B6

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ACTIVITY RECORD FOR BILLING

BAH-00543203 IP5-00176565
Master MOHAMMED ARZAAN ASIM
19-11-2022 3 Y 7 M 29 D (M)
Dr. RAMESH KONANKI

Name :_____

UHID No. : _____ Consultant: _____ Dept : _____

Date of Admission: _____ Time : _____ Date of Discharge : 21/7/26 Time: 3pm

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
18/7/26	2p	ER	PICU	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	DR. Sandeep Reddy	19/7/26	9711620	
2				
3				
4				
5				
6	DIC			
7				
8				
9				
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
18/2	CBP, RP2, Cdt:		
	MSf, RBS	26072182	[signature]
	CUE	26072262	[signature]
	EEG.	35953	
19/7/26	RBS	26072313	[signature]
19/7/26	CBP	26072434	[signature]
	DENGUE NS1, IgM	26072450	[signature]
20/7/26	RBS	26072612	[signature]
	CBP		
20/7/26	FLU Panel		
	MP OPTIMAL	26072683	[signature]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
18/7	INV 2 Monitor				
	Inf 2 PCMP			9710034	S
	O2				
19/7/26	INV. Monitor			9710038	
	Inf. pump		11am	9710038	Rani
	Oxygen		4pm	9710038	
20/7/26	INV. Monitor			9710038	Rani

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
18/7	N Placement	1	9710049	[illegible]
20/7	NHA	1	9712843	[illegible]

ANY OTHER INFORMATION

[illegible]

Date : 21/7/26 Time : 3pm Prepared By : [illegible]

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Reman [illegible]	8/M		

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034

TEL NO :+91 40 4466 5555

WEB : https://rainbowhospitals.in

SELF RESIDENT

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176565 **Admit Date** : 18-Jul-2026 **Admit Time** : 01:05 PM **UHID** : BAH-00543203

Patient Details :

Patient Name	: Master MOHAMMED ARZAAN ASIM	**Age**	: 3 Y 7 M 29 D
Guardian	: Mr MD ASIM MUJAHID	**DOB**	: 19-11-2022
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H NO 177, PHASE-4, APHB COLONY, NEAR KFC, Gachibowli Hyderabad Telangana INDIA 500032	**Phone No**	: 9710307891/ 7702706966
		E-mail	: ASIM.GAV@GMAIL.COM

Admission Details :

Bed Type : PICU-ISO **Bed No** : PICU ISO 218 **Ward Name** : 2F-PICU I

Room No : PICU ISO 218 **Admission Type** : First Visit

Contact Details :

Name : Mr MD ASIM MUJAHID **Relationship** : Father

Contact Address : H NO 177, PHASE-4, APHB COLONY, NEAR KFC, Gachibowli Hyderabad Telangana INDIA 500032 **Phone No** : 9710307891

Signature

Doctor Details :

Doctor Name	: Dr. RAMESH KONANKI	**Specialisation**	: PEDIATRIC NEUROLOGY
Referral Doctor	: Self	**Phone No**	:
Co-Consultant	: Dr. KAPIL BHAGWATRAO SACHANE		

Payment Details :

Deposit Amount : 30000.00

Payment Mode : DC/CC Card **Payor Name** : SELFPAY

MD. Arzaan Asim

RAH – 00543203

145

Patient Sticker

Dr. Ramesh. le

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1+1			
5	In-patient Medical record	1			
6	Doctors progress sheets	9			
7	Nursing plan of care and handover sheets	5			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaestesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	2			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	2			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	2			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)	3			
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list	1			
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Others =	6			
	Total No. of Pages	43			

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

Signature and Date : 21/7/26

(P.T.O)

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU / 2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

BAH-00543203 IPS-00176565
Master MOHAMMED ARZAAN ASIM
19-11-2022 3 Y 7 M 29 D (M)
Dr. RAMESH KONANKI

Arzaan

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	3½ yr child with history of	
	fever since yesterday night	
	c chills.	
	today morning - high grade 104°F	
	Seizures in the form of	
	posturing of limbs, upward of eyes	
	went to local hospital	
	gave Midaz Inj. twice subsided.	
	On arrival to ER	
	child had stiffening of limbs	
	initially right UL, LL	
	followed by left UL, LL	
	gave Midaz spray	
	Inj. Lorazepam 1.4 mg.	
	Inj Levipil 20mg/kg	
	↓	
	20mg/kg.	
	Stiffening - better	
	En ambulance 1 episode of stiffening	
	c tachycardia	
	Inj. Lorazepam 1.4 mg given	

