

BAH-00662115 IP5-00176586
Baby AARVI DIGAMBAR SHINDE
12-10-2023 2 Y 9 M 9 D (F)
Dr. UJJWALA DESAI

Patient Sticl



Baby AARVI DIGAMBAR SHINDE (2 Y 9 M 9 D F)
NIN/00930/NIN/00582 NIN/00076
BA26073228006

SURGERY DETAILS

Date : 21/07/24
Patient Name: Baby Aarvi Digambar Date of Birth: 12-10-2023 Age: 2y
Gender: Female Ward: OT UHID No.: 662115
Date of Surgery: 21/07/24 ☒ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2
Name of the Surgery : minor 2 80

Time in : 10:30am

Time Out : 11:45am

	NAME	AMOUNT
1. Surgeon	D. Nait B. Thylke	
2. Anaesthetist	D. Hemabindu	
3. Assistant Surgeon		
4. OT Technician	Venkat	
5. Circulating Nurse		
6. Assistant Nurse	Sugata, Jyothi	

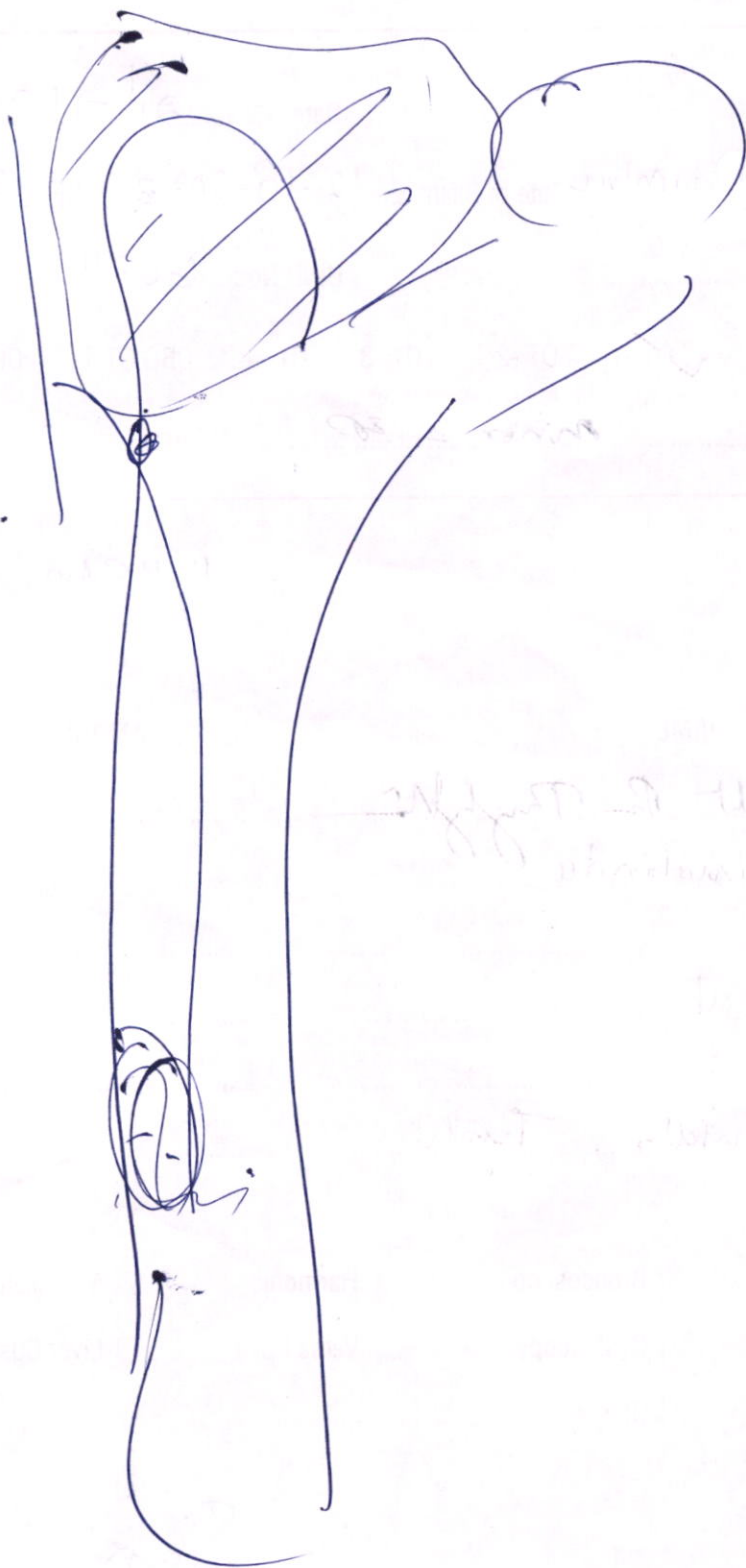
Special Equipment: ☐ Laparoscopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9714654

Order by: Jyothi



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
15/7/26	8:50 pm	CL	118 (first floor)	Ramadev
21/07/26	9:15 am	118	OT (nos)	Graves
21/7	12:10 pm	OT	118	D

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr Venkat Ram Thudrala	20/2	9213299	Bushup
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible][illegible]

BABY. AARVI
 BAH-0066215

Patient Number

5433

2y/12day

138D

CONSUMABLES OF OT

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Circulating staff : Technician : Date : Time : 9:30 AM

Anaesthesia Disposables			Surgical Disposables			Disposables (Baby Side)		
Issued	Used		Issued	Used		Issued	Used	
ET tube 3.5, 4.0, 4.5	1/1	—	Major Pack	1	1	Inj Vit.K		
LMA 2	1	01	Sutures			Cord Clamp		
ECG leads : A (P) N	5	03	Monocryl 4-0, 3-0, 5-0	2/2	1	Suction Catheter		
HME filter : A (P) N	1	01	Gloves 7-7.5	4/2	1	Feeding Tube		
Syringes : 10 cc	10	4	Surgical blade 11	1	1	Vacuum Suction Set		
05 cc	10	4	NG tube 6, 8, 10	1/1	1	Surgical Gloves		
02 cc	10	2	Cautery pencil	1	1	Gauze Pack		
01 cc	2	1	Koochies XL	1	1	Syringe 1ml / 2ml		
Cautery plate : A (P) N	1	01	Ointments			Surgical Blade # 20		
IV set	1	01	Suction Catheter			Koochies (S)		
RL	1	01	Cap, Mask	5/5	1/5	NG 500 ml	1	1
NS : 10ml / 100ml / 500ml / 1000ml	3/1	2/1	Gauze Pack	2/2	2/2	Transo #x	1	1
O2 mask (P)	1	—	Mop Pack	1	1	200cc, 300cc, 500cc	1/1	1/1
Aspirator 0.1	1/1	—	Steristrip					
Fentanyl	1	01	Underpad	1	1	Tr cambe 2224	1/1	—
Morphine			Draw sheet	1	1	Dexa	1	—
Ketamine			Abgel			Tramexa	1	01
Propofol	2	01	Foleys catheter			Mimisplene	1	01
Rocuronium	1	—	Urobag			NG 5, 6, 7, 8, 9, 10		—
Glycopyrolate	1	—	Chest Drainage Catheter			Section cath 6, 8, 10		—
Myopyrolate + Neostigmine	2	—	Bandage			Atropine	1	01
Ondansetron	1	—	Tegaderm			Adrenaline	1	01
Pencan 25g/ Spinal Needle 22	1	01	Ioban			Midez (Laxicard)	1/1	0/1
Bupivacaine 0.25%	1	01	Double J Stent			g site	1	—
Bupivacaine 0.25% (Heavy)			Vacuum Suction set	1	1	Splint 3 + 1 NO	1/1	—
Antibiotics			Plastic Bed Sheet			Nasol Airway 16/18/20/24	1/1	0/1
Suppositories			Betadine Solution	1	1	Dexamide 50	1	—
Anamol : 80mg / 250mg / 170 mg	1/1	—	Microshield	1	1	Clonidine	1	—
Supridol : 100mg			Cotton Balls	1	1	500cc p.molne	1/1	—
Justin : 12.5 mg / 25mg / 100mg	1/1	01	Latex Gloves	10	10	Stethy	1	—
Tab. Misoprost : 200mg			Ramdone Scrub	1	1			
Vacuum set	1	01	Saral					
Gauze	3	01						
Gloves all	4	—						
IV P.C.M	1	01						
3-way 100+100mm	1/1	—						

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 9714302

Ordered by : [Signature]

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

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
18/7/26	IV Placement	1	9710131	Punit
19/7/26	NHA	(1)	9710765	sep
20/7/26	PAC	(1)	9711855	sep
20/7/26	PAC	(1)	971369	(84)

ANY OTHER INFORMATION

(1) OSG small parts - Right hip

Date : 23/7

Time : 2 10am

Prepared By : Chandan

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Chandan	Q-10-1		

ADMISSION SHEET

Registration Details :


Admission No : IP5-00176586 Admit Date : 18-Jul-2026 Admit Time : 08:16 PM UHID : BAH-00662115

Patient Details :

Patient Name	: Baby AARVI DIGAMBAR SHINDE	Age	: 2 Y 9 M 6 D
Guardian	: Mr DIGAMBAR MOHANRAO SHINDE	DOB	: 12-10-2023
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: AT HARNALI , HUNGUNDA (PO), BILOLI (TQ) Kundalwadi Nanded Maharashtra INDIA 431711	Phone No	: 9890202280/ 7036905004
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : GENERAL WARD Bed No : GW 118 Ward Name : 1F-GENERAL WARD I
Room No : GW 118 Admission Type : First Visit

Contact Details :

Name : Mr DIGAMBAR MOHANRAO SHINDE Relationship : Father
Contact Address : AT HARNALI , HUNGUNDA (PO), BILOLI (TQ) Phone No : 9890202280
Kundalwadi Nanded Maharashtra INDIA 431711

NHA
Signature

Doctor Details :

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

Payment Details :

Deposit Amount : 0.00
Payment Mode : Cash Payor Name : SELFPAY



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

BAH-00662115 IP5-00176586
Baby AARVI DIGAMBAR SHINDE
12-10-2023 2 Y 9 M 6 D (F)
Dr. UJJWALA DESAI





Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

cf fever :: 7d.

Rt leg pain & restriction of
movement :: 10d.

History of present illness :

Premorbidly well child.

developed intermittent @ leg pain :: 10d.

decreased walking

developed fever 7d ago. low to moderate
grade, no chills.

a/w increased pain @ Rt leg.

not weight bearing.

restriction of movements

gradually
progressive.

to current state.

was admitted for 1d 17/7 → 18/7.

received meropenem, linezolid, cefepime for 1d.

outside labs - $8.2 > \frac{12K}{65/30} < 2.5L$ CRP-80

17/7 USG - Subcutaneous edema in medial aspect of
Rt thigh S/O cellulitis.

