

By

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No. : _____ Dept : _____

BAH-00660111 IP5-00175690
Master NAGAMALLA JAYANTH
31-10-2025 0 Y 8 M 0 D (M)
Dr. SANDEEP REDDY

Date of Admission : _____ Tim _____ rge : _____ Time: _____



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Abhishek ✓	02/10/25	9684602	Papay
2	Dr. Brundawani ✓	02/10/25	9684704	Brundawani
3	Dr. Ramesh ✓			
4	Dr. Brundawani ✓	03/10/25	9686281	Brundawani
5	Dr. Achila ✓			
6	DI			
7				
8				
9				
10				

[illegible]

Date _____

Investigations

Order No.

Signature

17

CBP, 21 & RB

26065628



217126

CBP, R_{P2}, Albumin

26066023

Lamin

26066022

2135

02107

EEG

032931

Palash

317126

Electrolyte

26066395

Lami

RBS

26066441

3681.26

ABC

26066637

Spoke

check x-ray

032976

x-ray

023069



MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
1/7	Inv: Monitor	Stop			
	Inf: Pump			9681339	[Signature]
	Inf: 2 Pump				
	Syr: 2 Pump				
	Syr: 2 Pump			9681339	
	Syr: 2 Pump				
	Ventilator				
	Alpha bed				
2/7/26	Inv. Monitor	Stop		9678330	[Signature]
	Inf. pump			9678330	
	Inf. pump			9683132	
	Ventilator			9681339	
	Alpha. Bed			9683132	
	Syr. pump			9681339	
	Syr. pump			9681339	
3/7/26	Inv. Monitor	Stop		9678330	[Signature]
	Inf. pump			9678330	
	Ventilator			9681339	
	Alpha. Bed			9683132	
	Syr. pump			96831339	

[illegible]

ANY OTHER INFORMATION

CXRY - (2)
x-ray - (8)
CXR - (7)

Date : 9/2/26 Time : 10am Prepared By : [Signature]

Date : 28/7/26

Time : 10 am

Prepared By :

Usp

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor

Shariya?

Ques

B4

MLC

ACTIVITY RECORD FOR BILLING

Name : _____
UHID No. : _____
Date of Admission : _____ Time : _____
Room / Bed No : _____ Ward : _____

BAH-00660111 IP5-00175690
Master NAGAMALLA JAYANTH
31-10-2025 0 Y 7 M 27 D (M)
Dr. SANDEEP REDDY
Barcode

Consultant: _____ Dept: _____

Date of Discharge : _____ Time: _____

Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
27/6/26	9:50pm	ER	PICU	[Signature]

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	DR. Raniga. B ✓	28/6/26	9678958	[Signature]
2	DR. Sri. parthe ✓	29/6/26	9680132	[Signature]
3	DR. Venkat Rami ✓	29/6/26	9680132	[Signature]
4	Dr. Sudhar ✓	not showing (Uterus around)		
5	Dr. poornima ✓	30/6/26	9681590	[Signature]
6				
7				
8				
9				
10				

INVESTIGATIONS			
Date	Investigations	Order No.	Signature
22/6	CBP, PT APT		
	Blood c/s, CRP	26064786	Paleyh
	RBS	26064801	
	Skeletal survey	032124	
	EEG	032120	
	CT head plain	032125	
29/6	CBP, SLG RB	26064999	}
	EEG	32354	
30/6	RBC, SLG	26065327	}
	CRP	32351	

Investigations

Order No.

Signature

2216

UBP, PP ADTP

Blood c/s, CRP

DBS

Skeletal survey

EEG

CT head plain

26084786

26064801

032124

032 120

032125

2016

CBP SLG RB

h h h

260 b n q q q

32354

30/6

RB, SH

OK

2606532

32551



MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
27/6	INr monitor			9678331	Palesh
	INF pump				
	INF pump				
	S. pump				
	Oxygen				
28/6	inv. Monitor		11am	9678331	An
	Inf. Pump				
	Inf. Pump				
	Sys. Pump				
	O2				
30/6	inv. Monitor			9678331	An
	Inf. Pump			9680198	
	O2			968240	An
	ventilator.				
	Sys. pump				
	Sys. pump				

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
28/6	MLC charges	①	9678319	parish
	TV placement	①	9678332	
	Arterial line			
28/6/26	PAC for MEI	①	9678959	Lau
30/6	Blood transfusion			
29/6/26	End Intubation	①		
	laryngoscopy		9681334	
	conscious sedation			
	PICC line	①	9681589	
30/6	Wet	①		

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

B4

ACTIVITY RECORD FOR BILLING

Name : _____

BAH-00660111 IP5-00175690
Master NAGAMALLA JAYANTH
31-10-2025 0 Y 8 M 3 D (M)
Dr. SANDEEP REDDY

UHID No. : _____ IP No : _____ Dept : _____

Date of Admission: _____ :charge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Brundharani	04/07	9688429	Palash
2	DR. Venkata Ram	4/7	9688429	E
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

[illegible]

[illegible]

ANY OTHER INFORMATION

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.....

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.....

.....

Date : Time : Prepared By :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

ADMISSION SHEET
Registration Details :

Admission No : IP5-00175690

Admit Date : 27-Jun-2026

Admit Time : 11:07 PM UHID : BAH-00660111

Patient Details :

Patient Name : Master NAGAMALLA JAYANTH

Age : 0 Y 7 M 27 D

Guardian : NAGAMALLA ASHOK

DOB : 31-10-2025 01:00 AM

Gender : Male

Religion :

Occupation :

Martial Status : Single

 Address (H) : #.1-56 RAJUPETA Tipparthi Nalgonda
 Telangana INDIA 508247

Phone No : 9059661146

E-mail : nomailid@gmail.com

Admission Details :

Bed Type : PICU

Bed No : PICU 211

Ward Name : 2F-PICU I

Room No : PICU 211

Admission Type : First Visit

Contact Details :

Name : NAGAMALLA ASHOK

Relationship : Father

 Contact Address : #.1-56 RAJUPETA Tipparthi Nalgonda
 Telangana INDIA 508247

Phone No :



Signature

Doctor Details :

Doctor Name : Dr. SANDEEP REDDY

Specialisation : PEDIATRIC INTENSIVE CARE

Referral Doctor : Self

Phone No :

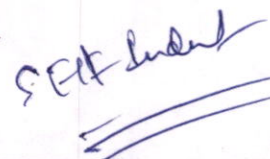
Co-Consultant : Dr. KAPIL BHAGWATRAO SACHANE

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELF PAY



ADMISSION SHEET

Registration Details :

Admission No : IP5-00175690 Admit Date : 27-Jun-2026 Admit Time : 11:07 PM UHID : BAH-00660111

Patient Details :

Patient Name	: Master NAGAMALLA JAYANTH	Age	: 0 Y 7 M 29 D
Guardian	: NAGAMALLA ASHOK	DOB	: 31-10-2025 01:00 AM
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: #.1-56 RAJUPETA Tipparthi Nalgonda Telangana INDIA 508247	Phone No	: 9059661146
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type : PICU Bed No : PICU 211 Ward Name : 2F-PICU I
Room No : PICU 211 Admission Type : First Visit

Contact Details :

Name	: NAGAMALLA ASHOK	Relationship	: Father
Contact Address	: #.1-56 RAJUPETA Tipparthi Nalgonda Telangana INDIA 508247	Phone No	:

Signature

Doctor Details :

Doctor Name	: Dr. SANDEEP REDDY	Specialisation	: PEDIATRIC INTENSIVE CARE
Referral Doctor	: Self	Phone No	:
Co-Consultant	: Dr. KAPIL BHAGWATRAO SACHANE/ Dr. BANDI RAMYA		

Payment Details :

Deposit Amount	: 83337.80
Payment Mode	: DC/CC Card
Payor Name	: SELFPAY

ADMISSION SHEET



Registration Details :

Admission No : IP5-00175690 Admit Date : 27-Jun-2026 Admit Time : 11:07 PM UHID : BAH-00660111

Patient Details :

Patient Name	: Master NAGAMALLA JAYANTH	Age	: 0 Y 7 M 28 D
Guardian	: NAGAMALLA ASHOK	DOB	: 31-10-2025 01:00 AM
Gender	: Male	Religion	:
Occupation	:	Marital Status	: Single
Address (H)	: #.1-56 RAJUPETA Tippiarhi Nalgonda Telangana INDIA 508247	Phone No	: 9059661146
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type : PICU Bed No : PICU 211 Ward Name : 2F-PICU I
Room No : PICU 211 Admission Type : First Visit

Contact Details :

Name : NAGAMALLA ASHOK Relationship : Father
Contact Address : #.1-56 RAJUPETA Tippiarhi Nalgonda Phone No :
Telangana INDIA 508247

Signature

Doctor Details :

Doctor Name : Dr. SANDEEP REDDY Specialisation : PEDIATRIC INTENSIVE CARE
Referral Doctor : Self Phone No :
Co-Consultant : Dr. KAPIL BHAGWATRAO SACHANE

Payment Details :

Deposit Amount : 30000.00
Payment Mode : Cash Payor Name : SELF PAY

PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor: PICU Asperrofa

Date: 27/06/26

Type of Admission: ☐ OPD ☐ ER ☐ Referral (if referral, Doctor's Name: _____)

Start Time of Assessment: 9:00pm Weight: 2.7kg

Allergic History: _____

Chief Complaints: No Seizure Activity since 3 days
H/O Trauma 3 days back

Pediatric Assessment Triangle

A Appearance - TICLS doll sick looking

B Breathing

C Circulation

☒ Normal

☐ Abnormal

☐ Pallor ☐

☐ Cyanosis ☐

☐ Mottling ☐

☐ Bleeding ☐

☐ ↑ WOB

☐ ↓ WOB

☒ Normal

☐ Gasping / Apnea

Initial Physiological Status: ☐ Stable ☒ Unstable

☐ Life Threatening ☐

☐ Non Life Threatening ☐

Any urgent interventions needed: ☐ Yes ☒ No

If Yes See Low Flow

Significant Past History: H/O Trauma 3 days back

Medication History: on Anti epileptics 3 days

Relevant Investigations: CT Head

Primary Assessment

Airway ☒ Open

☐ Maintainable

☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☒ No

If Yes See Low Flow

Breathing

Rate: 12/min SpO₂ on FiO₂ 98%

Rhythm: slow

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR

☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: _____

Palpation Findings (If necessary) _____

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____

Circulation

HR: 163

BP: 111/68/94 mmHg

Pulse Volume: ☒ Central 30 ☒ Peripheral 30

If in Shock: ☒ Compensated ☒ Hypotensive

Muffled Heart Sound: ☐ Yes ☒ No

Engorged Neck Veins: ☐ Yes ☒ No

CFT ☐ Central ☒ Peripheral

Murmurs: ☐ Yes ☒ No

Liver Span: ☒ ☐

ECG: ☒ ☐

Any Signs of Heart Failure: ☐ Yes ☒ No

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

Disability

GCS: 12/15 AVPU: *Spontaneous eye opening +*

Pupils: ☒ Responsive ☐ Non-Responsive

Size: ☐ Right 1mm ☐ Left 2mm

Active Seizures: ☐ Yes ☒ No Sugars: 89 mg/dl

Signs of Neurological compromise

Any urgent interventions needed: ☐ Yes ☒ No

If Yes *Anti epileptics*

Exposure

Temp: 99.6°F

Any Rash: ☐ Yes ☒ No

If yes describe the rash

Active bleed ☒

Lacerations ☐ Abrasions ☐ bruises ☐

Describe:

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☒ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings: *Head injury on left side*

No Trauma 3 days back w/ convulsions 3 days

Labs Planned:

CT HEAD

Sr. Electrolytes

Treatment Planned:

Inj. MGNES

Inj. Lacosamide

Inj. LEVITEL

Inj. EPTOIN

Drip 10% 100ml

NIB

Need for Oxygen: ☒ Yes ☐ No if yes Low Flow ☒ High Flow ☐ PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): *Traumatic Brain Injury*

Assessment done by *T. Pawan*

Name of the Doctor: *T. Pawan*

Signature: *T. Pawan*

Date & Time: *27/06/22 @ 11pm*

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor:

Signature:

Date & Time:



ADMISSION CRITERIA – PICU

Admission / Transfer from:

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

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

- ☐ All patients requiring mechanical ventilation;
- ☐ Patients with impending respiratory failure;
 - ☐ Upper airway obstruction;
 - ☐ Lower airway obstruction;
 - ☐ Alveolar disease; and
 - ☐ Unstable airway;
- ☐ All Paediatric patients after successful resuscitation;
- ☐ **Comatose Patients;**
 - ☐ Meningitis, encephalitis; ☐ Hepatic encephalopathy; ☐ cerebral malaria;
 - ☐ Head injury; ☐ Poisonings; and ☐ Status epilepticus;
- ☐ **All types of shock/hemodynamic instability:**
 - ☐ Septic shock;
 - ☐ Hypovolemic shock; (Bleeding emergencies such as gastrointestinal bleeding, bleeding diathesis, disseminated intravascular coagulation; Cardiogenic shock; myocarditis, cardiomyopathy, congenital heart disease; Neurogenic shock; and Multiple trauma;
- ☐ Cardiac arrhythmias after consulting with the treating consultant
- ☐ Hypertensive Emergencies;
- ☐ Severe acid base disorders;
- ☐ Severe electrolyte abnormalities;
- ☐ Diabetic ketoacidosis (Ph < 7.2, altered sensorium, hyperglycemia)
- ☐ Acute renal failure; Patients requiring acute hemodialysis, hemofiltration and peritoneal dialysis;
- ☐ **Post-Operative Patients;**
 - ☐ Requiring ventilation;
 - ☐ Unstable patients; and
 - ☐ Post-operative patients after open heart surgery, neurosurgery, thoracic surgery and other patients after major general surgery with potential for respiratory/haemodynamic instability;
- ☐ Patients requiring nitric oxide therapy;
- ☐ Malignant hyperpyrexia;
- ☐ Acute hepatic failure
- ☐ Severe dehydration with mental status change;
- ☐ Asthma requiring hourly nebulization/getting tired with increasing oxygen requirement/mental status change.
- "UNSTABLE" PATIENT IS DEFINED AS**
 - ☐ HR < 50 or > 160 per minute or more than upper normal limit according to age. BP < 90 systolic and < 50 diastolic and/or requiring inotropic support. Arrhythmia or risk of sudden arrhythmia.
 - ☐ Signs of peripheral poor perfusion or suspicion of any type of shock.
 - ☐ Capillary refill time > 4 seconds.
 - ☐ Children Blood pressure (Syst.) < [70 + (2 × age "Years")].
- Respiratory failure or high risk of failure or airway obstruction:**
 - ☐ Respiration rate < 5 per minute below the normal or > 10-15 per minute above the normal range for age.
 - ☐ O₂ Saturation < 90 % or need for O₂ > 4 Litres per minute by normal face mask. Abnormal ABG: PH < 7.25, PaO₂ < 60 torr, PaCO₂ > 50 torr.
 - ☐ Distress and risk of exhaustion
- ☐ **Change of level of consciousness: GCS < 13.**
- ☐ **Persistent oliguria with acidosis.**

Signature of the Doctor: Name of the Doctor: Date & Time:

DISCHARGE CRITERIA – PICU

Discharge to:

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

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

- ☐ Stable hemodynamic parameters.
- ☐ Stable respiratory status (patient extubated with stable arterial blood gases) and airway patency at least for 24 hours with no respiratory distress needing continuous monitoring.
- ☐ Minimal oxygen requirements that do not exceed patient care unit guidelines.
- ☐ Intravenous inotropic support, vasodilators, and antiarrhythmic drugs are no longer required or, when applicable, low doses of these medications can be administered safely in otherwise stable patients in a designated patient care unit.
- ☐ Cardiac dysrhythmias are controlled.
- ☐ Neurologic stability with control of seizures.
- ☐ Removal of all hemodynamic monitoring catheters.
- ☐ Routine peritoneal or hemodialysis with resolution of critical illness not exceeding general patient care unit guidelines.
- ☐ Patients with mature artificial airways (tracheostomies) who no longer require excessive suctioning.

Signature of the Doctor:

Name of the Doctor :

Date & Time:

PEDIATRIC INTENSIVE CARE ADMISSION RECORD

Date: 27/6/26 Time: 10:45pm

Patient Assessment Form:

Informant: ☐ Father ☐ Mother ☒ Other

Presenting Complaints / Chief Complaints :

Child was brought to ER with alleged history of fall from the bike (bike hit from side) (2y) (M) On Wednesday around 12pm @ Panagadu, Nalgonda now presented with seizures and vomitings.

CT scan: RT SDH. CT chest & abdomen: (N).

Child was admitted in Osmania hospital for one day but seizures were continued despite treatment (Antiepileptics).
Seizure started 1hr after incident, Vomiting since today. Levetiracetam, Eptoin, Lacosamide.

Now the patient came with continuous seizures i.e., at least 2-3 episodes per day.
3 e/o vomitings today - non bilious, non projectile not associated with any blood stain.

Past History (Including previous treatment and investigations) :

No significant previous history

Birth and Developmental History :

3kg / full term / EL-25CS / H/O NICU admission for 2 days d/t doll activity, poor feeding

Immunization History :

Immunized upto date as per NIS

H / O Allergy :

No H/O allergy

Family History :

No H/O seizures

No significant family history

Provisional Diagnosis : Traumatic Brain Injury

Prism III score at 24 hrs of admission : Worse SOFA Score :

☐ Referred Patient - ☒ Self Referral - ☐ Rainbow Patient

Transferring Unit : ☐ Ward ☐ OT - Transported? ☐ Yes ☐ No - If yes : ☐ Long (> 30 kms) ☐ Short (< 30 kms)

Referring Consultant :

Admitting Consultant : PICU as per Rota

Indication for PICU referral : Seizures

PLAN OF CARE

Preventive aspects of the treatment : Further brain damage.

Desired goals of the treatment : Resolution & prevention of seizures

PLANNED INVESTIGATIONS

CT Head with cervical spine
RP,
PT/APTT/INR
Blood c/s
EEG
USG Abdomen
Skeletal survey
eFAST

PLANNED MANAGEMENT

IV CEFTRIAXONE
IV PANTOPRAZOLE
INJ. LEVIPIL
INJ. EPTOIN
INJ. LACOSAMIDE
IV Fluids

Final Diagnosis: Traumatic Brain Injury

Doctor's Signature : Bharath

Name : BHARATH REDDY

Date : 27/06/2026

Time : 11:00 PM

Consultant's Signature : Dr. Venkat Sandeep Reddy. K

Name : Reg. No: TSMC/FMR/15713

Date : 27/06/2026

Time : 11:30 AM



PROGRESS NOTES AND DOCTOR'S ORDER

MLC

Date & Time	Progress Notes	Doctor's Order
27/6/25 10 PM	C/S/B Dr. Sandeep Δ: Severe TBI / RTA Child was on a bike (moving bike). When it was hit by a 4-wheeler. Child fell on the ground. Taken to Gyanika Hosp.. CT Brain: SDH (RT side) CT chest & abd. (N) Child had persistent seizures & multiple vomiting episodes. & dull sensorium. ① Levipil, Lacosamide, Epoin. Seizures still persisting, so took LMA 4 shifts & kept. O/E: CKU & dull activity. Q on 2L/min SpO₂: 99% PR: 156/min RR: 28/min BP: 94/70 Chest: B/L clear CNS: SIS 2+ PA: soft RT	Plan: ① Ceftriaxone. ② Ty TT. ③ B.I. NS. ④ Lacosamide Levipil. Skeletal survey EPAST USG Abdomen EEG. Neuro opinion. Keep intubation things ready. RPL, PT/DAVE/APTT, CRP. Blood culture. Skeletal survey CT Brain & cervical spine Survey Neuroprotective measures. DNS 10ml/hr. B.I. NS 2ml/hr. Noted by Soumya JIP 27/6/25 P.T.O.



PROGRESS

27/6/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	CT Scan On Brain	
28/6/24 12 am	<u>C/D/W Dr. Nibin</u> CT Brain: Rt side SDH present. Cerebral edema @ ? Infarct.	
	<u>C/D/W Dr. Sudheer</u> Rt humerus condylar fracture - present.	
	<u>C/D/W Dr. Praneeth</u> CT Brain: Rt side SDH & cerebral edema. No active intervention needed.	
	<u>C/D/W Dr. Venket</u> Rt humerus supracondylar fracture. (Buckle #) Needs splinting. (or splint splinting).	

[illegible]

DAILY ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 27/06/26 Day of Admission : Day 1 Today's Date & Time : 28/06/26
 PRISM - III Score in first 24hrs. of Admission : Today's SOFA Score :

OVERVIEW	Diagnosis : RTA / TBI RT sided SDH & Rt humerus condylar #	Current Issues : Seizures Fever spike
	VITAL SIGNS Today's Wt. (kg) : 7kg Temp. Blood sugar issues : 110 @ 7AM	
RESPIRATORY SYSTEM	Respiratory System Findings : (Air entry, breath sounds, s/o distress etc.) : B/L air entry ⊕	
	CXR : SPO ₂ : 100% O ₂ by NC / FM / NRB mask / Oxyhood, at 2 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 : Suctioning Needs : Any Nebs : ICD ? ☐ Yes ☒ No, if Yes, details : Plan of care : Keep intubation things bedside	
CARDIO VASCULAR	Cardio Vascular System Clinical Exam. (Heart sounds, murmur etc.) : HR-163/min	
	Quality of Pulses : Good cap refill Time : 3sec Liver Edge : cm below Rt costal margin	
	Blood Pressures : NIBP : 96/65 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 : (Rt) Hand 22G - Day 1 Central line in situ : ☐ Yes ☒ No Place of central line & its condition : Day of arterial line : Day 1 Day of Central line : Plan of Care : (Rt) 22G P-cannula ? (L) 22G P-cannula Day 1	
CNS	Neuro Exam : E4V2M4	
	Pupils : (Rt) 2mm Reacting to light Sedation Used ? ☐ Yes ☒ No Any paralysis ? ☐ Yes ☒ No (L) 3mm sluggish Types of Paralysis : Types of Sedation : Types of Paralysis : Relevant CT Scan, MRI EEG, Neurosonogram etc. : EEG ongoing Inf. Levetiracetam Plan of Care : Antiepileptics, MRI plan for tomorrow Inf. Lacosamide	
	Ramsay Sedation Score :	

FLUIDS STATUS NUTRITION AND G.I	☒ NPO ☐ PO feeds ☐ NG Feeds ☐ NJ Feeds ☐ GT Feeds	
	I / O / Balance : <u>-70</u> / (+/-) Input : ml/k/d UO : <u>4.2</u> ml/kg/hr Stools :	
	NG output : PO intake :	
	Feed Formula : Feed Schedule :	
INFECTION	IV Fluids - Type of IVF : <u>DNS</u> @ <u>10</u> ml / hr (<u>35%</u> 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	
NEPHROLOGY ISSUES	Labs : Na <u>133</u> K <u>5.1</u> Cl <u>100</u> Ca <u>9.7</u> Mg P HCO3 Sr. Amylase : Sr. Lipase :	
	Latest LFT : <u>(N)</u>	
	Abd Exam : <u>soft, NT</u>	
	Any organomegaly ? ☐ Yes ☒ No - If yes, describe :	
HEMATOLOGY	Plan (G.I. & Liver) :	
	☐ Febrile ☐ Afebrile Current Antibiotics Details (antibiotic name and day #) :	
	Cultures Sent ? ☒ Yes ☐ No - If yes, details : <u>Blood c/s sent on (27/6)</u>	
	Describe c/s Reports :	
CARE PROTOCOLS	Other Labs (Latex, Serology, etc) :	
	Ongoing Antibiotics :	
	Sr. Creat : <u>0.2</u> Bld. Urea : <u>18</u> Other Relevant Labs :	
	P.D. ☐ Yes ☒ No - If yes, details :	
FINAL COMMENTS	Diuretics : ☐ Yes ☒ No - If yes, details :	
	Catheterized : ☐ Yes ☒ No - If yes, then day of Catheter :	
	Relevant Radiology (USC, MCUG radioisotope scan etc) :	
	Plan of Care :	
CARE PROTOCOLS	Relevant Labs (CBP etc) : <u>22/6</u>	
	Any Coagulopathy : <u>79</u> <u>14770</u> <u>2.91</u> <u>73-5/21-2</u>	
	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	
FINAL COMMENTS	If yes, then details :	
	Pending Lab Results : ☐ Yes ☒ No	
	If yes, then details :	
	Pending Consultations : ☒ Yes ☐ No	
FINAL COMMENTS	If yes, then details : <u>Neuro Conso Hcton</u>	
		
		
		

ORDER

(P.T.O)



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

Dr Sandeep .

Date & Time	Progress Notes	Doctor's Order
28/6/25 10 AM	<u>Counselling notes.</u> patient is being monitored for seizures through EEG. patient is drowsy, movements are less, after admission no further seizures are present. There is edema around lesion. It will decrease further after 3 to 4 days. Tomorrow we will do MRI brain to look for damage. Today neurology consultation is being taken. patient condition discussed with neurosurgeon & conservative management advised. Right humerus fracture present. Cerebral edema if increases, it may herniate. Brainstem herniation if occurs, may cause death. Edema will increase day by day after day of injury. Left side weakness is present. paralysis is present on left side, chances of recovery present. physiotherapy will be required. 1 to 2% chances of life risk & death present. patient attenders explained about condition.	
		 Dr Nathan
	N. Venkanna Father	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/4/26 4pm	Neuroteam Severe TBI Severe → No fever → No clinical seizure → EEG improving meds (-) (H) Alopecia (B) facial weakness (L) LL & UL weakness	(R) SBH plus (1) B/vp Phenolene (2) MRI with MR angiogram T/m
		Noted by neuro 28/6/26 @neuro

BAH-00660111 IP5-00175690
Waster NAGAMALLA JAYANTH
31-10-2025 0 Y 7 M 27 D (M)
Dr. SANDEEP REDDY



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/06/26 9:00am	1/B Sandeep Reddy	
	→ Δ: TBI = (Rt) sided SOH	
	→ Pupils b/L → 3mm (Rt) sluggish (Rt) reaction to light	
	→ E4 VLM	
	→ Hemodynamically stable	PLAN
	TFI = 60% (include all Intuit)	1) keep thiy ready for escalation of respiratory therapy.
	→ Few bp (Rt)	2) feed electrolytes @ 4:00pm. CBC
	→ On ceftriaxone	3) MRI to plan (T1m) + MRA.
		4) Start feed via NG after looky for basilar fracture
		5) USG abdomen today.
		6) Neurology opinion
		7) Ortho opinion.
		8) (T) Skeletal survey

Dr. Venkat Sandeep Reddy, K
Reg. No. 15417/MR/15713

noted by
Vennela
28/6/26
9:10am

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31-10-2025 0 Y 7 M 27 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

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Date & Time	Progress Notes	Doctor's Order
22/6/26 SP	<u>consulting notes</u> They're no clinical seizures > 12 hrs there is weakness on (R) LL & UL. CT scan is like (R) SDH & (R) infarct w/ edema. we we'll plan MRI with next depending on child stability. N. Verkame father	Bed 4 <u>Dr. Rame</u>

[illegible]

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 Viaster NAGAMALLA JAYANTH
 31-10-2025 0 Y 7 M 27 D (M)
 Dr. SANDEEP REDDY



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/6/26 2pm	c/s/B severe TBI RTA Rt sided SDH left paresthesia of movements Rt humerus condylar H. on O₂ via NP @ 2lit/min on 3% NS 0.5ml/kg/hr. Hemodynamically stable. chest - air entry R/L ⊕ NRBS PLA - 10A CNS - E₄V₂M₄ EEG ongoing. anisoconia left 2mm Rt 3mm. HR - 164/min RR - 34/min SpO₂ - 100% BP - 100/60 mm Hg.	PICU Team Plan - NPO - IV Fluids to continue - continue 3% NS. - Ser-electrolytes (T/M) CBP - MRI brain c MR angiogram (T/M) - Back up Inj: phenobarbitone - w/t seizures. - w/t ↓ activity DTA set Noted by rennala 28/6/26 @ 7pm P. b. b. m.