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

(P.T.O)

BAH-00543203 IP5-00176565
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	O/E: Movements of left UL, LL (+), on & off. ↓sed movements of right UL, LL. Tone - ↑sed ? posturing.	
	GRBS : 233	
	Ketones : 0.2	
	past history : At 4 months of age - Febrile seizure ? meningo encephalitis	
	- C/D/w Neurology team. (Dr. Vineeth sir)	
	Vitals - SpO2 - 99% RA	
	HR - 119/min	
	BP - 94/55 (67)	
	RR - 32/min.	
	Temp - 98°F.	
GCS - $E_{4}V_{2}M_{5}$.		

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/o/B Burutown C/D/W Dr. Ramesh	
18/11/26 4pm	A: Complex ~~Bud~~ febrile seizure.	Plan:-
	Fever x 1 day. Seizure x 1 day. - 1st episode at home GTCS lasting for 5min - 2nd, 3rd episode stiffness of 4 limbs. first left then right lasting for 8-10 mins at RCH, Kondapur - 4th episodes on the way (ambulance) to RCH, Banjara Hills.	① Send CBP, RP, Ca/Mg, RBG, CRP, c/e. ② Ceftriaxone. ③. Levetiracetam. ④. Back up: Lacosamide. If fails: Midazolam.
®	Levipil 40mg/kg at RCH Kondapur. 1 Midaz nasal spray. 2 doses ~~levipil~~ lorazepam till now.	⑤ Keep intubation things ready. ⑥ Keep midazolam & ketamine ready bedside. ⑦ NPO. ⑧ iv fluid DNS 30ml/hr.
O/E:-	Child on room air. SpO₂: 99% PR: 116/min RR: 34/min BP: 94/56	

N.B Anjali 18/11/26@2PM

P.T.O.

BAH-00543203 IP5-00176565
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19-11-2022 3 Y 7 M 29 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Chest : B/L clear.	
	CVS : S1S2 (+).	
	No murmur.	
	CNS : E1 V2 M5.	
	Pupil : 3+ 3+.	
	Tone : (N).	
	PA : Soft. NT.	
		Salvaj.

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4PM 18/07/2026	S/B Dr. Sandeep	
	Δ Complex febrile Seizure - Status Epilepticus	A/W
		① Keep in PICU today
	Plan	
	① Status Epilepticus - fever provoked	② Lumbar puncture and MRI Brain on progress
	On low flow oxygen @ 2L/min	③ EEG now.
	Hemodynamically stable	④ Watch for seizures.
	Chest: B/L AE ⊕ Equal.	⑤ I/O charting
	NVE	
	RR: 36/min	
	P/A Soft BS ⊕	
	CNS B/L pupils Equal & RTL	
	HR: 120/min	N.B
	SpO2 100%.	Anjali 18/7/26.
	BP 110/64 (SD) mmHg	@4pm

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19-11-2022 3 Y 7 M 29 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/2/26 10:30pm	c/s/B Neuroteam	
	EEG (N) background sleepmarkers (+) no IEDs	

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

BAH-00543203 IP5-00176565
Master MOHAMMED ARZAAN ASIM (M)
19-11-2022 3 Y 7 M 29 D
Dr. RAMESH KONANKI

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DAILY ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 18/07/26 Day of Admission : (D2) Today's Date & Time : 19/7/26

PRISM - III Score in first 24hrs. of Admission : 0 Today's SOFA Score : 0

OVERVIEW

Diagnosis : complex febrile seizures.

Current Issues : fever spikes (2 spikes yesterday) 4 max (102.6°F)

VITAL SIGNS Today's Wt. (kg) : Temp.: Blood sugar issues :

RESPIRATORY SYSTEM

Respiratory System Findings : (Air entry, breath sounds, s/o distress etc.) : B/L AE (+), chest clear.

CXR : –

SPO_2 : 100% on 2L/min O_2 by NC / FM / NRB mask / Oxyhood, at ... L / min

Ventilatory Support : ☐ Yes ☑ No - Day # of Vent : ... **Nitric Oxide :** ☐ Yes ☑ No - If Yes, details : ...

Ventilatory Settings : Leak around ETT : – Delivered Vt : –

ABG : ... $EtCO_2$: ... P/F ratio : ... O.I. : ...

Chest Physiotherapy Plan : – Nil – Suctioning Needs : – Nil –

Any Nebs : – Nil) **ICD ?** ☐ Yes ☑ No, if Yes, details : ...