- thickening of right synovium.

minimal streak of fluid in
Rt joint cavity

- @ inguinal lymphadenopathy

17/7 USG abd - cystitis



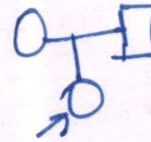
Pediatric Multiorgan History & Physical Examination

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

⊖

Birth & Neonatal History:

Ⓢ perinatal transition



Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History :

Developed as per age

Immunization History :

Immunised as per age.



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 12.3 kg (Centile _____)

On Examination :

Temperature : 97.8°F Pulse Rate : _____ B.P. _____ SPO2 98% JRA

Resp. rate and type of breathing : _____ Rt leg semiflexed @ hip & knee.

Rash ⊖ Ⓡ mild swelling & restriction of movement

Lymphadenopathy Inguinal LN ⊕ ⊕

Oedema : Ⓡ pedal edema ⊕ no redness.

Allergies (if any): ⊖ no other lymphadenopathy

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BAL ⊕

Any addles sounds : ⊖

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S₁ S₂ ⊕

Any murmur : ⊖

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

Per Abdomen :

Inspection _____

Palpation : Soft, NT

Ausculation : BS ⊕

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score :

15 / 15

Cranial Nerves :

NAD

Motor System:

Nutriton :

Tone:

Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR

Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Regular

Clinical Summary & Diagnostic:

Rt hip arthritis & Rt thigh cellulitis
@ medial aspect.



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: to prevent complications

Desired goals of the treatment: hemodynamic stability

Planned Labs:

CBP
CRP, PCT
Blood c/s
RP₂ S. Abstr. + 1 Plain
USG Rt. hip & Tm.
CUE

Planned Management

• Meropenem
• Linezolid
• Ibuprofen Syp.
• IV fluids @ 1/2 maint
• Inj leomeprazole.

noted by
R. Desai
18/7/24
9:10pm

Signature of the Doctor: [Signature]

Name of the Doctor: Sanithi

Date & Time: 18/7/24 8:30PM

Signature of the Consultant: [Signature]

Name of the Consultant: Dr. Ujjwala Desai

Date & Time: 18/7/24

DR. UJJWALA DESAI
Registration No. 90550



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/24 12 AM	Seen by Resident Asis - (R) hip ^{septic} arthritis labs reviewed. child asleep; afebrile hemodynamically stable chest clear abd. soft hydration fair	Plan 1. Continue medicals as charted. 2. Send CUE. 3. Trace Blood C/S 4. US G (R) hip & thigh T/m
19/7/24 8 AM	Seen by Resident Asis - (R) hip ^{septic} arthritis & (L) thigh cellulitis. No fever since admission No fecal issues. pain & restricting movement oral intake less O/E child alert, afebrile hemodynamically stable.	Plan 1. Continue ceftriaxone Meropenem linezolid. 2. RT hip USG today 3. Ortho consultation 4. Send CUE 5. monitor vitals & uniform eos.
DR. UJJWALA DESAI Registration No: 90550	MRL RT Hip & thigh Anus & ch	Salutari

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/10	Admitted by Venkatesh (Ortho)	
		Plan
		MRI Both hips & Rt thigh
		under anesthesia
20/10/23 10 AM	Seen by Resident ASis - Rt hip septic arthritis E Rt thigh cellulitis No fever spikes pain & tenderness (+) O/E Child alert, afebrile hemodynamically stable chest clear abdomen soft hypernat pain	By Plan 1. continue medications as charted 2. monitor vitals & inform SOS 3. Ortho opinion
20/10/23 4:30 PM	Seen by Resident ASis - Rt hip septic arthritis proximal femur head osteomyelitis hemodynamically stable	Plan 1. Plan Incision & Drainage tomorrow 2. PAC, POC to be done 3. NPO as per PAC. 4. monitor vitals & inform SOS.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 9 AM	Seen by Resident ASis - (R) Septic arthritis S/P I&D POD-1. spontaneously moving (R) hip. No pain but under control No fevers O/E child asleep, afebrile hemodynamically stable. chest clear, abd soft.	Plan 1. Continue LINEZOLID MEROPENEM 2. monitor vitals 3. Trace marrow wash US. Sanitini
	Blood clt - NG pt. 48hrs.	Continue IV antibiotic.
	↓ Tremors, brd.	
22/7/26 4 PM	Seen by Resident ASis - (R) Septic arthritis S/P I&D POD-1 No fever issues accepting orally hemodynamically stable	DR. UJJWALA DESAI Registration No: 90550 22/7/26 4 PM Plan 1. Continue medication as charted 2. Trace marrow wash AFB, gram staining, U/S Sanitini
	DR. UJJWALA DESAI Registration No: 90550	Sanitini

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/7/26. 8:45 AM.	Seen by Resident. Assis - (R) hip septic arthritis S/P IcyD POD-2. No fevers pain under control. movements of (R) leg (L). O/E child alert, afebrile hemodynamically stable. chest clear, abd. soft.	Plan 1. Continue LINEZOLID MEROPENEM } Do. 2. Thru microbiological investigations. 3. Ortho consultation for discharge plan \$ santia
		Stop Tremadol.
	IV Meropenem BD.	
	IV. Linezolid 600	DOV
	BD injection	Drug
	Afternoon oral. Ibuprofen	9am
	8yp Betron	
		DR. UJJWALA DESAI Registration No: 90550
		23/7/26



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



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

[illegible]



CROSS CONSULTATION FORM

Doctor Name : Dr. Venkatesh Date : 20/7/24 Time : 4:30p

Diagnosis : 1

Hospital :

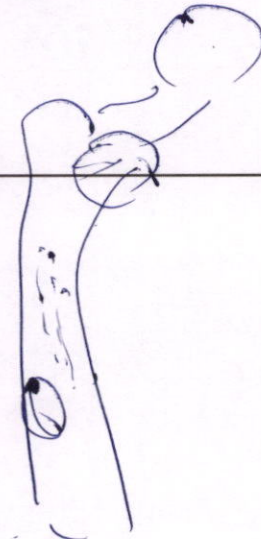
Type of Referral :

- ☐ Emergency
☐ Urgent
☐ Non Urgent

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

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

Findings and Recommendations :



Signature:

Dr. Venkatesh
2. Venkatesh

ma) - subchalcic chond

- m - narrow chond

g. per a chond n
(R24 regn - 10th
occh

2 - chond
- chond
(R24
and
occh

omg (2) ground form
right regn -

fl = 280 (mm)

Consultant :

Name : Dr. Venkatesh Signature : [Signature] Date & Time : 4:30p

20/7/2024

10:00 am
Cyr
✓
✓

BAH-00662115 IP5-00176586
 Baby AARVI DIGAMBAR SHINDE
 12-10-2023 2 Y 9 M 6 D (F)
 Dr. UJJWALA DESAI



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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

RESULT SHEET

BG - B + ve.

Date	18/7	22/7			
Time	10 PM.				
Hb	7.5	7.7			
PCV	23.7	25.7			
RBC	3.9	4.11			
WBC	12.3 k	12.14 k			
N/L	(35/53)	(43/41)			
Platelets	3.97 L	7.67 L			
CRP	62	25 ↓			
ESR					
PCT	5.94	0.38 ↓			
RBS					
Na	137				
K	4.2				
Cl	106				
Ca/Mg					
Phosphate					
Urea	12				
Creatinine	0.3				
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid		2.			
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L	H ₂ O ₃	16			

Date	19/7/26					
Time						
CUE - Alb	⊖					
CUE - Sugar	⊖					
CUE - Ketones	Trace					
CUE - PUS Cells	3-4					
CUE - RBC Cells	0					
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : 20/7/26 stool clg - NA for 48hr

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI :

Others (ECG, Contrast Studies etc.) :

BAH-00862115 IP5-00176586
Baby AARVI DIGAMBAR SHINDE (F)
12-10-2023 2 Y 9 M 6 D
Dr. UJJWALA DESAI

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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 : Sanithi

Date & Time : 18/7/26 8PM

Nurse Name & Signature : Ranveer

Date & Time : 18/7/26 at 8:20pm

Ward

VERIFIED BY: Name



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : <u>5mg TRAMADOL</u>				Date Time	<u>22/7</u>	<u>2:30 PM</u>														
Dose	Route	Frequency	Start Dt.																	
<u>12mg</u>	<u>IV</u>	<u>TID</u>	<u>22/7</u>																	
Name & Signature of the Doctor Starting the Drugs:				<u>Sahitni</u> <u>23/7/26</u> <u>STOP</u> <u>9pm</u> <u>2pm</u> <u>10pm</u>																
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																			

Signature

VERIFIED BY : Name

AC

BAH-00662115 IP5-00176586
 Baby AARVI DIGAMBAR SHINDE
 12-10-2023 2 Y 9 M 6 D (F)
 Dr. UJJWALA DESAI



DRUG CHART

Date of Admission: 18/7/26 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 : <u>Syp PARACETAMOL</u>				Date Time															
Dose <u>4 ml</u>	Route <u>PO</u>	Frequency <u>SOS</u>	Start Date <u>18/7</u>																
Doctor's Signature <u>Sanithi</u>		Valid Period	Pharm.																
Additional Instructions: <u>temp > 100°F (5/140)</u> <u>max 6 hourly.</u>																			
DRUG : <u>Syp IBUGESIC (5/100)</u>				Date Time															
Dose <u>6 ml</u>	Route <u>PO</u>	Frequency <u>SOS</u>	Start Date <u>18/7</u>																
Doctor's Signature <u>Sanithi</u>		Valid Period	Pharm.																
Additional Instructions: <u>temp > 102°F</u> <u>max 8 hourly</u>																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			



REGULAR PRESCRIPTIONS

Weight. 12 kg Ward. 5A

VERIFIED

VERIFIED

VERIFIED

VERIFIED

DRUG : <u>Inj. LINEZOLID</u>				Date	Time
Dose	Route	Frequency	Start Date	18/7	19/7
120mg	IV	TID	18/7/26	6AM	X
Name & Signature of the Doctor				2PM	X
Starting the Drugs:				10PM	X
Additional Instructions:				2PM	X
Daily Doctor's Endorsement by a Sign				2PM	X
DRUG : <u>Inj. MEROPENEM</u>				Date	Time
Dose	Route	Frequency	Start Date	18/7	19/7
500mg	IV	TID	18/7/26	6AM	X
Name & Signature of the Doctor				2PM	X
Starting the Drugs:				10PM	X
Additional Instructions:				2PM	X
Daily Doctor's Endorsement by a Sign				2PM	X
DRUG : <u>Inj. ESOMEPRAZOLE</u>				Date	Time
Dose	Route	Frequency	Start Date	18/7	19/7
10mg	IV	OD	18/7/26	10PM	X
Name & Signature of the Doctor				2PM	X
Starting the Drugs:				10PM	X
Additional Instructions:				2PM	X
Daily Doctor's Endorsement by a Sign				2PM	X
DRUG : <u>Syp. IBUPROFEN</u>				Date	Time
Dose	Route	Frequency	Start Date	18/7	19/7
6ml	P/O	TID	18/7/26	6AM	X
Name & Signature of the Doctor				2PM	X
Starting the Drugs:				10PM	X
Additional Instructions:				2PM	X
Daily Doctor's Endorsement by a Sign				2PM	X



		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.	

