : ________ External Genitelia : /

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

BAH-00661076 IP5-00176152
Master ABDUL HUNAIN
01-03-2026 0 Y 4 M 8 D (M)
Dr. NALLA ANURAAG REDDY

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Alert.

Cranial Nerves :

Motor System:

Nutriton : NAD

Tone: Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials:**

Plantars

Sensory System :

Not intact

Bladder / Bowel : Regular.

Clinical Summary & Diagnostic:

Anemia ~~patter~~. + evaluation (Anemia).

(P.T.O.)

BAH-00661076 IP5-00176152
Master ABDUL HUNAIN
01-03-2026 0 Y 4 M 8 D (M)
Dr. NALLA ANURAAG REDDY

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: failure

Desired goals of the treatment : hemodynamic stability -

Planned Labs:

CBP
Retic count
S. ferritin
S. Creatinine
+ 2 extra EDTA

NIB
Sagar
9/7/26
2:35 pm

Planned Management

Nasoclear drops
reserve 10 ~~ml~~ PRBC

NIB
Sagar
9/7/26
2:35 pm

DR. SANDHYA VADDADI
Registration No: 71664

Signature of the Doctor: .....
Name of the Doctor: Sakuthi
Date & Time: 9/7/26. 1PM.

Signature of the Consultant: .....
Name of the Consultant: Dr. Anurag Reddy
Date & Time: 10/7/26 @ 10.00am

BAH-00661076 IP5-00176152
Master ABDUL HUNAIN
01-03-2026 0 Y 4 M 8 D (M)
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(7)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Evening Rounds	
09/07/26 4pm	Baby presented with Severe Anaemia	Plan
		PRBC transfusion
	clinically stable	
	No feverspikes	+ Supplements
	vitals (N)	
	CVS, RS (N)	· To trace Sr. Ferritin
	P/A - spleen (+)	
	CNS - NAD	noted by [illegible] 013735 at 9pm
		T Pavani
	Morning Round	
10/07/26	Anaemia &Evaluation.	
		Remaining PRBC Today
	clinicaly stable	
	vitals stable	Trace Sr. Ferritin.
	CVS, RS (N)	
		continue supplements
	P/A → spleen (+)	folic acid to cont
	· CNS - NO FND	
		T Pawan

DR. SANDHYA VADDADI
Registration No: 71664.

BAH-00661076 IP5-00176152
Master ABDUL HUNAIN
01-03-2026 0 Y 4 M 8 D (M)
Dr. NALLA ANURAAG REDDY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

BAH-00661076 IP5-00176152
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01-03-2026 0 Y 4 M 8 D (M)
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RESULT SHEET

A Positive

Date	09/07/26					
Time						
Hb	5.0					
PCV / MCV	14.7/71					
RBC	2.07					
WBC	17,7~~8~~0					
N/L	35/60					
Platelets	2,90,000					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine	0.3					
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~~ Retic	5 %					

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Jeeth -	293					

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

BAH-00661076 IP5-00176152
Master ABDUL HUNAIN
01-03-2026 0 Y 4 M 8 D (M)
Dr. NALLA ANURAAG REDDY

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Sheet No: .....

REGULAR PRESCRIPTIONS

Weight ..... Ward .....

DRUG : VITCOFOL Drops

Dose	Route	Frequency	Start Dt.
1ml	Oral	OD	9/7

Name & Signature of the Doctor Starting the Drugs: T. Pavani

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time: 9/7 — 8pm

DRUG : Vit D3 drops

Dose	Route	Frequency	Start Dt.
1ml	Oral	OD	9/7

Name & Signature of the Doctor Starting the Drugs: T Pavani

Additional Instructions: 1ml - 400IU.

Daily Doctor's Endorsement by a Sign

Date/Time: 9/7 — 9pm

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time:

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time:

VERIFIED BY : Nan ..... Signature .....

Patient Sticker

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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

DRUG :

Dose	Route	Frequency	Start Dt.	Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.	Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.	Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.	Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

BAH-00661076 IP5-00176152
Master ABDUL HUNAIN
01-03-2026 0 Y 4 M 8 D (M)
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DRUG CHART

Date of Admission: 9/7/26. 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 : CROCIN DROPS				Date / Time
Dose	Route	Frequency	Start Date	
0.9ml	oral	SOS (6 H)	9/07/26	
Doctor's Signature		Valid Period	Pharm.	
T. Pavani				
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:				

Sig. ..... VERIFIED BY : Name .....