Plan of care : Plan to taper O_2 support

CARDIO VASCULAR SYSTEM

Cardio Vascular System Clinical Exam. (Heart sounds, murmur etc.) : S1S2 (+) No murmurs

Quality of Pulses : Good cap refill Time : <3sec Liver Edge : – cm below Rt costal margin

Blood Pressures : NIBP : ... IBP : ... CVP : ...

Infusion of : ☐ Dopamine – mcg / kg / min - ☐ Dobutamine – mcg / kg / min

☐ Epinephrine – mcg / kg / min - ☐ Nor Epinephrine – mcg / kg / min

☐ Milrinone – mcg / kg / min

Any Other Infusions : ...

Last 2D Echo Findings : ...

Size of the heart and lung fields in latest CXR : ...

Arterial line in situ : ☐ Yes ☑ No Place of art, line & its condition : ...

Central line in situ : ☐ Yes ☑ No Place of central line & its condition : ...

Day of arterial line : – Day of Central line : –

Plan of Care : ...

CNS

Neuro Exam : E4V5M6 (15/15)
pupil - 2mm equal & reacting to light

Pupils : – **Sedation Used ?** ☐ Yes ☑ No **Any paralysis ?** ☐ Yes ☑ No

Types of Sedation : ... Types of Paralysis : ...

Relevant CT Scan, MRI EEG, Neurosonogram etc. : ...

Plan of Care : ...

... Ramsay Sedation Score : ...

FLUIDS STATUS NUTRITION AND G.I

☐ NPO ☐ PO feeds ☐ NG Feeds ☐ NJ Feeds ☐ GT Feeds

I / O / Balance : +50 ml (+/-) .... Input : .... ml/k/d UO : .... ml/kg/hr Stools : ....

NG output : .... PO intake : ....

Feed Formula : .... Feed Schedule : ....

IV Fluids - Type of IVF : DNS @ 30 ml / hr (.......... times maintenance)

TPN : ☐ Yes ☑ No - If yes, details : ....

.... % of Dext, Glu Inf Rate (mg/kg/min) .... Amino Acids (gm/kg/day) .... Lipids (gm/kg/day)

(18/7) .... Cal/kg/d .... Nitrogen .... Trace elements & MVI

Labs ; Na 133 4.9 Cl 100 Ca .... Mg .... P .... HCO3 .... Sr. Amylase : .... Sr. Lipase : ....

Latest LFT : ....

Abd Exam : soft, Nondistended c/c NR.

Any organomegaly ? ☐ Yes ☑ No - If yes, describe : ....

Plan (G.I. & Liver) : ....

IVF - 720ml
Medications - 40ml
760ml
65/01
Maintain

INFECTION

☐ Febrile ☑ Afebrile Current Antibiotics Details (antibiotic name and day #) : ....

Cultures Sent ? ☐ Yes ☑ No - If yes, details : INJ CEFTRIAXONE-D2

Describe c/s Reports : ....

Other Labs (Latex, Serology, etc) : ....

Ongoing Antibiotics : ....

NEPHROLOGY ISSUES

Sr. Creat : 0.4 Bld. Urea : 21 Other Relevant Labs : ....

P.D. ☐ Yes ☑ No - If yes, details : ....

Diuretics : ☐ Yes ☑ No - If yes, details : ....

Catheterized : ☐ Yes ☑ No - If yes, then day of Catheter : ....

Ralevant Radiology (USC, MCUG radioisotope scan etc) : ....

Plan of Care : ....

HEMATOLOGY

Relevant Labs (CBP etc) : 11.6 > 6480 / 83/12 < 1.94 lac

Any Coagulopathy : ....

Relevant Transfusion History : ....

Plan of Care : ....

CARE PROTOCOLS

VAP Bundle Used ? : ☐ Yes ☐ No ☑ NA

CRBSI Bundle Used ? : ☐ Yes ☐ No ☑ NA

CA - UTI Bundle Used ? : ☐ Yes ☐ No ☑ NA

Patient Managed as per Relevant Protocols : ☐ Yes ☐ No ☐ NA

If yes, then details : ....

Pending Lab Results : ☐ Yes ☑ No

If yes, then details : ....

Pending Consultations : ☐ Yes ☑ No

If yes, then details : ....