R. SANDEEP REDDY

[illegible]



DAILY ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 27/6/26 Day of Admission : (3) Today's Date & Time : 29/6/26

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

OVERVIEW	Diagnosis : Severe TBI / RTA / Rt sided SDH / left UL & LL pncity / Rt humerus # condylar	Current Issues : low grade fever spikes left pncity of maxilla
	VITAL SIGNS Today's Wt. (kg) : Temp.: Blood sugar issues :	
RESPIRATORY SYSTEM	Respiratory System Findings : (Air entry, breath sounds, s/o distress etc.) : air entry BL @.	
	CXR : 27/6/26.	
	SPO ₂ : 100% O ₂ by NC / FM / NRB mask / Oxyhood, at 2 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 : Suctioning Needs :	
	Any Nebbs : ICD ? ☐ Yes ☒ No, if Yes, details :	
	Plan of care :	
CARDIO VASCULAR SYSTEM	Cardio Vascular System Clinical Exam. (Heart sounds, murmur etc.) : HR - 150/min	
	Quality of Pulses : good cap refill Time : <3sec Liver Edge : cm below Rt costal margin	
	Blood Pressures : NIBP : 110/70 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 : NO cardiomegaly	
	Arterial line in situ : ☒ Yes ☐ No Place of art, line & its condition : Rt radial	
Central line in situ : ☐ Yes ☒ No Place of central line & its condition :		
Day of arterial line : D3 Day of Central line : -		
Plan of Care :		
CNS	Neuro Exam : E + V3 M5 3/- NS 0.5ml/kg/hr	
	Pupils : 2mm BLc 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 : plan MRI brain + MR encephalogram	
Ramsay Sedation Score :		

FLUIDS STATUS NUTRITION AND G.I	☒ NPO ☐ PO feeds ☐ NG Feeds ☐ NJ Feeds ☐ GT Feeds I / O / Balance : <u>- 99</u> / (+/-) Input : ml/k/d UO : <u>300</u> ml/kg/hr Stools : NG output : PO intake : Feed Formula : Feed Schedule : IV Fluids - Type of IVF : <u>DNS</u> @ <u>10</u> 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 <u>146</u> K <u>4.1</u> Cl <u>116</u> Ca Mg P HCO3 Sr. Amylase : Sr. Lipase : Latest LFT : Abd Exam : <u>so. A</u> Any organomegaly ? ☐ Yes ☒ No - If yes, describe : 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 : <u>ceftriaxone D3</u> Other Labs (Latex, Serology, etc) : Ongoing Antibiotics :	
	NEPHROLOGY ISSUES Sr. Creat : Bld. Urea : 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 : Relevant Radiology (USC, MCUG radioisotope scan etc) : Plan of Care :	
	HEMATOLOGY Relevant Labs (CBP etc) : Any Coagulopathy : <u>7.2) 8540 62430 2.87</u> 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 : <u>BL ch</u> Pending Consultations : ☐ Yes ☐ No If yes, then details :
FINAL COMMENTS		

Doctor's Name (Handover given) : S
 Signature : K. SATHYA
 Date & Time : 29/6/26

Doctor's Name (Handover taken) : Dr. prabhakar
 Signature : S
 Date & Time : 29/6/26, Sam



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PROGRESS NOTES AND DOCTOR'S ORDER

$\Delta A'B'C'$
Sindhuja





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~~2. M. J. J.~~



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Mr. SANDEEP REDDY



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Date & Time	Progress Notes	Doctor's Order
29/06/26 1:40 PM	<u>Counselling Notes</u> ⇒ Explained about MRI findings that causing seizure activity → Weakness was improved compared to yesterday → Inj methylprednisolone was to be given to see further improvement → If child is active and there are no more seizure activity, child will be shifted to ward → Humerus # was addressed and cast applied.	Dr. Sandeep.
	<u>N. Venkara</u> <u>father</u>	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/10/2025 7pm	ck/b dr. sandeep.	
	Δ Severe TBI Polytrauma	Plan: 1) Continue 3% NaCl
	MRI s/o Extensive Cytotoxic Edema	2) New Canula
	No mass effect.	3) No New Canula on Right hand
	Stable on mannitol	4) Upgrade feeds till 60 ml / Q3H
	Hemodynamically stable	2 Keep plan
	Vitals	Feeds IVF
	PR - 131 bpm	10 ml 10 ml
	RR - 22 bpm	↓ ↓
	SpO ₂ - 100% E R/A.	30 ml 5 ml
		↓ ↓
		60 ml stop
		5) 100 paracetamol
		Continue for next 3 days
		<i>N.B. Archya</i>

Date & Time	Progress Notes	Doctor's Order
20/6/06	Left Nucleus no force going. Sensory: improving → start eye opening start limb movement Paucity of movements - (PUL) LL Sh pupils → unequal reactive to light EEG done in the evening:- NO IEDs. NO electrographic seizure Adv: forced every if it occurs continue steroids	
	AP divided into	



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DAILY ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 27/6/26 Day of Admission : Day -4 Today's Date & Time : 30/6/26 8 AM

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

OVERVIEW	Diagnosis : <u>severe TBI / Rt side SDH</u> <u>Rt humerus fracture</u> <u>condylar</u>	Current Issues : <u>seizures</u>
	VITAL SIGNS Today's Wt. (kg) : <u>Left UL limb: parest</u> Blood sugar issues :	
RESPIRATORY SYSTEM	Respiratory System Findings : (Air entry, breath sounds, s/o distress etc.) : <u>BAC (T) Clear</u>	
	CXR : _____	
	SPO ₂ : <u>98%</u> O ₂ by NC / FM / NRB mask / Oxyhood, at <u>Face mask 5L</u> 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 : _____ Suctioning Needs : _____	
	Any Nebbs : _____ ICD ? ☐ Yes ☒ No, if Yes, details : _____	
	Plan of care : _____	

CARDIO VASCULAR SYSTEM	Cardio Vascular System Clinical Exam. (Heart sounds, murmur etc.) : <u>Spun</u> <u>HR - 140</u>	
	Quality of Pulses : <u>good</u> cap refill Time : <u>~2 sec</u> Liver Edge : _____ cm below Rt costal margin	
	Blood Pressures : NIBP : <u>120/70/80 mmHg</u> 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 : _____	
CNS	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 : <u>E3 V2 M4</u> <u>3% NS 0.5 mg/kg/hr</u>	
	Pupils : <u>3mm reacting</u> <u>3mm sluggish reacting</u> Sedation Used ? ☐ Yes ☒ No Any paralysis ? ☐ Yes ☒ No	
	Types of Sedation : _____ Types of Paralysis : <u>mg levetir 20mg/kg/dose</u>	
	Relevant CT Scan, MRI EEG, Neurosonogram etc. : <u>mg lorazepam 4mg/kg/dose</u>	
	Plan of Care : <u>mg meprobamate 30mg/kg</u>	

FLUIDS STATUS NUTRITION AND G.I.	☒ NPO ☐ PO feeds ☐ NG Feeds ☐ NJ Feeds ☐ GT Feeds I / O / Balance : <u>+30</u> / (+/-) Input : <u>3.6</u> ml/k/d UO : <u>3.4</u> ml/kg/hr Stools : NG output : PO intake : Feed Formula : Feed Schedule : IV Fluids - Type of IVF : <u>DNS</u> @ <u>11 ml/hr</u> 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 <u>143</u> K <u>4.0</u> Cl <u>112</u> Ca Mg P HCO3 Sr. Amylase : Sr. Lipase : Latest LFT : Abd Exam : <u>soft</u> <u>Intake</u> - <u>264 ml</u> Any organomegaly ? ☐ Yes ☒ No - If yes, describe : <u>Hepatomegaly - 120 ml</u> Plan (G.I. & Liver) :		
	INFECTION ☒ Febrile ☐ Afebrile Current Antibiotics Details (antibiotic name and day #) : Cultures Sent ? ☒ Yes ☐ No - If yes, details : <u>sig ceftriaxone - DU</u> Describe c/s Reports : Other Labs (Latex, Serology, etc) : Ongoing Antibiotics :		
NEPHROLOGY ISSUES	Sr. Creat : Bld. Urea : 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 : Relevant Radiology (USC, MCUG radioisotope scan etc) : Plan of Care :		
	HEMATOLOGY Relevant Labs (CBP etc) : <u>29/6/26</u> Any Coagulopathy : <u>7.2 8540 2.87</u> Relevant Transfusion History : <u>62</u> Plan of Care : <u>30</u>		
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		

Doctor's Name (Handover given) : Dr Nathan

Signature : [Signature]

Date & Time : 30/6/26 8AM

Doctor's Name (Handover taken) : Sulay

Signature : [Signature]

Date & Time : 30/6/26 8.15

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IP5-00175690

Waster NAGAMALLA JAYANTH

31-10-2025

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(M)

Dr. SANDEEP REDDY



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/26 8am	<u>NUTRITION REVIEW</u>	
	PBW : 7kg (25th Centile)	STOOL PASSED = 0
	REE : 372.3 kcal/d	Hb: 7.2 Plt: 2.87
		Alb: 4.1
	NA Feeds	
	Nan Excella pro	
	C1: 30 ml dilution	
	60 ml @ 2nd hourly	Recall Vol = 220 ml/d
		(with NPO)
	17 scoops for REE	7 scoops for Recall
	Vol = 510 ml/d for REE	
	65 ml @ 3rd hourly for REE	
	<u>MACROS (REE)</u>	<u>MACROS (RECALL)</u>
	Cal : 374 ; 53.4 kcal/kg/d	Cal : 154 ; 22 kcal/kg/d
	Prot : 8.16 ; 1.16 g/kg/d	Prot : 3.36 ; 0.48 g/kg/d
	Carbs : 44.7 ; 6.3 g/kg/d	Carbs : 18.4 ; 2.6 g/kg/d
	Fat : 17 ; 2.4 g/kg/d	Fat : 7 ; 1 g/kg/d
		<u>Present Feed: 60ml/2nd hourly</u>
		Child is on NPO
		Dietitian Manica



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/25 9am	dsfB Neuroteam Severe TBI - 2nd ALERD - (R) hemiparesis - (IP) facial palsy ? (IP) gaze palsy <u>Issues</u> → No fever → Sensorium improving → (R) hemiparesis + (IP) facial weakness ? (IP) gaze palsy <u>o/s</u> mice (-) pupils / R 2mm RTCL L 2mm RTCL Anisocoria (R) side deviation of angle of mouth tone db / db db db DTRs ○ 2/5 3-1/5 2/5 3/5	plu (1) cont. IVMP (2) physiotherapy longly if v/s risk of sepsis
		DR. ABHISHEK R JAIN Registration No: 2757

BAH-00660111 IP5-00175690
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 31-10-2025 0 Y 7 M 29 D (M)
 Dr. SANDEEP REDDY



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		C/S / R Dr. Sandeep
30/6/26. 2pm	Δ: Severe TBI / 2 ALARD Lt facial palsy Lt gaze palsy Issue: Encephalopathy Hemiparesis. Lt facial palsy Irrigula bulging	Plan: ① EEG review. ②. Lateral position nursing ③ keep intubation thing ready. ④ CBP now 4hr. If Ht < 7g/dl, transfuse.
	CHU on 24hr oxygen. SpO ₂ = 99% PR: 100% RR: 24/hr	⑤ PRBC now .
	CNI: E ₃ V ₂ M ₄ Pupils: 2+ 2+ (sluggish) Tm: Reduced.	



Dr Sandeep

Date & Time	Progress Notes	Doctor's Order
30/6/26 10 PM	<u>Counselling notes.</u> patient had traumatic brain injury, near by area will have swelling, It will increase due course time, will damage near by cells, There will be no enough space to accommodate, will cause pressure effect will cause edema further. If Brain stem is involved risk of death is present. Damaged area in brain will not recover further. MRI brain was showing edema, yesterday steroids has started. Anti edema measures are being followed. 7 to 10 days after injury are important for long term ^{cerebral} neuro disability can occur in future. Due to edema encephalopathy present. If seizures continue further ventilator may be required. seizures can be Clinical or electrographic seizures. If required IVIG can be given.	
	Uncle L. J. J.	M Dr Nathan



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/8/26 5pm	45/B Dr. Sandeep	Plan
	AS:- Severe TBI / ALERD	1) CXR
		2) ABG
	Issues:- 1) electrographic seizures - High seizure burden	3) arterial line
	2) Encephalopathy	4) Neuroprotective measures
	intubated in view of worsening encephalopathy	5) keep head in midline
	on AetPC:- FiO ₂ - 60%, PEEP - 6, PIP - 18, rate - 35/min	6) IVIG 10 gm over 6 hrs today
	hemodynamically stable	7) continue IV steroids
	HR - 150/min	8) midazolam @ 2 µg/kg/min
	BP - 116/70 mm. Hg.	9) EEG monitoring
	pupils - B/L 3mm, reacting to light.	10) Titrate midazolam
		11) CBP tomorrow morning
		12) electrolytes tomorrow morning
		13) w/f fever spikes
		14) Morphine @ 60 µg/kg/hr.

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DAILY ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 27/6/26 Day of Admission : Day - 5 Today's Date & Time : 11/7/26 8 AM

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

OVERVIEW	Diagnosis : Severe TBI / Rt Side SRTI Rt humerus fracture condylar	Current Issues : Electrophysic seizures
----------	--	---

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

RESPIRATORY SYSTEM	Respiratory System Findings : (Air entry, breath sounds, s/o distress etc.) :	BAE @ clear
	CXR :	
	SPO ₂ :	98% O ₂ by NC / FM / NRB mask / Oxyhood, at ventilation L / min
	Ventilatory Support : ☒ Yes ☐ No - Day # of Vent :	2 Nitric Oxide : ☐ Yes ☐ No - If Yes, details :
	Ac/cp FIO ₂ - 40% PIP - 14 RR - 30 PEEP - 7	
	Ventilatory Settings : Leak around ETT :	Delivered Vt :
	ABG : 30/6/26 pH - 7.4 PCO ₂ - 44 PO ₂ - 257 EtCO ₂ : P/F ratio : 514 O.I. : 1.75	
	Chest Physiotherapy Plan :	Suctioning Needs :
	Any Nebbs :	ICD ? ☐ Yes ☐ No, if Yes, details :
	Plan of care :	

CARDIO VASCULAR SYSTEM	Cardio Vascular System Clinical Exam. (Heart sounds, murmur etc.) :	Stems +12 - 120
	Quality of Pulses :	good cap refill Time : ~ 2 sec Liver Edge : cm below Rt costal margin
	Blood Pressures : NIBP :	IBP : 100/60 (70) mmHg 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 :	left radial
Central line in situ : ☒ Yes ☐ No Place of central line & its condition :	left PICC line	
Day of arterial line :	D 1 Day of Central line : D 1	
Plan of Care :		

CNS	Neuro Exam :	E1 VTH2 Iy leupit 20mg/kg/day 3x NS 1mg/kg/hr
	Pupils :	Rt - 2mm sluggish reaction Iy lacosamide 4mg/kg/day
	Types of Sedation :	Iy morphine 6mg/kg/min Sedation Used ? ☒ Yes ☐ No Any paralysis ? ☐ Yes ☒ No
	Relevant CT Scan, MRI EEG, Neurosonogram etc.	Iy midazolam 2mg/kg/min
	Plan of Care :	Iy methylprednisolone 30mg/kg/day - D3
		Ramsay Sedation Score :

FLUIDS STATUS NUTRITION AND G.I	☒ NPO ☐ PO feeds ☐ NG Feeds ☐ NJ Feeds ☐ GT Feeds	
	I / O / Balance : <u>+119</u> / (+/-) Input : <u>3.6</u> ml/k/d UO : <u>2.9</u> ml/kg/hr Stools :	
	NG output : PO intake :	
	Feed Formula : Feed Schedule :	
	IV Fluids - Type of IVF : <u>DNS</u> @ <u>10 mg/hr</u> 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 <u>138</u> K <u>3.1</u> Cl <u>108</u> Ca Mg P HCO3 Sr. Amylase : Sr. Lipase :	
	Latest LFT :	
Abd Exam : <u>Soft</u>		
Any organomegaly ? ☐ Yes ☒ No - If yes, describe :		
Plan (G.I. & Liver) :		
<u>iv fluids - 240 ml</u> <u>3% Infusions - 168 ml</u> <u>other Infusions - 120 ml</u> <u>medication - 120 ml</u> <u>648 ml</u>		
INFECTION	☐ Febrile ☒ Afebrile Current Antibiotics Details (antibiotic name and day #) :	
	Cultures Sent ? ☐ Yes ☒ No - If yes, details :	
	Describe c/s Reports :	
	Other Labs (Latex, Serology, etc) :	
Ongoing Antibiotics :		
<u>90% 4F</u> <u>Aug ceftriaxone - D5</u>		
NEPHROLOGY ISSUES	Sr. Creat : <u>0.2</u> Bld. Urea : <u>18</u> 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 :	
	Relevant Radiology (USC, MCUG radioisotope scan etc) :	
Plan of Care :		
HEMATOLOGY	Relevant Labs (CBP etc) :	
	Any Coagulopathy :	
	Relevant Transfusion History :	
	Plan of Care :	
<u>1/2/26</u> <u>9.1</u> <u>52.80</u> <u>1.73/ach</u> <u><50</u> <u>37</u>		
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	ECG monitoring .	

Doctor's Name (Handover given) : Dr. Nathan

Signature : [Signature]

Date & Time : 1/2/26 8AM

Doctor's Name (Handover taken) : Dr. [Signature]

Signature : [Signature]

Date & Time : [Signature]

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	clb Neuro team 1st/26 Traumatic Brain injury → refractory Tams status epilepticus 20 to AEPD. no further episodes after midazolam 2mg/kg. 1st/26 given of 1: vitals → stable subtle clonus - HR 70 eye opening to deep tactile stimulation. - CR → mild asymmetric myoclonic. - normalised spasticity - exaggerated reflexes. EEG 1: no electrophysic seizure post midazolam	
	stop EEG planned to start tapering midazolam by tomorrow morning. EEG for 1 hour in evening.	Adv 1:- continue midaz. @ 2mg/kg/day Backup: 1mg/kg/day 2mg/kg/day 1st/26 today.

DR. ABHISHEK K JAIN
 Registration No. 275
 Abhishek

BAH-00660111 IP5-00175690
Waster NAGAMALLA JAYANTH
31-10-2025 OY8M0D (M)
Dr. SANDEEP REDDY




PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



Bed-4

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/2/25 10:12 am	Counsell-proter	Dr. Abhishek Jain
	→ In EEG → nearly 25 ep nodes of electrographic seizures. i.e. clinical correlate. (Apnea, UROEB, dense to one side) → Intubated, MV. loaded i.e. ANH, seizure medication. Started on Intr. midazolam infusion since yesterday by bpm - No electrographic/clinical seizure → Every EEG → we will repeat. If no clinical/electrographic seizure - plan to taper & stop midazolam infusion. Then we can plan to extubate tomorrow. → To perform full stimuli → Eye opening present. currently on sedation because of asynchrony on ventilator → DUMP x (Td), DUC → 2grom/kg over 3 days will be planned infotol	
	<u>Uncle</u> <u>v. Venkanna</u>	

Dr. Abhishek Jain



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/7/2026 12:00 PM	Seizure TBI Repetitive status	e/s/B Dr. Sandeep plan
	No further seizure on ETG	① Full feeds 60 ml 3rd hour
	Hemodynamically stable	② Off sedation (morphine) as usual
	Robust feeds well on ACP	③ Target 200ml Negative Balance
	18/6 cm g Hw	④ Continue Ventilator
	PO ₂ - 40%	⑤ 80% Larynx
	Rel - 30/min	⑥ +1m S-Albumin
		CBP
		-RP ₂
		⑦ EEG - E Monitoring
		avoid my (Signature)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/1/25 @ 3pm	SB Dr. Sandeep Reddy	
	A Severe TBP Refractory Status Epilepticus	Ad ① continue mechanical ventilation
	Diagn ① Complete status epilepticus	② Lungs @ 5cm now over bronch
	② On minimal ventilation Hemodynamically stable	③ Target nephro balance
	Chest Blunt Epul MVA No def Bx Cox: Bx rupt Epul APL	④ Di have any midday sendway 4 Lungs
	HR: 150/min RR: 40/min SpO2: 99-100%	⑤ continue midday at 20mg/min
		⑥ watch for sepsis
		⑦ watch for fever
		Dr. Venkat Sandeep Reddy. K Reg. No: TSMC/FRM/15713

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



PROGRESS NOTES AND DOCTOR'S ORDER

Dr Sandeep

Date & Time	Progress Notes	Doctor's Order
1/7/25 4:30 PM	<u>Counselling notes.</u> patient had severe traumatic brain injury, having bleeding at multiple sites. No surgical intervention as of now. There will be diffuse cerebral edema, will lead to increase in intracranial pressure, we are giving anti-edema measures. 7 to 10 days after injury edema will increase after that start decreasing. Seizures are abnormal movements. MRI brain showing diffuse involvement of Right cerebral hemisphere leading to present condition. Special medication IVIG is being given. Seizure medication midazolam infusion is going, sedation, consciousness present, if patient is improving patient can be weaned off ventilator. If brain stem is involved risk of death is present. Neurodisability due to neuronal damage long-term disability can occur in further course of time. patient condition explained to attenders in their own language. child came with status epilepticus at presentation. MRI brain showing diffuse cerebral edema. we are giving steroids & IVIG. child child is ventilated now. edema can be decreased increase initially 7 to 10 days of injury. long-term neurodisability can occur in future. N. Jankana	Dr Nandeen



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/26 8am	<u>NUTRITION REVIEW</u>	
	PBW: 7Fg (25th Centile)	STOOL PASSED = 0
	REE: 372.3 kcal/d	Hb: 9.5 WBC: 7720
	BAR: 72 kcal/kg/d ✓	Plt: 2.04 Alb: 3.1
	NG Feeds	✓
	Nan Excella pro	
	C1:30 ml dilution	Recall vol = 410 ml/d
	60 ml Q 3rd hourly	[58 cal/kg/d]
	17 scoops For REE	14 scoops For Recall
	Vol = 510 ml/d for REE	
	65 ml Q 3rd hourly For REE	✓
	<u>MACROS (REE)</u>	<u>MACROS (RECALL)</u>
	Cal: 374; 53.4 kcal/kg/d	Cal: 308; 44 kcal/kg/d
	Prot: 8.16; 1.1 g/kg/d	Prot: 6.72; 0.96 g/kg/d
	Carbs: 44.7; 6.3 g/kg/d	Carbs: 36.8; 5.26 g/kg/d
	Fat: 17; 2.4 g/kg/d	Fat: 14; 2 g/kg/d ✓
		<u>Present Feed: 60 ml/3rd hourly</u>
	Amr 2/7/26 g/may	Dietha Mowice



DAILY ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 27/6/20 Day of Admission : Day 5 Today's Date & Time : 27/6/2025 8 AM
PRISM - III Score in first 24hrs. of Admission : Today's SOFA Score :

OVERVIEW	Diagnosis : <u>Severe TBI</u> <u>Refractory status Epilepticus</u>	Current Issues : <u>Electrographic seizure - Improving.</u> <u>1 fmc spike.</u>
VITAL SIGNS	Today's Wt. (kg) : <u>7 kg</u> Temp.: <u>98.5°F</u> Blood sugar issues :	
RESPIRATORY SYSTEM	Respiratory System Findings : (Air entry, breath sounds, s/o distress etc.) : <u>BAE @, clear</u>	
	CXR : <u>[Image]</u>	
	SPO ₂ : <u>100% on FiO₂ 40%</u> 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 : _____	
	<u>PEEP : 18/5, Rate : 30/min</u>	
	Ventilatory Settings : Leak around ETT : <u>NA</u> Delivered Vt : <u>0.6l</u>	
	ABG : <u>30.6 - pH - 7.4 / PCO₂ = 44</u> EtCO ₂ : <u>30</u> P/F ratio : <u>514</u> O.I. : <u>1.7</u> <u>Lac. 0.9</u>	
	Chest Physiotherapy Plan : _____ Suctioning Needs : _____	
CARDIO VASCULAR SYSTEM	Any Nebs : _____ ICD ? ☐ Yes ☒ No, if Yes, details : _____	
	Plan of care : _____	
	Cardio Vascular System Clinical Exam. (Heart sounds, murmur etc.) : <u>HR : 114/min</u>	
	Quality of Pulses : <u>good</u> cap refill Time : <u>< 3 sec</u> Liver Edge : _____ cm below Rt costal margin	
	Blood Pressures : NIBP : _____ IBP : <u>115/68 mmHg</u> CVP : _____	
	Infusion of : ☐ Dopamine _____ mcg / kg / min - ☐ Dobutamine _____ mcg / kg / min	
	☐ Epinephrine _____ mcg / kg / min - ☐ Nor Epinephrine _____ mcg / kg / min	
	☐ Milrinone _____ mcg / kg / min	
CNS	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 : <u>① radial</u>	
	Central line in situ : ☒ Yes ☐ No Place of central line & its condition : <u>② PICC line</u>	
	Day of arterial line : <u>D2</u> Day of Central line : <u>D2</u>	
	Plan of Care : _____	
	Neuro Exam : <u>E, V, M</u> <u>Inj Levetiracetam, Inj Lacosamide, 3-1-NS</u>	
Pupils : <u>2mm / 2mm reacting to light</u> Sedation Used ? ☒ Yes ☐ No Any paralysis ? ☐ Yes ☒ No		
Types of Sedation : _____ Types of Paralysis : _____		
Relevant CT Scan, MRI EEG, Neurosonogram etc. : <u>Inj midazolam 2mcg/kg/min</u>		
Plan of Care : <u>Inj Methylpred (P.u.)</u>		
Ramsay Sedation Score : _____		