BAH-00661076 IP5-00176152
Master ABDUL HUNAIN
01-03-2026 0 Y 4 M 8 D (M)
Dr. NALLA ANURAAG REDDY

REGULAR PRESCRIPTIONS

Weight. 7.9kg Ward. ....

DRUG: NASOCLEAR drops				Date ▸ Time ▾	9/7
Dose	Route	Frequency	Start Date	10am	X
	N/D.	TID	9/7		
Name & Signature of the Doctor Starting the Drugs: Ramesh				2pm	X
Additional Instructions: 2 drops each nostril				10pm	Gaya Suhi.
Daily Doctor's Endorsement by a Sign					

DRUG: D ELICES-2 Drops				Date ▸ Time ▾	
Dose	Route	Frequency	Start Date		
0.5ml	oral	OD	9/7		
Name & Signature of the Doctor Starting the Drugs: T. Pavani					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

DRUG: Vit-D3 drops				Date ▸ Time ▾	
Dose	Route	Frequency	Start Date		
0.5ml	oral	OD	9/7		
Name & Signature of the Doctor Starting the Drugs: T. Pavani					
Additional Instructions: 1mo - 400mg IV					
Daily Doctor's Endorsement by a Sign					

DRUG: Syp. CALCIMAX +				Date ▸ Time ▾	9/7
Dose	Route	Frequency	Start Date		
2ml	oral	OD	9/7		
Name & Signature of the Doctor Starting the Drugs: T. Pavani				8pm	Gaya Suhi
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

Patient Sticker

Weight. 5-9 kg 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.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
09/07/26	4:30pm	PRBC	30ml over 4hours	IV		
09/07/26	10M	Inj lasix	0.3ml midway	IV		
~~09/07/26~~		~~Inj AVIL~~	~~0.1ml~~	~~IV~~		
10/07	9am	PRBC	70ml over 4hrs	IV		
10/07	12pm	Inj LASIX	0.3ml midway	IV		

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

01-03-2026 0Y4M8D (M)
Dr. NALLA ANURAAG REDDY

I.V. FLUIDS CHART

Weight. 5.9kg 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

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

BAH-00661076 IP5-00176152
Master ABDUL HUNAIN
01-03-2026 0 Y 4 M 8 D (M)
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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: GR 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	VITAMIN D DROPS	0.5ml	PO	OD	9/7/26	☑ C ☐ DC
2	FERROUS ASCORBATE	0.5ml	PO	BD	9/7/26	☑ 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 : Sahithi

Date & Time : 9/7/26 1PM.

Nurse Name & Signature: Sagar

Date & Time : 9/7/26 @ 2:20 pm

BAH-00661076 IP5-00176152
Master ABDUL HUNAIN
01-03-2026 0 Y 4 M 8 D (M)
Dr. NALLA ANURAAG REDDY

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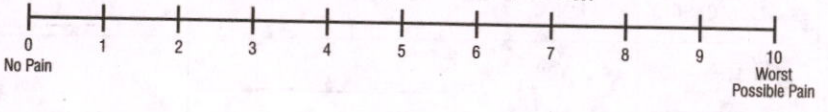
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
9/7/26	2:20 pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil Nil	[signature]
				☐ 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		
				☐ 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		

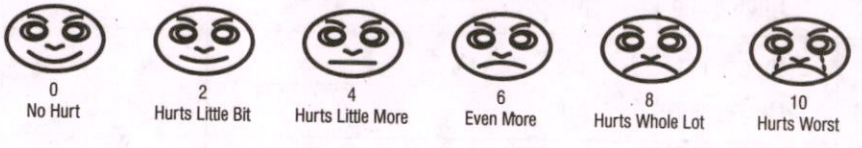
Re-assessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within 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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INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 9/7 Time:	4pm	7pm.	10pm.	3Am	6Am	
Doctor/Nurse/Family Concern?						
Temperature (F)	*98.4°F	*98.5°F	98.2°F.	98.2°F	98.2°F.	
Heart Rate (bpm) and Blood Pressure (mmHg) *	96 (46) 58	90 (60) 59	96 (66) 56	96 (66) 56	97 (78) 67	
Note: BP does not score in early warning scoring						
Heart Rate (Number)	148 b/m	150 b/m	146 b/m.	102 b/m	115 b/m	
Resp. Rate (bpm) (Over 1 Minute) *						
Resp Rate (Number)	18 b/m	19 b/m	19 b/m	19 b/m	19 b/m	
Resp Distress: Mod/ Severe / None / Mild						
Receiving O_2 (l/min) O_2 Saturations (%)	99%	98%	98%	98%	98%	
Conscious Level: Normal / Altered	C	C	C	C	C	
GCS *	15/15	15/15	15/15	15/15	15/15	
TOTAL SCORE Number of shaded boxes	0	0	6	6	6	
Pain Score	0	0	9	8	8	
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	