[illegible]

VERIFIED BY : Nan

арн

Securely
Apply
Synthetic
Wound Dressing

I.V. FLUIDS CHART

Weight. 12 kg. Ward.



Concentration of I.V. Fluid
 (in ml./hr = Mcg/kg/min. etc)

Route

Flow Rate
 ml/hr

Doctor
 Sign

Nurse
 Sign

Date of
 Stopping

Doctor
 Sign

Nurse
 Sign

18/7/26
 9:30 PM

DNS
 (1/2 maint)

IV

24
 ml/hr

\$

Pranika
 Desai

20/7
 10:30 AM

\$

20/7
 21/7

DNS
 100% maint
 clearing NPO

IV

45
 ml/hr

\$

Chandana
 Arjun

22/7 \$

Pranika
 Desai

Signature

VERIFIED BY : Name

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)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 22/10/23	Time: 10:55 PM
Doctor / Nurse / Family Concern? 6am 10am 10:55 PM 1pm 6pm 9:30pm	
Temperature (F)	
Heart Rate (bpm)	
and	
Blood Pressure (mmHg) *	
Note: BP does not score in early warning scoring	
Heart Rate (Number)	118L 130b/m 121b/m 144b/m
Resp. Rate (bpm) (Over 1 Minute) *	
Resp Rate (Number)	28L 29b/m 28b/m 26b/m
Resp Mod/ Severe Distress None / Mild	
Receiving O ₂ (l/min) O ₂ Saturations (%)	98% 100% 90% 100%
Conscious Level Normal / Altered	
GCS *	15/15 15/15 15/15 15/15
TOTAL SCORE	
Number of shaded boxes	1 1 1 1
Pain Score	0 0 0 0
Observer's Initials	0 0 0 0

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-0062115 IP5-00176586
Baby AARVI DIGAMBAR SHINDE
12-10-2023 2 Y 9 M 8 D (F)
Dr. UJJWALA DESAI



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

PRESCHOOL (1-5 years)

Children's Observation &
Early Warning Scoring Chart

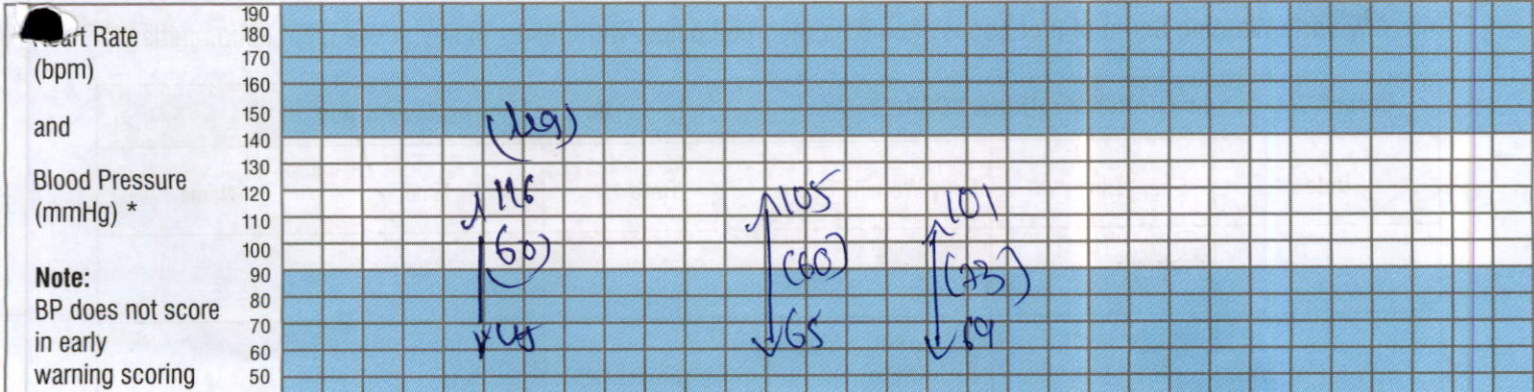
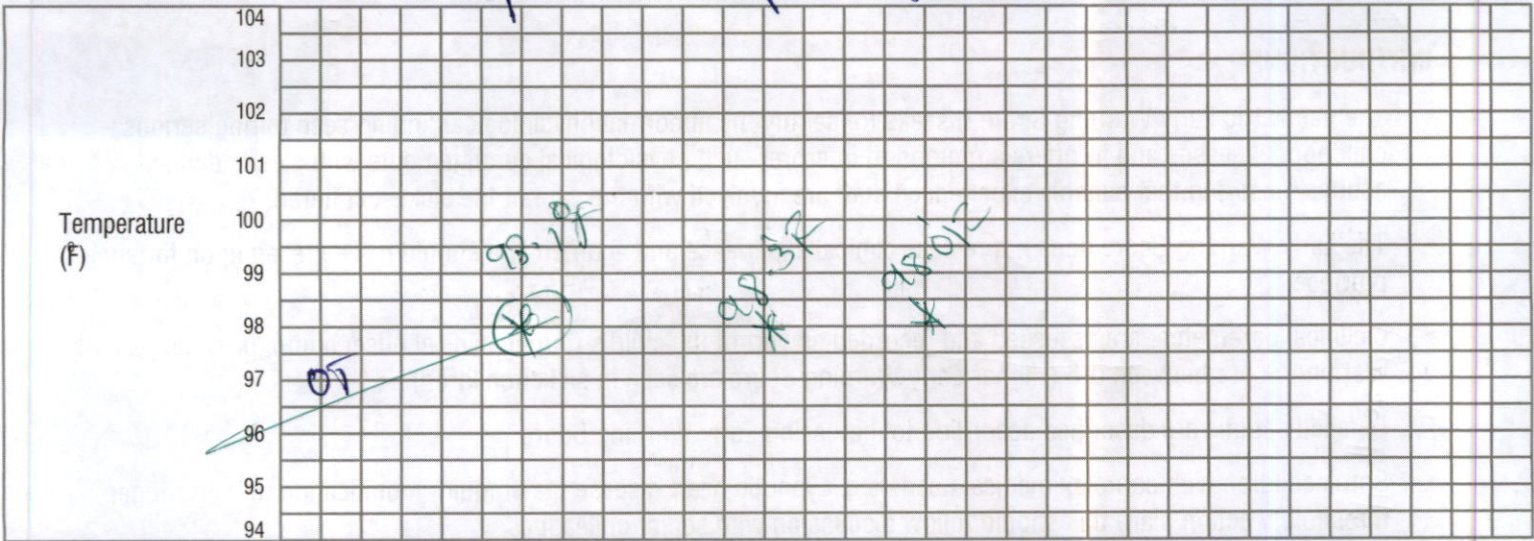
Pratiksha
Rainbow
Children's
Hospital
It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/07/23 Time: 10:30

Doctor / Nurse / Family Concern? *nm* *6pm* *10p* *2a*



Heart Rate (Number) *105 bpm* *118* *108*



Resp Rate (Number) *36 bpm* *28* *28*

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min)
O₂ Saturations (%) *98.1* *98.4* *98.1*

Conscious Level Normal / Altered

GCS * *15/15* *15/15* *15/15*

TOTAL SCORE

Number of shaded boxes *1* *1* *1*

Pain Score *0* *0* *0*

Observer's Initials *O* *O* *O*

ACTIONS

NB: Scores 3 should be recorded overleaf

Score 1 : Continue normal observation by staff nurse

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

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

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- 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)



EARLY WARNING SCORE: CHILDREN'S UNIT

21/12/26

Date : 20/07/26	Time:	10am	1pm	6pm	10pm	2AM	6AM
Doctor / Nurse / Family Concern?							
Temperature (F)	104						
	103						
	102						
	101						
	100						
	99	98.0 F *					
	98			98.0 F	98.0 F	98.0 F	98.0 F
	97						
	96						
	95						
94							
Heart Rate (bpm) and Blood Pressure (mmHg) *	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
Note: BP does not score in early warning scoring	90						
	80						
	70						
	60						
	50						
	107						
	108						
	100						
	95						
	85						
Heart Rate (Number)	150 bpm		140 bpm	142 bpm	113 bpm	112 bpm	
Resp. Rate (bpm) (Over 1 Minute) *	70						
	60						
	50						
	40						
	30						
	20						
	10						
	26 bpm		25 bpm	26 bpm	26 bpm	27 bpm	
	Resp	Mod/ Severe					
	Distress	None / Mild					
Receiving O ₂ (l/min)							
O ₂ Saturations (%)	100%	99%	97%	98%	98%		
Conscious Level	Normal						
	Altered						
GCS *	15/15	15/15	14/15	14/15	14/15		
TOTAL SCORE							
Number of shaded boxes	0	1	1	1	1		
Pain Score	0	0	0	0	0		
Observer's Initials							

ACTIONS

NB: Scores 3 should be
 recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00662115 IP5-00176586
Baby AARVI DIGAMBAR SHINDE
12-10-2023 2 Y 9 M 6 D (F)
Dr. UJJWALA DESAI



No. : RCH/ FRM / CLINICAL / 125

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

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 19/7/25	Time: 20:12
Doctor / Nurse / Family Concern?	10am 2pm 6pm 10pm 2am 6am
Temperature (°F)	104 103 102 101 100 99 98 97 96 95 94
Heart Rate (bpm)	190 180 170 160 150 140 130 120 110 100 90 80 70 60 50
Blood Pressure (mmHg) *	100 90 80 70 60 50
Note: BP does not score in early warning scoring	
Heart Rate (Number)	110b/m 107b/m 115b/m 111b/m 110b/m
Resp. Rate (bpm) (Over 1 Minute) *	70 60 50 40 30 20 10
Resp Rate (Number)	27b/m 26b/m 28b/m 27b/m 27b/m
Resp Mod/ Severe Distress None / Mild	
Receiving O ₂ (l/min) O ₂ Saturations (%)	99% 100% 98% 99% 100%
Conscious Level Normal Altered	
GCS *	15/15 15/15 15/15 15/15 15/15
TOTAL SCORE	
Number of shaded boxes	
Pain Score	
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. Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.
NB: Scores 3 should be recorded overleaf	