FINAL COMMENTS

- Plan to stop i/v fluids & encourage orally.
- plan to send blood c/s.
- ~~[illegible]~~
- Plan to upgrade antibiotics (i/v/o persistent fever spikes)

Doctor's Name (Handover given) : Jyoti

Signature : Dr JYOTI

Date & Time : 19/7/26 8:00 AM

Doctor's Name (Handover taken) : [signature]

Signature : [signature]

Date & Time : 19/7/26 @8AM

BAH-00543203 IP5-00176565
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/s/B Neurotean	
19/7/26 8am	fever triggered (R) focal to o/l tonic clonic	
	?FS(F) ?Remote symptomatic	
	Issues	
		plan
	→ fever persistent	
	→ irritable; 2 spo. vomitings	(1) change levipil to oral
	→ No recurrent seizures	
	o/e	
	conscious	
	EOM full	(2) shift to ward
	No facial weakness	
	Speech good	N.By Maus
	tone (N)	19/7/26 @ 8:30AM
	Good antigravity movement	
		(3) Backup:- Inj. Lacosamide
	EEG (N)	
	Bhy	D. Vineet

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

(P.T.O)

BAH-00543203 IP5-00176565
Master MOHAMMED ARZAAN ASIM
19-11-2022 3Y8M0D (M)
Dr. RAMESH KONANKI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/26.	c/s/o Dr. Sandeep	
	Ass – Complex febrile seizures – status epilepticus	
	Issues –	Plan
	• Fever spikes (+) (4-5 spikes)	1. w/f seizures
	• 3 episodes of vomitings – 2 in night, 1 in morning	2. Inj. PARACETAMOL if fever spikes (+)
	• irritability (+)	3. Send CBP, ~~Serology~~ If platelet fall, send Dengue NSI, IgM.
	• No further episodes of seizures.	4. After CBP report Shift to ward.
	vitals – T – 99°F	
	HR – 100/min	
	SpO_2 – 99% @ RA	
	RR – 26/min	
	o/e –	N. By Manu 19/7/26 @ 11:45AM Dr. Hinaya
	RS – BAE (+), lungs clear	
	CVS – S_1S_2 (+)	
	PA – Soft	
	CNS – NAD	
	EEG – (N)	

BAH-00543203 IP5-00176565
Master MOHAMMED ARZAAN ASIM
19-11-2022 3 Y 8 M 0 D (M)
Dr. RAMESH KONANKI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/26 2pm	[illegible]	
	Δ:- Complex febrile seizures	
	Status Epilepticus	Plan
		1) Continue Inj ceftriaxone
	Issues:- Fever spikes.	Inj esomeprazole
	Irritability.	2) Trace Dengue NS1, IgM
	no further Vomiting.	
	no further seizure activity	3) w/f fever spikes.
	child on Roomair	seizure activity
	Hemodynamically stable.	4) Monitor Vitals
		Inform SOS
	Resp, P/A, CVS } ⓝ	
		Dr Jayasri
	Vitals- stable.	

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(2)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/26 3pm	c/s/B Dr. Sandeep	Plan
	Ac:- febrile status epilepticus	1) observe in ICU today
		2) CBP tomorrow morning
	Issues:- 1) fever spikes	
	2) ↓ plt count	3) Monitor BP
	↓ WBC count.	4) w/f low pulse pressure, peripheral perfusion
	on room air	
	Hemodynamically stable	5) w/f + fever + seizures
	Systemic exam^n - (N)	
	accepting orally well	6) Trace dengue NS1 Ag + IgM
		7) Tab. Maguion 1/4 th tablet / BD
		8) SOS ferritin
		9) RP-1, INR H/M if dengue +
		Dr. Pratap
		N.By Haseeb 19/7/26 @4PM

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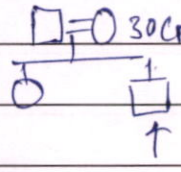
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/26 9pm	C/S/B Neuroteam	
	Fever triggered (Lt) focal to B/L clonic tonic seizures. ? Febrile seizures (+) ? ~~Remote symptom~~	
	3Y8M  30cm	DOI - 2 DOA - 2
	Development - (N) H/o ? viral encephalitis @ 3months of age. H/o fever : 2days. H/o 2 episodes of seizures - yesterday. 1st episode @ home ⇒ ~~tonic~~ uprolling of eyeballs → tonic posturing of both (L) UL & LL → GTCS ~ 5mins 2nd episode @ ER ⇒ tonic posturing of both (Lt) UL & LL.	
	Issues: Fever spikes (+) ; No fresh seizures. 1 episode of vomiting irritability (+) flushing (+). platelets → ↓ trend ; EEG - (N)	
	O/E: Child conscious EOM - full B/L pupils Normal size RTL.	Adv (1) Inj. Ondansetron stat (2) vitals monitoring

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Speech - Good (3)	Trace Dengue report
	No facial weakness	
	Tone - (N)	
	B/L symmetrical antigravity movement (+)	

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DAILY ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 18/2/26 Day of Admission : D3 Today's Date & Time : 20/2/26

PRISM - III Score in first 24hrs. of Admission : ..... Today's SOFA Score : .....