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.

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)

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

Total 24 hrs. Intake		**Total 24 hrs. Output**	

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FLUID CHART

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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.
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							
9/7	08:00 am											
	09:00 am											
	10:00 am			New Admission								
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
9/7	02:00 pm	-									0	pooja
	03:00 pm	-									0	
	04:00 pm			7.4ml						100ml	0	
	05:00 pm	milk		7.4ml							0	
	06:00 pm			7.4ml						50ml	0	
	07:00 pm			7.4ml							0	
Total Intake : 29.6 ml.						Total Output : 150ml.						
10/7	08:00 pm			—							0	[illegible]
	09:00 pm	Milk	D	—						50ml	0	
	10:00 pm			—							0	
	11:00 pm		B	—							0	
	12:00 am			—						80ml	0	
	01:00 am		M	—							0	
Total Intake :						Total Output : 130ml						
10/7	02:00 am		D	—						50ml	0	
	03:00 am			—							0	
	04:00 am			—							0	
	05:00 am		B	—							0	
	06:00 am			—						70ml	0	
	07:00 am		M	—							0	
Total Intake : 2-						Total Output : 120ml						

Total 24 hrs. Intake	29.6ml ÷ 5.94kg	Total 24 hrs. Output	400/3.9cc/kg

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 12:40 p.m. Mode of Arrival: Mother help Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction No Allergy reactions Body Weight: 5.95 Kg

Height: 62.50 cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
NA	NA	NA

Family History: Healthy family

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

If yes please list, ...

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

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

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

Observations: Weight: 5.95 kgs Length: 62.50cm Head Circumference (< 2 years): .....

Temp.: 98.5F HR: 152 b/m RR: 32 b/m BP: 99/48 (50).

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

Fall Risk Assessment: ☑ Yes ☐ No Score: 0 (Document in the Humpty Dumpty Sheet)

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

Pain Screening: ☐ Yes ☑ No If Yes, Pain Score: 10 Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker

Character of Pain ..... Location ..... Frequency ..... Duration .....

FUNCTIONAL SCREENING: ☑ No Abnormalities Detected

☐ Mobility Problem ☐ Walking Problem

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormalities Detected

☐ Underweight ☐ Overweight ☐ Special Feeding Method

☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

Inform consultant for positive criteria

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NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☑ Night Date: 9/6/26

Assessment: Baby having ct hydration loading [illegible]

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	* Asses the child Genu condition	9pm	* Assessed the child Genu condition	
10pm	* monitor vital signs	11pm	* monitor vital signs	
12Am	* maintain I/O chart	1Am	* maintained I/O chart	* Baby fine good
2Am	* Administer medication as per doct ord	3Am	* Administer medication as	
5am	* provide comfortable position	6am	* provided comfortable position	

Re-Assessment: with hourly vital monitoring

Special Notes: watch for [illegible] & any abnormal.

Nurse Signature: [signature] Nurse Name: [signature] Date & Time: 10/6/26 @ 6am

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NURSING CARE RECORD

Shift: ☐ Morning ☑ Afternoon ☐ Night

Date: 9/7/26

Assessment: patient heaving 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
2pm	* Assess the patient general condition.	2:30pm	* Assessed the patient general condition.	patient is stable.
4pm	* monitor vitals.	4:30pm	* monitored vitals	
5pm	* Maintains personal heygiene.	5:20pm	* maintained personal heygiene.	
6pm	* Ensure safety	6:30pm	* provided side rails	
7pm	* Maintains I/v chart.	7:20pm	* maintained I/v chart	
8pm	* Administer medications.	8pm	* Administered medications.	

Re-Assessment: patient feels better.