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 18/7	Time: 80 PM	2 AM	6 AM		
Doctor / Nurse / Family Concern?					
Temperature (°F)	104				
	103				
	102				
	101				
	100	98.5°F	97.5°F	96.3°F	
	99				
	98				
	97				
	96				
	95				
Heart Rate (bpm)	190				
	180				
	170				
	160				
	150				
	140				
	130				
	120				
	110				
	100				
Blood Pressure (mmHg) *	90	103/65 (74)	100/60 (73)	102/60 (74)	
	80				
	70				
	60				
	50				
	190				
	180				
	170				
	160				
	150				
Heart Rate (Number)	105 bpm	108 bpm	112 bpm		
Resp. Rate (bpm) (Over 1 Minute) *	70				
	60				
	50				
	40				
	30				
	20				
	10				
	Resp Rate (Number)	23 bpm	25 bpm	25 bpm	
	Resp Distress	Mod/ Severe			
	None / Mild				
Receiving O ₂ (l/min)					
O ₂ Saturations (%)	99%	99%	100%		
Conscious Level	Normal				
Altered					
GCS *	15/15	15/15	15/15		
TOTAL SCORE					
Number of shaded boxes	1	1	1		
Pain Score	0	1	2		
Observer's Initials	2	1	2		

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00662115 IP5-00176586
 Baby AARVI DIGAMBAR SHINDE
 12-10-2023 2 Y 9 M 6 D (F)
 Dr. UJJWALA DESAI



Patient

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

FLUID CHART

Sheet No. : ①

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

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



FLUID CHART

Sheet No. : 2

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	Sign.	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	Nurse
			Mouth	I.V	N.G							
18/10/23	08:00 am					/		/	/		0	
	09:00 am			24ml		/		/	/		0	
	10:00 am	ONS	24ml			/		/	/		0	Surat
	11:00 am		24ml			/		/	/		0	Surat
	12:00 pm		24ml			/		/	/		0	Surat
	01:00 pm					/		/	/		0	Surat
Total Intake :					Total Output :							
19/10/23	02:00 pm			24ml		/		/	/		0	
	03:00 pm			24ml		/		/	/		0	Surat
	04:00 pm	ONS	24ml			/		/	/		0	Surat
	05:00 pm					/		/	/		0	Surat
	06:00 pm					/		/	/		0	Surat
	07:00 pm					/		/	/		0	Surat
Total Intake :					Total Output :							
19/10/23	08:00 pm		24ml			/		/	/		0	Chander
	09:00 pm		24ml			/		/	/		0	Chander
	10:00 pm	ONS				/		/	/		0	Chander
	11:00 pm					/		/	/		0	Chander
	12:00 am					/		/	/		0	Chander
	01:00 am		24ml			/		/	/		0	Chander
Total Intake :					Total Output :							
20/10/23	02:00 am		Npo	24ml		/		/	/		0	Chander
	03:00 am			24ml		/		/	/		0	Chander
	04:00 am			24ml		/		/	/		0	Chander
	05:00 am	ONS	24ml			/		/	/		0	Chander
	06:00 am					/		/	/		0	Chander
	07:00 am					/		/	/		0	Chander
Total Intake :					Total Output :							
Total 24 hrs. Intake					Total 24 hrs. Output							

BAH-00662115 IP5-00176586
 Baby AARVI DIGAMBAR SHINDE
 12-10-2023 2 Y 9 M 7 D (F)
 Dr. UJJWALA DESAI



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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
20/10	08:00 am	DNS			/		/		/		0	Srivasthi	
	09:00 am				/		/		/		0		
	10:00 am				/		/		/		0		
	11:00 am				/		/		/		1		cannula changed
	12:00 pm				/		/		/		0		
	01:00 pm				/		/		/		0		
Total Intake :						Total Output :							
21/10	02:00 pm	DNS		R e f u s e d	/		/		/		0	Srivasthi	
	03:00 pm				/		/		/		0		
	04:00 pm				/		/		/		0		Srivasthi
	05:00 pm				/		/		/		0		
	06:00 pm				/		/		/		0		
	07:00 pm				/		/		/		0		
Total Intake :						Total Output :							
22/10	08:00 pm	NO IV			/		/		/		0	Sushma	
	09:00 pm			/		/		/		0			
	10:00 pm			/		/		/		0			
	11:00 pm			/		/		/		0	Sushma		
	12:00 am			/		/		/		0			
	01:00 am			/		/		/		0			
Total Intake :						Total Output :							
23/10	02:00 am	NO IV			/		/		/		0	Sushma	
	03:00 am			/		/		/		0			
	04:00 am			/		/		/		0	Sushma		
	05:00 am			/		/		/		0			
	06:00 am			/		/		/		0			Sushma
	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							
21/7	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :					Total Output :						
21/7	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
	Total Intake :					Total Output :						
21/7	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
	Total Intake :					Total Output :						
22/7	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							

BAH-00662115 IP5-00176586
 Baby AARVI DIGAMBAR SHINDE
 12-10-2023 2 Y 9 M 9 D (F)
 Dr. UJJWALA DESAI



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						
20/12	08:00 am		Milk						✓	0	Appu
	09:00 am									0	
	10:00 am	125								0	
	11:00 am								✓	0	
	12:00 pm	1							✓	0	
	01:00 pm									0	
Total Intake :					Total Output :						
21/12	02:00 pm									0	Pur
	03:00 pm								✓	0	
	04:00 pm	No								0	
	05:00 pm	100				✓			✓	0	
	06:00 pm									0	
	07:00 pm					✓				0	
Total Intake :					Total Output : M-2 U-2						
22/12	08:00 pm									0	Ch
	09:00 pm								✓	0	
	10:00 pm	No								0	
	11:00 pm	100				n			✓	0	
	12:00 am					p				0	
	01:00 am								✓	0	
Total Intake :					Total Output : M-0 U-3						
23/12	02:00 am									0	Ch
	03:00 am								✓	0	
	04:00 am	No								0	
	05:00 am	100				n			✓	0	
	06:00 am									0	
	07:00 am									0	
Total Intake :					Total Output : M-0 U-2						

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						

BAH-00662115 IP5-00176586
 Baby AARVI DIGAMBAR SHINDE
 12-10-2023 2 Y 9 M 6 D (F)
 Dr. UJJWALA DESAI



NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 18/7

Assessment: Baby having Poor 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
10am	→ Assess the baby general Condition	10:10am	→ Assessed the baby general Condition	baby Condition is stable
12am	→ monitor the vitals	12:10am	→ monitored the vitals	
2am	→ maintain IV fluid's	2:10am	→ maintained IV fluid's	
4am	→ Provide comfortable position	4:10am	→ Provided comfortable position	
6am	→ Administer medication as per doctor order's	6:10am	→ Administered medication as per doctor order's	

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name: Pooja

Date & Time: 19/7 @ 8am



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 19/11/26

Assessment: Baby having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the general condition of the child	8/5 am	→ Assessed the general condition of the child.	By done all the procedures ... both girls good
10am	→ Monitor the vital signs	10/5 am	→ Monitored the vital signs.	
12pm	→ provide comfortable position	2pm	→ provided comfortable position.	
3pm	→ Maintain good nutritional food	4pm	→ Maintained good nutritional food.	
6pm	→ provide solid meals	6:30 pm	→ provided solid meals.	
7:30 pm	→ Administer medication as per doctor order	8pm	→ Administered medication as per doctor order.	

Re-Assessment:

Special Notes:

MRI (t/m) sedation both hip & thigh anesthesia

Nurse Signature:

Nurse Name: Swarna

Date & Time: 19/11/26 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 19/7/24

Assessment: pt having dull activity

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
☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the pt General Condition	8:10pm	→ Assessed the pt General Condition	
10pm	→ Check the vital signs	10:10pm	→ Checked the vital signs	
12am	→ plan for Administration medication	12:10am	→ Providing medication as per doctor Order	
2am	→ plan for S/O Chest	2:10am	→ maintaining S/O Chest	
	→ plan for MRI		→ T/m MRI	
8am	→ plan for Comfortable position	8:10am	→ Providing Comfortable position	pt is stable

Re-Assessment: Re-Assessment Every 4th hrly

Special Notes: MRI T/m

Nurse Signature: As

Nurse Name: Chandan

Date & Time: 20/7/24 2pm

BAH-00662115 IP5-00176586
Baby AARVI DIGAMBAR SHINDE
12-10-2023 2 Y 9 M 6 D (F)
Dr. UJJWALA DESAI



NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SI

☐ Night

Date: 20/7/26

Assessment: Baby having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the general condition of the baby	8am	Assessed the general condition of the baby	by done all these to improve baby condition
8:30am	Baby went to MRI and came back ward.	11:30am	Baby went to MRI & came back ward	
12pm	Dr. Ujjwala mam advis ortho consultation.	12pm	Dr. Ujjwala mam advised ortho consultation	
6pm	monitor vital sings & record	6pm	monitor vital sings & record	
7pm	Administer medication as per doctor orders	7pm	Administered medication as per doctor orders.	

Re-Assessment:

Special Notes:

in session & drainage t/m.

Nurse Signature:

Sravanthi

Nurse Name:

Sravanthi

Date & Time:

20/7/20 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/10/23

Assessment: Baby having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 PM	Assess the pt general condition.	9 PM	Assess the pt general condition	By done all implementation as per order
9 PM	monitor vital sign	10 PM	monitored vital sign	
10 PM	maintain IO chart	11 PM	maintain IO chart	
11 PM	provide comfortable position	12 AM	provided comfortable position	
12 AM	Administer medication as per order	6 AM	Administered medication as per order	

Re-Assessment:

Special Notes:

Tim Surgery NPO - 3:30 AM

Nurse Signature: Su

Nurse Name: Rushing

Date & Time: 21/10/23 @ Day

BAH-00662115 IP5-00176586
 Baby AARVI DIGAMBAR SHINDE
 12-10-2023 2 Y 9 M 8 D (F)
 Dr. UJJWALA DESAI



NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 21/07/26

Assessment: Baby having mild pain of lower legs.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the baby general Condition	8:10a	Assessed the baby general Condition and monitored the vitals and recorded.	By doing all above procedure baby Condition improving well.
8:30am	and monitor the vitals and record.	8:45a	Continued medication as per chart.	
8:50am	Continue DMS @ 45 ml/hr.	9:10am	Continued DMS @ 45 ml/hr	
9am	Blood Group - B+ve. it's reserve. Brother Ramesh.	9:20am	Blood Group - B+ve. it's reserved brother Ramesh. Npo at 3:30am.	
9:30am	Npo at 3:30am	9:35am	Provided Comfortable position advised	
9:40am	Continue medication as per chart.	9:45am	USG screening done	
9:45am	Provide Comfort position.	9:50am	shifted OT.	
9:50am	Shift to OT.			

Re-Assessment: Re assessment done

Special Notes: Plan for Rt Hip & Thigh Incision and Drainage.