OVERVIEW

Diagnosis : Complex Febrile Seizures

Current Issues : Fever spikes (3). - 101.3°F

VITAL SIGNS Today's Wt. (kg) : 14 kg Temp.: Blood sugar issues :

RESPIRATORY SYSTEM

Respiratory System Findings : (Air entry, breath sounds, s/o distress etc.) : BAE (+), clear RR : 38/min.

CXR : —

SPO_2 : 99% @ RA O_2 by NC / FM / NRB mask / Oxyhood, at ..... L / min

Ventilatory Support : ☐ Yes ☑ No - Day # of Vent : ..... **Nitric Oxide :** ☐ Yes ☑ No - If Yes, details : —

Ventilatory Settings : Leak around ETT : — Delivered Vt : —

ABG : — $EtCO_2$: — P/F ratio : — O.I. : —

Chest Physiotherapy Plan : Nil Suctioning Needs : .....

Any Nebs : Nil. **ICD ?** ☐ Yes ☐ No, if Yes, details : .....

Plan of care : —

CARDIO VASCULAR SYSTEM

Cardio Vascular System Clinical Exam. (Heart sounds, murmur etc.) : S1 S2 (+) HR :- 115/min

Quality of Pulses : Equal cap refill Time : <3sec Liver Edge : — cm below Rt costal margin

Blood Pressures : NIBP : 97/56 mmHg IBP : — CVP : .....

Infusion of : ☐ Dopamine ..... mcg / kg / min - ☐ Dobutamine ..... mcg / kg / min

☐ Epinephrine — mcg / kg / min - ☐ Nor Epinephrine ..... mcg / kg / min

☐ Milrinone — mcg / kg / min

Any Other Infusions : —

Last 2D Echo Findings : —

Size of the heart and lung fields in latest CXR : .....

Arterial line in situ : ☐ Yes ☑ No Place of art. line & its condition : .....

Central line in situ : ☐ Yes ☑ No Place of central line & its condition : .....

Day of arterial line : ..... Day of Central line : .....

Plan of Care : .....

CNS

Neuro Exam : E4 V5 M6

Pupils : 2 mm equal & reactive **Sedation Used ?** ☐ Yes ☐ No **Any paralysis ?** ☐ Yes ☐ No

Types of Sedation : — Types of Paralysis : .....

Relevant CT Scan, MRI EEG, Neurosonogram etc. : —

Plan of Care : .....

Ramsay Sedation Score : .....

FLUIDS STATUS NUTRITION AND G.I

☐ NPO ☐ PO feeds ☐ NG Feeds ☐ NJ Feeds ☐ GT Feeds

I / O / Balance : -445 / (+/-) .... Input : .... ml/k/d UO : 2.7cc ml/kg/hr Stools : ....

NG output : .... PO intake : ....

Feed Formula : .... Feed Schedule : ....

IV Fluids - Type of IVF : DNS @ 25 ml/hr ml / hr (.................. times maintenance)

TPN : ☐ Yes ☐ No - If yes, details : ....

.... % of Dext, Glu Inf Rate (mg/kg/min) .... Amino Acids (gm/kg/day) .... Lipids (gm/kg/day)

.... Cal/kg/d .... Nitrogen .... Trace elements & MVI

Labs : Na 133 K 4.0 Cl 100 Ca 8.8 Mg 1.9 P .... HCO3 .... Sr. Amylase : .... Sr. Lipase : ....

Latest LFT : ....

Abd Exam : soft, non distended

Any organomegaly ? ☐ Yes ☑ No - If yes, describe : medication = 40ml.

Plan (G.I. & Liver) : ....

....

....

INFECTION

☑ Febrile ☐ Afebrile Current Antibiotics Details (antibiotic name and day #) : ....

Cultures Sent ? ☐ Yes ☑ No - If yes, details : ....

Describe c/s Reports : Inj Ceftriaxone - D_3.

Other Labs (Latex, Serology, etc) : ....

Ongoing Antibiotics : ....

....

NEPHROLOGY ISSUES

Sr. Creat : 0.4 Bld. Urea : 21 Other Relevant Labs : ....