Special Notes:

Nurse Signature: [signature] Nurse Name: pooja Date & Time: 9/7/26 @ 8pm

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Nalla Anuraag Department: ER Date of Admission: 9/7/26

SITUATION

Diagnosis: Anemia ↓ evaluation

Any Infection: ☐ Yes ☐ No ☐ Not Known
If Yes Specify: NA

	Area / Shift Time	ER 2:35 pm	onco. 8pm.	onco 8AM			
BACKGROUND	Medical Condition (Any special condition to be noted):	Nil	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°F	98.4°F	98.4°F			
	Res:	24 b/m	24 b/m	24 b/m			
	SpO_2:	100%	99%	100%			
	Pulse:	103 b/m	102 b/m	112 b/m			
	BP:	95/51	90/50	90/62			
	Fall Risk Score:	12	12	12			
	Pain Score:	0	0	0			
Recommendations	Safety Needs:	YES	side rails	SAP 20%			
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	Nil	NA	NA			
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	Nil	NA	NA			
Post Operative Procedure Special Orders:		Nil	NA	NA			
Handed Over By Name :		Sagar	pooja	BLY			
Signature :							
Date:		9/7/26	9/7	10/7/26			
Time:		2:35 pm	8 pm	8AM			
Taken Over By Name :		ch.pooja	BLY	D/C.			
Signature :							
Date:		9/7	9/7/26				
Time:		2:40 pm	8				

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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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THE HUMPTY DUMPTY SCALE 9/7 10/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	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			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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			
	TOTAL		12	12			

Intervention : -Fall Risk : Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position		Yes	Yes			
	Call device within reach		Yes	Yes			
	Wheels Locked		Yes	Yes			
	Room free of clutter		Yes	Yes			
	Adequate Lighting		Yes	Yes			
	Wheel Chair Support		No	No			
	Other Intervention(s) Specify		NO	NO			
	Nurse's Name :		Sapna				
	Signature :						
	Date :		9/7	10/7			
	Time :		2:20 pm				

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BRADEN 'Q' SCALE

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					Date :	9/1/26	10/1	
					Time :	2:26pm	4	
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	
"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	
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	
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	
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	
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	
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	
					TOTAL SCORE	28	28	
					Evaluator's Name			

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

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

Risk 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

BAH-00661076 IP5-00176152
Master ABDUL HUNAIN
01-03-2026 0 Y 4 M 8 D (M)
Dr. NALLA ANURAAG REDDY

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Rainbow® Children's Hospital
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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		
9/7/26	2:20 pm	7.	Infection control measures	M	4	O	-1	1	-	

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

BAH-00661076 IP5-00176152
Master ABDUL HUNAIN
01-03-2026 0 Y 4 M 8 D (M)
Dr. NALLA ANURAAG REDDY

MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis: Anemia de escalation

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
9/7/26 2:20 pm	☑ Medical ☐ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	MONITER VITALS	H. STABLE	RESERVE PRBC TX		☐ Nursing ☐ Others:
9/7/26 2:20 pm	☐ Medical ☑ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	RESERVE PRBC TX	H- Stability	vitals monitoring		☑ Medical ☐ 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:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

AH-00661076 IP5-00176152
laster ABDUL HUNAIN
1-03-2026 0 Y 4 M 8 D (M)
r. NALLA ANURAAG REDDY

BLOOD TRANSFUSION

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Name: ABDUL HUNAIN Age: 4M Gender: Male ☑ Female ☐

UHID.No : 661076 Date: 9/7/26

Type of Blood Product:

☐ Fresh Frozen Plasma	☑ Packed Red Blood Cells	☐ Random Donor Platelets
☐ Cryoprecipitate	☐ Single Donor Platelet	☐ Whole Blood
☐ Albumin	☐ Red Blood Cell	☐ Others .....

I ABDUL hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immunodeficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

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

.....