FLUIDS STATUS NUTRITION AND G.I.	☐ NPO ☐ PO feeds ☒ NG Feeds ☐ NJ Feeds ☐ GT Feeds I / O / Balance : <u>+11.3</u> / (+/-) Input : ml/k/d UO : ml/kg/hr Stools : NG output : PO intake : <u>60ml/0.5h</u> Feed Formula : <u>Nampro sty 1</u> Feed Schedule : <u>@ 60ml, 2hr</u> IV Fluids - Type of IVF : <u>DNS</u> @ <u>2</u> 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 K Cl Ca Mg P HCO3 Sr. Amylase : Sr. Lipase : Latest LFT : Abd Exam : <u>sgt NT</u> Any organomegaly ? ☐ Yes ☒ No - If yes, describe : Plan (G.I. & Liver) : <u>IVF - 48ml</u> <u>3.1 NS - 108ml</u> <u>Infusom - 48ml</u> <u>Medication - 120ml</u> <u>384ml</u>	
	☐ Febrile ☒ Afebrile Current Antibiotics Details (antibiotic name and day #) : Cultures Sent ? ☐ Yes ☒ No - If yes, details : Describe c/s Reports : Other Labs (Latex, Serology, etc) : Ongoing Antibiotics : <u>Inj ceftazoxime (D6)</u> <u>(50+5)</u>	
INFECTION		
NEPHROLOGY ISSUES	Sr. Creat : <u>0.2</u> Bld. Urea : <u>18</u> 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 : Relevant Radiology (USC, MCUG radioisotope scan etc) : Plan of Care :	
HEMATOLOGY	Relevant Labs (CBP etc) : 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 taper midazolam if seizure activity	

Doctor's Name (Handover given) : Jayab

Signature : JN

Date & Time : 11/2/26 @ 8am

Doctor's Name (Handover taken) : Surya

Signature : Sh

Date & Time : 11/2/26

Date & Time	Progress Notes	Doctor's Order
9/7/20 10 am	Cerebral notes	Dr Ahmed Jom
	No electrographic seizure after starting midazolam.	
	Spontaneous eye opening, @ oral distal spontaneous movement, head movement - stable.	
	Spontaneous respiratory effort @, but poor effort. plan to extubate by today evening / tm morning.	
	In case of recurrence of seizure - might need to start midazolam again	
		Antes

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		C/S/B. Dr. Sandeep.
2/10/25 up		Plan:-
	Issue: Seizure 100.5°F Encephalopathy Hemiparesis.	① EEG now. ② Cont antiepileptic ③ Cont Ceftriaxone ④ Cont MFS 30mg/kg ⑤ NG feeds 80ml/23hr ⑥ If no seizure episode A appropriate consensus plan extubation then.
	CKU on SIMV-PC FiO ₂ : 40% PIP: 17 PEEP: 5 Ret: 20/min SpO ₂ : 96% PR: 129/min RR: 25/min BP: 118/72.	⑦ Target negative balance.
	Chart: R/L clear. CUS: SIS ₂ F CNS: E3 VTM4 Pupil: 2+ 2+ (sluggish) Tm: @.	Suk 2



DAILY ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 27/6/25 Day of Admission : Day - 6 Today's Date & Time 3/7/26 TAN
PRISM - III Score in first 24hrs. of Admission : Today's SOFA Score :

OVERVIEW	Diagnosis : Severe TBI Refractory status epilepticus Rt humerus condylar fracture	Current Issues : Fever spikes
	VITAL SIGNS Today's Wt. (kg) : Temp. : Blood sugar issues :	
RESPIRATORY SYSTEM	Respiratory System Findings : (Air entry, breath sounds, s/o distress etc.) : BHEP Clear	
	CXR : SPO ₂ : 98% O ₂ by NC / FM / NRB mask / Oxyhood, at Ventilation L / min	
	Ventilatory Support : ☒ Yes ☐ No - Day # of Vent : Day - 3 Nitric Oxide : ☐ Yes ☐ No - If Yes, details :	
	SIMV/PC PIP - 40cm H ₂ O PEEP - 5 RR - 12	
	Ventilatory Settings : Leak around ETT : ABG : 30/6 pH - 7.4 pO ₂ - 44 pCO ₂ - 25.7 Lac - 0.9 HCO ₃ - 26.8 Chest Physiotherapy Plan : Suctioning Needs : 514 1.75	
CARDIO VASCULAR SYSTEM	Any Nebs : ICD ? ☐ Yes ☐ No, if Yes, details :	
	Plan of care :	
	Cardio Vascular System Clinical Exam. (Heart sounds, murmur etc.) : Spurs HR - 120	
	Quality of Pulses : good cap refill Time : 2 sec Liver Edge : cm below Rt costal margin	
	Blood Pressures : NIBP : IBP : 110/70 (80) mmHg 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 : Left radial Central line in situ : ☒ Yes ☐ No Place of central line & its condition : Left PICC Day of arterial line : D3 Day of Central line : D3 Plan of Care :	
CNS	Neuro Exam : E3VT H5 Pupils : 3mm 3mm reaction to light	
	Sedation Used ? ☐ Yes ☒ No Any paralysis ? ☐ Yes ☒ No	
	Types of Sedation : Types of Paralysis : Relevant CT Scan, MRI EEG, Neurosonogram etc. : Inf Metyl prednisolone 30mg/kg/day Plan of Care : tab clonazepam 1 + 1	
	Ramsay Sedation Score :	

FLUIDS STATUS NUTRITION AND G.I.	☐ NPO ☐ PO feeds ☒ NG Feeds ☐ NJ Feeds ☐ GT Feeds I / O / Balance : <u>+257</u> / (+/-) Input : <u>4.8</u> ml/k/d UO : <u>3.6</u> ml/kg/hr Stools : NG output : PO intake : Feed Formula : <u>Nan pro stage - I</u> Feed Schedule : <u>80 ml 3rd hourly</u> IV Fluids - Type of IVF : <u>DNS</u> @ <u>2 ml/hr</u> 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 K Cl Ca Mg P HCO3 Sr. Amylase : Sr. Lipase : Latest LFT : Abd Exam : <u>soft</u> Any organomegaly ? ☐ Yes ☒ No - If yes, describe : Plan (G.I. & Liver) :	
	☒ Febrile ☐ Afebrile Current Antibiotics Details (antibiotic name and day #) : Cultures Sent ? ☒ Yes ☐ No - If yes, details : <u>sup ceftazone - D7</u> Describe c/s Reports : Other Labs (Latex, Serology, etc) : Ongoing Antibiotics :	
	Sr. Creat : <u>0.2</u> Bld. Urea : <u>23</u> 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 : Relevant Radiology (USC, MCUG radioisotope scan etc) : Plan of Care :	
	Relevant Labs (CBP etc) : <u>2/5/26 9.5 7720 2.0u lach</u> Any Coagulopathy : Relevant Transfusion History : Plan of Care :	
	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 <u>plan extubation</u> <u>keep npo</u> <u>trace serum electrolytes</u>	

Doctor's Name (Handover given) : Dr. mother

Signature : [Signature]

Date & Time : 3/7/26 7 AM

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

Signature : [Signature]

Date & Time : 3/7/26, 8 AM

Date & Time	Progress Notes	Doctor's Order
	def <u>Naurokan</u> 2/7/26 Traumatic Brain Injury with repetitory status epilepticus 6pm with inflammatory cytotoxic edema L? Hypoxic L? AICD. No further clinical or electrographic seizures. - Depressed of force spike. ok - vitals - stable. - HMF - eye opening to tactile stimulation. - Pancytopenia of WBC & RBC counts. - Growing type 1 tumor U/L Admitted to room.	Monday stopped at 12pm. adv. - FEE till 8pm. - vitals. - Add lab. close



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 8am	<u>NUTRITION REVIEW</u>	
	PBW: 7kg (25th centile)	8 TOOL PASSED = 2 Bristol-6 ✓
	REE: 372.3 kcal/d ✓	Hb: 9.5 WBC: 7.20
	EAR: 72 kcal/kg/d ✓	Plt: 2.04L Alb: 3.1 ✓
	NG Feeds	
	Nan Excella pro	
	U1: 30ml dilution	
	80 ml @ 3rd hly	Recall vol = 520 ml/d (74 cal/kg/d)
	17 scoops for REE	17 scoops for Recall
	Vol = 510 ml/d for REE	
	65 ml @ 3rd hly for REE	
	<u>MACROS (REE)</u>	<u>MACROS (RECALL)</u>
	Cal: 374 ; 53.4 kcal/kg/d	Cal: 374 ; 53.4 kcal/kg/d
	Prot: 8.16 ; 1.16 g/kg/d	Prot: 8.16 ; 1.16 g/kg/d
	Carbs: 44.7 ; 6.3 g/kg/d	Carbs: 44.7 ; 6.3 g/kg/d
	Fat: 17 ; 2.4 g/kg/d	Fat: 17 ; 2.4 g/kg/d
		✓ Present Feed: 80 ml/3rd hly
		Child is on NPO
	Bmw 3/7/26 9:30w	
		Dietitian Mounica



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/11/26. 8:30 AM	c/s/b neurology severe TBI c Acute symptomatic seizure c Left hemiparesis c B/L R/L cufflammatory/ ischemic secondary. Brain involvement (AERO)	Advice 2. plan Extubation today 3. Connect 1 AED to oral today evening
	- 2 severe spikes - tolerating CPAP - Encephalopathy improving c spontaneous eye opening c inconsistent fixate Good blink to light c Good spontaneous effort E4V+M3. B/L pupil left 3mm Right 2mm RTL.	3. 31. NACL need discuss. 4. Remove Foley; 5. Stop 31. N's
	cough @ c. OTR brk Left paucity of movements	6. Add nutritional supplements 7. Physiotherapy 8. Shift to oral AEDs N.B. Gerd.
	284 - Diffuse slow & absent deep impulses	Dr. Anand Vg

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
03/07/2025 9:46 AM	clsb Mr. Sandeep Reddy	
	A Severe TBI T Refractor.	<u>Plan</u>
	Right Supracondylar Epilept	1) Stop 3% NaCl.
	hemium #	2) Contn luj. cefmaxal
	Left hemiparesis.	w/f fewe spuer
	on CPAP/RS 40% FiO_2	3) P/a 6 $\rightarrow$ 4 $\rightarrow$ 0.
	PEEP-5	30mm gap
	PR-6.	4) Plan extubation today
	off sedation	5) luj. methylprednolone
	Npm.	4mg/kg/day BD.
	O/E Tracking (+).	6) Chest xray preextubation
	eye open (+)	7) Remove A/eye after
	moving limbs (+) CR > L)	extubation
	Hemodynamically stable	N.B. JH/An. 1/2/25

Date & Time	Progress Notes	Doctor's Order
3/7/26 10:05am	(counselling note)	Dukamish Konanhi
	- No seizure recurrence after stopping midazolam infusion - Plan to extubate today, monitoring on CPAP support. After extubation sometimes breathing difficulty can occur requiring ventilation	
	N. Venkanna father	Dukamish



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
03/07/26 11:00 AM	<u>Extubation Notes</u>	
	<u>Indication</u> - Patient aroused & deemed suitable for extubation	
	Pre extubation Assessment	
	GCS - E4V7M5	
	Hemodynamically stable (not on any inotropes)	
	Secretion - Minimal	
	Spontaneous Breathing trial - passed.	
	Ventilation setting before extubation - PC/AC - 18/5 Rate 230/min	
	ABG - pH -	
	Cuff leak - NO	
	<u>Extubation Notes</u>	
	Patient was suctioned orally & through ET. Cuff was deflated and Endotracheal tube removed. no further post extubation patient was nebulized $\pm$ 3% Nal & Adrenaline. cough reflex & Gag reflex - <u>intact</u>	
	Post extubation status	
	Patient on 5 L/min Face Mask	
	<u>Vitals</u> : HR - 118/min	
	SpO ₂ - 100% on 5 L/min.	
	BP - 128/76 (100)	
	RR - 41/min	
		Plan - To do ABG after 1 hr - (12 pm)
		CXR at 4 hr after extubation
		(3 pm)
		Dr. Trilok
		P.B.
		20/07

Date & Time	Progress Notes	Doctor's Order
2/17/26	4/5/B PICU team	Plan
5pm	ASL - Severe TBI / refractory status epilepticus / AICPD / Rt. supracondylar humerus fracture on room air HR - 122/min SpO₂ - 100% BP - 121/79 mm Hg. RR - 32/min RS - BAE (+) clear P/A - soft. CNS - EIV₂M₆ pupils - B/E 2mm, reactive to light. paucity of movements of left UL & LL	1) w/ hypertension 2) 2iv EEG 3) w/ seizures 4) NA feeds 60 ml / Q3H 5) stop iv fluids. 6) w/ fever spikes N. Sybil. Dr. Pradyum



PROGRESS NOTES AND DOCTOR'S ORDER

~~Amira~~
4/2/26
qum.

Dietitian
Maurice



DAILY ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 07/16 Day of Admission : Day 1 Today's Date & Time : 04/07
PRISM - III Score in first 24hrs. of Admission : Today's SOFA Score :

OVERVIEW	Diagnosis : Severe TBI Refractory Status Epilepticus - ALERD Rt Humeral supracondylar #		Current Issues : Encephalopathy	
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 @, clear			
	CXR :			
	SPO ₂ : 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 : 7.46 / 34 / 44 / 0.9 / 25 EtCO ₂ : P/F ratio : O.I. : pH pCO ₂ PO ₂ Lac HCO ₃			
	Chest Physiotherapy Plan : Suctioning Needs : 10			
	Any Nebbs : 10 ICD ? ☐ Yes ☐ No, if Yes, details :			
	Plan of care : 10			
	CARDIO VASCULAR SYSTEM	Cardio Vascular System Clinical Exam. (Heart sounds, murmur etc.) : HR - 160 bpm		
Quality of Pulses : Good cap refill Time : < 3 sec Liver Edge : cm below Rt costal margin				
Blood Pressures : NIBP : IBP : 99/89(100) 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 : Left Radial				
Central line in situ ☐ Yes ☐ No Place of central line & its condition : Left PICC				
Day of arterial line : Day Day of Central line : Day				
Plan of Care :				
CNS	Neuro Exam : E 3 M 5 Excess Cnx & Irritability Intubated			
	Pupils : 2mm B/L Reacting to light 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 :			

Doctor's Name (Handover taken) :

Signature :

Date & Time :

Date & Time	Progress Notes	Doctor's Order
7/26 1:15 PM	CLS/D Mr. Sandeep Reddy. Δn - Severe TBI / Refrac Current mne - Excessive irritability & crying on Room Ais SpO₂ - 100% HR - 169/min BP - 107/64 (88 mmHg)	Plan - shift to ICU PICU-2 - Make methylprednisolone OP today - get two opinion (Dr Venkatraman) - (Informed). noted by praveen k

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
01/11/25 5:00pm	C/S/B PIW team (Dr. Sandeep)	
	Diagnosis: Severe TBI & Refractory Status Epilepticus T ALERD & (RT) Supracondylar humerus # & (LT) hemiparesis	
	Issues: No fresh issues child started accept orally.	<u>PLAN</u> 1) Shift to PICU-11 2) If stable will be shifted to ward tomorrow.
	→ On ceftriaxone	3) If good oral intake (C) remove Ryle's tube 4) Rest & same
	T - 98.4°F	
	P - 154ml (feed)	
	R - 84ml	
	BP - 106/64 mmHg	
	SpO ₂ - 100% on 4L	
	<i>[Signature]</i> Dr. Varneth	<i>[Signature]</i> noted by Dr. Varneth
	01/11/25 5:00pm	

BAH-00660111

IP5-001756s

Master NAGAMALLA JAYANTH

31-10-2025

0 Y 8 M 4 D

Dr. SANDEEP REDDY

(M)



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ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 07/10/26 Day of Admission : 8 Today's Date & Time : 05/07/26 8:00am
PRISM - III Score in first 24hrs. of Admission : Today's SOFA Score :

OVERVIEW	Diagnosis : Severe TBI - Refractory (status epilepticus) ALERT @ supracondylar humerus #		Current Issues : → Gaze #. → Fracture → @ hemiparesis	
	VITAL SIGNS Today's Wt. (kg) : Temp.: Blood sugar issues :			
RESPIRATORY SYSTEM	Respiratory System Findings : (Air entry, breath sounds, s/o distress etc.) : AECDE @ chest clear			
	CXR : _____			
	SPO ₂ : _____ 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 : Yes Suctioning Needs : _____			
	Any Nebs : _____ ICD ? ☐ Yes ☐ No, if Yes, details : _____			
	Plan of care : ct chest pg timber			
	CARDIO VASCULAR SYSTEM	Cardio Vascular System Clinical Exam. (Heart sounds, murmur etc.) : No murmur		
Quality of Pulses : good cap refill Time : 2 sec Liver Edge : _____ cm below Rt costal margin				
Blood Pressures : NIBP : _____ IBP : 96/60 mmHg 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 : @ radial				
Central line in situ : ☐ Yes ☐ No Place of central line & its condition : @ PICC				
Day of arterial line : 05 Day of Central line : 05				
Plan of Care : _____				
CNS	Neuro Exam : GCS = 15/15 irritability @ Excess G @ syp leipil			
	Pupils : 6/2 mm RL @ Sedation Used ? ☐ Yes ☒ No Any paralysis ? ☐ Yes ☒ No			
	Types of Sedation : _____ Types of Paralysis : _____			
	Relevant CT Scan, MRI EEG, Neurosonogram etc. : tab Clobazam syp lorazepam			
Plan of Care : → ct neuro monitoring				
Ramsay Sedation Score : _____				

FLUIDS STATUS NUTRITION AND G.I.	☐ NPO ☒ PO feeds ☐ NG Feeds ☐ NJ Feeds ☐ GT Feeds I / O / Balance : <u>+121</u> / (+/-) <u>571</u> Input : <u>440</u> ml/k/d UO : <u>2.6</u> ml/kg/hr Stools : <u>Pasred</u> NG output : _____ PO intake : _____ Feed Formula : <u>Na Pro ②</u> Feed Schedule : <u>Adlib</u> IV Fluids - Type of IVF : _____ @ _____ 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 _____ K _____ Cl _____ Ca _____ Mg _____ P _____ HCO3 _____ Sr. Amylase : _____ Sr. Lipase : _____ Latest LFT : _____ Abd Exam : _____ Any organomegaly ? ☐ Yes ☐ No - If yes, describe : _____ Plan (G.I. & Liver) : _____	
	☐ Febrile ☒ Afebrile Current Antibiotics Details (antibiotic name and day #) : _____ Cultures Sent ? ☐ Yes ☐ No - If yes, details : _____ Describe c/s Reports : <u>Day ⑨ ceftriaxone</u> Other Labs (Latex, Serology, etc) : _____ Ongoing Antibiotics : _____	
INFECTION		
NEPHROLOGY ISSUES	Sr. Creat : <u>0.2</u> Bld. Urea : <u>22</u> 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 : _____ Relevant Radiology (USC, MCUG radioisotope scan etc) : _____ Plan of Care : _____	
HEMATOLOGY	Relevant Labs (CBP etc) : _____ 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	<u>May consider shift to ward.</u> 	

Doctor's Name (Handover given) : Wah

Signature : Dr. Wah

Date & Time : 05/07/16
8:00am

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

Signature : Dr. Pradyum

Date & Time : 5/7/16, 8am

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/26	UHB Dr. Sandeep.	Plan
12pm	- Child is high on room air - HR - 134/min - RR - 47/min - SpO₂ - 97% on RA - Ikg - 97/58 (77) - Stool passage - Taking well orally	1) Remove PICC line 2) change to oral augmentin 3) stop methylprednisolone 4) Shift to ward Remove arterial line



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/9/26 7 PM	ICU B Neuro team Severe TBI - ICU ALERD ICU (P) gaze palsy - (P) 5th cranial palsy ICU (P) anisocoria <u>Observed</u> → No fever → Encephalopathy improving → Oral intake good o/p MCS (-) (P) gaze preference deviation of angle of mouth to right very good 3/5 3/5 3/5 2/5 pupils ← 2w RTL 3w sluggish RTL	plu (1) continue physiotherapy (2) shift to ward 7/m indicated by neurologist

Date & Time	Progress Notes	Doctor's Order
	<u>C/S Numbness</u>	
5/11/26 9 AM	TB with acute symptomatic epilepsy 20 to ALERD (diffuse pattern).	
	- No further clinical or electrographic seizure - Sedation - Topiramate.	
	O/E vitals - stable. - HR - 80 bpm - CN - pupils asymmetry (Quick reflexes (prolapse)). ? mouth deviation to R. - Note: Auralisation hypotonia.	R - Suboptimal blink to bright light. R - 2/5 L - 2/5 D - 2/5 U - 2/5 V - 2/5 H - 2/5 A - 2/5 S - 2/5 O - 2/5 T - 2/5 E - 2/5 N - 2/5 I - 2/5 G - 2/5 M - 2/5 P - 2/5 F - 2/5 C - 2/5 B - 2/5 J - 2/5 K - 2/5 X - 2/5 Y - 2/5 Z - 2/5 AA - 2/5 BB - 2/5 CC - 2/5 DD - 2/5 EE - 2/5 FF - 2/5 GG - 2/5 HH - 2/5 II - 2/5 JJ - 2/5 KK - 2/5 LL - 2/5 MM - 2/5 NN - 2/5 OO - 2/5 PP - 2/5 QQ - 2/5 RR - 2/5 SS - 2/5 TT - 2/5 UU - 2/5 VV - 2/5 WW - 2/5 XX - 2/5 YY - 2/5 ZZ - 2/5 AA - 2/5 BB - 2/5 CC - 2/5 DD - 2/5 EE - 2/5 FF - 2/5 GG - 2/5 HH - 2/5 II - 2/5 JJ - 2/5 KK - 2/5 LL - 2/5 MM - 2/5 NN - 2/5 OO - 2/5 PP - 2/5 QQ - 2/5 RR - 2/5 SS - 2/5 TT - 2/5 UU - 2/5 VV - 2/5 WW - 2/5 XX - 2/5 YY - 2/5 ZZ - 2/5
		Schv. stop steady vitals. Shift to ward MR ON
	DR. ABHISHEK JAIN Registration No: 2797	



NURSING INITIAL ASSESSMENT FOR PICU

Date of Admission: 27/6/26 @ 10 PM
Source of Admission: ☐ OPD ☐ Ward ☒ Other: Emergency.
Reason for Admission: One episode of Seizures / Fall from bed 25/6/26
Admission Diagnosis: Seizures / Traumatic Brain Injury.
Accompanied By: ☒ Parent ☐ Guardian ☐ Other Name: _____
Primary Language: ☒ Telugu ☐ English ☒ Hindi ☐ Other Specify _____
Do you require an interpreter? ☐ Yes ☐ No
Allergies: ☒ Yes ☐ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: _____
If yes, identify _____

Source of Information: ☒ Family ☐ Patient ☐ Others, Specify _____

	Past Medical History	Past Surgical History	Last Hospital Admission
SIGNIFICANT HISTORY	25/6/26 Before Admission in another hospital	No Significant	in another hospital.
	Family History:		
	Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☒ No If yes please list, _____		
	Was the child's birth normal? ☐ Yes ☒ No If No, please describe problems: <u>Yes</u> Are the child's immunization up to date? ☒ Yes ☐ No		
CURRENT MEDICATIONS	Taking Medications? ☒ Yes ☐ No If yes, Fill the reconciliation form Medicine brought to the hospital? ☒ Yes ☐ No		
Observations: Weight: <u>7kg</u> Length: _____ Head Circumference (< 2 years): _____ Temp.: <u>98.5°F</u> HR: <u>165 b/m</u> RR: <u>27 b/m</u> BP: <u>96/68</u> Pain Score: <u>01</u> Specify Site: _____ (Follow Pain Assessment Sheet & Document) Fall Risk Assessment: ☒ Yes ☐ No Score: <u>12</u> (Document in the Humpty Dumpty Sheet) Risk of Pressure Sore (Braden Q Score <u>22</u>) (Document in the Braden Q Assessment Sheet)			



Behavioural Status on Admission :

☐ Sleeping ☐ Crying ☒ Calm ☐ Distressed/Console ☐ Drowsy

FUNCTIONAL SCREENING: If a patient needs assistance with any of the following inform consultant

☐ Mobility problem ☐ Walking Problem ☒ No Abnormality Detected
☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

☐ Underweight ☐ Overweight ☐ Special Feeding Method
☐ Feeding Problem ☐ Special diet ☒ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☐ No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With Family

Siblings in household ☒ Yes ☐ No (if yes How Many?) Brothers

Orientation has been given regarding the following aspects:

☒ ID Band in situ
☒ Bedside safety explained
☒ PICU Routine: Doctor's rounds/Medication time
☒ Visiting policy explained

Orientation given to: ☐ Family ☐ Others specify

Name of Person Orientation was given to:

Orientation not given Reason:

Nurse Name: Saumyadip

Nurse Signature: Saumyadip

Date & Time: 27/10/26 @ 10:20 pm

DISCHARGE PLAN

Source of Information: ☐ Family ☐ Friend

Will patient require transportation arrangements to go home: ☐ Yes ☐ No

Will Physiotherapy require at home: ☐ Yes ☐ No

Is home medical equipment anticipated: ☐ Yes ☐ No

Is home oxygen therapy anticipated: ☐ Yes ☐ No

Are dressing needs at home anticipated: ☐ Yes ☐ No

Any other needs anticipated: ☐ Yes ☐ No If Yes Specify

Discharge Medications: ☐ Yes ☐ No

Details:

Final Diagnosis:

Nurse Name: Saumyadip

Nurse Signature: Saumyadip

Date & Time: 27/10/26 @ 10:20 pm



Bed-4

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/11/26 12:57pm	counseling room no.2	- Dr. Sandeep
	Patient's attendants have been counseled about the condition of the child i.e.,	
	→ he is stable, had been seizure-free for >3 days.	
	→ He is taking feeds orally well.	
	→ we will shift to ward today.	
	→ Physiotherapy should be continued.	
	<i>m. prajwal</i>	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3pm	S/B Dr Arinash/Puro team Severe Traumatic Brain Injury/Repetitive Abr Epilepsy / AUCSD - Diffuse Fetter NO fever Comfortable on room air Hemodynamically stable check Blunt Epi MRI PA by BMD CM. Active apixle HR 140/min SpO2 98% OPA ↓ 30/min	① Shift to ward. ② continue on oxygen ③ SpO2 charting ④ watch for fever plus or sepsis ⑤ watch for dull activity Signature: [Signature]



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...GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
05/07/20 3:30 PM	<u>shifting NOTES</u>	
	Patient currently on Room air, orally accepting feeds well	
	shifting vitals	<u>Plan -</u>
	HR - 140/min	- watchful for fever spikes or seizures
	SpO ₂ - 98% - on Room Air	- watchful for dull Activity, info
	RR - 30/min	- Rest continue same <u>tit</u>
		<u>signs</u>



Date & Time	Progress Notes	Doctor's Order
06/07/2026 8:30 AM	<u>C/Sb PCW fellow</u> A Severe TBI with ALERO (R) Supracondylar # Refractory status Epilepticus (E) Hemiparesis (LL & UL)	<u>Plan:</u> 1) Inform Intake after 2 hours 2) 3L NaCl + Adrenaline Nem TID
<u>AED</u> Levin Lacosamide 188cc Clonazepam	<u>off</u> stable on room air chest B/L hemodynamically stable Intermittent shivering decreased intake since midnight No further seizures No fever spike	3) Continue oral amoxicillin clonazepam. 1 2

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/11/25 9 AM	Severe TBI - acute symptomatic refractory status epilepticus (Bilateral focal non motor seizures) 2040 ACERD / ? Hypoxic injury - no new issues - taking orally.	Neurotrans
01/11	Sensorium improving. - eye fixing & tracking, comfortable. Bk pupils reactive, unequal - Generalized hypotonia. Power → R - UL - P 3/5 L - UL - P 3/5 LL - P 3/5	PAPD (+) on - Unipl Tacson Clozapine
Adv:	- VEP on follow up - dead later	
DR. ABHISHEK RAJAN Registration No: 215	Continue Br, supplements, physiotherapy To decide on discharge after PICU consults.	