Nurse Signature: Srauli

Nurse Name: K. Srauthi ID 607682

Date & Time: 21/07/26 @

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 17/12/26

Assessment: Acute pain related to the procedure

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 pt General Condition.	2:30pm	Assessed the pt General Condition.	pt is Conscious & oriented
3pm	Relieve Pain & Discomfort	3:40pm	Relieved Pain & Discomfort	vital stable
	monitor vital signs	4:00pm	monitored vital signs	no bleeding
4pm	monitor for bleeding	4:30pm	monitored for bleeding	maintained
5pm	maintain I/O chart	5:40pm	maintained I/O chart	no vomiting
6pm	no status maintained	6:40pm	no broken, water given	shifted
7pm	pt shift to the ward	7:40pm	pt shifted to the ward	

Re-Assessment:

Special Notes:

Nurse Signature: [Signature] Nurse Name: [Signature] Date & Time: 21/12/26

BAH-00662115 IPS-00176586
 Baby AARVI DIGAMBAR SHINDE
 12-10-2023 2 Y 9 M 9 D (F)
 Dr. UJJWALA DESAI



NURSING CARE RECORD

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

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

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 21/12/26

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the general condition of the patient.	8pm	* Assessed the general condition of the patient.	By doing all the procedures the patient can be stable.
10pm	* maintain personal hygiene	10pm	* maintained personal hygiene.	
12am	* monitor vitals.	12am	* monitored vitals.	
2am	* maintain good nutrition	2am	* maintained good nutrition.	
6am	* provide comfortable position	6am	* provided comfortable position	

Re-Assessment:

Monitor vitals.

Special Notes:

Nurse Signature:

Nurse Name: @inya [018165]

Date & Time: 22/12/26 @ 8am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 22/7/26

Assessment: Baby Having pain at surgical site

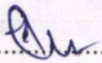
Goals

- ☒ 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
9am	→ Assess the Baby General condition, monitor vitals & Record	10am	→ Assessed the Baby General condition, monitored vitals & Recorded	By All these done pt condition is improved
11am	→ provide comfortable position	11:30am	→ provided comfortable position	
12pm	→ plan to start tramadol 1mg iv tid	12:30pm	→ planned to do start tramadol	
1pm	→ Administer medication as per doctor order	2pm	→ Administered medication as per doctor order	

Re-Assessment:

Special Notes:

Nurse Signature: 

Nurse Name: Anant Kulkarni (001266)

Date & Time: 22/7/26 02pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 22/7/26

Assessment: Baby having pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the baby general condition & monitor the vital sign.	3pm	Assessed the baby general condition & monitored the vital sign.	By doing all the procedure Baby condition is improved slowly
4pm	Maintain the Ilo chest	4:30 pm	Maintained the Ilo chest	
5pm	Administer the medication as per doctor order.	5:30 pm	Administered the medication as per doctor order.	
6pm	provide the comfortable position.	6:30 pm	provided the comfortable position.	
		7pm	Maintained the personal hygiene	

Re-Assessment:

Special Notes:

Nurse Signature: V. Ravina

Nurse Name: V. Ravina (007719)

Date & Time: 22/7/26 @ 8pm

BAH-00662115
Baby AARVI DIGAMBAR SHINDE
12-10-2023 2 Y 9 M 10 D
Dr. UJJWALA DESAI (F)

NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 22/7

Assessment: baby having pain at surgical site

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 pt general condition.	8:10pm	Assessed pt general condition.	by doing above all the care pt condition normal
10am	provide comfortable position.	10:10pm	provided comfortable position.	
12am	monitor vitals.	12:10am	monitored vitals & recorded.	
	maintain ilo chart		maintained ilo chart	
	colt pain.		Baby having pain at 10pm.	
2am	Ensure safety.	2:10am	administered tramadol medicine	
6am	Administer medications as per chart (for pain tramadol)	6:10am	Ensured safety.	
8am		8:10am		

Re-Assessment: monitored vitals, colt pain

Special Notes: pain at (0am) (Administered pain relief tramadol)

Nurse Signature: [Signature] Nurse Name: Anitha Date & Time: 23/7/26 (@ 8am)

BAH-00662115 IP5-00176586
 Baby AARVI DIGAMBAR SHINDE
 12-10-2023 2 Y 9 M 10 D (F)
 Dr. UJJWALA DESAI



NURSING CARE RECORD

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

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

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

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:

Pat



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. V.D. Department: Pediatrics Date of Admission: 18/7/23

SITUATION		Diagnosis: <u>Rt hip arthritis</u>						Any Infection: ☐ Yes ☒ No ☐ Not Known	
		If Yes Specify: _____							
BACKGROUND	Area	<u>1st floor</u>	<u>2nd floor</u>	<u>3rd floor</u>	<u>4th floor</u>	<u>5th floor</u>	<u>6th floor</u>	<u>7th floor</u>	<u>8th floor</u>
	Shift Time	<u>8-8pm</u>	<u>8pm-8am</u>	<u>8am-8pm</u>	<u>8pm-8am</u>	<u>8pm-8am</u>	<u>8pm-8am</u>	<u>8pm-8am</u>	<u>8pm-8am</u>
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>LEA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
ASSESSMENT	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>98.5F</u>	<u>98.5F</u>	<u>97.9</u>	<u>98.1F</u>	<u>98.0F</u>	<u>98.1F</u>	<u>98.1F</u>
		Res:	<u>26bpm</u>	<u>28bpm</u>	<u>28</u>	<u>28bpm</u>	<u>26bpm</u>	<u>26</u>	<u>26</u>
		SpO ₂ :	<u>98%</u>	<u>99</u>	<u>100%</u>	<u>100%</u>	<u>99bpm</u>	<u>99bpm</u>	<u>99bpm</u>
		Pulse:	<u>116bpm</u>	<u>107</u>	<u>110</u>	<u>116bpm</u>	<u>110bpm</u>	<u>107/52/62</u>	<u>113</u>
		BP:	<u>92/54</u>	<u>99/65</u>	<u>103/54</u>	<u>98/60</u>	<u>110/70</u>	<u>113</u>	<u>113</u>
		Fall Risk Score:	<u>0/10</u>	<u>0/10</u>	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>		
Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>LEA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Rutika</u>	<u>Rutika</u>	<u>Swarna</u>	<u>Chandan</u>	<u>Anura</u>	<u>Sushma</u>	<u>Sushma</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>18/7</u>	<u>19/7</u>	<u>19/7</u>	<u>20/7</u>	<u>20/7</u>	<u>21/7</u>	<u>21/7</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>8pm</u>	<u>8am</u>	<u>8pm</u>	<u>8am</u>	<u>8am</u>	
Taken Over By Name :		<u>Rutika</u>	<u>Swarna</u>	<u>Chandan</u>	<u>Sravanthi</u>	<u>Sushma</u>	<u>Sushma</u>	<u>Sushma</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>18/7</u>	<u>19/7</u>	<u>19/7</u>	<u>20/7</u>	<u>20/7</u>	<u>21/7</u>	<u>21/7</u>	
Time:		<u>8:30pm</u>	<u>2am</u>	<u>8pm</u>	<u>8am</u>	<u>8am</u>	<u>8am</u>	<u>8am</u>	

TRANSFERRING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Ujjwala Desai Department: Paediatric Date of Admission: 12/10/23

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	<u>RT RT Hip Arthroplasty</u>							
BACKGROUND	Area	Shift Time	<u>1st floor</u> <u>8am-9:30 am</u>	<u>OT</u> <u>9:30-11:30</u>	<u>1st floor</u> <u>9:30-11:30</u>	<u>1st floor</u> <u>8-8:30</u>	<u>1st floor</u> <u>8am-9:30</u>	<u>1st floor</u> <u>2pm-8pm</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:		Temp: <u>98.7°F</u>	<u>98.6°F</u>	<u>97.1°F</u>	<u>98.2°F</u>	<u>98.1°F</u>	<u>98.2°F</u>
	Res:		<u>26bpm</u>	<u>25bpm</u>	<u>26bpm</u>	<u>28L</u>	<u>29bpm</u>	<u>26bpm</u>
	SpO ₂ :		<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>	<u>99%</u>
	Pulse:		<u>112</u>	<u>84</u>	<u>116bpm</u>	<u>118bpm</u>	<u>120bpm</u>	<u>124bpm</u>
	BP:		<u>98/62</u>	<u>86/42</u>	<u>90/61</u>	<u>99/62</u>	<u>100/60</u>	<u>99/65</u>
	Fall Risk Score:		<u>0</u>	<u>1</u>	<u>1</u>	<u>1</u>	<u>1</u>	<u>1</u>
Recommendations	Pain Score:		<u>0/10</u>	<u>1/10</u>	<u>1/10</u>	<u>1/10</u>	<u>0/10</u>	<u>0/10</u>
	Safety Needs:		<u>NA</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Post Operative Procedure Special Orders:			<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :			<u>K. S. S. S. S.</u>	<u>Aravind</u>	<u>Aravind</u>	<u>Aravind</u>	<u>Ravina</u>	
Signature :			<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:			<u>21/10/23</u>	<u>21/10</u>	<u>21/10</u>	<u>22/10</u>	<u>22/10</u>	
Time:			<u>10:00 AM</u>	<u>1:00 PM</u>	<u>8:00 AM</u>	<u>2:00 PM</u>	<u>8:00 PM</u>	
Taken Over By Name :			<u>Aravind</u>	<u>K. S. S. S. S.</u>	<u>Aravind</u>	<u>Aravind</u>	<u>Aravind</u>	
Signature :			<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:			<u>21/10</u>	<u>21/10</u>	<u>22/10</u>	<u>22/10</u>	<u>22/10</u>	
Time:			<u>10:00 AM</u>	<u>1:00 PM</u>	<u>8:00 AM</u>	<u>2:00 PM</u>	<u>8:00 PM</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. U.D. Department: Paed Date of Admission: 18/7/23

SITUATION	Diagnosis: <u>At Rt Hip Arthritis</u>		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Area	Shift Time	<u>14:00</u> <u>8pm to 8am</u>					
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>NA</u>					
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:	<u>95.5°F</u>					
		Res:	<u>26</u>					
		SpO ₂ :	<u>99%</u>					
		Pulse:	<u>112</u>					
		BP:	<u>98/70</u>					
		Fall Risk Score:	<u>1</u>					
Pain Score:		<u>0/10</u>						
Recommendations	Safety Needs:		<u>NA</u>					
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:		<u>NA</u>					
	Special Diet:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:		<u>NA</u>					
Post Operative Procedure Special Orders:		<u>NA</u> <u>Attention 2nd day</u>						
Handed Over By Name :		<u>Ankita</u>						
Signature :		<u>[Signature]</u>						
Date:		<u>23/7</u>						
Time:		<u>8am</u>						
Taken Over By Name :		<u>Chandni</u>						
Signature :		<u>[Signature]</u>						
Date:		<u>23/7</u>						
Time:		<u>2pm</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	☐ 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:							