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Signature: A

Name: Arshiya

Date & Time 9/7/26 @ 4:30pm

Doctor (Who is talking the consent)

Signature: T

Name: T. Pavani

Date & Time 09/07/26

Witness

Signature: A

Name: Arshiya

Date & Time 9/7/26 @ 4:30pm

BAH-00661076 IP5-00176152
Master ABDUL HUNAIN
01-03-2026 0 Y 4 M 8 D (M)
Dr. NALLA ANURAAG REDDY

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BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 9/7/26 Time: 4:30pm

Blood Group of the Patient: A+ Blood Group on the Blood Bag: A+ positive

Blood Bank Issue No: BAH26-01599 Date of Collection: 4-7-2026 Date of Expiry: 15-8-2026

Date & Time of Starting Transfusion: 9/7/26 Planned duration of Transfusion: 4 hrs

Check for Correct Unit: ☑ Correct Patient: ☑

Blood products cross checked by: Nurse 1: Anuradha Nurse 2: Pooja

Before starting transfusion vitals: Temp: 98.6F HR: 100/m RR: 32/m BP: 84/58 SpO2 100%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO_2	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
9/7/26	15 Min	152 b/m	98.4°F	99/(50)48	98%	NA	NA	NA	NA
	15 Min	148 b/m	98.5°F	99/(56)50	99%	NA	NA	NA	NA
	30 Min	145 b/m	98.2°F	96/71	99%	NA	NA	NA	NA
	30 Min	150 b/m	98°F	99/(58)51	98%	NA	NA	NA	NA
	30 Min	150 b/m	98.2°F	90/(60)61	99%	NA	NA	NA	NA
	30 Hr	145 b/m	98.4°F	99/(72)60	98%	NA	NA	NA	NA
	1 Hr	142 b/m	98.4°F	90/(52)71	99%	NA	NA	NA	NA

Comments: .....

.....

Name of the Incharge-Nurse: ..... Name of the Nurse: .....

Signature of the Incharge-Nurse: ..... Signature of the Nurse: .....

Date & Time: ..... Date & Time: .....

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2, Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

LR-LEUCO REDUCED BLOOD CELLS IP PEDIA-1

Qty. 50 ml. Prepared from Whole human blood collected in 49 ml. of C.P.D./ SAGM Solution.

A

Rh Positive

HIV I & II/ HBsAG/ HCV - Non reactive
VDRL - Non reactive
MP - Negative
NAT(HIV I & II/ HBsAG/ HCV)- Non reactive

Unit No.: BAH26-01599
Blood Group: A Rh Positive
Collection Date: 04/Jul/2026
Expiry Date: 15/Aug/2026

1) Administer Without Warming. 2) Shake Gently Before Use. 3) Do Not Add Any Medication. 4) Check Blood Group on Label & Recipient's Group and Name Before Administration. With F n Set There /sc if Approj Antibo

Issue Label / CrossMatching Report

Patient : **MASTER.ABDUL HUNAIN -**
Patient's Blood Group :A Rh Positive
Hosp/Dr :Rainbow Childrens Hospital,dr er
UHID No.: BAH-00661076 Wd-Bed No.:

Product : LR-PRBC Pedia-1
Blood Group : A Rh Positive
Unit No.: **BAH26-01599**
XMatching Report:Compatible
X-matched by: PILLEM

Issue Dt : 09/Jul/2026
Colln. Dt :04/Jul/2026
Exp. Dt :15/Aug/2026
Issued By : PILLEM

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2, Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

CONSENT FOR BLOOD TRANSFUSION

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Name: Abdul HUNAIN Age: 4m Gender: Male ☑ Female ☐

UHID.No : BAH-00661076 Date: 10/07

Type of Blood Product:

- ☐ Fresh Frozen Plasma
- ☑ Packed Red Blood Cells
- ☐ Random Donor Platelets
- ☐ Cryoprecipitate
- ☐ Single Donor Platelet
- ☐ Whole Blood
- ☐ Albumin
- ☐ Red Blood Cell
- ☐ Others .....

I Avij hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immuno-deficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

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

N/A

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Signature: Avij

Name: Azhiya

Date & Time 10/07/26.

Doctor (Who is talking the consent)

Signature:

Name: T Pavani

Date & Time 10/07/26

Witness

Signature: Avij

Name: Azhiya

Date & Time

Doc. No. : RCHBH/ FRM / CLINICAL / 014

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రక్త మార్పిడి కొరకు అంగీకార పత్రము

రోగి పేరు: ..... వయస్సు: ..... లింగము ☐ పురుషుడు ☐ స్త్రీ

UHID. సంఖ్య : ..... తేదీ: .....

రక్త ఉత్పత్తి రకాలు:

☐ తాజా ఘనీభవించిన ప్లాస్మా ☐ ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు ☐ Random Donor Platelets

☐ క్రయోప్రెసిపిటేట్ ☐ ఒకే ధాత ప్లేటిలెట్స్ ☐ Whole Blood

☐ మొత్తం రక్తం ☐ ఎర్ర రక్త కణం ☐ ఇతరులు.....