Date & Time	Progress Notes	Doctor's Order
06/07/26 12pm	cl/b Dr. Sandeep off Hemodynamically stable on room air Chest - B/L Concussed Sounds	Plan: 1) Naso clear E B/L Nall + ache Neb to Contine 2) Discuss with Neurology team regarding clonazepam or any adjustment in AEDs 3) Plan discharge T/m Contlp.
06/7/26 4:30pm	cl/b PICU Fellow Δ Severe TBI (R) Supracondylar H (L) Hemiparesis Issues: Excessive Crying Chest - B/L Concussed Sounds Oral Intake - Improved than previous	Plan: 1) Contine Nebulization 2) plan discharge T/m 3) Inform SAS Contlp. <i>[Signature]</i>

Date & Time	Progress Notes	Doctor's Order
7/7/26	C/S/B Neuroleams	
	No fresh complaints No excessive crying & irritability Taking Orally	
	<u>O/E</u> : Severe TBI - Acute Refractory S.E (B/L focal non motor seizures 2° to AERD / hyponic injury)	
	<u>O/E</u> : Child conscious B/L pupils NSRL Excessive cry (R) or dystonia - intermittent (R) Gaze preference facial deviation toward (R) vitals - stable	Adv (1) Add Nasate plus (2) Add Iron, Ca, (3) plan (D)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
07/07/2026	clsb p/w below	
11:00am	A severe TBI with ALERD ① & supra condylar # ② Hemiparesis dx - hemodynamically stable accepting orally Chest - Cardiacs found ① hypernat than norm	Plan 1) plan surgery today 2) Keep on charge & ready ↑ needed

BAH-00660111 IP5-00175690
Waster NAGAMALLA JAYANTH
31-10-2025 0 Y 7 M 27 D (M)
Dr. SANDEEP REDDY



2nd
1st
2nd

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CROSS CONSULTATION FORM

Doctor Name: Dr. Ramya B Date: 28/6/26 Time: 10am

Diagnosis:

Hospital: RCH

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:

Severe Mild TBI

Signature:

Findings and Recommendations :

History noted.
Neurological issues:-
① Seizure - Biphasic worsening
② Seizure burden:- 2 episodes of clinical + 1 episode of electrographic seizure → ③ frontotemporal onset for 1 minute
③ motor deficit:- ④ Hemiparesis
Vitals:- vitals → stable.
HMF:- Eye opening to deep tactile stimulation.
E3V2M4, good post-breaths ④

Consultant :

Name: Dr. Ramya Signature: [Signature] Date & Time: 28/6/26
10am

-CN: Eyes: dolls eye - poor.
 pupils - unequal $\rightarrow$ R: reactive to light.
 -rough reflex (+).
 -facial $\rightarrow$ symmetrical creases.

-Motor: -Tactile stimulation
 withdrawal R >> L.

	R	L
LL - P	3-	2-
D	3-	2.

-UL - could not be assessed optimally.
 -Reflexes: -Exaggerated on the left

Treatment-

-no response to valproate.
 -ongoing antiedema measures

CT Scan

(R) sided hypodensity $\bar{c}$ bleed & #
 sp 2 (R) Hemispheric
 Infarct.

Adv:



B 2nd

CROSS CONSULTATION FORM

Doctor Name : Dr. Sudheer Date : 28/6/26 Time : 12:40 pm

Diagnosis :

Hospital : RCH

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:

Jayanth

Signature:

Findings and Recommendations :

US Abdomen

- Liver: @ in size & echotexture, no obvious contour/lesion noted
- Spleen
- Pancreas
- Rk, Lk: @ in size & echotexture, no perihilar for stranding/hematoma
- no significant lesion/pneumoperitoneum
- no obvious bowel dilation
- GB & CB: partially distended @

Consultant :

Name : DR. Sudheer

Signature :

Date & Time :

28/6/26 @ 12:40 pm

— with naked eye esoph + IVC @

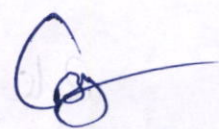
— SMA- SIV relation appears

maintained

Imp: No obvious solid organ injury

2 No obvious hemo/ pneumo
Peritoneum

For Clinical correlation


Dr. S. H. B. B.

BAH-00660111 IP5-00175690
Master NAGAMALLA JAYANTH
31-10-2025 0 Y 7 M 29 D (M)
Dr. SANDEEP REDDY



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CROSS CONSULTATION FORM

Doctor Name: Sri Partha Date: 29/6/2026 Time: 10am

Diagnosis: mod - Head Injury

Hospital: RCH

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:

Signature:

Findings and Recommendations:

Urgo NeuroSx Team (Dr. Sripartha / Dr. Parath)

Thank for referral

Alleges n/o trauma x 3 days ago - child pillion rider collided with vehicle
N/o Seizures at admitted hospital (Asmania Medical College),
Now presented 2 multiple seizures ~ 2-3/day

O/E E3V2M4

① Hemiparesis ④ $\leq \frac{UL}{LL} / 2/5$

Some antigravity movement on (R) side

cr s/o (R) sided hemispheric infarct with (R) thin acute SDH

Plan: Continue Antiepileptics, Anti Edema measures

• MRI Brain & MRA

• Monitor Vitals, GCS, Pupils

• Review SOS

Consultant:

Name: Dr. Sripartha

Signature: [Signature]

Date & Time: 29/6/26 10:00

BAH-00660111 IP5-00175590
Master NAGAMALLA JAYANTH
31-10-2025 0 Y 7 M 29 D
Dr. SANDEEP REDDY



CROSS CONSULTATION FORM

Doctor Name: Dr. Venkatesh Reddy Date: 29/6/25 Time: 1 PM
Diagnosis: Severe TBI / RTA / RT side SDH / left UCLC palsy RT humerus #
conjugate

Hospital: RH Banjara Hills
Referred for: ☒ Opinion ☐ Co-Management ☐ Transfer of care
Type of Referral :
☐ Emergency
☒ Urgent
☐ Non Urgent

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

for conjugate # humerus.

Signature: [Signature]

Findings and Recommendations :

[Signature]
Dr. Venkatesh

[Signature]
Dr. Venkatesh
Ref for Dr. Venkatesh

Ref for Dr. Venkatesh
(R) 12
hypocalcaemia (R) 12
1.
[Signature]

Consultant :
Name: Dr. Venkatesh Reddy Signature: [Signature] Date & Time: 29/6/25 1:30 PM

BAH-00660111 IP5-00175690
Master NAGAMALLA JAYANTH (M)
31-10-2025 0 Y 8 M 3 D
Dr. SANDEEP REDDY

1 sheet

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BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CROSS CONSULTATION FORM

Doctor Name: Ashli Vemayni Date: 03-07-26 Time: 4:55pm

Diagnosis: Scrub TB1; (R) supracondylar # humerus

Hospital: RCH - Bangalore

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:

Physiotherapy

Signature:

Findings and Recommendations :

S/p physiotherapy

Scrub TB1; & R of scapula -
Ergonomics

(R) supracondylar #

(R) humerus

estimated today

on dressing

[→ left PROM exs for CL & (R) joint
→ joint compression → (R) u
excessive length to child neck

Consultant :

Name: Ashli Signature: Ashli Date & Time: 03-07-26 4:55pm



2nd sheet
2nd
⑤
⑤

CROSS CONSULTATION FORM

Doctor Name: Poorna (PT) Date: 20/6/26 Time: 11:4u

Diagnosis: Severe TBI / RTA

Hospital: RCH

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:

Physiotherapy

Signature:

Findings and Recommendations :

S/B physiotherapist

clo: severe TBI / RTA

Ⓡ humerus #,

Ⓛ UL & LL hemiparesis

R/L:

→ PROM Ex's to Ⓛ UL & LL

— chest physio given

— Suctioning

Consultant :

Name: Poorna (PT) Signature: Poorna Date & Time: 11:4u



CROSS CONSULTATION FORM

Doctor Name: Dr. Nandha Reddy Date: 4/7/26 Time: 1:10 PM

Diagnosis:

Hospital: B. R. Chit Pa No 2

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:

Signature: _____

Findings and Recommendations :

R/v / Aggravation of chronic
② Hb

Child well aligned

→ Best ready to

Consultant :

Name: Dr. Nandha Reddy Signature: [Signature] Date & Time: 1:10 PM 4/7/26



RESULT SHEET

Date	3/7/26					
Time	6:30AM					
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na	136					
K	4.2					
Cl	104					
Ca/Mg						
Phosphate						
Urea						
Creatinine						
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						

BAH-00660111 IP5-00175690
 Master NAGAMALLA JAYANTH
 31-10-2025 0 Y 7 M 27 D (M)
 Dr. SANDEEP REDDY



MLC

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

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RESULT SHEET

Date	27/06/26	28/06/26	29/6/26	30/8/26	1/7/26	2/7/26
Time	11:50 PM	4:00 PM	5 AM	4:30 AM	4:30 AM	6 AM
Hb	7.9	7.2	7.2		9.1	9.5
PCV	25.6	24.3	24.2		28.9	30.4
RBC	3.64	3.29	3.33		3.86	4.00
WBC	14770	7850	8540		5280	7120
N/L	73.5/21.2	63.2/29.7	62/30		58/37	58.3/34
Platelets	291000	254000	2.87		1.73 lath	2.04
CRP	12	12				
ESR						
PCT						
RBS						
Na	133	146	146	143	138	142 ↑
K	5.1	4.6	4.1	4.0	3.1	3.7 ↑
Cl	100	119	116	112	108	108
Ca/Mg	9.7					
Phosphate	4.4					
Urea	18					23
Creatinine	0.2					0.2
ALP	244					
SGPT	39					
SGOT	38					
T.Bill/Conj	0.4/0.1					
T.Protein	6.8					
S.Albumin	4.1					
S.Globulin	2.7					3.1
A/G Ratio						
Uric Acid	4.1					
S.Amylase	37					
Sr.Lipase						
Blood Lactate						
S.Cholesterol	137					
PT/INR	14/1					
APTT	30					
CSF Protein / Sugar						
Cells						
N/L						

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: ICU

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	T. CLOBAZAM	1 tab (1 tab = 5mg)	PO	HS	4/7/26	☒ C ☐ DC
2	SYD LEVIRIL	1.4 ml (20 mg/kg/day)	PO	Q 12hly	5/7/26	☒ C ☐ DC
3	SYD LACOSAMIDE	2 ml (1 ml = 15mg) (8 mg/kg/day)	PO	Q 12hly	5/7/26	☒ C ☐ DC
4	SYD STROCIT	1 ml (1 ml = 100mg) (10-15 mg/kg/day)	PO	OD	4/7/26	☒ C ☐ DC
5	SYD COENZYME Q	3 ml	PO	OD	4/7/26	☒ C ☐ DC
6	SYD CALCIMAX-P	2.5 ml	PO	OD	5/7/26	☒ C ☐ DC
7	SYD BEVON	2.5 ml	PO	OD	05/7/26	☒ C ☐ DC
8	T. LANZOL	1/2 tab (1 tab = 15mg)	PO	OD	05/7/26	☒ C ☐ DC
	AUGMENTIN	5 ml (5 ml = 200 mg)	PO	BD		☒ C ☐ DC
						☐ C ☐ DC

* C- Continue, DC - Discontinue

RECORDED / VERIFIED BY

Jyoti (DR JYOTI)

4/26 3:40pm

Joher

6 @ 4:20 PM

Sheet No:

REGULAR PRESCRIPTIONS

Weight 7kg Ward PICU

DRUG: INI PANTOPRAZOL Date/Time 28/6/25 30/6/25 10/7/25 31/7/25

Dose 7mg Route IV Frequency Q24H Start Dt. 27/06/25

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

Additional Instructions: changed to oral cancel

Daily Doctor's Endorsement by a Sign: [Signature]

DRUG: INI PARACETAMOL Date/Time 28/6/25 30/6/25 1/7/25

Dose 100mg Route IV Frequency TID Start Dt. 28/6

Name & Signature of the Doctor Starting the Drugs: [Signature]

Additional Instructions: 2 Jeds Vindicta

Daily Doctor's Endorsement by a Sign: [Signature]

DRUG: INI STROCT Date/Time 29/6/25

Dose 100mg Route IV Frequency OD Start Dt. 29/6

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign:

DRUG: INI STROCT Date/Time 29/6/25 1/7/25

Dose 100mg Route IV Frequency OD Start Dt. 29/6

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

Additional Instructions: 10-15mg/kg/day

Daily Doctor's Endorsement by a Sign: [Signature]



Sheet No:

REGULAR PRESCRIPTIONS

Weight 7kg Ward PW

DRUG : <u>Trj. METHYL PREDNISOLONE</u>				Date Time	<u>29/6</u>
Dose	Route	Frequency	Start Dt.		
<u>210mg</u>	<u>IV</u>	<u>OD</u>	<u>29/6</u>		
Name & Signature of the Doctor Starting the Drugs:				<u>[Signature]</u>	
Additional Instructions:				<u>30 mg/kg/dose</u>	
Daily Doctor's Endorsement by a Sign				<u>[Signature]</u>	

DRUG : <u>Trj. METHYL PREDNISOLONE</u>				Date Time	<u>30/6</u>
Dose	Route	Frequency	Start Dt.		
<u>70mg</u>	<u>IV</u>	<u>OD</u>	<u>30/6</u>		
Name & Signature of the Doctor Starting the Drugs:				<u>[Signature]</u>	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign				<u>[Signature]</u>	

DRUG : <u>Trj. METHYL PREDNISOLONE</u>				Date Time	<u>30/6 11A 2/2</u>
Dose	Route	Frequency	Start Dt.		
<u>200mg</u>	<u>IV</u>	<u>OD</u>	<u>30/6</u>		
Name & Signature of the Doctor Starting the Drugs:				<u>[Signature]</u>	
Additional Instructions:				<u>30mg/kg/dose</u>	
Daily Doctor's Endorsement by a Sign				<u>[Signature]</u>	

DRUG : <u>Tab. COBAZAN</u>				Date Time	<u>2/7 3/7 4/7 5/7 6/7</u>
Dose	Route	Frequency	Start Dt.		
<u>1tab</u>	<u>PO</u>	<u>HS</u>	<u>2/7</u>		
Name & Signature of the Doctor Starting the Drugs:				<u>[Signature]</u>	
Additional Instructions:				<u>30mg/kg/dose</u>	
Daily Doctor's Endorsement by a Sign				<u>[Signature]</u>	

Signature

VERIFIED BY : Name

Sheet No:

REGULAR PRESCRIPTIONS

Weight 7kg

Ward

DRUG: <u>Syp. LEVIPIL</u>				Date Time	<u>3/7</u>	<u>4/7</u>	<u>5/7</u>	<u>6/7</u>
Dose	Route	Frequency	Start Dt.	<u>10</u>	<u>Am</u>	<u>✓</u>	<u>10</u>	<u>Am</u>
<u>1.4ml</u>	<u>PO</u>	<u>Q12H</u>	<u>03/07</u>	<u>Am</u>	<u>✓</u>	<u>10</u>	<u>Am</u>	<u>10</u>
Name & Signature of the Doctor Starting the Drugs:								
<u>Sowjanya</u>								
Additional Instructions:								
<u>20mg/kg/dose</u>								
Daily Doctor's Endorsement by a Sign				<u>U U U</u>				

DRUG: <u>Syp. LACOSAMIDE</u>				Date Time	<u>3/7</u>	<u>4/7</u>	<u>5/7</u>	<u>6/7</u>
Dose	Route	Frequency	Start Dt.	<u>6</u>	<u>Am</u>	<u>✓</u>	<u>10</u>	<u>Am</u>
<u>2ml</u>	<u>PO</u>	<u>Q12H</u>	<u>03/07</u>	<u>Am</u>	<u>✓</u>	<u>10</u>	<u>Am</u>	<u>10</u>
Name & Signature of the Doctor Starting the Drugs:								
<u>Sowjanya</u>								
Additional Instructions:								
<u>1ml = 15mg; 8mg/kg/day</u>								
Daily Doctor's Endorsement by a Sign				<u>U U U</u>				

DRUG: <u>INT METHYL PREDNISOLONE</u>				Date Time	<u>3/7</u>	<u>4/7</u>
Dose	Route	Frequency	Start Dt.	<u>10</u>	<u>Am</u>	<u>✓</u>
<u>7mg</u>	<u>IV</u>	<u>BD</u>	<u>29/06</u>	<u>Am</u>	<u>✓</u>	<u>10</u>
Name & Signature of the Doctor Starting the Drugs:						
<u>Dr. Srinivas</u>						
Additional Instructions:						
<u>(1mg/kg/dose)</u>						
Daily Doctor's Endorsement by a Sign				<u>U U U</u>		

DRUG: <u>Syp. STROCIT</u>				Date Time	<u>3/7</u>	<u>4/7</u>	<u>5/7</u>	<u>6/7</u>
Dose	Route	Frequency	Start Dt.	<u>1ml</u>	<u>PO</u>	<u>OD</u>	<u>30/7</u>	
Name & Signature of the Doctor Starting the Drugs:								
<u>Sowjanya</u>								
Additional Instructions:								
<u>10-15mg/kg/day</u>								
Daily Doctor's Endorsement by a Sign				<u>U U</u>				



Sheet No:

REGULAR PRESCRIPTIONS

Weight 11kg Ward

DRUG : <u>Syp. COENZYME Q</u>				Date Time	<u>3/7</u>	<u>4/7</u>	<u>5/7</u>	<u>6/7</u>
Dose	Route	Frequency	Start Dt.					
<u>3ml</u>	<u>PO</u>	<u>OD</u>	<u>3/7</u>					
Name & Signature of the Doctor Starting the Drugs: <u>Sowjanya</u>				2 <u>PM</u> <u>3/7</u> <u>4/7</u> <u>5/7</u> <u>6/7</u>				
Additional Instructions:								
Daily Doctor's Endorsement by a Sign				<u>0 0</u>				

DRUG : <u>Syp. CALCIMAX P</u>				Date Time	<u>3/7</u>	<u>4/7</u>	<u>5/7</u>	<u>6/7</u>	<u>7/7</u>
Dose	Route	Frequency	Start Dt.						
<u>2.5ml</u>	<u>PO</u>	<u>OD</u>	<u>03/07</u>						
Name & Signature of the Doctor Starting the Drugs: <u>Sowjanya</u>				6 <u>AM</u> <u>3/7</u> <u>4/7</u> <u>5/7</u> <u>6/7</u> <u>7/7</u>					
Additional Instructions:									
Daily Doctor's Endorsement by a Sign				<u>0 0 0</u>					

DRUG : <u>Syp. BEVON</u>				Date Time	<u>3/7</u>	<u>4/7</u>	<u>5/7</u>	<u>6/7</u>	<u>7/7</u>
Dose	Route	Frequency	Start Dt.						
<u>2.5ml</u>	<u>PO</u>	<u>OD</u>	<u>03/07</u>						
Name & Signature of the Doctor Starting the Drugs: <u>Sowjanya</u>				6 <u>AM</u> <u>3/7</u> <u>4/7</u> <u>5/7</u> <u>6/7</u> <u>7/7</u>					
Additional Instructions:									
Daily Doctor's Endorsement by a Sign				<u>0 0 0</u>					

DRUG : <u>Syp. POTCEUR</u>				Date Time	<u>3/7</u>	<u>4/7</u>
Dose	Route	Frequency	Start Dt.			
<u>5ml</u>	<u>PO</u>	<u>BD</u>	<u>3/7/24</u>			
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Praty...</u>						
Additional Instructions:						
Daily Doctor's Endorsement by a Sign				<u>0 0</u>		



Sheet No:

REGULAR PRESCRIPTIONS

Weight 14kg

Ward

DRUG : <u>AM CANZOL</u>				Date/Time	<u>4/5/7 6/7 alt</u>
Dose	Route	Frequency	Start Dt.		
<u>1/2 tab</u>	<u>PO</u>	<u>OD</u>	<u>04/02/24</u>		
Name & Signature of the Doctor Starting the Drugs:				<u>6 AM x</u> <u>Pay 1000</u> <u>5/12/24</u> <u>Pragada</u> <u>Nikita</u>	
Additional Instructions:					
<u>1 tab : 15 kg</u>					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>INT METHYL PREDNISOLONE</u>				Date/Time	<u>4/7</u>
Dose	Route	Frequency	Start Dt.		
<u>20 mg</u>	<u>IV</u>	<u>OD</u>	<u>04/02/24</u>		
Name & Signature of the Doctor Starting the Drugs:				<u>10 PM</u> <u>AA</u>	
Additional Instructions:				<u>Cmg (kg/done)</u>	
Daily Doctor's Endorsement by a Sign					
DRUG : <u>INS METHYL PREDNISOLONE</u>				Date/Time	<u>4/7</u>
Dose	Route	Frequency	Start Dt.		
<u>7mg</u>	<u>IV</u>	<u>OD</u>	<u>4/7</u>		
Name & Signature of the Doctor Starting the Drugs:				<u>1000 Red</u> <u>Pragada</u>	
Additional Instructions:				<u>7mg</u>	
Daily Doctor's Endorsement by a Sign					
DRUG : <u>SYP. AUGMENTIN</u>				Date/Time	<u>5/6/7</u>
Dose	Route	Frequency	Start Dt.		
<u>5ml</u>	<u>P.O.</u>	<u>BD</u>	<u>04/02/24</u>		
Name & Signature of the Doctor Starting the Drugs:				<u>MS</u> <u>S</u>	
Additional Instructions:				<u>10 PM</u> <u>1000 Red</u> <u>Pragada</u>	
Daily Doctor's Endorsement by a Sign					

VERIFIED

Signature

VERIFIED BY: Nam



Sheet No:

REGULAR PRESCRIPTIONS

Weight 7.69 Ward

DRUG : 3% NaCl + Adrenaline				Date/Time	6/7/23/17
Dose	Route	Frequency	Start Dt.		
	NEB	TID	06/07	6am	10pm
Name & Signature of the Doctor Starting the Drugs: <i>Dr. K. S. Reddy</i>					
Additional Instructions: 2ml 3% NaCl Adrenaline 2ml					
Daily Doctor's Endorsement by a Sign					
DRUG : NASOCLEAR SALINE DROPS				Date/Time	6/7/23/17
Dose	Route	Frequency	Start Dt.		
1 drop	Nasoal	Q6H	06/07	12pm	10pm
Name & Signature of the Doctor Starting the Drugs: <i>Dr. K. S. Reddy</i>					
Additional Instructions: 1 drop in each nostril					
Daily Doctor's Endorsement by a Sign					
DRUG : Cyp. NEUCITI PLUS				Date/Time	
Dose	Route	Frequency	Start Dt.		
3.5ml	PO	Q12H	7/6		
Name & Signature of the Doctor Starting the Drugs: <i>Ravijanya</i>					
Additional Instructions: 5ml = 500mg					
Daily Doctor's Endorsement by a Sign					
DRUG : Cyp. TONOFERON				Date/Time	
Dose	Route	Frequency	Start Dt.		
1.5ml	PO	OD	7/6		
Name & Signature of the Doctor Starting the Drugs: <i>Suraj</i>					
Additional Instructions: 5ml = 80					
Daily Doctor's Endorsement by a Sign					



REGULAR PRESCRIPTIONS

Weight. 71kg Ward. P110

DRUG: In: MEFTRAXONE				Date Time	27/6	28/6	29/6	30/6	1/7	2/7	3/7	4/7	5/7
Dose	Route	Frequency	Start Date	10 AM	X								
350mg	IV	Q12H	27/06/25										
Name & Signature of the Doctor Starting the Drugs: T. Pavani													
Additional Instructions:				10 AM 20mg 20mg 20mg 20mg 20mg 20mg 20mg 20mg 20mg 20mg 20mg 20mg 20mg									
Daily Doctor's Endorsement by a Sign				10 AM 20mg 20mg 20mg 20mg 20mg 20mg 20mg 20mg 20mg 20mg 20mg 20mg 20mg									

DRUG: In: LEVIPIL				Date Time	27/6	28/6	29/6	30/6	1/7	2/7	3/7
Dose	Route	Frequency	Start Date	10 AM	X						
140mg	IV	Q12H	27/06/25								
Name & Signature of the Doctor Starting the Drugs: T. Pavani											
Additional Instructions: 20mg/14y/dose				10 AM 20mg 20mg 20mg 20mg 20mg 20mg 20mg 20mg 20mg 20mg 20mg							
Daily Doctor's Endorsement by a Sign				10 AM 20mg 20mg 20mg 20mg 20mg 20mg 20mg 20mg 20mg 20mg 20mg							

DRUG: In: EPTOIN				Date Time	27/6	28/6	29/6	30/6	1/7	2/7	3/7
Dose	Route	Frequency	Start Date	6 AM	X						
180mg	IV	Q12H	27/06/25								
Name & Signature of the Doctor Starting the Drugs: T. Pavani											
Additional Instructions: 5mg/kg/day				6 AM 5mg/kg/day 5mg/kg/day 5mg/kg/day 5mg/kg/day 5mg/kg/day 5mg/kg/day 5mg/kg/day 5mg/kg/day 5mg/kg/day 5mg/kg/day 5mg/kg/day							
Daily Doctor's Endorsement by a Sign				6 AM 5mg/kg/day 5mg/kg/day 5mg/kg/day 5mg/kg/day 5mg/kg/day 5mg/kg/day 5mg/kg/day 5mg/kg/day 5mg/kg/day 5mg/kg/day 5mg/kg/day							

DRUG: In: LACOSAMIDE				Date Time	27/6	28/6	29/6	30/6	1/7	2/7	3/7
Dose	Route	Frequency	Start Date	6 AM	X						
28mg	IV	Q12H	27/06/25								
Name & Signature of the Doctor Starting the Drugs: T. Pavani											
Additional Instructions: .8mg/kg/day				6 AM .8mg/kg/day .8mg/kg/day .8mg/kg/day .8mg/kg/day .8mg/kg/day .8mg/kg/day .8mg/kg/day .8mg/kg/day .8mg/kg/day .8mg/kg/day .8mg/kg/day							
Daily Doctor's Endorsement by a Sign				6 AM .8mg/kg/day .8mg/kg/day .8mg/kg/day .8mg/kg/day .8mg/kg/day .8mg/kg/day .8mg/kg/day .8mg/kg/day .8mg/kg/day .8mg/kg/day .8mg/kg/day							

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	Dose
		Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Route	Start Date	Dose	Dose	Dose	Dose	Dose
		Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Name & Signature of the Doctor		Dose	Dose	Dose	Dose	Dose
		Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Additional Instructions:		Dose	Dose	Dose	Dose	Dose
		Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.