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	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				
	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				
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	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				
	Outpatient Area	1	1				
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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				
TOTAL			12				

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		NY				
Call device within reach		Y				
Wheels Locked		Y				
Room free of clutter		Y				
Adequate Lighting		Y				
Wheel Chair Support		no				
Other Intervention(s) Specify		no				
Nurse's Name :		Ank				
Signature :		ld				
Date :		23/2				
Time :		@ 6m				

BAH-00662115 IP5-00176586
 Baby AARVI DIGAMBAR SHINDE
 12-10-2023 2 Y 9 M 6 D (F)
 Dr. UJJWALA DESAI



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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	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	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1	1	1
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	1
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
TOTAL			12	12	12	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	yes	yes	yes
Call device within reach	yes	yes	yes	yes	yes
Wheels Locked	yes	yes	yes	yes	yes
Room free of clutter	yes	yes	yes	yes	yes
Adequate Lighting	yes	yes	yes	yes	yes
Wheel Chair Support	no	no	no	no	no
Other Intervention(s) Specify	no	no	no	no	no
Nurse's Name :		Deepa	Shruti	Shruti	Shruti
Signature :		Deepa	Shruti	Shruti	Shruti
Date :		18/7	19/7	20/7	21/7
Time :		8:30 PM	6:00 PM	6:00 PM	6:00 PM



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
22/07	10pm	pain 1	pen at surgical site	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	ms & tramadol	Anika
23/7	1am	0/10	ns	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Anika
				☐ 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		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

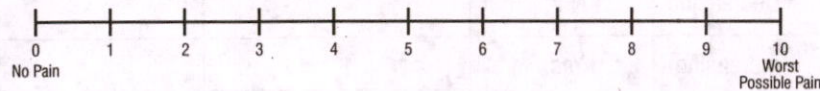
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	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

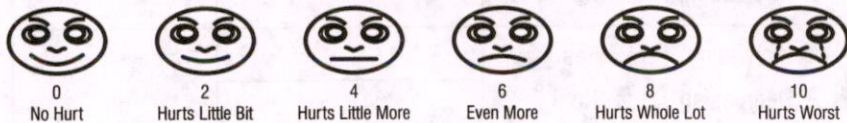
Numerical Pain Scale (Obstetric and Gynecology)



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			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-	-	-	-	-	-	-	cannula change
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-	-	-	-	-	-	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-	-	-	-	-	-	-	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-	-	-	-	-	-	-	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-	-	-	-	-	
Signature of the Nurse				Suresh Appu, Day Appu, R. C.									

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 : Pulakesh P. Name : Pulakesh P.

Signature of Ward In Charge :

Signature : Neeraja Devi Name : Neeraja Devi



CHECKLIST FOR THROMBOPHLEBITIS

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

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 : Dr. Desai Name : Dr. Desai

Signature of Ward In Charge :

Signature : Neeraj Name : Neeraj



BRADEN 'Q' SCALE

					Date : 22/12/23	23/12/23		
					Time : 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.tremity 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 meat 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		
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								
					TOTAL SCORE		28	24
					Evaluator's Name		Dr. Ujjwala Desai	Dr. Ujjwala Desai

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-00652115
Baby AARVI DIGAMBAR SHINDE
12-10-2023 2 Y 9 M 6 D (F)
Dr. UJJWALA DESAI

BRADEN 'Q' SCALE

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	18/11	19/11	20/11	21/11
					Time :	8:30	6am	8am	6pm
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:xtremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	28	28
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Rat	82	Q	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

BAH-00662115 IP5-00176586
Baby AARVI DIGAMBAR SHINDE
12-10-2023 2 Y 9 M 9 D (F)
Dr. UJJWALA DESAI

Patient




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


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

POST-SURGICAL CARE PLAN FORM

Procedure Done: 280.
Post-Surgical Diagnosis: Obstructed 7 mm in diameter & 12 mm in length, Cant. pass. per

Post-Operative Monitoring Parameters /Frequency:

Wound Care:

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

When to Start Mobilization:

Special Referrals:

The new order for all required medications documented in the doctor order/medication sheet:

☒ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up


Treating Surgeon
(Signature & Stamp)

Date: 21/11/2023 Time: 11:45 AM

Note: Plan of care will be readjusted if necessary.

9³⁰ am

DATE: 03/06/2005
TIME: 14.00

NAME: [Signature]
MR. [Signature]

24 9M
: 4.5 PM

Sex:

Proposed Operation:

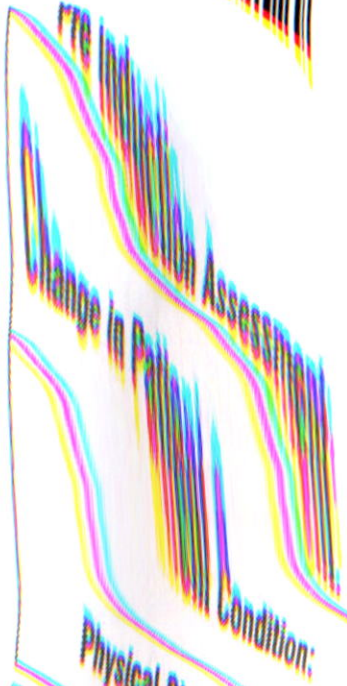
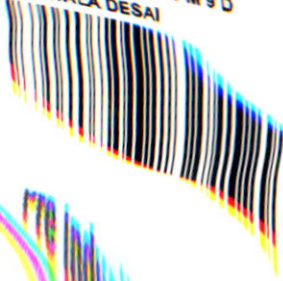
High Cerebral

ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Other Data:

HIV:	X-Ray:
HBS Ag:	ECG:
HCV:	2D Echo:
Blood group:	Stress/Angio:
Other:	

BAH-00662115 IP5-00176586
Baby AARVI DIGAMBAR SHINDE
12-10-2023 2 Y 9 M 9 D
Dr. UJJWALA DESAI



ANAESTHESIA C

Physical Status:

Condition:

10/ram

☐ Yes

☒ No

Patient Identified

Fasting

☒ Consent Present

Pre-OP Diagnosis:

B.P / CRT: 90/54

SpO₂: 100

Operation: T

Surgeon:

Dr. Hip Anurag + Dr. Raghav

Anaesthesiologist

TIME
N.O / AIR / O₂ / RM
HALO / SO / SEVO
Drugs:

1030 x 11 x 30
11/11/11
3-4-7

DRUGS MIDAZOLAM
FALC



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Dr. S. Halim

Time Received : 11:50 AM

Time Discharged :

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site : <u>228</u>	☐ O ₂ Mask ☐ Tracheostomy ☐ Oral Airway	☐ Nasal Prongs ☒ T-Piece ☐ Nasal Airway
		Vomiting : ☐ Yes ☒ No NG Tube : ☐ Yes ☒ No Drain : ☐ Yes ☒ No Urinary Catheter : ☐ Yes ☒ No Chest Tube : ☐ Yes ☒ No Nil Oral : ☐ Yes ☒ No IV Fluids : Oral Feeds :	Drug :	

POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES			OUT	SCORING INTERPRETATION
			30	60	90		
Able to move 4 extremities voluntary or on command	= 2	1	1	1	1		A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to move 2 extremities voluntary or on command	= 1						
Able to move 0 extremities voluntary or on command	= 0						
Able to breathe & cough freely	= 2	2	2	2	2		
Dyspnea or limited breathing	= 1						
Apneic	= 0						
BP $\pm$ 20 of Pre Anaesthetic level	= 2	2	2	2	2		
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1						
BP $\pm$ 50 of Pre Anaesthetic level	= 0						
Fully awake	= 2	1	1	1	2		
Arousable on calling	= 1						
Not responding	= 0						
Pink	= 2	2	2	2	2		
Pale, dusky, blotchy, jaundiced, other	= 1						
Cyanotic	= 0						
TOTAL		8	8	9			

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
21/7	11:50 AM	1/10		<u>Dr. S. Halim</u>

Pain Tool Used: ☐ N PASS ☒ FLACC ☐ Wong Baker ☐ NPS

Anaesthesiologist Name : Dr. S. Halim

Anaesthesiologist Signature : [Signature]

Date & Time :

PACU Nurse Name : [Signature]

PACU Nurse Signature : [Signature]

Date & Time : 21/7/2023

Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU) : 118

Date & Time : 21/7/2023

Patient Sticker

Department of Anaesthesiology

CSE /Spinal /Epidural Position : Space : Technique (LOR/LOS)

Parasthesia : Yes/No if yes details :

Any other issues :

b)

[illegible]

Catheter Removed by and Tip Inspected :

Discharge /Shifting ordered by

Doctor Name:

Date and Time :

Aarvi D. Shinde

CONSENT FOR ANAESTHESIA

 Authorization By: ☐ Patient ☒ Patient Attendant

 Operative Procedure: I & D of @ High cellulitis

 Anaesthesiologist: Dr. Subramanyam Surgeon: Dr. Venkat Ram

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery. Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk(s): The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders
☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease
☐ Others Laryngospasm, bronchospasm

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☒ Regional Anaesthesia ☒ General Anaesthesia ☐ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

 Patient / Patient Attendant:

 Signature: Nita

 Name: Nita

 Relationship with patient: Mother

 Date & Time: 20/7/26 9:00pm

Witness:

Signature: _____

Name: _____

Date & Time: _____

Doctor (who is taking consent):

 Signature: Arkhila Name: DR-ARKHILA-K Date 20/7/26 Time: 8:50pm

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్థానం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

లిజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై లిస్ట్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ లిజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్థిరియల్ లైన్, నాపిజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, లిజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వేచ్ఛగా భావించి, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00662115 IP5-00176586 Baby AARVI DIGAMBAR SHINDE (F) 12-10-2023 2 Y 9 M 9 D Dr. UJJWALA DESAI		Date & Time of Admission 18/07/2023 8:15 PM	Date & Time of Transfer Order 21/07/2023
Transfer Ordered by DR. Venkat Rao		Reason for Transfer surgery.	
From Unit OT	To Unit 118	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If Yes, what?	Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring [Signature]		Name of Person Ordered Transfer Dr. Venkat Rao	
Patient & Clinical Records Received by : Gravantei			
Date & Time of Patient Received : 21/7 2pm			

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

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

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
18/7	8:50 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rat
19/7	9:50 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	f
19/7	11 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chandan
20/7	6 am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chandan
20/7	2 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Anurag
20/7	11 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sushma
21/7	6 am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sushma
21/7	11:50 pm	1/10	SS	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Devi
				☐ 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:

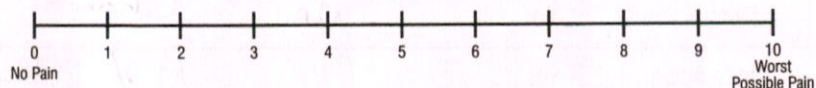
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain pain-relieving intervention.
 - d) Within 30 – 60 minutes after intervention.