నేను ..... ఇందు మూలముగా రెయిన్బో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నపుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడీస్, హైపటైటీస్ బి సర్ఫేస్ యాంటిజన్, హైపటైటీస్ యాంటిబడీస్, మలేరియా మరియు సిఫ్లిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణిత కాల పరిమితి లో జరిగినప్పటికి పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలెత్తవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు .....

.....

పైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి చికిత్స చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. చికిత్స చేస్తున్న సమయంలో అన్ని రకముల రక్తమార్పిడులకు (మొత్తం రక్తం / లేదా రక్త ఉత్పతులు ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ఫ్రెష్ ఫ్రోజెన్ ప్లాస్మా, క్రయోప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెండెంట్)

సంతకము .....

పేరు .....

తేదీ మరియు సమయము .....

సాక్షి

సంతకం .....

పేరు .....

తేదీ మరియు సమయము .....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము .....

పేరు .....

BAH-00661076 IP5-00176152
Master ABDUL HUNAIN
01-03-2026 0 Y 4 M 8 D (M)
Dr. NALLA ANURAAG REDDY

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BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 10/7 Time: 11:15 AM

Blood Group of the Patient: A (+ve) Blood Group on the Blood Bag: A (+ve)

Blood Bank Issue No: BAH26-01599 Date of Collection: 4/7/26 Date of Expiry: 15/8/26

Date & Time of Starting Transfusion: 10/7, 11:15AM Planned duration of Transfusion: 4 hrs.

Check for Correct Unit: ☑ Correct Patient: ☑

Blood products cross checked by: Nurse 1: Garsi Nurse 2: Laxman.

Before starting transfusion vitals: Temp: 98°F HR 124 b/m RR: 28 b/m BP: 90/50 SpO 99%.

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO_2	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
10/7	15 Min	112	98°	90/50	99%.	NA	NA	NA	NA
10/7	15 Min	114	98°	90/50	99%.	NA	NA	NA	NA
10/7	30 Min	116	98°	90/60	99%.	NA	NA	NA	NA
10/7	30 Min	120	98°	90/60	99%.	NA	NA	NA	NA
10/7	30 Min	122	98°	90/50	99%.	NA	NA	NA	NA
10/7	1 Hr	102	98°	90/50	99%.	NA	NA	NA	NA
10/7	1 Hr	118	98°	90/50	90%.	NA	NA	NA	NA

Comments: .....

.....

Name of the Incharge-Nurse: Pooja Name of the Nurse: Garsi

Signature of the Incharge-Nurse: Pooja Signature of the Nurse: GS

Date & Time: 10/7, 11 AM Date & Time: 10/7, 11 AM

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2, Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

LR-LEUCO REDUCED BLOOD CELLS IP PEDIA-2

Qty. 70 ml. Prepared from Whole human blood collected in 49 ml. of C.P.D./ SAGM Solution.

A

Rh Positive

HIV I & II/ HBsAG/ HCV - Non reactive
VDRL - Non reactive
MP - Negative
NAT(HIV I & II/ HBsAG/ HCV)- Non reactive

Unit No.: BAH26-01599
Blood Group: A Rh Positive
Collection Date: 04/Jul/2026
Expiry Date: 15/Aug/2026

1) Administer Without Warming. 2) Shake Gently Before Use. 3) Do Not Add Any Medication. 4) Check Blood Group on Label & Recipient's

Gro... ...ion Set
Witl... ...t Usc if
The... ...9)
App...
Anti...

Issue Label / CrossMatching Report

Patient : MASTER.ABDUL HUNAIN -
Patient's Blood Group :A Rh Positive
Hosp/Dr :Rainbow Childrens Hospital,dr er
UHID No.: BAH-00661076 Wd-Bed No.:

Product : LR-PRBC Pedia-2
Blood Group : A Rh Positive
Unit No.: **BAH26-01599**
XMatching Report:Compatible
X-matched by: Premalatha

Issue Dt : 10/Jul/2026
Colln. Dt :04/Jul/2026
Exp. Dt :15/Aug/2026
Issued By : Premalatha

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Lic No. 46/HD/TS/2018/BB/G