P.D. ☐ Yes ☑ No - If yes, details : ....

Diuretics : ☐ Yes ☑ No - If yes, details : ....

Catheterized : ☐ Yes ☑ No - If yes, then day of Catheter : ....

Ralevant Radiology (USC, MCUG radioisotope scan etc) : ....

Plan of Care : ....

....

HEMATOLOGY

Relevant Labs (CBP etc) : ....

Any Coagulopathy : CBP :- 11.8 > 2.86.0 / 65.5/24 ↓ 1.58L

Relevant Transfusion History : ....

Plan of Care : ....

....

CARE PROTOCOLS

VAP Bundle Used ? : ☐ Yes ☐ No ☑ NA

CRBSI Bundle Used ? : ☐ Yes ☐ No ☑ NA

CA - UTI Bundle Used ? : ☐ Yes ☐ No ☑ NA

Patient Managed as per Relevant Protocols : ☐ Yes ☐ No ☐ NA

If yes, then details : ....

....

Pending Lab Results : ☑ Yes ☐ No

If yes, then details : Trace CBP

....

Pending Consultations : ☐ Yes ☐ No

If yes, then details : ....

....

FINAL COMMENTS

Trace CBP, Dengue Serology

Doctor's Name (Handover given) : Jayesh

Signature : JY

Date & Time : 20/7/26 @ 8AM

Doctor's Name (Handover taken) : Dr. Pratyusha

Signature : ....

Date & Time : 20/7/26, 8AM

BAH-00543203 IP5-00176565
Master MOHAMMED ARZAAN ASIM
19-11-2022 3 Y 8 M 0 D (M)
Dr. RAMESH KONANKI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26	c/s/B Neuroteam	
9am	Fever triggered (R) focal to BTC	
	Issues	
	→ fever spikes persistent	plan
	→ No recurrent seizures	
		(1) Trace CBP
	o/e	(2) shift to ward
	Conscious	
	irritable.	
	EOM full	N.By [signature]
	No facial weakness	20/7/26
	Speech good	@9:30AM
	No meningeal signs	
	Good antigravity	
	movements	
		DR. ABHISHEK R JAIN
		Registration No: 2757
		[signature]

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/22	C/S/B Dr. Kapil	
10 AM	D: Complex Febrile Seizure	plan:
	Partial Sz - I Impaires awareness	1) Send flu panel
	- Child has no seizures after admission	2) Neurology opinion
		3) Trace Bloods
	Issue:	4) Send MP optimal
	- fever spikes persistent	
	- NO focal deficits	5) Can be shifted to room after neurology.
	HR - 114/min	
	RR - 32/min	
	SpO2 - 100% RA.	
	O/E:	
	CVS:- B/L pupil 2mm equal reactive to light	
	- no focal deficits	
	- moving all 4 limbs	
	GCS - 15/15	
	Other sys. exam - WNL	

DR. SHAIKH FARHANA RASHID
Registration No: 66229

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19-11-2022 3 Y 8 M 1 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/24 1:30pm	Shifting notes.	
	Complex febrile seizures	
	child afebrile, No seizures, Hemodynamically stable	Plan
	shifting vitals —	1- Trace Flu panel, MP optimal, Blood cls.
	T - 98.6°F,	
	HR - 102/min	
	RR - 26/min	
	BP - 101/55 mm Hg.	
		Dr. Hiwaja.

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26	CTS/B Neuroteam	
	Fever triggered seizures. (LF) clonic to B/L tonic clonic seizures.	
	+ 6 episodes	
	Issues: fever spikes (+) ; platelets ↓ trend No fresh seizures.	
		fu panel - we. DOI - 4 DOA - 4
	O/E: Child Asleep B/L pupils normal size to light Tone - N / N N / N power - (N) DTR: +2 Vitals - stable	Adv 1) Trace malaria & B/C/S report 2) Vitals monitoring 3) Repeat CBP tfm . explain - (+)

DR. ABHISHEK R JAIN
Registration No: 2767

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

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Master MOHAMMED ARZAAN ASIM (M)
19-11-2022 3 Y 8 M 1 D
Dr. RAMESH KONANKI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/s I/B PICU fellow (Dr Jyoti)	
21/07/26	Dx - Complex febrile convulsion	
	issues - fever spikes	Plan
	No c/o Sz thereafter	1.) Trace Malaria & Blood C/S Report
	on Room Air	
	chest - B/L AE ⊕ equal clear	2.) w/f fever spikes
		3.) continue I/V antibiotics & anticpileptics
	Abd - soft, Non distended	
	CNS/CVS / NAD	
	flu panel - Negative	Jyoti