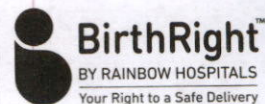
STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
27/6/26	11:20 PM	INJ VALPROATE	140mg	iv	[Signature]	Sushu Rishu
29/6	3 AM	Syp. MEFTAL	3ml	PO	KSPK	Sushu Abhinav
30/06	12:30 AM	INJ-PHENO BARBITONE	70mg	IV	[Signature]	Raj Sushu
30/06	1:10 AM	INJ. MIDAZOLAM	1mg	IV	[Signature]	Sushu Sushu
30/6	9:00 AM	Phenytoin	140mg	IV	[Signature]	Raj Sushu
30/6	5:20 PM	xy ABC	70mg	iv over 24hr	[Signature]	Raj Sushu
30/6/26	7 PM	IVlg	100ml (10gm)	iv over 6 hrs	[Signature]	Pratya Sushu
1/7/26	6:30 AM	2ij. LASIX	5mg	IV	[Signature]	Pratya Sushu
1/7/26	3:20 PM					

I.V. FLUIDS CHART

Weight. 71kg Ward. p1w

Date	Time	position of I.V. Fluid (If infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
27/6/26	10pm	IVF DNS	IV	30ml	<i>[Signature]</i>	<i>[Signature]</i>		<i>[Signature]</i>	
27/6/26	11pm	3% DNS	iv	10ml/h	<i>[Signature]</i>				
27/6/26	11pm	DNS	iv	10ml/h	<i>[Signature]</i>	<i>[Signature]</i>	27/6	<i>[Signature]</i>	Kennela Subrata
27/6/26	11pm	3% DNS	iv	7ml/h	<i>[Signature]</i>	<i>[Signature]</i>	27/6	<i>[Signature]</i>	Kennela Subrata
28/6/26	6 AM	DNS	IV	10ml/h	<i>[Signature]</i>	<i>[Signature]</i>		<i>[Signature]</i>	<i>[Signature]</i>
28/6/26	6 AM	3% NS	IV	7ml/h	<i>[Signature]</i>	<i>[Signature]</i>	28/6	<i>[Signature]</i>	neel subrata
28/6/26	7 PM	3% NS	IV	4ml/h	<i>[Signature]</i>	<i>[Signature]</i>	29/06 2:30pm	<i>[Signature]</i>	K. A Dhruva
29/6/26	4 PM	3% NS	IV	4ml/h	<i>[Signature]</i>	<i>[Signature]</i>	30/6	<i>[Signature]</i>	<i>[Signature]</i>
30/6/26	8 AM	3% NS	IV	4ml/h	<i>[Signature]</i>	<i>[Signature]</i>	1/7	<i>[Signature]</i>	<i>[Signature]</i>
1/7/26	6:30 AM	3% NS	IV	7 ml/h	<i>[Signature]</i>	<i>[Signature]</i>	2/7	Jayan	<i>[Signature]</i>



Patient Sticker

I.V. FLUID CHART

DATE	TIME	Composition of I.V. FLUID (if infusion, mention ml / hr = Mcg / kg / min. etc.)	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
10/11	10:30	100ml 0.9% NaCl	IV	100					
10/11	11:30	100ml 0.9% NaCl	IV	100					
10/11	12:30	100ml 0.9% NaCl	IV	100					
10/11	13:30	100ml 0.9% NaCl	IV	100					
10/11	14:30	100ml 0.9% NaCl	IV	100					
10/11	15:30	100ml 0.9% NaCl	IV	100					
10/11	16:30	100ml 0.9% NaCl	IV	100					
10/11	17:30	100ml 0.9% NaCl	IV	100					
10/11	18:30	100ml 0.9% NaCl	IV	100					
10/11	19:30	100ml 0.9% NaCl	IV	100					
10/11	20:30	100ml 0.9% NaCl	IV	100					
10/11	21:30	100ml 0.9% NaCl	IV	100					
10/11	22:30	100ml 0.9% NaCl	IV	100					
10/11	23:30	100ml 0.9% NaCl	IV	100					
10/11	00:30	100ml 0.9% NaCl	IV	100					
10/11	01:30	100ml 0.9% NaCl	IV	100					
10/11	02:30	100ml 0.9% NaCl	IV	100					
10/11	03:30	100ml 0.9% NaCl	IV	100					
10/11	04:30	100ml 0.9% NaCl	IV	100					
10/11	05:30	100ml 0.9% NaCl	IV	100					
10/11	06:30	100ml 0.9% NaCl	IV	100					
10/11	07:30	100ml 0.9% NaCl	IV	100					
10/11	08:30	100ml 0.9% NaCl	IV	100					
10/11	09:30	100ml 0.9% NaCl	IV	100					
10/11	10:30	100ml 0.9% NaCl	IV	100					
10/11	11:30	100ml 0.9% NaCl	IV	100					
10/11	12:30	100ml 0.9% NaCl	IV	100					
10/11	13:30	100ml 0.9% NaCl	IV	100					
10/11	14:30	100ml 0.9% NaCl	IV	100					
10/11	15:30	100ml 0.9% NaCl	IV	100					
10/11	16:30	100ml 0.9% NaCl	IV	100					
10/11	17:30	100ml 0.9% NaCl	IV	100					
10/11	18:30	100ml 0.9% NaCl	IV	100					
10/11	19:30	100ml 0.9% NaCl	IV	100					
10/11	20:30	100ml 0.9% NaCl	IV	100					
10/11	21:30	100ml 0.9% NaCl	IV	100					
10/11	22:30	100ml 0.9% NaCl	IV	100					
10/11	23:30	100ml 0.9% NaCl	IV	100					
10/11	00:30	100ml 0.9% NaCl	IV	100					
10/11	01:30	100ml 0.9% NaCl	IV	100					
10/11	02:30	100ml 0.9% NaCl	IV	100					
10/11	03:30	100ml 0.9% NaCl	IV	100					
10/11	04:30	100ml 0.9% NaCl	IV	100					
10/11	05:30	100ml 0.9% NaCl	IV	100					
10/11	06:30	100ml 0.9% NaCl	IV	100					
10/11	07:30	100ml 0.9% NaCl	IV	100					
10/11	08:30	100ml 0.9% NaCl	IV	100					
10/11	09:30	100ml 0.9% NaCl	IV	100					
10/11	10:30	100ml 0.9% NaCl	IV	100					
10/11	11:30	100ml 0.9% NaCl	IV	100					
10/11	12:30	100ml 0.9% NaCl	IV	100					
10/11	13:30	100ml 0.9% NaCl	IV	100					
10/11	14:30								



BirthRightTM
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: Jayanth

Weight: 7 Kg kgs

Sheet No:

[illegible]

BAH-0066011 IP5-00175690
 Master NAGA A JAYANTH
 31-10-2025 JY 8 M 0 D (M)
 Dr. SANDEEP REDDY

Rainbow®
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 It takes a lot to treat the little.

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

SEDATION CHART (SEDATION & PARALYTICS)

Drugs belong to "High Risk / High Alert" medicines.
 (Cardia, hypotension and respiratory depression while administering these drugs)

SIAGAMALLA JAYANTH

Age : 8yr Gender : ☒ Male ☐ Female

7K3

UHID No. : BAH-0060111

Sheet No. :

Date	Time	Name of Drugs	Composition	Dose Range	Dr's Sign.	Nurse Sign.	Stop Date	Dr's Sign.	Nurse Sign.
30/6/20	3:50pm	MIDAZOLAM	1ml = 1mg	(2-10 µg/kg/min) @0.8 ml/hr (C2)	Raj	Raj/pat	02/07	Raj	Sudhakar
30/6/20	5pm	2ij. MORPHINE	7mg in 50 ml 5% DEXTROSE	1-3 ml/hr (20-60 mcg/kg/hr)	praty	Raj/pat	02/07	Raj	praty

CALCULATIONS FOR SOME COMMONLY USED DRUGS :

Fentanyl : 1ml = 50mcg vial, take 4ml in 16 ml NS thus 1ml = 10mcg ; 0.1-0.4 ml/kg/hr (1-4mcg/kg/hr)
 NOTE : In older children more than 20kg weight, take 8ml in 12ml of NS thus 1ml=20 mcg;0.2-0.8ml/kg/hr (1-4 mcg/kg/hr)
 Midazolam : (Undiluted) 1ml = 1mg ; 0.1-0.5 ml/kg/hr (1.6-8 mcg/kg/min)
 Ketamine : Weight x 30 mg/kg in 50ml NS ; 1-4ml/hr (10-40mcg/kg/min)
 Dexmedetomidine : 1ml (100mcg) in 24 ml NS ; 1ml = 4mcg ;0.05 -0.2 ml/kg/hr (0.2 - 0.7 mcg/kg/hr)

Docu.No: RCHBH /FRM / CLINICAL / 154

Morphine : Weight x 1 mg/kg in 50ml 5% Dextrose 1-3 ml/hr - 20-60 mcg/kg/hr
 Propofol : 1ml = 10mg ; 0.1-0.4 ml/kg/hr (1-4mg/kg/hr)
 Vecuronium Powder : 4mg, diluted with 4ml NS (1ml-1mg), take 2ml in 8ml NS (1ml-0.2mg)
 0.25 ml/kg/hr - 1.3 ml/kg/hr (0.05-0.15mg/kg/hr)
 Pancuronium : (1ml -2mg) take 1ml in 9ml NS(1ml-0.2mg) 0.1ml/kg/hr-0.3ml/kg/hr (0.02-0.06mg/kg/hr)

IV INFUSION MEDICATION CHART (INOTROPES & VASOPRESSORS)

(All the drugs in this category belong to "High Risk / High Alert" medicines. Please watch for tachycardia / bradycardia, hypertension / hypotension any cardiac arrhythmia, patency of IV line, status of skin at IV site and color and perfusion of the fingers and toes while administering these drugs)

Patient Name : Age : Gender : ☐ Male ☐ Female

Weight : UHID No. : Sheet No. :

Date	Time	Name of Drugs	Composition	Dose Range	Dr's Sign.	Nurse Sign.	Stop Date	Dr's Sign.	Nurse Sign.

CALCULATIONS FOR SOME COMMONLY USED DRUGS :

Dopamine : Wt. x 30 mg in 50ml of 5% Dextrose ; 0.5 - 1ml/hr - 5-10mcg/kg/min

Dobutamine : Wt X 30mg in 50ml of 5 Percent Dextrose 0.5-1ml/hr; 5-10 mcg/kg/min

Epinephrine : Wt. x 0.3mg in 50ml of 5% Dextrose ; 0.1-0.5mcg/kg/min - 1-5ml/hr

Nor-epinephrine : Wt. x 0.3mg in 50ml of 5% Dextrose ; 1-5ml.hr - 0.1-0.5mcg/kg/min

Milrinone : Wt. X 1.5mg in 50ml of 5% Dextrose ; 1ml/hr - 1.5ml/hr - 0.5-0.75mcg/kg/min

Sodium Nitroprusside : 3mg/kg in 50ml D5 ; 0.5ml/hr - 4ml/hr (0.5-4mcg/kg/hr)

Nitroglycerine : 3ml/kg in 50ml D5 ; 0.5ml/hr - 5ml/hr (0.5-mcg/kg/min)

Labetalol : 0.25 - 3mg/kg/hr ; (1ml=5mg) ; take 2ml in 18ml NS(1ML-0.5 MG) 0.5- 1.5ml/kg/hr (0.25 - 3mg/kg/hr)

1-10-2022
r. SANDEEP REDDY

IP5-00175690

ЭАН-00660111

3AH-00660111
Master NAGAMALLA JAYANTH
0Y8M1D

31-10-2025

0Y8M1D

(M)

31-10-2025
Dr. SANDEEP REDDY



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It takes a lot to treat the little



BirthRight™

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Your Right to a Safe Delivery

STAT / ONCE ONLY DRUGS

Name:

Weight: 4 kgs

Sheet No:

[illegible]

CLINICAL / 136

BAH-00660111
Master NAGAMALLA JAYANTH
31-10-2025 0 Y 8 M 6 D
Dr. SANDEEP REDDY (M)

(M)

No. : RCH / FRM / CLINICAL / 124

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

Pratiksha
Rainbow
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 31/07 Time: 20⁰⁰ 6⁰⁰

Doctor/Nurse/Family Concern?

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94

98.5°F
98.1°F

Heart Rate
(bpm)

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

184/108
187/110

Heart Rate (Number)

105bpm 102bpm

Resp. Rate (bpm)
over 1 Minute *

70
60
50
40
30
20
10

Resp Rate (Number)

26bpm 28bpm

Resp Mod/ Severe
Distress None / Mild

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

0.1 100%

Conscious Level
Normal Altered

GCS *

15/15 15/15

TOTAL SCORE

Number of shaded boxes

1 1

Pain Score

0 0

Observer's Initials

U 0

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 incharge and PICU /NICU fellow or PICU/NICU 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)



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 06/10/25	Time: 2pm	6am	10am	2pm	10pm
Doctor/Nurse/Family Concern?					
Temperature (°F)	104				
	103				
	102				
	101				
	100				
	99				
Heart Rate (bpm)	190				
	180				
	170				
	160				
	150				
	140				
Blood Pressure (mmHg) *	130				
	120				
	110				
	100				
	90				
	80				
Note: BP does not score in early warning scoring	70				
	60				
	50				
	40				
	30				
	20				
Heart Rate (Number)	190				
	180				
	170				
	160				
	150				
	140				
Resp. Rate (bpm) over 1 Minute *	70				
	60				
	50				
	40				
	30				
	20				
Resp Rate (Number)	70				
	60				
	50				
	40				
	30				
	20				
Resp Mod/ Severe Distress None / Mild	70				
	60				
	50				
	40				
	30				
	20				
Receiving O ₂ (l/min) O ₂ Saturations (%)	70				
	60				
	50				
	40				
	30				
	20				
Conscious Normal Level Altered	70				
	60				
	50				
	40				
	30				
	20				
GCS *	70				
	60				
	50				
	40				
	30				
	20				
TOTAL SCORE	70				
	60				
	50				
	40				
	30				
	20				
Number of shaded boxes	70				
	60				
	50				
	40				
	30				
	20				
Pain Score	70				
	60				
	50				
	40				
	30				
	20				
Observer's Initials	70				
	60				
	50				
	40				
	30				
	20				

ACTIONS

NB: Scores 3 should be recorded overleaf

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 5/12 Time: 5 PM 18

Doctor/Nurse/Family Concern?

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94

98.6 F

Heart Rate
(bpm)

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

130 bpm

Resp. Rate (bpm)
Over 1 Minute) *

70
60
50
40
30
20
10

28 bpm

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

100%

Conscious Normal
Level Altered

GCS *

15/15

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

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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)



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	1 milk									
	05:00 pm										
	06:00 pm	NO milk									
	07:00 pm	NO IVF									
Total Intake :						Total Output :					
	08:00 pm										
	09:00 pm	1 milk									
	10:00 pm	NO									
	11:00 pm	NO IVF milk									
	12:00 am	1									
	01:00 am										
Total Intake :						Total Output :					
	02:00 am										
	03:00 am	1									
	04:00 am	NO									
	05:00 am	NO IVF									
	06:00 am	1									
	07:00 am										
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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
6/7/26			Mouth	I.V	N.G								
	08:00 am	↑				/			/	✓	0	Ch	
	09:00 am		milk			/					0	Ch	
	10:00 am	No Intake				/					0	Ch	
	11:00 am					/					0	Ch	
	12:00 pm	↓				/			✓	0	Ch		
01:00 pm										0	Ch		
Total Intake :						Total Output :							
6/8	02:00 pm	↑				/			/		0	Ch	
	03:00 pm		milk			/					0	Ch	
	04:00 pm	No Intake				/			✓	0	Ch		
	05:00 pm	↓				/				0	Ch		
	06:00 pm	↑				/			✓	0	Ch		
	07:00 pm					/			✓	0	Ch		
Total Intake :						Total Output :							
6/9	08:00 pm	↑	milk	-		/			/		0	Ch	
	09:00 pm			-		/	✓		✓	0	Ch		
	10:00 pm	No Intake	milk	-		/				0	Ch		
	11:00 pm	↓		-		/			✓	0	Ch		
	12:00 am	↑	milk	-		/				0	Ch		
	01:00 am			-		/				0	Ch		
Total Intake :						Total Output :							
7/2	02:00 am	↑		-		/			/		0	Ch	
	03:00 am		milk	-		/			✓	0	Ch		
	04:00 am	No Intake		-		/				0	Ch		
	05:00 am	↓		-		/			✓	0	Ch		
	06:00 am	↑		-		/				0	Ch		
	07:00 am			-		/			✓	0	Ch		
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

3AH-00660111 IP5-00175690
 Viaster NAGAMALLA JAYANTH
 31-10-2025 0 Y 8 M 1 D (M)
 Dr. SANDEEP REDDY



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: 1-7-2026

Assessment: Seizure

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 child	9pm	> Assessed the general condition of the child	All plans are implemented
10pm	> monitor seizures	11pm	> Monitored for seizure	
12pm	> Continue the child in mechanical	1pm	> Continued the child in mechanical ventilation	
2pm	> Send CBP, RP2	3pm	> CBP, RP2 send	
5pm	> Administered medications as per drug chart	6pm	> Administered medication as per drug chart	

Re-Assessment:

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Vindya

Date & Time: 2-7-2026 6am



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 2/7/26

Assessment: Fever Spies

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
8:00 AM	Assess the baby general Condition	8:30 AM	Assessed the baby general Condition	All Planing are Implemented.
9:00 AM	Check the vitals & recorded	10:00 AM	Checked the vitals & recorded	
11:00 AM	Administer fluid as per doctor orders.	12:00 PM	Administered fluid as per doctor orders.	
1:00 PM	Continue NG feeds 60-80 ml every 2nd/hr	2:00 PM	Continued NG feeds 60-80 ml every 2nd/hr	
3:00 PM	manage fever Spies	4:00 PM	managed fever Spies	
5:00 PM	Today EEG	6:00 PM	Today done EEG	

Re-Assessment: Reassessment done

Special Notes: manage fever Spies.

Nurse Signature: Suchismita

Nurse Name: Suchismita

Date & Time: 2/7/26 @ 8:00 PM

IP5-00175690
Dr. SANDEEP REDDY
0 Y 7 M 27 D
(M)

NURSING CARE RECORD

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Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 28/6/2026 @ 8AM

Assessment: Baby is PBL

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	To assess the baby general Condition	9AM	Assessed the baby general Condition	All plans are implemented
10AM	To monitor the vitals & Recorded	11AM	Monitored the vitals &	
12PM	To maintain P/O chart	1PM	Maintained P/O chart & Recorded	
2PM	IV fluids DNS	3PM	Continue DNS 10ml/hr on flow	
4PM	plan for electrolytes, CBP	4:30PM	ser electrolytes, CBP done	
5PM	3:1. NS, baby is on NPO	6PM	Continue NPO	
8PM	To administer the medications as per drug chart	8PM	Administered the medications as per drug chart	

Re-Assessment:

Re-assessment done

Special Notes:

w/F Respiratory distress, seizure activity

Nurse Signature: Vennela

Nurse No: Vennela

Date & Time: 28/6/26 @ 8PM

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 27/6/20

Assessment: Assess the baby Conditions

- | | | | | | | |
|-------|---|--|---|---|---|---|
| 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
10:30 PM	Observe pt Conditions	10:30 PM	observe pt Condition	all the implementation are done as per drug charts
12 AM	monitored vitals & records	12:30 AM	monitored vitals & records	
2 AM	X-Ray Done	2:30 AM	X-Ray Done	
4 AM	EEG plan	4:30 AM	EEG Done	
6 AM	lab as per Doctor advice	6:30 AM	lab Sampled as per dr. advice	
	Arterial line plan		Arterial line Done	
	Administered medication as per drug charts		Administered medication as per drug charts.	

Re-Assessment: Re-Assessment done

Special Notes: w/f Seizures, w/f Fever Spikes, w/f Distress

Nurse Signature:  Nurse Name: Samyadip Date & Time: 28/6/20 @ 6 AM



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 29-6-2026

Assessment:

Status epilepticus

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	9am	> Assessed the general condition of the child	
10am	> DO MRI brain I contrast	11am	> MRI brain done	All plans are implemented.
12pm	> Continue 8% AS due to cerebral edema	2pm	> 8% AS continued	
3pm	> Monitor child for seizure and fever spikes	5pm	> Monitored child for seizure activity fever spikes	
6pm	> Administered medication	7pm	> Administered col medication	

Re-Assessment:

Don. monitor seizure activity

Special Notes:

Nurse Signature: Vindhya

Nurse Name: Vindhya

Date & Time: 29-6-2026 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 28/6/20

Assessment: Assessed the baby condition.

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the general of the baby.	8pm	* Assessed the general of the baby.	All plans are implemented.
10pm	* monitor vital signs & record.	10:30pm	* monitored vital signs	
11pm	* maintain Ilo chart	11:30pm	* maintained Ilo chart.	
12AM	* Baby is on NPO	1AM	* Baby is on NPO till further order.	
2AM	* plan for MRI TIM @ 8:30AM	3AM	* planned for MRI TIM @ 8:30AM	
4AM	* send CBP, sr electrolytes.	4:30AM	* send CBP, sr electrolytes	
5AM	* Administer the medication as per doctor's order.	6AM	* Administered medications as per doctor's order.	
7AM	* provide comfortable position.	8AM	* provided comfortable position	

Re-Assessment: Done

Special Notes: WLF seizures and fever spikes.

Nurse Signature:
 Nurse Name: Navaneetha
 Date & Time: 29/6/20 @ 2AM



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 29/6/26

Assessment: to the baby's general condition.

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	→ Monitor to the baby condition	9pm	→ Assessed to the baby general condition.	→ All are the implant under doctor order and record and Report.
10pm	→ monitor vital on Z/O Chart	11pm	→ monitored vital chart on Z/O Chart	
12Am	→ Administer medication given as per drug chart.	1Am	→ medication given as per chart.	
2Am	→ Continue 31.NS.	3Am	→ going to 31.NS	
4Am	→ Plan Put cannula	5Am	→ w/F SIZURES	
6Am	→ stop I/V fluids	7Am	→ w/F Fever spike.	
	→ encouraging feeding	9Am	→ 2nd hourly feeding (60ml)	

Re-Assessment: Re-Assessment done.

Special Notes: w/F SIZURE SPIKE w/F Fever spike

Nurse Signature: [Signature]

Nurse Name: Raj

Date & Time: 30/6/26 4Am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 30/6/26 v

Assessment: Asses my General condition

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
8 AM	→ Asses the general condition of pt	9 PM	Assessed the general condition of pt	All planned Implem.
10 AM	→ monitoring vital & Resp	4 PM	→ monitored vital signs & resp	
12 PM	→ Administer medication	1 PM	→ Administered medication	
2 PM	→ Plan intubate	3 PM	→ Intubated	
4 PM	→ Plan blood transfusion	5 PM	→ Blood transfusion DOL	
6 PM	→ plan catheter	7 PM	→ catheter DOL	
7 PM	→ plan plebix	8 PM	→ plebix	

Re-Assessment: DOK

Special Notes: ut Distress

Nurse Signature: (Signature)

Nurse Name: Rahu

Date & Time: 30/6/26 08:16



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 30/6/26

Assessment: Assessed general condition of child.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess general condition of child	9pm	Assessed general condition of child	All plans are Implemented.
10pm	Monitor vital signs	11pm	monitored vital signs	
12Am	Maintain I/O chart	1Am	Maintained I/O chart	
2Am	Continue morphine Infusion	3Am	Continued morphine Infusion	
4Am	wt f fever spikes	5Am	wt f fever spikes	
6Am	Administer medications as per chart	7Am	Administered medications as per chart	

Re-Assessment: The Assessment done.

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Shreya

Date & Time: 01/7/26 @ 2pm



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 01/07/26

Assessment: Assess the patient condition.

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 patient condition.	8:30AM	Assessed the patient condition.	All the Plans are implemented
9AM	monitor the vitals	9:30AM	monitored the vitals.	
10AM	maintain the I/O chart.	10:30AM	maintained the I/O chart.	
12PM	watch for seizure	1PM	watched for seizure	
1PM	Plan to stop morphine	2PM	Stopped morphine	
6PM	plan to start NG feeding.	6:30PM	started NG feeding Peptamin Junior.	

Re-Assessment: RE-Assessment done

Special Notes: watch for seizure.

Nurse Signature: Suchismita

Nurse Name: [Signature]

Date & Time: 01/07/26 @ 4:00PM



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 3/7/26

Assessment: Assess the baby condition.

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:Am	Assess the general condition of the baby.	9Am	Assessed the general condition of the baby.	Baby condition is improved.
9Am	monitor vital's signs	10Am	monitered vitals signs	
11Am	stop. stop 3/1 NS & my ced mase	11:30Am	plan extubation as done & set on face mask.	
11:30Am	plan extubation & set on face mask	12 pm	chest x-ray as be done & ABG done	
13 pm	chest x-ray pre extubation	1 pm	maintained I/O cheest.	
4 pm	mainten I/O cheest	5 pm	post extubation	
6 pm	Administer the medication as per doctor's order	7 pm		

Re-Assessment: 6

Special Notes: w/f. fever hypertension

Nurse Signature: @harshana

Nurse Name: @Bail

Date & Time: 3/7/26 8pm.