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





INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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 | 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		
18/7/26	8:50 pm	2	Treatment and care plan	M	1	0	1	2		<i>[Signature]</i>
19/7/26	9 am	9	Self care	M	1	0	1	1		<i>N. Kote</i>

Part - III: CODES

Who was taught: PT: Patient		F: Father		M: Mother		S: Spouse		Sn: Son		D: Daughter		C: Caregiver		O: Other (Specify)	
Learning Barriers:															
1. No Learning Barriers		4. Language Barrier		7. Impaired Thought Process/Cognitive limitations		10. Financial Difficulties		13. Cultural/Religion Practice							
2. Physical Impairment		5. Educational Level		8. Responsibilities at Home		11. Beliefs and Values		14. Others (Specify)							
3. Emotional Barriers		6. Desire / Motivate to Learn		9. Cultural Differences		12. Impaired Vision/ or Hearing									
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed															
Mechanism/s to overcome barrier/s:															
1. None		3. Reassurance & Support		5. Respect values & beliefs		7. Other, Specify									
2. Obtain translator		4. Teach Family / Others		6. Respect Cultural / Religion Preference											
Understanding:															
1. Verbalizes Understanding				2. Demonstrates Understanding				3. Needs Review							



MULTI-DISCIPLINARY PLAN OF CARE FORM

Dia

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
18/7/20 8:59 pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	clo fever :- 1 week. clo hip pain (-) difficulty in walking	H. stability	11 antibiotics	[Signature]	☒ Nursing ☐ Others:
18/7/20 8:50 pm	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	fever 1 week	H. stability	→ IV fluids → 1 IV ANTIBIOTIC	[Signature]	☐ Medical ☐ Others:
19/7/20 9 AM	☐ Medical ☐ Nursing ☒ Others: Dr. Desai	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Rt hip arthritis Rt thigh cellulitis.	Soft stool	RDA E :- 1256 kcal/d P :- 29 g/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:



DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: Advice doctor orders

2. Destination Post Discharge: ☐ Home

Family Members Notified (Person Contacted)

☒ Transfer

Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

☐ Medication	☒ Yes	☐ No
☐ Bathing	☐ Yes	☒ No
☐ Eating	☐ Yes	☒ No
☐ Walking	☐ Yes	☒ No
☐ Dressing	☐ Yes	☒ No
☐ Toileting	☐ Yes	☒ No

Explain to parent's

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Personal Hygiene

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date and Time: 18/7 @ 10pm

PATIENT TRANSFER FORM

BAH-00662115 IP5-00176586 Baby AARVI DIGAMBAR SHINDE 12-10-2023 2 Y 9 M 6 D (F) Dr. UJJWALA DESAI 		Date & Time of Admission 18/11/2023 8:16 pm	Date & Time of Transfer Order 18/11/2023 9:10 pm
		Transfer Ordered by Dr. Anishkumar	Reason for Transfer Admission
From Unit A	To Unit 118 First floor	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 21	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ N/A If Yes, what?	Patient shifted with ID band: Yes ☒ No ☐	
Number of Imaging Films NA		If No:	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Pandey		Name of Person Ordered Transfer Dr. Anishkumar	
Patient & Clinical Records Received by : Geeta K			
Date & Time of Patient Received : 18/11/2023			

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

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



REQUEST FOR CREDIT FACILITY

To,
The Credit Billing,
Tenet Diagnostics,
Banjara Hills, Hyderabad.

Patient details: BAH-00662115 IP5-00176586
Baby AARVI DIGAMBAR SHINDE
12-10-2023 2 Y 9 M 6 D (F)
Dr. UJJWALA DESAI


Dear Sir/Madam,

We are sending the above mentioned patient for the diagnostic test MRI Both Hips with
Right High T2 contrast & Anaesthesia in your diagnostic center on credit basis. Request
you to kindly do the needful. The bill will be settled by Rainbow Hospital, billing department as per the agreement. For
any further queries, please contact the billing manager.

Order ID: 5-000 9711174

Thanking you,
Department of Inpatient Billing

Coordinator:

Signature: P. Manikyan
Name: P. Manikyan
Date & Time: 19/7/26 @ 10:22am

Billing Executive:

Signature: [Signature]
Name: A. Sridhar
Date & Time: 19/7/26
Mobile (Billing Manager): 9247505898

Manager on Duty (MOD):

Signature: [Signature]
Name: B. Niveditha
Date & Time: 19/7/26 @ 02:55pm
Mobile: 9676838787

Docu. No: RCH/ FRM/ GENERAL/ 663

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Aarvi Digambar Shinde Age: 2y 9m Sex: F UHID.No: BAT-006621K

Date: 20/7/26 Time: 12:00 AM Proposed Operation: MRI both hips with

Diagnosis: Right Hip Arthritis Right thigh cellulitis

B.P / CRT: H.R: Weight: 12kg ASA Physical Status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 7.5 Glucose: Protein: HIV: X-Ray:
PCV: 23.7 Urea: 12 Alb: HBS Ag: ECG:
WBC: 12,300 Creat: 0.3 Total Bill: HCV: 2D Echo:
Plate: 397 plate Na: 137 Dir. Bill: Blood group: Stress/Angio:
PT: K: 4.2 LDH: T3: Other:
PTT: Ca++: Alk phos: T4:
INR: Mg++: Amylase: TSH:
Cl-: 106 SGOT/SGPT:

Allergies: NRDA

Medical History: CVS:

RESP: Not Significant Diabetes: * NVD / Full term / 3.5kg / after NICU admission 6 days due meconium aspiration
CNS: * Vaccinated as per schedule
Renal: * Milestones achieved as per age
Hepatic / GE: Physical Activity: Active
Others:

Past Anaesthetic History: -

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Mentohyoid Distance: Neck: (N) Teeth: All teeth intact
Lungs: BAE (+) * H/o fever & cold 3-4 days back
Heart: S, S (+) (Subsided)
CNS: Grossly Intact fever on & off
Pregnant: ☐ Yes ☐ No ☒ NA Venous Access Site: (R) hand Spine Exam for regional:

Anaesthetic Plan: ☒ MAC ☐ REGIONAL ☐ GA-ETT ☐ LMA

Peri-Operative Plan Explained to the Patient: ☒ Yes ☐ No

Attender

CURRENT MEDICATIONS	DOSAGE
<u>Diy. LINEZOLID</u>	<u>120mg</u>
<u>Diy. MEROPENEM</u>	<u>500mg</u>
<u>Diy. ESOMEPRAZOLE</u>	<u>10mg</u>
<u>Syp. IBUPROFEN</u>	<u>6m</u>

Pre-Operative Instructions:

- DVT Prophylaxis: Explained
- NIL ORAL Water / ORS 2 Hours
Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☒ Discussed with Patient / Attender
- Other Instructions:

Signature: Dr. S. S. S. S. Name: Dr. K. S. S. S.

ANAESTHESIA CHART

Pre-Induction Assessment: Change in Patient Condition: ☐ Yes ☒ No		Fasting Status: <u>confirmed</u>	
Physical Status: ☒ Patient Identified		☒ Consent Present	
☒ Chart Reviewed			
H.R: <u>120/min</u>	B.P / CRT:	SpO ₂ : <u>100</u>	R.R: Last Feed:
Pre-OP Diagnosis: <u>B/L hip arthritis</u>		Operation: <u>MRI B/L Hips + Right Thigh</u> Date: <u>20/7/2026</u>	
Surgeon:		Anaesthesiologist: <u>Dr. Tejaswini</u> Technician:	

TIME N ₂ O / AIR / O ₂ LPM HALO / SO / SEVO Drugs:	8 AM 8:30 9 AM MIDAZOLAM 0.6mg GLYCOPYRROLATE 80mcg PROPOFOL 18mg + 10mg 3mg for every 5min KETAMINE 12mg FIO ₂ / SaO ₂ 100 100 100 100 100 ET CO ₂ ECG Temperature Urine Output	Antibiotic Suppository Blood Loss NOTES
---	--	--

B.P V Systolic A Diastolic X Mean • Heart Rate Tourniquet on Time Tourniquet off Time Throat Pack In Throat Pack Out	
--	--

LAB Values ABG GRBS Others	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;"> ☐ Equipment Checked and Functional ☐ BP ☐ Cuff Site: ☐ Art Site: ☐ EKG Lead ☐ Temp Site ☐ FIO₂ Monitor ☐ Agent Monitor ☒ Pulse Oximeter ☐ Capnograph ☐ Ventilator ☐ Nerve Stimulator Position: ☐ Pressure Points Checked </td> <td style="width:30%;"> Temp: ☐ HME ☐ Fluid Warmer ☐ Cling Film ☐ OH Warmer ☐ Hugger's ☐ Cotton Wool ☐ Other Times: Anaes Start: <u>8 AM</u> OP Start: <u>✓</u> OP End: <u>9:20 AM</u> Leave OR: Anaesthesia: ☐ GA ☐ Monitored Anaesthesia Care ☐ Regional Line (Size & Location) ☐ CVP: ☐ ART: ☐ IV: ☐ IV: ☐ IV: </td> <td style="width:40%;"> Induction ☐ IV ☐ Inhal ☐ Pre O₂ ☐ RSI ☐ Others ☐ Mask ☐ SGA ☐ Airway ☐ Oral ☐ Nasal ETT# at cm ☐ Oral ☐ Nasal ☐ Cuff ☐ Tracheostomy ☐ Topical ☐ Drug: ☐ Awake ☐ Direct Vision ☐ Video Laryngoscopy ☐ Stylette / Bougie ☐ Fiberoptic Blade# Attempts: Difficulty Why? </td> </tr> </table>	☐ Equipment Checked and Functional ☐ BP ☐ Cuff Site: ☐ Art Site: ☐ EKG Lead ☐ Temp Site ☐ FIO ₂ Monitor ☐ Agent Monitor ☒ Pulse Oximeter ☐ Capnograph ☐ Ventilator ☐ Nerve Stimulator Position: ☐ Pressure Points Checked	Temp: ☐ HME ☐ Fluid Warmer ☐ Cling Film ☐ OH Warmer ☐ Hugger's ☐ Cotton Wool ☐ Other Times: Anaes Start: <u>8 AM</u> OP Start: <u>✓</u> OP End: <u>9:20 AM</u> Leave OR: Anaesthesia: ☐ GA ☐ Monitored Anaesthesia Care ☐ Regional Line (Size & Location) ☐ CVP: ☐ ART: ☐ IV: ☐ IV: ☐ IV:	Induction ☐ IV ☐ Inhal ☐ Pre O ₂ ☐ RSI ☐ Others ☐ Mask ☐ SGA ☐ Airway ☐ Oral ☐ Nasal ETT# at cm ☐ Oral ☐ Nasal ☐ Cuff ☐ Tracheostomy ☐ Topical ☐ Drug: ☐ Awake ☐ Direct Vision ☐ Video Laryngoscopy ☐ Stylette / Bougie ☐ Fiberoptic Blade# Attempts: Difficulty Why?
☐ Equipment Checked and Functional ☐ BP ☐ Cuff Site: ☐ Art Site: ☐ EKG Lead ☐ Temp Site ☐ FIO ₂ Monitor ☐ Agent Monitor ☒ Pulse Oximeter ☐ Capnograph ☐ Ventilator ☐ Nerve Stimulator Position: ☐ Pressure Points Checked	Temp: ☐ HME ☐ Fluid Warmer ☐ Cling Film ☐ OH Warmer ☐ Hugger's ☐ Cotton Wool ☐ Other Times: Anaes Start: <u>8 AM</u> OP Start: <u>✓</u> OP End: <u>9:20 AM</u> Leave OR: Anaesthesia: ☐ GA ☐ Monitored Anaesthesia Care ☐ Regional Line (Size & Location) ☐ CVP: ☐ ART: ☐ IV: ☐ IV: ☐ IV:	Induction ☐ IV ☐ Inhal ☐ Pre O ₂ ☐ RSI ☐ Others ☐ Mask ☐ SGA ☐ Airway ☐ Oral ☐ Nasal ETT# at cm ☐ Oral ☐ Nasal ☐ Cuff ☐ Tracheostomy ☐ Topical ☐ Drug: ☐ Awake ☐ Direct Vision ☐ Video Laryngoscopy ☐ Stylette / Bougie ☐ Fiberoptic Blade# Attempts: Difficulty Why?		