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19-11-2022 3 Y 8 M 1 D
Dr. RAMESH KONANKI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26 09 AM	c/c/B Neuroteam →	

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

(P.T.O)

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19-11-2022 3 Y 7 M 29 D (M)
Dr. RAMESH KONANKI

RESULT SHEET

Date	18/7/26	19/7/26	20/7/26
Time	3:30pm	12:30pm	8:30AM
Hb	11.6	11.8	10.8
PCV	35.8	37.4	33.4
RBC	4.75	4.82	4.41
WBC	6,480	2860 ↓	2500 ↓
N/L	83.2/12	65.8/24.	39.2/45.2
Platelets	1.94 L	1.58 L ↓	1.28 ↓
CRP	6 .		
ESR			
PCT			
RBS			
Na	133		
K	4.0		
Cl	100		
Ca/Mg	8.8/1.8		
Phosphate			
Urea	21		
Creatinine	0.4		
ALP			
SGPT			
SGOT			
T.Bill/Conj			
T.Protein			
S.Albumin			
S.Globulin			
A/G Ratio			
Uric Acid			
S.Amylase			
Sr.Lipase			
Blood Lactate			
S.Cholesterol			
PT/INR			
APTT			
CSF Protein / Sugar			
Cells			
N/L			

Date	18/07/26					
Time	7:30pm					
CUE - Alb	Nil					
CUE - Sugar	Nil					
CUE - Ketones	Trace					
CUE - PUS Cells	2-3 cells					
CUE - RBC Cells	0					
CUE Nitrite	Neg.					
leucocyte	Neg					
crystal/cast	Absent					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : 19/07 Dengue NS1 Ag + IgM :- Negative (verbally)

MP Optimal

20/07 | Flu panel - Negative

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI

…ars (ECG, Contrast Studies etc.) :

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MEDICATION RECONCILIATION FORM

Drug Allergies: .....

☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

From: ..... ER .....

Shifted to: ..... RW .....

MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, IG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
Inj. LEVIPIL	IV	28 mg	12H	18/7/22	☐C ☐DC
					☐C ☐DC
					☐C ☐DC
					☐C ☐DC
					☐C ☐DC
					☐C ☐DC
					☐C ☐DC
					☐C ☐DC
					☐C ☐DC

* C- Continue, DC - Discontinue

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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 / 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.

RSES - 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 : Inj PARACETAMOL				Date ▸ Time ▾	18/7/26	18/7	19/7	20/7	21/7
Dose	Route	Frequency	Start Date		9pm [signature]	6AM [signature]		4:15PM [signature]	5:30 am Sona
200mg	IV	SOS	18/7		4pm Anjali	3pm [signature]	10:30 pm Sona		
Doctor's Signature	Valid Period	Pharm.							
[signature]									
Additional Instructions:									

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

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

VERIFIED BY : Name .... Signature

BAH-00543203 IPS-00176969
Master MOHAMMED ARZAAN ASIM
19-11-2022 3 Y 7 M 29 D (M)
Dr. RAMESH KONANKI

REGULAR PRESCRIPTIONS

Weight: 14 kg. Ward: PW

DRUG: INJ CEFTRIAXONE.

Dose	Route	Frequency	Start Date
700 mg	iv.	BD	18/7

Name & Signature of the Doctor Starting the Drugs: Sukaya.

Additional Instructions:

Date ▸ / Time ▾: 18/7, 19/7, 20/7, 21/7

6AM: X (18/7)

6PM: Anjali

Daily Doctor's Endorsement by a Sign

DRUG: INJ LEVETIRACETAM.

Dose	Route	Frequency	Start Date
280 mg	iv	BD	18/7.

Name & Signature of the Doctor Starting the Drugs: Sukaya.

Additional Instructions:

Date ▸ / Time ▾: 18/7, 19/7

6AM: X (18/7)

6PM: Anjali palesh

Stop

Daily Doctor's Endorsement by a Sign

DRUG: INJ ESOMEPRAZOLE

Dose	Route	Frequency	Start Date
30 mg	iv	OD	18/7

Name & Signature of the Doctor Starting the Drugs: Suky.