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 02/10/2026

Assessment: Assess the portland condition

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
7am	need to maintain airway and oxygenation.	7am	maintained airway and continue ventilator support	By doing all procedure portland condition is improving.
8am	need to maintain fluid balance.	8am	maintained fluid balance.	
9am	need to maintain good nutritional status.	9am	maintained nutritional status.	
10am	Prevent infection.	10am	using antt technique.	
11am	ensure safety	11am	Provided side skills.	
12pm	need to give family education	12pm	explained to parents about portland condition.	
1pm	Administer medications as per dr order.	1pm	Administered medications as per dr order.	

Re-Assessment: Re assess next day

Special Notes: Plan for Discharge tomorrow.

Nurse Signature: *Buddh*

Nurse Name: Buddhader

Date & Time: 02/10/2026 @ 11am

BAH-00660111 IP5-00175690
Master NAGAMALLA JAYANTH
31-10-2025 0 Y 8 M 3 D (M)
Dr. SANDEEP REDDY



NURSING CARE RECORD

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Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 4/7/20

Assessment: Assess the baby condition

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 condition	8am	Assessed the baby condition	All plans are implemented
	monitor the vital		condition	
12pm	single	1pm	monitored the vital	
	maintained the chart		single maintained	
2pm	nan procella 3rd hourly	3pm	± lo chart	
4pm	60ml given	5pm	feed given	
6pm	given comfort position	7pm	given comfort position	

Re-Assessment: done

Special Notes:

Nurse Signature: [Signature]

Nurse Name: prenalika

Date & Time: 4/7/20 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/26

Assessment: NG feeds start

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 baby general condition	9pm	Assess the baby general condition	All points are implemented
10pm	monitored the vital sign's	11pm	monitored the vital sign's	
12 Am	provide comfortable position		Provided comfortable position	
	Ilo chart maintain	1Am	Ilo chart maintained	
2Am	child in NG feeds 3rd hourly	3Am	NG Feeds Nampro 1:30ml/60ml/hr	
4Am	60 ml fluids stop		fluids stop	
	WIF fever spikes	5Am	WIF fever spikes	
6Am	WIF seizures / hypertension		WIF seizures / hypertension	
	Administer medication as per chart	7Am	Administer medication as per the chart	

Re-Assessment: ~~Continue~~ continue NG feeds / Ilo fluids stop

Special Notes: WIF hypertension, seizures, fever.

Nurse Signature: Sindhuja Nurse Name: Sindhuja Date & Time: 3/7/26 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/11/26

Assessment: TBI

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ assess to the baby general condition.	9pm	→ Assess to the baby condition	→ API and the implant under doctor's care and report.
10pm	→ monitor vital on 2/0 chart.	11pm	→ monitor vital on 2/0 chart.	
	→ medication given as per chart.	1pm	→ Add on full star medication given as per chart.	
12pm	→ w/f Tachymegia	3pm	→ orally allowed.	
2pm	→ w/f Fever spike.	5pm	→ monitor urine output.	
4pm	→ w/f Sizable	5pm	→ w/f Fever spike.	
6pm	→ plan to shift forward.	4pm	→ w/f Sizable	
	→ orally allowed.	4pm	→ Position changes	
			→ maintain personal hygiene.	

Re-Assessment: Re-assessment done

Special Notes: w/f Fever spike w/f

Nurse Signature: Nurse Name: Date & Time: 5/11/26 4pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/7/26

Assessment: Baby having discomfort

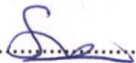
Goals

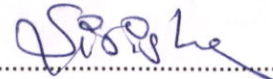
- ☒ Maintain Airway and Oxygenation ☐ Relieve Pain & Discomfort ☒ Maintain Fluid Balance ☐ Improve Activity Tolerance ☒ Maintain Good Nutritional Status ☐ Maintain Skin Integrity
☒ Maintain Personal Hygiene ☒ Prevent Infection ☐ Meet Elimination Needs ☒ Ensure Safety ☐ Early Ambulation Reduce Anxiety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

Time	Plan of Care	Time	Implementation	Evaluation
4PM	→ Assess the baby general Condition	4:10PM	→ Assessed the baby general Condition	baby Condition is improve
5PM	→ monitor the vital's	5:10PM	→ monitored the vital's	
6PM	→ Provide comfortable Position	6:10PM	→ Provided comfortable Position	
7PM	→ Administer medication as Per doctor order's	7:10PM	→ Administered medication as Per doctor order's	

Re-Assessment:

Special Notes:

Nurse Signature: 

Nurse Name: 

Date & Time: 5/7



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 05/07/26

Assessment: Baby having Irritable

- 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 baby general condition and monitor the vitals and record.	8:10 PM	Assessed the baby general condition and monitored the vitals and recorded.	By doing all above procedure baby condition improving well.
10:40 PM	After the doctor review advice continue the medication as per chart.	10:10 PM	After the doctor review advised continued the medications as per chart.	
12am	Watch for seizures/fever spikes.	12:10am	watched for seizures/fever spikes.	
2am	Provide comfortable rest position.	2:10am	Provided comfortable rest position.	
6am	Allow oral feeds fully accepting.	6:10 am	Allowed oral feeds fully accepting.	
8am	Ensure the safety needs.	8:10 am	Ensured the safety needs.	

Re-Assessment: Re assessment done

Special Notes: Watch for fever spikes/seizures or dull activity. Inform PICU follows

Nurse Signature: [Signature]

Nurse Name: K. Sravanthi ID: 607682

Date & Time: 06/07/26 @ 8am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 6/7/26

Assessment: slightly baby condition now

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8a	Assess the pt general condition.	8:10a	Assessed pt general condition.	by doc above all the care pt addition is now
10a	Monitor vital signs		monitored vitals	
12p	maintain 16 chd	12:10p	monitored 16 chd	
	Ensure safety.		Ensured safety.	
2pm	Administer medication as per chd.	2:10p	Administered medication as per chd	
	doctor advice plan d/c tomorrow		planned disched tomorrow	

Re-Assessment: Monitor vitals

Special Notes: plan d/c tomorrow

Nurse Signature:

Nurse Name: Anshu

Date & Time: 6/7/26 2pm

BAH-00660111 IP5-00175690
Master NAGAMALLA JAYANTH
31-10-2025 0 Y 8 M 6 D (M)
Dr. SANDEEP REDDY



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: 06/07/2026

Assessment: Baby having improving well

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 baby general condition and monitor the vitals and record.	8:10 PM	→ Assessed the baby general condition and monitored the vitals and recorded	By doing all above procedure baby condition improving well
10pm	→ After the rounds advice continue the medication as per chart.	10:10 PM	→ After the rounds advice continued the medication as per chart.	
12am	→ Watch for seizures / fever spikes.	12:10 am	→ watched for seizures / fever spikes.	
2am	→ Provide comfortable rest position.	2:10 am	→ Provided comfortable rest position.	
3am	→ Advice 3% Nacl + Adrenaline TID, nasoclear q4hrly.	3:10 am	→ Advice 3% Nacl + Adrenaline TID, nasoclear q4hrly.	
6am	→ Allow oral feeds fully accepting	6:10 am	→ Allowed oral feeds fully accepting	
8am	→ Ensure the safety needs	8:10 am	→ Ensured the safety needs.	

Re-Assessment: Re assessment done

Special Notes: Advice 3% Nacl + Adrenaline TID 4 nasoclear q4hrly

Nurse Signature:

Nurse Name: neelika

Date & Time: 07/07/26 @ 8am

BAH-00660111 IP5-00175690
Master NAGAMALLA JAYANTH
31-10-2025 0 Y 8 M 6 D (M)
Dr. SANDEEP REDDY



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

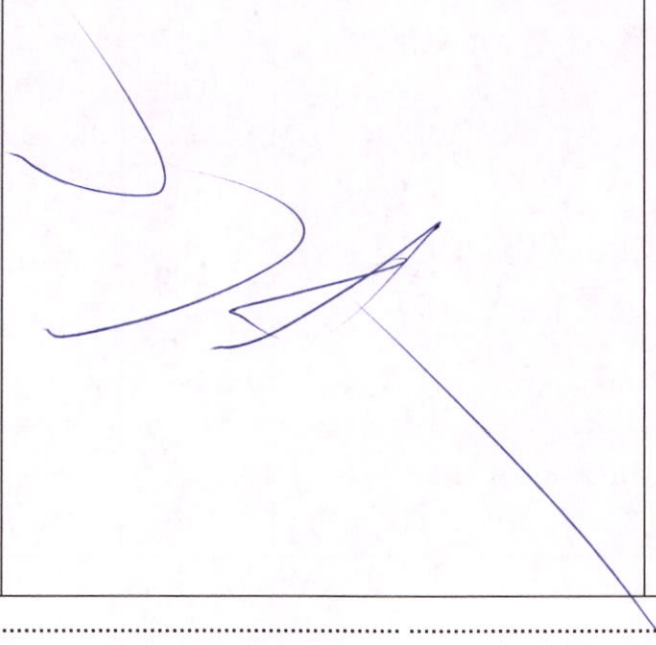
Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
				

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sandeep Reddy Department: 1st floor Date of Admission: 27.06.24

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:			
	<u>Asa Seizures</u>					
BACKGROUND	Area	Shift Time	<u>1st floor</u> <u>8pm - 8am</u>	<u>2nd floor</u> <u>8pm - 8am</u>	<u>1st floor</u> <u>8pm - 8am</u>	<u>1st floor</u> <u>8pm - 8am</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>98.6°F</u>	<u>97.5°F</u>	<u>98.3°F</u>	<u>98.2°F</u>
		Res:	<u>26bpm</u>	<u>26</u>	<u>26bpm</u>	<u>22bpm</u>
		SpO ₂ :	<u>100%</u>	<u>99%</u>	<u>99%</u>	<u>99</u>
		Pulse:	<u>130bpm</u>	<u>116</u>	<u>111bpm</u>	<u>110bpm</u>
		BP:	<u>88/51(62)</u>	<u>96/80</u>	<u>98/60</u>	<u>100/80</u>
		Fall Risk Score:	<u>9</u>	<u>9</u>	<u>0/10</u>	<u>1</u>
Pain Score:		<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>
	Physiotherapy		☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Post Operative Procedure Special Orders:			<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Handed Over By Name :			<u>K. Brauankhi</u>	<u>Anitha</u>	<u>Chandana</u>	<u>Nikitha</u>
Signature :			<u>Braun</u>	<u>AN</u>	<u>Ch</u>	<u>N</u>
Date:			<u>06/07/24</u>	<u>6/7</u>	<u>6/7</u>	<u>7/7</u>
Time:			<u>@ 8am</u>	<u>@ 2pm</u>	<u>@ 2pm</u>	<u>8am</u>
Taken Over By Name :			<u>Anitha</u>	<u>Chandana</u>	<u>Nikitha</u>	<u>Sharada</u>
Signature :			<u>AN</u>	<u>Ch</u>	<u>N</u>	<u>Sh</u>
Date:			<u>6/7/24</u>	<u>6/7</u>	<u>6/7</u>	<u>7/7</u>
Time:			<u>@ 8am</u>	<u>@ 2pm</u>	<u>8pm</u>	<u>8am</u>

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area						
	Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ 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:					
		Safety Needs:					
Recommendations	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:							

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND		DOA : 27/6/26		Diagnosis : Traumatic Brain Injury		Surgery / Procedures :		
		Allergies : NO		Post OP Day : 28-6-2026				
Date :	27/6/26	28/6/26	28/6/26	28-6-2026	29/6/26	30/6/26		
	Area	Area	Area	Area	Area	Area		
Shift Time	PIU right	PIU Day	PIU Night	PIU Day	PIU Night	PIU Day		
	Diet :	NPO	NPO	NPO	NH feed	NH feed	NPO	
Ventilation (RA, NP, NIV, VENTI)	NP	NP	NP	RA	RA	vent		
INVASIVE LINES	1.	Cannula ②	Cannula ②	Cannula ②	Cannula ①	Cannula ②		
	2.	Arterial ①	Arterial ②	Arterial ②				
	3.		Arterial line ①	Arterial line ①				
	4.							
ASSESSMENT	Infusions / Transfusions	DNS	DNS	DNS	DNS	3% NS	DNS	
		3% NS	3-1-NS	3% NS	3% NS		3% NS	
		ABP flush	ABP flush	ABP flush			ADP En	
							MIDAL	
	PU Prophylaxis	NA	NA	NA	NO	NA	NA	
	DVT Prophylaxis	NA	NA	NA	NO	NA	NA	
	Vitals	BP	98/62	98/63	80/73	120/72	127/75	127/75
		PR	171	162b/m	154b/m	124	120	120
		RR	27	28b/m	30b/m	30b/m	45	40
		SpO ₂	100%	99.8%	99.8%	98%	100%	100%
		Temp	98.6°F	99.3°F	99.8°F	98.6°F	98.9°F	100.1°F
	Pain Score	0	0/10	0/10	0/10	0/10	0/10	
	LOC (Alert, Conscious, Confusion, Unconscious)	conscious	conscious	conscious	conscious	conscious	unconscious	
	Skin Integrity (Intact / Bedsore / Any other condition)	Intact	Intact	Intact	Intact	Intact	Intact	
	Restraints If any	NA	NA	NA	NA	NA	NA	
Fall Risk (Vulnerable (Y/N) if yes score)	Yes	Yes	Yes	Yes	Yes	Yes		
(Ambulation, walking, moving with assistance, bed ridden)	Moving	Moving	Moving	Moving	Moving	Red Risk		
ADL (Dependent / Non-Dependent)	Dependent	Dependent	Dependent	Dependent	Dependent	Dependent		
Critical Lab Test / Values (if any)	Nil	Nil	Nil	Nil	Nil	Nil		

Note : RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Investigations Procedures	Date :	27/6/26	28/6/26	28/6/26	29-6-2026	29/6/26	30/6/26
		Area Shift Time	PIU night	PIU Day	PIU Night	PIU Day	PIU Night	PIU Day
Ordered / Planned		Followed doctors Orders	Followed doctors Orders	Followed doctors order	Followed by doctors order	Followed by doctor order	Follow DOCT ORDER	
Due		NO due	NO Due	NO due	NO due	NO due	NO Due	
Reports Pending		Blood c/s reports	NO Reports pending	NO Reports pending	NO reports pending	NO report pending	NO Repos pen	
Referrals (If any)		NO referrals	NO referrals	NO referrals	NO referrals	NO referrals	NO Refers	
Remarks (Special Interventions like, Drainage Tube flushing etc.)		NO remarks	NO remarks	NO Remarks	NO remarks	NO Remarks	NO Remarks	
Handed Over By Name :		Sirajuddin	Vennela	Navaneetha	Vindya	Raj	Rah	
Signature :		S.D	Ven	Nav	Vindya	Raj	Rah	
Date :		28/6/26	28/6/26	28/6/26	29-6-2026	30/6/26	30/6/26	
Time :		@ 8AM	@ 8pm	@ 8AM	8pm	8AM	8PM	
Taken Over By Name :		Vennela	Navaneetha	Vindya	Raj	Rah	Ashu	
Signature :		Ven	Nav	Vindya	Raj	Rah	Ashu	
Date :		28/6/26	28/6/26	28-6-2026	29/6/26	30/6/26	30/6/26	
Time :		@ 8AM	@ 8pm	8am	8PM	8PM	@ 8PM	

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND		DOA :	Diagnosis :	Surgery / Procedures :					
		Allergies :	Post OP Day :						
		Date :	30/6/26	01/07/26	2-7-2026	21/7/26	21/7/26	3/7/26	
		Area	PICU	PICU	PICU	PICU	PICU	PICU	
		Shift Time	Night	Day	Night	Day	Night	Day	
		Diet :	NPO	NPO	Nut feed	Nut feed	Nut feed	Nut feed	
		Ventilation (RA, NP, NIV, VENTI)	Venti	Venti	Venti	Venti	Venti	F/m	
INVASIVE LINES	1.	Cannula	Cannula	Cannula	Cannula	Cannula	Cannula	Cannula	
	2.	Pic line	Pic line	Pic line	Pic line	Pic line	Pic line	Pic line	
	3.	Arterial line	Arterial line	Arterial line	Arterial line	Arterial line	Arterial line	Arterial line	
	4.								
ASSESSMENT	Infusions / Transfusions		DNS	DNS	DNS	DNS	DNS	DNS	
			3% NS	3% NS	3% NS	3% NS	3% NS	3% NS	
			Morphine	Morphine	Morphine	Morphine	Morphine	Morphine	
			Mida 2	Mida 2	Mida 2	Mida 2	Mida 2	Mida 2	
			ABP flush	ABP flush	ABP flush	ABP flush	ABP flush	ABP flush	
	PU Prophylaxis		NA	NA	NA	NA	NA	NA	
	DVT Prophylaxis		NA	NA	NA	NA	NA	NA	
	Vitals	BP	120/70	91/51	101/57	98/72	101/61	120/70	
		PR	125	118	124	160	119b/m	110	
		RR	30	30	30	26	20b/m	34	
		SpO ₂	100%	100%	100%	100%	100%	100%	
		Temp	98.5°F	98.6°F	99.0°F	98.7°F	98.6°F	98.6°F	
	Pain Score		0	0	0	0	0	0	
	LOC (Alert, Conscious, Confusion, Unconscious)		unconscious	unconscious	unconscious	conscious	conscious	conscious	
	Skin Integrity (Intact / Bedsore / Any other condition)		Intact	Intact	Intact	Intact	Intact	Intact	
Restraints If any		NA	NA	NA	NA	NA	NA		
Fall Risk (Vulnerable (Y/N) if yes score)		Yes	Yes	Yes	Yes	Yes	Yes		
(Ambulation, walking, moving with assistance, bed ridden)		Bed ridden	Bed ridden	Bed ridden	Bed ridden	Bed ridden	Bed ridden		
ADL (Dependent / Non-Dependent)		Dependent	Dependent	Dependent	Dependent	Dependent	Dependent		
Critical Lab Test / Values (if any)		Nil	Nil	Nil	Nil	Nil	Nil		

Note : RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Investigations Procedures	Date :	30/6	01/07/26	1-7-2026	2/7/26	2/7/26	3/7/26
		Area	PICU Night	PICU Day	PICU Night	PICU Day	PICU Night	PICU Day
		Shift Time						
Ordered / Planned			Followed doctor's orders	Followed all the doctor's orders	Followed all the doctor's orders	Followed by doctor's orders	Followed doctor's order	Followed by doctor's order
Due			No Due	No due	No due	No due	No due	No due
Reports Pending			No Reports pending	No Reports pending	No Reports pending	No Reports pending	No Reports pending	No Reports pending
Referrals (If any)			No Referrals	No Referrals	No Referrals	No Referrals	No Referrals	No Referrals
Remarks (Special Interventions like, Drainage Tube flushing etc.)			No Remarks	No Remarks	No Remarks	No Remarks	No Remarks	No Remarks
Handed Over By Name :			Ashma	Suchismita	Vindhya	Suchismita	Budhadev	Jyoti
Signature :			Ashma	Suchismita	Vindhya	Suchismita	Budhadev	Jyoti
Date :			01/7	01/07	2-7-2026	2/7/26	3/7/26	3/7/26
Time :			8 AM	8 PM	8 AM	8:00 PM	8 PM	8 PM
Taken Over By Name :			Suchismita	Vindhya	Suchismita	Budhadev	Jyoti	Vindhya
Signature :			Suchismita	Vindhya	Suchismita	Budhadev	Jyoti	Vindhya
Date :			01/07/26	2-7-2026	2/7/26	2/7/26	3/7/26	3/7/26
Time :			8 AM	8 PM	8:00 AM	8 PM	8 AM	8 PM



NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND		DOA : 27/6/26		Diagnosis : Severe TBI		Surgery / Procedures :		
		Allergies : NO		Post OP Day :				
SITUATION & BACKGROUND	Date :	31/7/26	4/7/26	4/7/26	5/7/26			
	Area	ICU	ICU	ICU	ICU			
	Shift Time	PM Night	PM Night	PM Night	PM Day			
	Diet :	NG feed	NG feed	NG feed	NG feed			
	Ventilation (RA, NP, NIV, VENTI)	RA	RA	RA	RA			
INVASIVE LINES	1.	Arterial line	Arterial line	Arterial line	Arterial line			
	2.	Cannula	Cannula	Cannula	Cannula			
	3.	Picc line	Picc line	Picc line	Picc line			
	4.							
ASSESSMENT	Infusions / Transfusions	Picc line flush ABP flush	Picc line flush ABP flush	Picc line flush ABP flush	Picc line flush ABP flush			
	PU Prophylaxis	NA	NA	NA	NA			
	DVT Prophylaxis	air bed	air bed	air bed	air bed			
	Vitals	BP	118/96	112/90	119/60	95/62		
		PR	115	118	120	142 bpm		
		RR	35	38	40	54 bpm		
		SpO ₂	98%	98%	100%	100 ml		
		Temp	98.3°F	98.6°F	98.8°F	98.7°F		
	Pain Score	0/10	0/10	0/10	0/10			
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert	Alert	Alert	Alert			
Skin Integrity (Intact / Bedsores / Any other condition)	Intact	Intact	Intact	Intact				
Restraints If any	Physical NA	Physical NA	Physical NA	Physical NA				
Fall Risk (Vulnerable (Y/N) if yes score)	Yes	Yes	Yes	Yes				
(Ambulation, walking, moving with assistance, bed ridden)	moving	moving	moving	moving				
ADL (Dependent / Non-Dependent)	Dependent	Dependent	Dependent	Dependent				
Critical Lab Test / Values (if any)	Nil	Nil	Nil	Nil				

Note : RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Investigations Procedures	Date :	3/7/26	4/7/26	4/7/26	5/7/26		
		Area						
		Shift Time	pm Night	pm Day	pm Night	pm Day		
		Ordered / Planned	Followed doctor's order	Followed doctor's order	Followed doctor's order	Followed doctor's order		
		Due	no due	no due	no due	no due		
		Reports Pending	no reports pending	no reports pending	no reports pending	no reports pending		
		Referrals (If any)	no referrals	no referrals	no referrals	no referrals		
		Remarks (Special Interventions like, Drainage Tube flushing etc.)	no remarks	no remarks	no remarks	no remarks		
		Handed Over By Name :	Sindhuja	pranali	Raj	Syokhi		
		Signature :	Sindhuja	Pranali	Raj	Syokhi		
Date :	4/7/26	4/7/26	5/7/26	5/7/26				
Time :	8 AM	8 PM	8 AM					
Taken Over By Name :	pranali	Raj	Syokhi	Srishta				
Signature :	Pranali	Raj	Syokhi	Srishta				
Date :	4/7/26	4/7/26	5/7/26	5/7				
Time :	8 PM	8 PM	8 AM	4 PM				

PAIN ASSESSMENT FORM

Date	Time	Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
27/6/26	9:50 AM	0/10	NR	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Penceels
28/6/26	2 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sourinjar
28/6/26	8 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sourinjar
28/6/26	10 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Vennel
28/6/26	1 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Vennel
28/6/26	6 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	nil
28/6/26	10 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Nil
29/6/26	2 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Nil
29/6/26	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Nil
29-6-2026	10 AM	0/10	NR	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NR	Unchitra

Re-assessment Frequency:

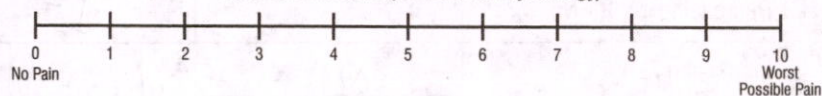
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

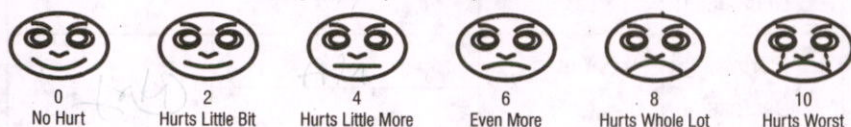
Numerical Pain Scale (Obstetric and Gynecology)



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





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
01/07/26	10AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
01/07/26	2PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
1-7-2026	8pm	0/10	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NO	Vindhye
2-7-2026	12pm	0/10	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NO	Vindhye
2-7-2026	4pm	0/10	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NO	Vindhye
2-7-2026	8pm	0/10	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NO	Vindhye
2-7-26	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	[Signature]
2-7-26	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
2/7/26	10pm	0/10	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NO	[Signature]
2/7/26	2pm	0/10	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NO	[Signature]

Re-assessment Frequency:

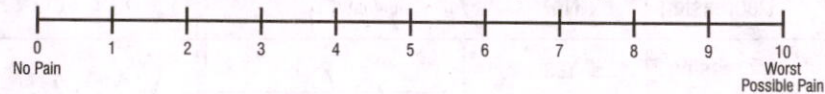
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

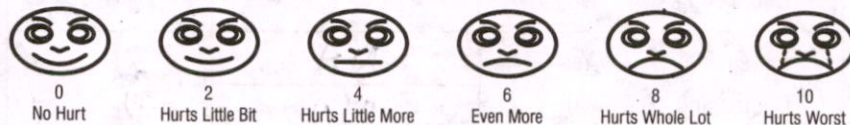
Numerical Pain Scale (Obstetric and Gynecology)



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
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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





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
29-6-2025	2pm	0/10	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NO	Vishaya
29-6-2025	6pm	0/10	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NO	Vishaya
29/6/25	10pm	0/10	RT Hand	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inf-PCM	Res
30/6/25	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Res
30/6/25	6am	0/10	RT hand	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inf-PCM	Res
30/6/25	4pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Res
30/6/25	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Res
30/6	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Res
01/7/25	4pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Res
01/07/25	8AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Res

Re-assessment Frequency:

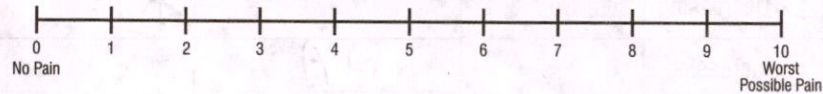
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

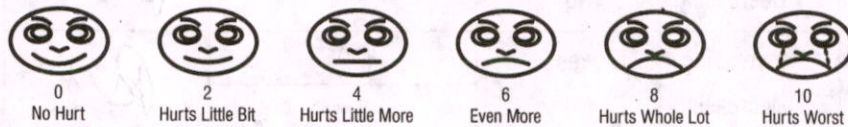
Numerical Pain Scale (Obstetric and Gynecology)