Regional: Extremity Specify: ☐ Spinal ☐ Epidural ☐ Caudal Others: Position: Site: Needle Size: Depth: Paresthesia ☐ Yes ☐ No Catheter at skin cm Drug Name & Conc: Bolus: Infusion: Block Level: Comments: Transportation to ☐ PACU ☐ ICU ☐ Other Relaxant Reversed ☐ Yes ☐ No ☐ NA Name of the Doctor: Signature of the Doctor:
--



UNIT RECORD

Received in PACU by : Time Received : Time Discharged :

< RESP < PULSE > BLOOD PRESSURE >	250		250	IV Cannula Site :
	240		240	☐ O ₂ Mask ☐ Nasal Prongs
	230		230	☐ Tracheostomy ☐ T-Piece
	220		220	☐ Oral Airway ☐ Nasal Airway
	210		210	Vomiting : ☐ Yes ☐ No Drug:
	200		200	NG Tube : ☐ Yes ☐ No
	190		190	Drain: ☐ Yes ☐ No
	180		180	Urinary Catheter: ☐ Yes ☐ No
	170		170	Chest Tube: ☐ Yes ☐ No
	160		160	Nil Oral ☐ Yes ☐ No
	150		150	IV Fluids:
	140		140	Oral Feeds:
	130		130	
	120		120	
	110		110	
	100		100	
	90		90	
	80		80	
	70		70	
	60		60	
	50		50	
	40		40	
	30		30	
	20		20	
	10		10	
0		0		

POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES			OUT	SCORING INTERPRETATION
			30	60	90		
Able to move 4 extremities voluntary or on command	= 2	ACTIVITY					A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to move 2 extremities voluntary or on command	= 1						
Able to move 0 extremities voluntary or on command	= 0						
Able to deep breathe & cough freely	= 2	RESPIRATION					
Dyspnea or limited breathing	= 1						
Apneic	= 0						
BP $\pm$ 20 of Pre Anaesthetic level	= 2	CIRCULATION					
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1						
BP $\pm$ 50 of Pre Anaesthetic level	= 0						
Fully awake	= 2	CONSCIOUSNESS					
Arousable on calling	= 1						
Not responding	= 0						
Pink	= 2	COLOR					
Pale, dusky, blotchy, jaundiced, other	= 1						
Cyanotic	= 0						
TOTAL							

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

Pain Tool Used: ☐ N PASS ☐ FLACC ☐ Wong Baker ☐ NPS

Anaesthesiologist Name :

Anaesthesiologist Signature:

Date & Time:

PACU Nurse Name :

PACU Nurse Signature:

Date & Time:

Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU):

Date & Time:



Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

CSE /Spinal /Epidural Position : Space : Technique (LOR/LOS)

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR	Comments
			Left	Right	BP	Pulse		

Delivery Details : Time : APGAR: SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :



CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☐ Patient Attendant

Operative Procedure: MRP Both hips with Right Thigh

Anaesthesiologist: Dr. K. Sri Surya

Surgeon:

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk(s): The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders
☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease
☐ Others Desaturation

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☐ Regional Anaesthesia ☐ General Anaesthesia ☒ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: Nita

Name: Nita

Relationship with patient: Mother

Date & Time: 20/7/26 12:15 AM

Witness:

Signature: S. S. S. S.

Name: K. S. S. S.

Date & Time: 20/7/26 @ 12:15 AM

Doctor (who is taking consent):

Signature: Dr. K. Sri Surya Name: Dr. K. Sri Surya

Date: 20/7/26 Time: 12:15 AM

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్థావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

లిజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్మల్ బ్లడ్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ లిజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాక్కులు, లిజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్:

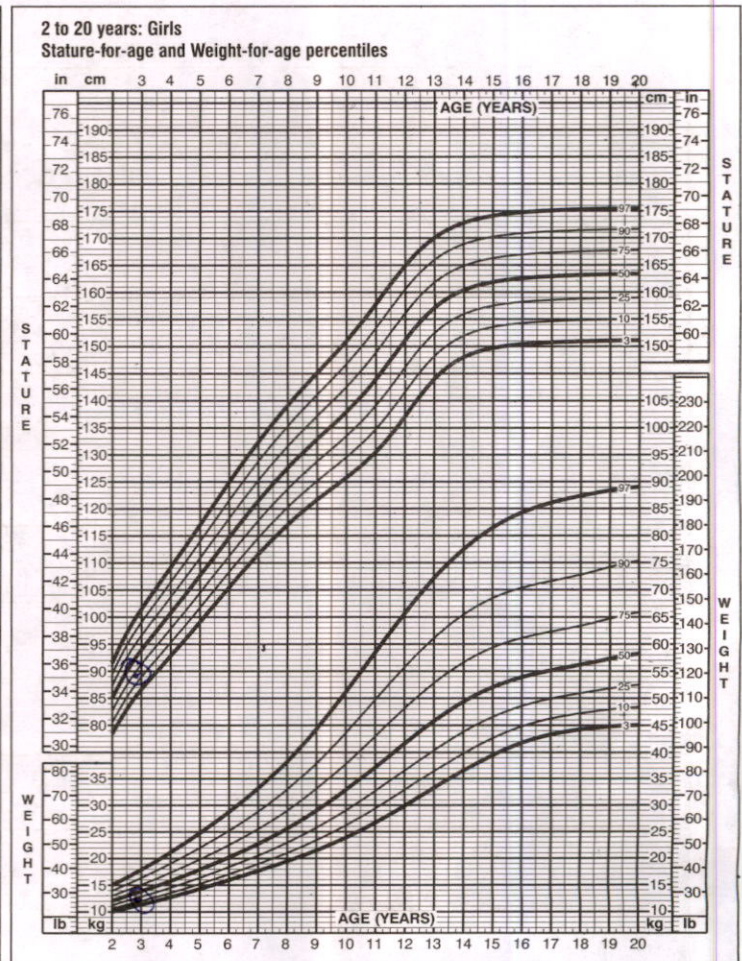
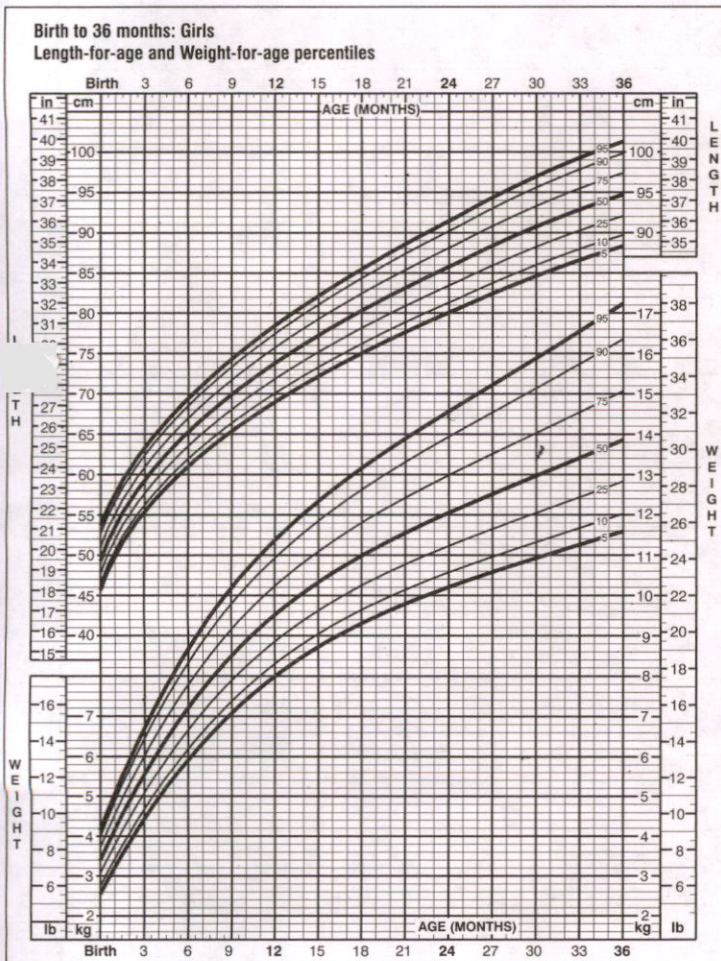
సంతకం: పేరు: తేదీ & సమయం:

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 19/7/26 Time: 9 AM

Weight: 12.3 kgs Centile: >10th
 Height: 89 cms Centile: >10th
 Inference: underweight child
 RDA: — Calories: 1250 kcal/d Protein: 21 g/d
 Diet Recommendations: soft diet
 Re-Assessment: Avoid spicy, chilled and outside foods
 Food Allergies: NO Veg/Non-veg: non-veg
 Diagnosis: Rt hip arthritis, Rt thigh cellulitis @ medical aspect
 Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral
 Patient's Signature: Nita

GROWTH CHART (GIRLS)



Dietician's Name: Manisha

Dietician's Signature: Manisha

Daily Notes:

20/7/26
11AM

Child is stable Oral Intake is Better

Continue to Soft diet.

— NEither

22/7/26
10AM

Child is stable Oral Intake is Optimal

Continue to Soft diet.

— NEither

23/7/26
8am

child is stable. Intake is better
accepting orally soft diet

NEither