Additional Instructions:

Date ▸ / Time ▾: 18/7, 19/7, 20/7, 21/7

6AM

Daily Doctor's Endorsement by a Sign

DRUG: Syp LEVETIRACETAM

Dose	Route	Frequency	Start Date
3 ml	PO	BD	19/7

Name & Signature of the Doctor Starting the Drugs: Dr Vineeth

Additional Instructions:

Date ▸ / Time ▾: 19/7, 19/7, 20/7, 21/7

6 am

6 pm

21/7

Daily Doctor's Endorsement by a Sign

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight 14 kg Ward PW

DRUG : Tab. MAGVION

Dose	Route	Frequency	Start Dt.
1/4 tab	PO	BD	19/7/22

Name & Signature of the Doctor Starting the Drugs: Dr. pratyusha

Additional Instructions: (1 tab = 400 mg)

Daily Doctor's Endorsement by a Sign

Date / Time	19/7	20/7	21/7
10 am	X		
10 pm			

DRUG : Syp LEVITRIACETAM

Dose	Route	Frequency	Start Dt.
2ml	PO	BD	21/7

Name & Signature of the Doctor Starting the Drugs: Dr. ka

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	21/7
6am	
6pm	

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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

Patient Sticker

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Sheet No: .... **REGULAR PRESCRIPTIONS** Weight .... Ward ....

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ / Time ▾

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ / Time ▾

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ / Time ▾

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ / Time ▾

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

Dr. RAMESH KONANKI

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

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

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

Signature .....

VERIFIED BY the .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
19/7	10pm	Inj. ONDANSETRON	2mg	IV		

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Master MOHAMMED ARZAAN ASIM
19-11-2022 3 Y 7 M 29 D (M)
Dr. RAMESH KONANKI

I.V. FLUIDS CHART

Weight. 14KG Ward. PCW

Date	Time	Composition of I.V. Fluid (In infusion, mention 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	2pm.	DNS	iv	30ml/hr			19/7/26		

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

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Master MOHAMMED ARZAAN ASIM
19-11-2022 3 Y 8 M 1 D (M)
Dr. RAMESH KONANKI

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

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/7 Time:

Doctor / Nurse / Family Concern?

Temperature (F)

Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring

Heart Rate (Number)

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

Resp. Rate (Number)

Resp Distress	Mod/ Severe / None / Mild
Receiving O_2(l/min)	
O_2Saturations (%)	
Conscious Level	Normal / Altered
GCS *	
TOTAL SCORE Number of shaded boxes	
Pain Score	
Observer's Initials	

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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19-11-2022 3 Y 8 M 1 D (M)
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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.

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 20/7/26

Time	3pm	3:30pm	6pm	10:00pm	10:30pm	11pm	12am
Doctor / Nurse / Family Concern?							
Temperature (F) (94–104)	100.3 F Sponge	100.7 INJ PCM	98.5F	100.8F (Sponging)	100.8F (Inj PCM)	98.9F	100. (Sponging)
Heart Rate (bpm) and Blood Pressure (mmHg) * (50–190)	90 / 65 / 70	97 / (70) / 75	107 / 55 / 60		107 / (69) / 55		
Heart Rate (Number)	120 b/mt	122 b/mt	120 b/mt		117 b/m		
Resp. Rate (bpm) (Over 1 Minute) * (10–70)							
Resp Rate (Number)	28 br/mt	28 br/mt	29 b/mt		26 b/m		
Resp Distress: Mod/ Severe							
Resp Distress: None / Mild							
Receiving O_2 (l/min)							
O_2 Saturations (%)	99%	96%	98%		98%		
Conscious Level: Normal							
Conscious Level: Altered							
GCS *	15/15	15/15	13/15		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		

Note: BP does not score in early warning scoring

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00543203 IP5-00176565
Master MOHAMMED ARZAAN ASIM
19-11-2022 3 Y 8 M 1 D (M)
Dr. RAMESH KONANKI

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
20/7	02:00 pm	NO IVF	CURD RICE		NA			NA			0	Rama
	03:00 pm										0	
	04:00 pm										0	
	05:00 pm									✓	0	
	06:00 pm										0	
	07:00 pm										0	
Total Intake :						**Total Output :**						
20/7	08:00 pm	NO IVF	Idly Vada				✓			✓ ✓	0	Ra
	09:00 pm										0	
	10:00 pm										0	
	11:00 pm										0	
	12:00 am										0	Ra
	01:00 am										0	
Total Intake :						**Total Output :**						
21/7	02:00 am	NO IVF					NP			✓	0	Ra
	03:00 am										0	
	04:00 am										0	
	05:00 am										0	
	06:00 am										0	Ra
	07:00 am										0	
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

BAH-00543203 IP5-00176565
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FLUID CHART

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Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
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	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	