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





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
09/07/26	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Reddy
3/7/26	10AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Reddy
3/7/26	2PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Reddy
3/7/26	6PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Reddy
3/7/26	8PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sindhu
4/7/26	12AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sindhu
4/7/26	8AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sindhu
4/7/26	10AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	prema
4/7/26	6PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	prema
4/7/26	10PM	0/10	NP	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Reddy

Re-assessment Frequency:

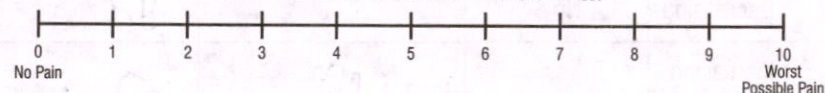
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

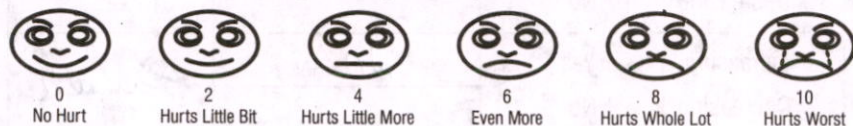
Numerical Pain Scale (Obstetric and Gynecology)



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





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
05/10/25	2 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	for
05/10/25	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	for
05/17	10 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	for
05/17	2 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	for
05/17	6 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	for
05/17	10 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Brave
06/17	2 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Brave
06/17	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Brave!
6/7	2 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Ching
6/7	10 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	N/A

Re-assessment Frequency:

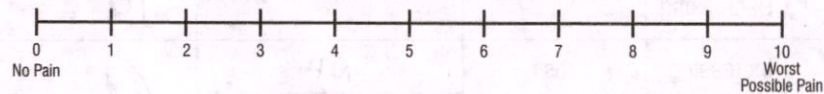
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

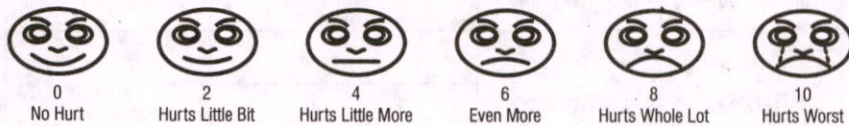
Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
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Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
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Wong - Baker (Pediatrics) Above 7 Years



0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Even More 8 Hurts Whole Lot 10 Hurts Worst



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
26	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	aliki
				☐ 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:

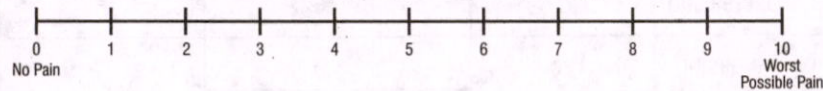
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
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 - Prior to pain relieving intervention.
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PAIN 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

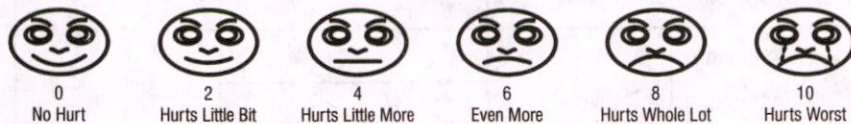
Numerical Pain Scale (Obstetric and Gynecology)



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





BRADEN 'Q' SCALE

					Date :	01/7	2/7	3/7	4/7
					Time :	6AM	6AM	6PM	6PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		3	3	3	3
"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	1	1
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.		3	3	3	3
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.		3	3	3	3
FRICION-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	3	3
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.		2	2	3	3
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.		3	3	3	3
TOTAL SCORE						21	22	19	19
Evaluator's Name						Sandeep Reddy			

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

3AH-00660111 IP5-00175690
 Master NAGAMALLA JAYANTH
 31-10-2025 0 Y 7 M 27 D (M)
 Dr. SANDEEP REDDY



BRADEN 'Q' SCALE

					Date : 27/10/2025	28/10	29/10	30/10
					Time : 9:50 AM	6 AM	6 AM	6 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	3	3	3	3
"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.	3	3	3	3
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.	3	3	3	3
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 mean and dairy products. Occasionally eats between meals. Does not require supplementation.	3	3	3	3
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.	3	3	3	3
TOTAL SCORE					24	24	24	24
Evaluator's Name					Reena	SD	Rhy	SD

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for "At Risk" Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for "Moderate Risk" Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for "High Risk" Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



BRADEN 'Q' SCALE

				Date :	5/11	6/11	7/11	
				Time :	4pm	6am	8am	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	3	3	3	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	1	1	1	
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.	3	3	3	
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.	3	3	3	
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."	3	3	3	
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.	3	3	3	
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.	3	3	3	
				TOTAL SCORE	19	19	19	
				Evaluator's Name	Dr. Sandeep F Eddy	Dr. Sandeep F Eddy	Dr. Sandeep F Eddy	

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



THE HUMPTY DUMPTY SCALE 27/6 28/6 29/6 30/6 01/7

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	✓	✓	✓	✓
Call device within reach	YES	X	X	X	X
Wheels Locked	YES	✓	✓	✓	✓
Room free of clutter	YES	✓	✓	✓	✓
Adequate Lighting	YES	✓	✓	✓	✓
Wheel Chair Support	NO	X	X	X	X
Other Intervention(s) Specify	NO	X	X	X	X
Nurse's Name :		S. S. S.	S. S. S.	S. S. S.	S. S. S.
Signature :		[Signature]	[Signature]	[Signature]	[Signature]
Date :		27/6	28/6	29/6	30/6
Time :		9:30 AM	6 AM	6 AM	4 PM

BAH-00660111
Waster NAGAMALLA JAYANTH
31-10-2025
Dr. SANDEEP REDDY
IP5-00175690
0 Y 8 M 0 D
(M)

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

2/1 3/2 4/2 2/2

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	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	
	Female	1					
Diagnosis	Neurological Diagnosis	4	4	4	4	4	
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3	3	3	3	3	
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	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	
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3	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	
Total			17	17	17	17	

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	
Call device within reach	No	No	No	Yes	
Wheels Locked	Yes	Yes	Yes	Yes	
Room free of clutter	Yes	Yes	Yes	Yes	
Adequate lighting	Yes	Yes	Yes	Yes	
Wheel chair support	No	No	No	No	
Other Intervention(s) Specify	No	No	No	No	
Nurse's Name:	Vineetha	Vineetha	Vineetha	Vineetha	
Signature:	Vineetha	Vineetha	Vineetha	Vineetha	
Date:	2-7-2023	3/11	4/11	2/2	
Time:	6:20	6:20	6:20	6:20	

THE HUMPTY DUMPTY SCALE *SH del 07*

PARAMETER	CRITERIA	SCORE	DATE <i>6am</i>	DATE <i>6am</i>	DATE	DATE	DATE
Age	Less than 3 years old	4	<i>4</i>	<i>4</i>			
	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	<i>2</i>	<i>2</i>			
	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	<i>1</i>	<i>1</i>			
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	<i>1</i>	<i>1</i>			
	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	<i>2</i>	<i>2</i>			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	<i>1</i>	<i>1</i>			
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	<i>1</i>	<i>1</i>			
Total			<i>12</i>	<i>19</i>			

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		<i>✓</i>	<i>✓</i>			
Call device within reach		<i>✓</i>	<i>✓</i>			
Wheels Locked		<i>✓</i>	<i>✓</i>			
Room free of clutter		<i>✓</i>	<i>✓</i>			
Adequate lighting		<i>✓</i>	<i>✓</i>			
Wheel chair support		<i>x</i>	<i>x</i>			
Other Intervention(s) Specify		<i>x</i>	<i>x</i>			
Nurse's Name:		<i>Raj</i>	<i>Shravya</i>			
Signature:		<i>Raj</i>	<i>Shravya</i>			
Date:		<i>SH</i>	<i>del 07</i>			
Time:		<i>4pm</i>	<i>6am</i>			



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		
2	One of the following signs is evident: * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			-	-	-	-	-	-		
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			-	-	-	-	-	-		
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			-	-	-	-	-	-		
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			-	-	-	-	-	-		
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-	-	-	-	-		
Signature of the Nurse						SD	Vel	Vel	Vel	Vel	Vel		

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 : Sani Name : Sani

Signature of Ward In Charge :

Signature : d Name : Birth



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		
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	1	-	-	-	-	-	-	-	Changed Cannula	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-	-	-	-	-		
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-	-	-	-	-	-		
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-	-	-	-	-	-		
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-	-	-	-		
Signature of the Nurse													

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 : Name :

Signature of Ward In Charge :

Signature : Name :



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		
2	One of the following signs is evident: * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-	-	-	-	-	-		
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-	-	-	-	-		
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-	-	-	-	-	-		
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-	-	-	-	-	-		
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-	-	-	-		
Signature of the Nurse				[Signature]									

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personnel ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : [Signature] Name : [Signature]

Signature of Ward In Charge :

Signature : [Signature] Name : [Signature]



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	6	0	0							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-							
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		-	-							
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-							
Signature of the Nurse													

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 : _____ Name : _____

Signature of Ward In Charge :

Signature : _____ Name : _____



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: *Telugu* 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		
22/6/20	9:00 AM	7	Infection control measures	M	4	0	1	1	-	Pen
22/6	9 AM	9	child on NPO	M	1	0	1	1	-	neela
3/7	8 PM	9	Diet NA feeds	M	1	0	1	1	-	Sindhu

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

Diagnosis:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
27/6/20	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Seizure Activity x Today x 7 pm.	H-Stability	CT Head	pavan.	☐ Nursing ☐ Others:
22/6/20	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Traumatic Brain Injury	H-Stability	IV fluids & IV medication		☐ Medical ☐ Others:
28/6/20	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Traumatic Brain Injury	H-Stability	IV fluids & IV antiepileptics	Venula	☒ Medical ☐ Nursing ☐ Others:
30/6	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Traumatic Brain Injury	H-Stability	Continue 3rd MS @ medication as per chart		☐ Medical ☒ Nursing ☐ Others:
30/6/20 8am	☐ Medical ☐ Nursing ☒ Others: Dietician	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	TBI	Child is on NPO	NPO till further advise	Mounica	☐ Medical ☐ Nursing ☒ Others:

URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 30/6/26

Date of Removal: 01/07/26

Parameters	Date	Shift Time	30/6/26 Day	30/6/26 Night	01/07/26 Day	1-7-2026 Night	2/7/26 Day	2/7/26 Night	3/7/26 Day
Need for the Catheter			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Hand Hygiene			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Usage of Sterile Equipment			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Is the Collection bag below the level of bladder			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Is Catheter dated as policy			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Collecting bag is been emptied regularly?			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Maintenance of closed system for the catheter			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Dressing clean and dry?			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Is the line removed as Policy?			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Performance of Perineal Care			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Onset of New Fever			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Asses for the leakage at the site of insertion			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Name of the Nurse			Rahit	Ashme	Suchismita	Vindya	Suchismita	Bhadradev	Sulbha
Signature of the Nurse			SR	Ashme	Suchismita	Vindya	Suchismita	Bhadradev	Sulbha



CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

Type of Line: ☒ PICC Line ☐ UAC ☐ UVC ☐ Other Date of Initial Line Insertion: 01/07/26 Duration of Central Line:

- Always perform hand hygiene before accessing central line
- Use Sterile gloves for handling central line
- Clean the hub with antiseptic solution every time before & after it is accessed
- Consider – antibiotic via central line before removal of the line
- Inspect Central line in each shift for the following

Parameters	Date	Shift Time	01/07/26 Day	1-7-2026 Night	2/7/26 Day	2/7/26 Night	3/7/26 Day	3/7/26 Night	4/7/26 Day
Can we remove Central Line today (Discuss in the clinical round)	☐ Yes ☒ No		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Evidence of any inflammation at insertion site (Redness / Swelling (If yes inform the doctor)	☐ Yes ☒ No		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Blood at insertion site (If yes inform the doctor)	☐ Yes ☒ No		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Any peeling of dressing? (If yes inform the doctor)	☐ Yes ☒ No		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Is dressing clean and dry? (If no inform the doctor)	☒ Yes ☐ No		☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Any leakage at insertion site? (If yes inform the doctor)	☐ Yes ☒ No		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Is there any obstruction to the infusion flow? (If yes inform the doctor)	☐ Yes ☒ No		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Dressing intact and labelled properly	☒ Yes ☐ No		☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Central line changed on	NA		NA	NA	NA	NA	NA	NA	NA
Name of the Nurse	Suchismita		Vinodha	Suchismita	Suchismita	Suchismita	Suchismita	Suchismita	Suchismita
Signature of the Nurse	[Signature]		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]

VENTILATOR CARE BUNDLE CHECK LIST

Date of Intubation: 30/6/26 No of Days on Ventilation: 1 Date of Tracheostomy:

Parameters	Date	Shift Time	30/6/26 Day	30/6 Night	01/07/26 Day	1-7-2026 Night	2/7/26 Day	2/7/26 Night	3/7/26 Day
Ready for Extubation today? (Discuss during the clinical round)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☒ Yes ☐ No	☒ Yes ☐ No
Is Sedation holiday discussed? (Discuss during the clinical round)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☒ Yes ☐ No	☒ Yes ☐ No
Is Ventilator Circuit visibly soiled? (If Yes - Please Change)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Is Suction container visibly Soiled? (If Yes - Please Change)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Inline Suction Used?			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Is AMBU bag soiled? (If Yes - Please Change)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Check AMBU bag kept in a clean, Non-Sealed plastic bag? (If No - please change)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Is there condensate in the ventilatory circuit? (If Yes - drain away from the patient)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Is Head End elevated by 15°-30° (for neonates 10°-15°)? (If No - please change)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Oral and Nasal Care every 4 Hrs			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Mouth Care with EBM (Only for Neonatal Patient)			☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA
Is ET / Oral Suction needed (2nd hrly)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Sterile Suctioning Done			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
DVT Prophylaxis			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Name of the Nurse			Ravi	Ashma	Suehismith	Vindya	Suehismith	Buddhader	Suehismith
Signature of the Nurse			[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]



BED SIDE CHECK LIST FOR NURSES

Date:	28/6/26	29/6	30/6	01/7	2-7-2026	3/7/26	4/7/26	5/7
Doctor's Orders	Followed	Followed	following	Followed	Followed	Followed	Followed	following doctor's.
Carried out or not	carried out	carried out	carried out	Carried out	Carried out	Carried out	carried out	Carried
Bed Side			clean				clean	clean
Structured Handover done	Done	done	Done	Done	Done	Done	done	done
IV Site	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Central Lines	NO	NO	NA	Yes	Yes	Yes	NA	Yes
Arterial Lines	Yes	Yes	NA	Yes	Yes	Yes	Yes	Yes
Feeding Catheter	NO	NO	Yes	Yes	Yes	Yes	Yes	NA
Urinary Catheter	NO	NO	NA	Yes	Yes	Yes	NA	NA
Skin Care	Yes	Given	Yes	Given	Given	Given	Given	Yes
Eye Care	Yes	Given	Yes	Given	Given	Given	Given	Yes
Mouth Care	Yes	Given	Yes	Given	Given	Given	Given	Yes
Sterillum Bottle, Stethoscope	Bed side	Bed side	Bed side	Bed side	Bed side	Bed side	Bed side	Bed side
Suction Bottle (Should be clean & empty)	clean	clean	empty	Empty	Empty	Empty	empty	empty
Intubation Tray	Ready	Ready	Ready	Ready	Ready	Ready	Ready	Ready
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	Loaded	Loaded	Loaded	Loaded	Loaded	Loaded	Loaded	Loaded
Ventilator Tubing, (Any Water, Blood)	NO	NO	NO	NO	NO	NO	NA	NA
Humidification	NO	NO	NA	Yes	Yes	Yes	Yes	NA
Check all Infusion (Labelling, Correct Preparation)	Labelling	Labelling	Labelling	Labelling	Labelling	Labelling	Labelling	Labelling
Chest Physio & Neb	NO	NO	NO	NO	NO	NO	NA	NA
Handed Over By Name :	S.P	Sanveetha	Ray	Thiru	Indya	Sanveetha	Sanveetha	Ray

Checked & Handover given by

Name of the Nurse : Soumyadip

Signature : Soumyadip

Date & Time : 28/6/26 @ 12 AM

Checked & Handover taken by

Name of the Nurse : Vennela

Signature : Vennela

Date & Time : 28/6/26 @ 8 PM

BAH-00660111 IP5-00175690
Master NAGAMALLA JAYANTH
31-10-2025 0 Y 7 M 27 D (M)
Dr. SANDEEP REDDY



IN
CARE UNIT

Rainbow®
Children's
Hospital
It takes a little more time.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: NAGAMALLA JAYANTH Age: Gender: Male ☒ Female ☐

UHID.No: Date: 27/06/2026

I Vasantha S/o, D/o, W/o, Venkanna hereby
declare that our patient Master/Baby who is related to me as Grand son
is getting admitted in the Pediatric Intensive Care Unit of Rainbow Children's Hospital on 27/6/26

The doctors have explained to me in a language understood by me that my child has following health related issues :

Seizures, vomitings, fever

The doctors have clearly explained to me that my patient Master / Baby during his /
her stay in the Pediatric Intensive Care Unit may undergo various medical and surgical procedures like airway management,
mechanical ventilation, Central Line Insertion, Peripherally Inserted Central Catheter Line and arterial line placements, chest drain,
or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure
shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is implied
that I give consent for various invasive procedure to save the life of my child. I understand that a sick child in Pediatric Intensive Care
Unit has life threatening medical conditions.

I understand that when a child is sick in the Pediatric Intensive Care Unit with multiple medical and surgical procedures performed
upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of infections,
bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child Master / Baby :

in the Pediatric Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved
from various procedures, high risk medications and infections in the Pediatric Intensive Care Unit and treat him/her with all
necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant : chas oes

Signature: Vasantha

Name: Vasantha

Relationship with Patient: Grand mother

Date & Time: 27/06/26 : 10:25 PM

Doctor (who is taking the consent) :

Signature: Bharath

Name: BHARATH REDDY

Date & Time: 27/06/2026 : 10:30 PM

Docu. No. : RCHBH / FRM / CLINICAL / 013

Witness :

Signature: Ravi

Name: Ravi

Date & Time: 27/6/26 @ 10:30 PM

**పిల్లల ఇంటెన్సివ్ కేర్ యూనిట్ లో
అడ్మిషన్ కొరకు సమ్మతి**

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

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

రోగి పేరు వయస్సు లింగం ☐ పు ☐ స్త్రీ

యు.హె.ఐ.డి ☐

నేను s/o. d/o. w/o.

..... అనే బాలుడు / బాలిక యొక్క బికిత్త మేరకు రెయిన్సీ పిల్లల అనుపత్తి లోని పిల్లల ఇంటెన్సివ్ కేర్ యూనిట్

తేదీ నాడు పూర్తి సమ్మతితో చేర్చితిని.

మా బాలుడి / బాలిక లో ఈ కింద తెలిపిన ఆరోగ్య సమస్యల గురించి బిద్నూ నిపుణుడు నాకు అర్థమగు భాషలో వివరించితిరి.

.....

రెయిన్ బో బిల్డ్స్ హాస్పిటల్ లోని పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో చేరించి జిడ్డుకు ఆరోగ్య సంబంధిత సమస్యలు ఉన్నాయని వైద్యులు నాకు అర్థమయ్యే భాషలో వివరించారు. రోగి పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో ఉన్న సమయంలో అతను వివిధ వైద్య మరియు శస్త్ర చికిత్సలకు లోనవుతారని వైద్యులు నాకు స్పష్టంగా వివరించారు. ఎయిర్ వే మేనేజ్ మెంట్, మెకానికల్ వెంటిలేషన్, బొడ్డు ధమని కాథెటర్, బొడ్డు నీర మరియు ధమనుల కాథెటర్ వంటి. పెరిపెరల్ ఇన్ఫర్జన్ చేయబడిన నెంట్రిల్ కాథెటర్ లైన్ మరియు ఆర్టిబి లైన్ ప్లేస్ మెంట్స్, ఛాతీ డ్రైయిన్ లేదా పెరిటోనియల్ డ్రైయిన్ ఇన్సర్షన్ మొదలైనవి.

అటువంటి ప్రక్రియలు చేస్తున్నప్పుడు నాకు సమాచారం ఇవ్వబడుతుందని మరియు దీనికి ప్రత్యేక సమ్మతి ఉంటుందని వైద్యులు నాకు చెప్పారు. ఏదేమైనప్పటికీ, ఏదైనా ప్రాణాంతక అత్యవసర పరిస్థితుల్లో సమాచారం తీసుకోవడానికి సమయం లేకపోతే నా జిడ్డు ప్రాణాన్ని కాపాడేందుకు ఇతర వైద్య ప్రక్రియలకు నేను సమ్మతి ఇస్తున్నాను.

పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో అనారోగ్యంతో ఉన్న పిల్లవాడికి ప్రాణాంతకమైన వైద్య పరిస్థితులు ఉన్నాయని అర్థం చేసుకోవడమైనది.

ఒక జిడ్డు అనారోగ్యంతో పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో ఉన్నప్పుడు అతని/ఆమెపై నిర్వహించబడు అనేక వైద్య మరియు శస్త్రచికిత్సా విధానాలతో ఈ అధిక ప్రమాదకరమైన విధానాల వల్ల సంభవించు నష్టాలు మరియు అధిక ప్రమాదకరమైన మందుల రూపంలో అంటువ్యాధులు, రక్తస్రావం, శ్వాసపరమైన, చర్మం మరియు ఇతర కణజాల నష్టం మొదలైనవి కలగవచ్చు. డాక్టర్లు నాకు బాగా అర్థమయ్యే భాషలో వివరించారు.

మా బాలుడు / బాలిక ను ఇంటెన్సివ్ కేర్ యూనిట్ (పి.ఐ.సి.యు) లో చేర్చుకొని అవసరమయ్యే వైద్యం చేయుటకు నేను వైద్య బృందానికి నా సమ్మతి ద్వారా వదులుస్తున్నాను.

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకము

పేరు

పేరు

వైద్యుడు (ఏవరైజ్ సమ్మతి తీసుకుంటున్నారో)

తేదీ మరియు సమయము

సంతకము

పేరు

DOCU.No.: RCHBH/FHM/CLINICAL/013

BAH-00660111 IP5-00175690
 Master NAGAMALLA JAYANTH
 31-10-2025 0 Y 7 M 29 D (M)
 Dr. SANDEEP REDDY



Moderate Sedation Flow-Sheet

Immediate Pre-Sedation Assessment

B.P	PR	R.R	Temp	SPO ₂	Pain Score	Weight
	160	30	97.6 F	98%		7 kg

Diagnosis: RTA - Injury disorder

Procedure: MRI BRAIN + MR Angiogram

Comorbidities:

- ☒ Risk, benefits & alternatives discussed;
- ☐ Patient understand & elects to proceed
- ☒ Consents for procedure and sedation signed and dated

ASA Physical Status

- ☐ ASA PS 1: Healthy Patient
- ☐ ASA PS 2: Mild Systemic Disease, no functional limitations
- ☐ ASA PS 3: Severe Systemic Disease, functional limitations
- ☐ ASA PS 4: Severe Systemic Disease, constant threat to life
- ☐ ASA PS 5: Moribund Patient unlikely to survive 24 hrs.
- ☐ ASA PS 6: A declared braindead patient whose organs are being removed for donor purposes

☐ E: Emergency procedure

GCS: E M V

☒ IV Site: (U) 1cc Gauge: 26G

Sedation Plan: sedation

Allergies:

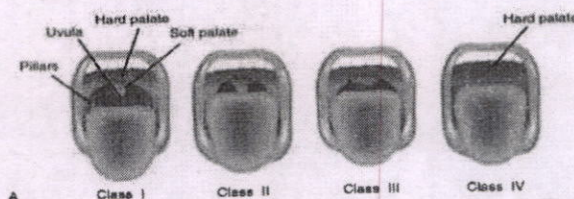
AIRWAY EVALUATION

Mouth:

- ☒ Normal
- ☐ Loose Teeth
- ☐ Small Mouth
- ☐ Protruding Incisors
- ☐ Receding Lower Jaw
- ☐ Dentures

Neck:

- ☐ Normal
- ☐ Decreased ROM
- ☐ Thyromental Distance Less Than 6 cm
- ☒ Short Neck



Mallampati Class: ☐ I ☐ II ☐ III ☐ IV

Monitoring of Patient Intra - Procedure

Procedure Monitoring

Heart Rate (HR), Respiratory Rate (RR), Oxygen Saturation (O₂ Sat) continuously monitored, and Level of Consciousness (LoC) to be monitored and recorded minimally every 15 minutes until 15 minutes after the last administration of any sedation, then every 30 minutes, then every 1 hour until stable. Respiratory status to be monitored continuously.

Level of Consciousness (LOC):

- ☐ A - Alert
- ☐ V - Verbally Responsive
- ☐ P - Painfully Responsive
- ☐ U - Unresponsive

TIME	BP	PR	RR	O ₂ Sat%	O ₂ Supplementation	Comments / Initials
Baseline						
9:45 AM		160	30	99%	6 L/min	
9:50 AM		166	30	99%	6 L/min	
10:15 AM		158	28	98%	6 L/min	

Stamp

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

BAH-00660111 IP5-00175690
Master NAGAMALLA JAYANTH
31-10-2025 0 Y 7 M 28 D (M)
Dr. SANDEEP REDDY



Patient Name : NAGAMALLA JAYANTH Age : Gender : Male ☐ Female ☐

UHID NO: Surgeon Name:

Anaesthesiologist : DR ADITI

Operative procedure planned : MRI BRAIN

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 without numbness can be achieved by infusing weak solutions of local anesthetics 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 mellitus | ☐ Renal failure |
| ☐ Hepatic disorders | ☐ Shock | ☐ Multiple organ failure | ☐ Polytrauma / Renal Tubular Acidosis |
| ☐ Incapacitating Chronic Obstructive Pulmonary Disease | | | |

☐ Others : DESATURATION, BRADYCARDIA, LARYNGOSPASM

- Comments :
- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient NAGAMALLA JAYANTH the above mentioned operation / Diagnostic / Therapeutic procedures MRI BRAIN

I authorize and give consent for anaesthesia (☐ Regional / ☐ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

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, asthmatic reactions, headaches.

I authorize the anaesthetic team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I 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 in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant: ☐ Yes ☒ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / Monitored Anesthesia Care to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

Patient / Patient Attendant :

Signature : N. Venkanna

Name : N. Venkanna

Relationship with Patient: elder father

Date & Time : 28/6/26 @ 11pm

Witness :

Signature : R. Srinath

Name : R. Srinath

Date & Time : 28/6/26 @ 11pm

Doctor (who is taking the consent) :

Signature : Dr. Aditya W

Name : Dr. Aditya W

Date & Time : 28/6/26 @ 11pm

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

BAH-00660111 IP5-00175690
Waster NAGAMALLA JAYANTH
31-10-2025 0 Y 7 M 28 D (M)
Dr. SANDEEP REDDY

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: Age: UHID.No:
Date: 21/6/26 Time: 6.45 Proposed Operation: MRI BRAIN + MR angiogram
Diagnosis: seizure disorder (CRTA) TBI
B.P / CRT: 96/68 H.R: 215/min Weight: 7Kg ASA Physical Status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:
Hgb: 7.2 → calm: 166/min! (fist) Glucose: 6.8 Protein: 4.1 HIV: X-Ray:
PCV: 24.3 Urea: 18 Alb: 4.1 HBS Ag: ECG:
WBC: 3.29 Creat: 0.2 Total Bill: 0.4/ HCV: 2D Echo:
Plate: 254000 Na: 133 Dir. Bill: 0.1/ Blood group: Stress/Angio:
PT: 14 K: 5.1 LDH: T3 Other:
PTT: 30 Ca++: 9.7 Alk phos: 37 T4
INR: 1 Mg++: Amylase: 39/38 TSH
Cl-: 100 SGOT/SGPT: 39/38

Allergies: NKOT

Medical History: CVS: RTA → taken to OSMAWASH free (P)
RESP: CT Breat SDH (RT side) Diabetes:
CNS: persistent seizure & multiple injury
Renal: E3 V2 M4
Hepatic / GE: RT humerus condylar #. present Physical Activity:
Others: RT humerus supracoracoid

Past Anaesthetic History:

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Mentohyoid Distance: Neck: Teeth:
Lungs: AERBE
Heart: S1S2
CNS: E3V2 M4 Arthralgia RUL
Pregnant: ☐ Yes ☐ No ☒ NA Venous Access Site: Spine Exam for regional:
IV LUL

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

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

CURRENT MEDICATIONS	DOSAGE
INT LEFTRIXONE	350mg 12 hourly
INT LEVITEL	
INT LACOSAMIDE	
INT PARACETAMOL	

Pre-Operative Instructions:

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

Signature: Name: Dr. Adarsh

→ give morning dose of antiplatelet before surgery for MRI
→ if Tachycardia persistent even in morning
→ consent document

BAH-00660111 IP5-00175690
Master NAGAMALLA JAYANTH
31-10-2025 0 Y 7 M 29 D (M)
Dr. SANDEEP REDDY



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Time Received : 10:00am 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>Lt leg</u> ☐ O ₂ Mask ☐ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ 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 : <u>Nil</u> Oral Feeds : <u>Nil</u>

POST ANAESTHESIA SCORE (Modified Aldrete Score)	IN	MINUTES			OUT	SCORING INTERPRETATION
		30	60	90		
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0	ACTIVITY	2	2	2		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 deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION	1	2	2		
BP $\pm$ 20 of Pre Anaesthetic level = 2 BP $\pm$ 20-50 of Pre Anaesthetic level = 1 BP $\pm$ 50 of Pre Anaesthetic level = 0	CIRCULATION	1	2	2		
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	1	2	2		
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	1	2	2		
TOTAL		6	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
29-6-2026	10:00am	0/10	Nil	Vinodhya

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

Anaesthesiologist Name :

Anaesthesiologist Signature:

Date & Time:

PACU Nurse Name : Vinodhya

PACU Nurse Signature: Vinodhya

Date & Time: 29-6-2026 10:00am

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: 29-6-2026 10:00am

EPIDURAL ANALGESIA RECORD

Date and Time :



CONSENT FORM FOR RESTRAINT

Patient Name : Jayanth. N UHID No : AAH - 0066011
Gender: ☐ Male ☐ Female Age : Date of Restraint : 30/06/26 Time of Restraint : 5:30pm

Type of Restraint:

Physical : ☒

Chemical : mouth

Duration of Restraint :

Any likely complications: ☐ Hypotension ☐ Bradycardia ☐ Injury to skin

Any alternatives: ☐ Yes ☐ No if 'Yes' Specify:

I have been explained the risk, benefits and alternatives of the same in the language that I know.

Patient Attendant :

Signature : [Signature]

Name : Bharadwaj

Relationship with Patient:

Date & Time : 30/6/26 @ 5:30pm

Witness :

Signature : Rahul

Name : Rahul

Address : Rainbow hostel.

Contact No: -

Date & Time: 30/6/26 @ 5:50pm

Doctor (who is taking the consent) :

Signature : [Signature]

Name : [Signature]

Date & Time : 30/06/26 5:30pm

నియంత్రణ కోసం సమృత్తి ఫారమ్

రోగి పేరు యు.హెచ్.బి.డి

వయస్సు లింగం పు స్త్రీ నియంత్రణ సమయం నియంత్రణ రకం:

నియంత్రణ రకాలు:

భౌతిక

రసాయన

నియంత్రణ యొక్క వ్యవధి

ఏదైనా సమస్యలు సంభవించే ఆస్కారం: అధిక రక్తపోటు గుండె తక్కువ వేగం తో కొట్టుకొనుట (బ్రాడీకార్డియా)

చర్మానికి గాయం

ఏదైనా ప్రత్యామ్నాయాలు అవును కాదు

నాకు తెలిసిన భాషలో వాటి వల్ల కలిగే నష్టాలు ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు వివరించబడ్డాయి

సహాయకుడు (అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమృత్తి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము



CONSENT FOR SPECIAL PROCEDURES

Patient Name : NAGAMALLA JAYANTH Gender: ☒ Male ☐ Female

UHID No : BAH - 0060111 Department : _____ Date : _____

I _____ S/D/W/O _____

Here by give consent for procedure of : PICC line

For my patient, Named : _____

The doctors have clearly explained to me that the procedure has following possible complications:

Bleeding, Infection.

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

Nil.

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr. Vikas

Patient Attendant :

Signature : [Signature]

Name : Raminder

Relationship with Patient: Father

Date & Time : 30/6/26 @ 6pm

Witness :

Signature : [Signature]

Name : Rahul Sapat

Date & Time : 30/6/26 @ 6pm

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Mathew

Date & Time : 30/6/26 6pm

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

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నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము



CONSENT FOR SPECIAL PROCEDURES

Patient Name : NAGAMALLA JAYANTH Gender: ☒ Male ☐ Female

UHID No : BAH-6066011 Department : _____ Date : _____

I _____ S/D/W/O _____

Here by give consent for procedure of : Foley's catheterization

For my patient, Named : _____

The doctors have clearly explained to me that the procedure has following possible complications:

bleeding, infection

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

NI

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr. Dhruva

Patient Attendant :

Signature : Rui

Name : Ravindra

Relationship with Patient: Father

Date & Time : 30/6/26 @ 6pm

Witness :

Signature : Rahul

Name : Rahul

Date & Time : 30/6/26 @ 6pm

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Nathan

Date & Time : 30/6/26 6pm

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

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నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము



CONSENT FOR SPECIAL PROCEDURES

Patient Name : NAGAMALLA JAYANTH Gender: ☒ Male ☐ Female

UHID No : BAH-006011 Department : _____ Date : _____

I _____ S/D/W/O _____

Here by give consent for procedure of : Intubation ✓

For my patient, Named : _____

The doctors have clearly explained to me that the procedure has following possible complications:

pneumothorax, infection,

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

Nil.

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: DR. prathusha

Patient Attendant :
Signature : [Signature]

Name : Prathusha

Relationship with Patient: Father,

Date & Time : 30/6/26 @ 4:30pm

Witness :
Signature : Rahul

Name : Rahul

Date & Time : 30/6/26 @ 4:30 PM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. natheer

Date & Time : 30/6/26 4:30pm

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

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నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు (అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము



CONSENT FOR SPECIAL PROCEDURES



Patient Name : Gender: ☒ Male ☐ Female

UHID No : Department : PICU Date : 27/06/26

I Vasanth S/D/W/O Venikanna

Here by give consent for procedure of : Arterial line

For my patient, Named :

The doctors have clearly explained to me that the procedure has following possible complications:

Infection, bleeding, Hematoma

The doctor have explained to me about the alternatives, risks and benefits for this procedure that : no!

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr. Sukanya

Patient Attendant :

Signature : [Signature]

Name : Vasantha

Relationship with Patient: Grand Mother

Date & Time : 27/06/2026 ; 10:45PM

Witness :

Signature : [Signature]

Name : Ravi

Date & Time : 27/6/26 @ 10:45PM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : BHARATH REDDY

Date & Time : 27/06/2026 ; 10:46PM

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం పురుషుడు స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

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నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము



CONSENT FOR BLOOD TRANSFUSION

Name: NAGAMALLA JAYANTH Age: 8m Gender: Male ☒ Female ☐
UHID.No: BAH-00660111 Date: 30/6/26

Type of Blood Product: ☐ Fresh Frozen Plasma ☒ Packed Red Blood Cells ☐ Random Donor Platelets
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood
☐ Albumin ☐ Red Blood Cell ☐ Others

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

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

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

Patient (Or Patient Relative / Guardian):

Signature: CHAS 2008

Name: CHAS 2008

Date & Time: 30/06/26 @ 2:00p

Doctor (Who is talking the consent)

Signature: Tyoti

Name: Dr Tyoti

Date & Time: 30/06/26 2:00pm

Witness

Signature: Rahul

Name: Rahul Satpati

Date & Time: 30/06/26 @ 2:00pm

రక్త మార్పిడి కొరకు అంగీకార పత్రము

రోగి పేరు: వయస్సు: లింగము ☐ పురుషుడు ☐ స్త్రీ
UHID. సంఖ్య: తేదీ:

రక్త ఉత్పత్తి రకాలు:

- | | | |
|---|---|---|
| ☐ తాజా ఘనీభవించిన ప్లాస్మా | ☐ ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు | ☐ Random Donor Platelets |
| ☐ క్రయాప్రెసిపిటేట్ | ☐ ఒకే ధాత స్టేటిలెట్స్ | ☐ Whole Blood |
| ☐ మొత్తం రక్తం | ☐ ఎర్ర రక్త కణం | ☐ ఇతరులు..... |

నేను ఇందు మూలముగా రెయిన్ఫీ ఆసుపత్రిలో ఆడ్మిట్ అయి ఉన్నప్పుడు పూర్తి బిక్త్రులో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికి/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హెచ్ బి యాంటీ బిడిన్, హైపటెటిస్ బి సర్వేస్ యాంటీజెన్, హైపటెటిస్ యాంటీబిడిన్, మలేరియా మరియు సిఫ్టిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణయకాల పరిమితిలో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెల్లత్తవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు

పైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి బిక్త్రు చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. బిక్త్రు చేస్తున్న సమయంలో అన్ని రక్తముల రక్తమార్పిడులకు (మొత్తం రక్తం / లేదా రక్త ఉత్పత్తులు ప్లాక్ చేయబడి ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ప్రిప్ ప్రోజెన్ ప్లాస్మా, క్రయాప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకం

పేరు

పేరు

తేదీ మరియు సమయము

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

CONSENT FOR BLOOD TRANSFUSION



3AH-00660111 IP5-00175690
 Master NAGAMALLA JAYANTH
 31-10-2025 0 Y 8 M 1 D (M)
 Dr. SANDEEP REDDY



Name: Age: 8 months Gender: Male ☒ Female ☐
 UHID.No : Date: 01/07/26

Type of Blood Product: ☐ Fresh Frozen Plasma ☐ Packed Red Blood Cells ☐ Random Donor Platelets
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood
☐ Albumin ☐ Red Blood Cell ☒ Others DVB

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

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

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

Patient (Or Patient Relative / Guardian):

Signature: [Signature]

Name: [Name]

Date & Time 01/07/26 at 03:30

Doctor (Who is talking the consent)

Signature: [Signature]

Name: [Name]

Date & Time 01/07/26 @ 3:30 PM

Witness

Signature: [Signature]

Name: [Name]

Date & Time 01/07/26 @ 3:30 PM

రోగి పేరు: వయస్సు: లింగము ☐ పురుషుడు ☐ స్త్రీ
UHID. సంఖ్య: తేదీ:

రక్త ఉత్పత్తి రకాలు:

- | | | |
|---|---|---|
| ☐ తాజా ఘనీభవించిన ప్లాస్మా | ☐ ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు | ☐ Random Donor Platelets |
| ☐ క్రయోప్రెసిపిటేట్ | ☐ ఒకే ధాత ఫ్లేటిలెట్స్ | ☐ Whole Blood |
| ☐ మొత్తం రక్తం | ☐ ఎర్ర రక్త కణం | ☐ ఇతరులు..... |

నేను ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడి/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. ధాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడీస్, హైపటెటిస్ జి సర్ఫేస్ యాంటిజన్, హైపటెటిస్ యాంటిబడీస్, మలేరియా మరియు సిఫిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణయ కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలెత్తవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు

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

సహాయకుడు(అటెండెంట్)	సాక్షి
సంతకము	సంతకం
పేరు	పేరు
తేదీ మరియు సమయము	తేదీ మరియు సమయము
వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)	
సంతకము	
పేరు	

CONSENT FOR BLOOD TRANSFUSION

Name: Jayanth N Age: 8m. Gender: Male ☒ Female ☐
UHID.No: BAH-00660111 Date: 30/06/26

Type of Blood Product: ☐ Fresh Frozen Plasma ☐ Packed Red Blood Cells ☐ Random Donor Platelets
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood
☐ Albumin ☐ Red Blood Cell ☐ Others 10/1g

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

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

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

Patient (Or Patient Relative / Guardian):

Doctor (Who is talking the consent)

Signature: [Signature] Signature: [Signature]

Name: Basim Name: Dr. Vamsi H

Date & Time: 30/6/26 5:30pm Date & Time: 30/06/26 5:30pm

Witness

Signature: [Signature]

Name: Ravi

Date & Time: 30/06/26 @ 5:30pm

రక్త మార్పిడి కొరకు అంగీకార పత్రము

రోగి పేరు: వయస్సు: లింగము ☐ పురుషుడు ☐ స్త్రీ
UHID. సంఖ్య: తేదీ:

రక్త ఉత్పత్తి రకాలు:

- | | | |
|---|---|---|
| ☐ తాజా ఘనీభవించిన ప్లాస్మా | ☐ ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు | ☐ Random Donor Platelets |
| ☐ క్రయోప్రెసిపిటేట్ | ☐ ఒకే ధాత ప్లేటిలెట్స్ | ☐ Whole Blood |
| ☐ మొత్తం రక్తం | ☐ ఎర్ర రక్త కణం | ☐ ఇతరులు..... |

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సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకం

పేరు

పేరు

తేదీ మరియు సమయము

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు



BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 30/6/26 Time: 3:50pm
 Blood Group of the Patient: B+ Blood Group on the Blood Bag: B+
 Blood Bank Issue No: BAA 26-01379 Date of Collection: 09/05/26 Date of Expiry: 31/05/26
 Date & Time of Starting Transfusion: 3:50pm Planned duration of Transfusion: 9 hrs
 Check for Correct Unit: ☒ Correct Patient: ☒
 Blood products cross checked by: Nurse 1: Rahul Nurse 2: Danbu
 Before starting transfusion vitals: Temp: 98.5⁰F HR: 125 RR: 35 BP: 110/68 SpO₂: 100%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
<u>30/6/26</u>	<u>15 Min</u>	<u>121</u>	<u>98.6⁰F</u>	<u>109/63</u>	<u>99%</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>-</u>
	<u>15 Min</u> <u>30 min</u>	<u>120</u>	<u>98.5⁰F</u>	<u>110/66</u>	<u>100%</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>-</u>
	<u>30 Min</u> <u>2 hr</u>	<u>123</u>	<u>98.5⁰F</u>	<u>115/62</u>	<u>100%</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>-</u>
	<u>30 Min</u> <u>2 hr</u>	<u>124</u>	<u>98.6⁰F</u>	<u>111/63</u>	<u>100%</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>-</u>
	<u>30 Min</u> <u>3 hr</u>	<u>123</u>	<u>98.6⁰F</u>	<u>101/64</u>	<u>100%</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>-</u>
	<u>1 Hr</u> <u>4 hr</u>	<u>121</u>	<u>98.5⁰F</u>	<u>109/65</u>	<u>100%</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>-</u>
	<u>1 Hr</u>								

Comments: all good

Name of the Incharge-Nurse: Danbu Name of the Nurse: Rahul
 Signature of the Incharge-Nurse: Danbu Signature of the Nurse: Rahul
 Date & Time: 30/6/26 @ 3:50pm Date & Time: 30/6/26 @ 3:50pm

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

LR-LEUCO REDUCED BLOOD CELLS IP PEDIA-1

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

B
Rh Positive

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

Unit No.: BAH26-01374
Blood Group: B Rh Positive
Collection Date: 09/Jun/2026
Expiry Date: 21/Jul/2026

1) Administer Without Warming. 2) Shake Gently Before Use. 3) Do Not
Add Any Medication. 4) Check Blood Group on Label & Recipient's
Group and Name Before Administration. 5) Use Sterile Transfusion Set
With Filter. 6) Do Not Dispense Without Prescription. 7) Do Not Use if
There is Any Visible Evidence. 8.) Store Between 2° C to 6° C 9)
Appropriate Compatible Cross Matched Blood Without Atypical
Antibodies in Recipient Should Be Used

Issue Label / Cross Matching Report

Patient : **MAST. NAGAMALLA JAYANTH**
Patient's Blood Group : B Rh Positive
Hosp/Dr : Rainbow Childrens Hospital, Sandeep Reddy
UHID No.: BAH-00660111 Wd-Bed No.:
Product : LR-PRBC Pedia-1
Blood Group : B Rh Positive
Unit No.: **BAH26-01374**
XMatching Report: Compatible
X-matched by: R.RAMESH

Issue Dt : 30/Jun/2026
Colln. Dt : 09/Jun/2026
Exp. Dt : 21/Jul/2026
Issued By : K. Alok

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

PATIENT TRANSFER FORM

BAH-00660111 IP5-00175690
Master NAGAMALLA JAYANTH
31-10-2025 0 Y 8 M 4 D (M)
Dr. SANDEEP REDDY



Date & Time of Admission <i>27/06/26 @ 11:10 PM</i>		Date & Time of Transfer Order <i>05/07/26 @ 3:40 PM</i>
Treating Consultant Name <i>Dr. sandeep</i>	Transfer Ordered by <i>Dr. sandeep</i>	Reason for Transfer <i>stable</i>
From Unit <i>PICU</i>	To Unit <i>ICU</i>	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File <i>130</i>	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what? <i>CT-1 MRI-1 X-ray 5</i>	Patient shifted with ID band: Yes ☒ No ☐ If No:
Number of Imaging Films		
Medications / Consumables / Surgicals / Hand over		
Sl.No.	Item Name	Quantity
1.	<i>ABG</i>	<i>2</i>
2.	<i>X-ray</i>	<i>5</i>
3.	<i>CT</i>	<i>1</i>
4.	<i>MRI</i>	<i>1</i>
5.	<i>USG</i>	<i>1</i>
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐		
Name & Signature of Person who is Transferring <i>[Signature]</i>		Name of Person Ordered Transfer
Patient & Clinical Records Received by : <i>Sirisha</i>		
Date & Time of Patient Received : <i>5/7/26 @ 4 PM</i>		

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



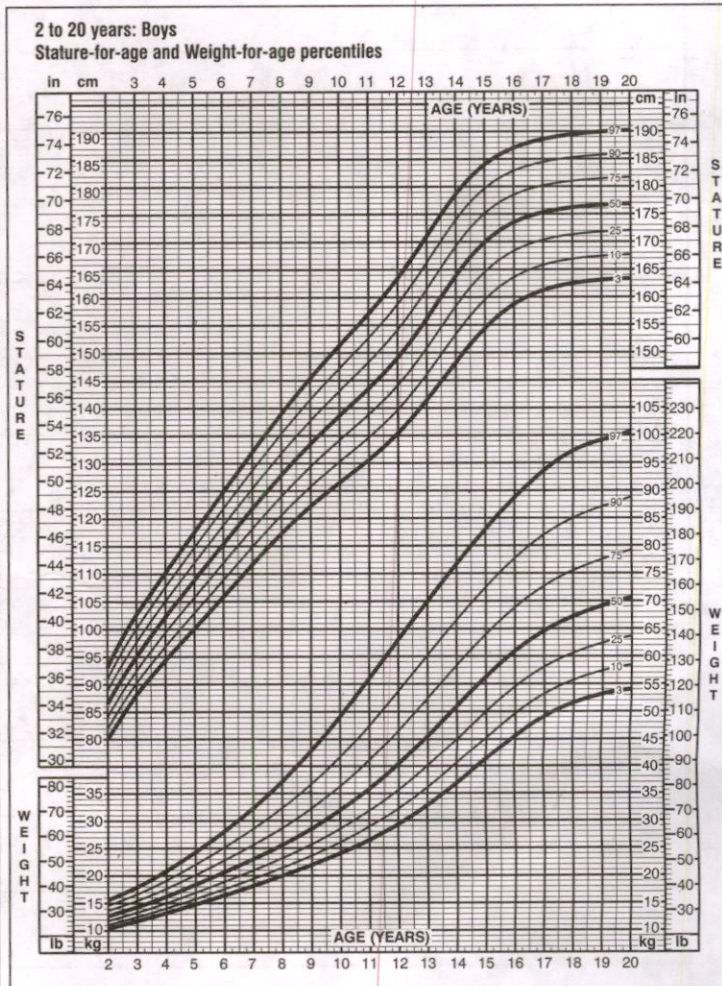
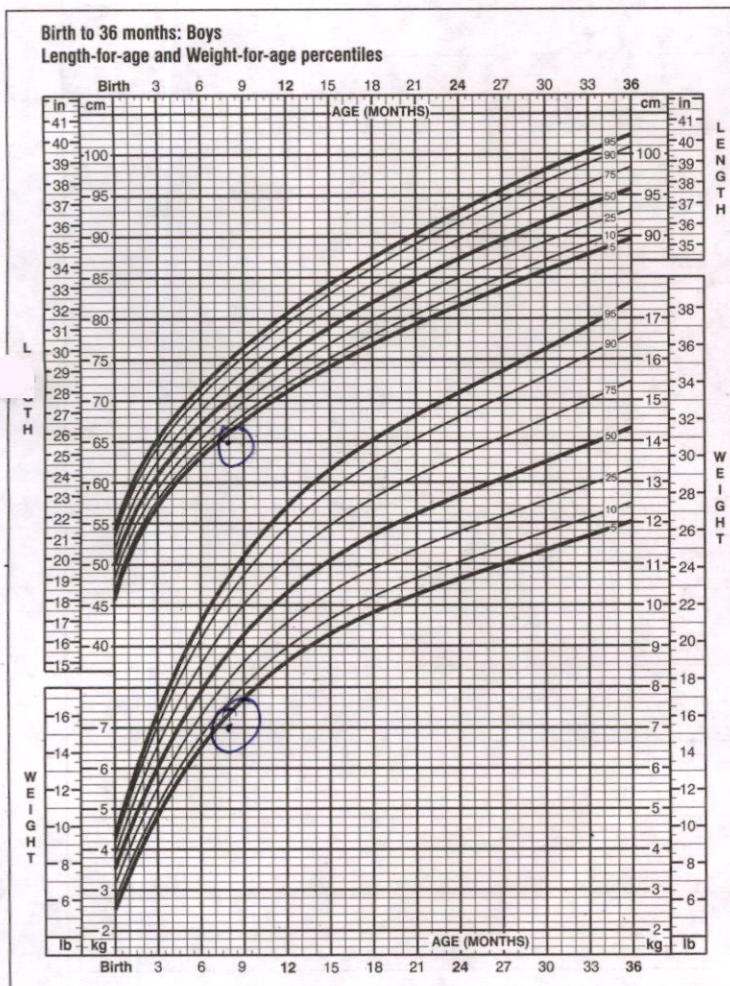
120

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 5/2/26 Time: 4 pm

Weight: 7 kgs Centile: < 5th
Height: 65 cms Centile: < 5th
Inference: Underweight child
RDA: - Calories: 98 kcal/kg/d Protein: 1.6 g/kg/d
Diet Recommendations: Nan pro stage II (1130ml) dilution
Re-Assessment: stage II weaning foods, HEE advised
Food Allergies: No Veg/Non-veg: Non-Veg
Diagnosis: Severe TBI / Refractory epilepsy / ALERD
Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral
Patient's Signature: N Venkama

GROWTH CHART (BOYS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha

Daily Notes:

6/7/26
Lokun

Child is stable Oral Intake is sub-optimal

Continue to Nourish (1:30ml) and stage II weaning foods.

- Monitor



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 24/6/2025 Time of arrival : 8-56 PM from bike at 25/6/2025
Chief Complaints : seizure activity since x 7 PM RBS : 89 mg/dL
Height : Weight : 2 Kgs BMI : Head Circumference (<2 years) : NA
Allergies : ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other : NA
If yes, identify : NO
Pain Screening : ☐ Yes ☒ No If Yes, Pain Score : 0/10 Pain Tool Used : ☐ N Pass ☒ FLACC ☐ Wong Baker
☐ Character : NA ☐ Location : NA ☐ Frequency : NA ☐ Duration : NA

RISK FOR FALL:

- ☐ If patient is < 6 years
tick below fall risk intervention directly
☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☐ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☐ No
• Uses furniture for support ☐ Yes ☐ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☐ No
• Weak ☐ Yes ☐ No
• Impaired ☐ Yes ☐ No

Mental Status: Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- ☒ Escort while ambulating
☒ Assist Patient
☒ Educate patient and family on fall precautions/prevention

Functional Screening: ☒ No Abnormalities Detected

- ☐ Mobility Problem
☐ Walking Problem
☐ Developmental Delay
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

- ☐ Underweight
☐ Overweight
☐ Feeding Problem
☐ Special diet
☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☒ No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With family

Siblings in household ☒ Yes ☐ No (if yes How Many?) 1

Cultural & Spiritual Needs: ☐ Yes ☒ No If Yes specify No Inform consultant for positive criteria.

Time of Initial assessment completed by ER Nurse : 8-58 PM

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

Time	Nursing Notes
9:00pm	→ Base seen by Dr-pavani
	→ vitals are checked
	→ IV Placement done
	→ samples collected
	→ CT Head
	→ shifted to PICU

Samples collected by: John

Time: 9:00pm

Samples sent by: NA

Time: NA

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 94b/m BP: 115/68(80) CFT: (2cc) RR: 23b/m SPO ₂ : 100% GCS: 15/15 Temperature: 99.5°F Pain Score: 0/10 Repeat RBS (if applicable): NR	Shift - out from ER to: PICU Time of Shift - out: 9:50 PM Handover given to: @Saumyadip @10pm (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

→ IV placement done

Name of the Nurse: Renuka Signature of the Nurse: R

Date & Time: 27/6/2024 9:00pm