

ADMISSION SHEET



Registration Details :

Admission No : IP5-00175975

Admit Date : 04-Jul-2026

Admit Time : 08:54 PM UHID : BAH-00604852

Patient Details :

Patient Name : Baby CHENNOJI AARAADHYA SAMHITHAA

Age : 1 Y 8 M 18 D

Guardian : Mr BALAJI CHARY

DOB : 16-10-2024 10:37 AM

Gender : Female

Religion :

Occupation :

Marital Status : Single

Address (H) : H NO 15-27/A/1 NBR COLONY RD NO 06
Meerpet Hyderabad Telangana INDIA 500097

Phone No : 9160538853/ 9052731000

E-mail : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : DELUXE ROOM

Bed No : DLX 326

Ward Name : 3F-ZONE C

Room No : DLX 326

Admission Type : First Visit

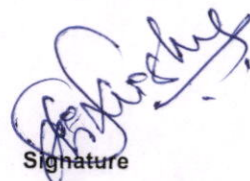
Contact Details :

Name : Mr BALAJI CHARY

Relationship : Father

Contact Address : H NO 15-27/A/1 NBR COLONY RD NO 06
Meerpet Hyderabad Telangana INDIA 500097

Phone No : 9160538853 / 9052731000


Signature

Doctor Details :

Doctor Name : Dr. VENKATA LAKSHMI A

Specialisation : GENERAL PEDIATRICS

Referral Doctor : DR. SUCHITHRA SRIRAMPUR

Phone No : 9177978202

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

BAH-00604852 IP5-00175975
Baby CHENNOJI AARAADHYA
16-10-2024 1 Y 8 M 18 D (F)
Dr. VENKATA LAKSHMI A

Consultant: _____ Dept : _____

Date of Admission: _____ Date of Discharge : _____ Time: _____



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
04/10/26	9:35 PM	ER	326 327A	[Signature]

Cross Consultation Visit

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

[illegible]

Signature

Samoh

Entered

Key

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
04/07	Ir Placement	①	88029	Samohy

ANY OTHER INFORMATION

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.....

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Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Aaraadhya

UHID ID:

Department:

Consultant:

BAH-00804852 IP5-00175975
Baby CHENNOJI AARAADHYA
16-10-2024 1 Y 8 M 18 D (F)
Dr. VENKATA LAKSHMI A





Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Fever x 2 days
Vomiting x 1 day.

History of present illness :

- Fever x 2 days
- high grade Tmax 104.2 F
 - no chills, no loose stools
no cold/cough
 - every 8hly → 104.1 F since 6 Pm
not relieved C
Curocin DS
 - ↓ oral intake 1 day.
a/w vomiting - 4-5 Epi
- after oral medication
intake.
 - non bilious
 - non projectile

no H/O travel, outside food history

H/O elder cousin having fever

no H/O antibiotic usage.



Pediatric Multiorgan History & Physical Examination

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

Not Significant

Birth & Neonatal History:

Normal antenatal & Perinatal
transition

□ TO
○ 2 yrs.

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

upper middle.

Developmental History :

Normally attained till date

Immunization History :

Immunized @ RCH as per IAP schedule
Last 18-24 months



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____
Weight (kgs)) 11.8 kg (Centile _____)

On Examination :

Temperature : 104.1°F Pulse Rate : 178 B.P. 103/65 SPO2 97% @ RA

Resp. rate and type of breathing : 26 bpm regular

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : Normal

Air entry & breath sounds : BAE ⊕, clear airways

Any addes sounds : _____

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

Cardiovascular System :

Inspection of precordium : Normal

Heart Sounds : S1 S2 ⊕

Any murmur : Nil

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

Per Abdomen :

Inspection Normal

Palpation : Soft, mild suprapubic tenderness

Ausculation : Bowel Sounds ⊕

Spine : Normal External Genitalia : Normal

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15/15

Cranial Nerves : Intact

Motor System:

Nutrition : Adequate

Tone : Equal bil

Power 4/5

Co-ordinator : well

Posture : —

Involuntary Movements : Nil

Reflexes :

DTR +++

Superficials: +++

Plantars Elicited - Flexor.

Sensory System :

Intact

Bladder / Bowel : adequate

Clinical Summary & Diagnostic:

Acute febrile illness (D₂)

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: dehydration, sepsis

Desired goals of the treatment: defecescence

Planned Labs:

CBP
CRP
5 viral Panel
Blood culture/sensitivity
CUE
Urine culture/sensitivity
Extra Plain
RP-2

Planned Management

① Inj Ceftriaxone
② Inj Ondansetron
③ Inj Pantoprazole
④ Inj Paracetamol
⑤ IVF DNS
NB (Lactulose)

Signature of the Doctor: Sohel

Name of the Doctor: Dr. Soheli

Date & Time:

Signature of the Consultant:

Name of the Consultant: DR. VENKATA LAKSHMIA

Date & Time:

Registration No: 50115

EFFICIENCY CHECK LIST OF CASE SHEET

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

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

Date & Time	Progress Notes	Doctor's Order
5/8/27 1:00am	<u>Qs/B Resolute</u>	
	AFI (D ₃)	<u>Plan</u>
	child has ongoing fever spikes	① Ij ceftriaxone ② Ij Ondansetron ③ Rest to continue
	oral intake - ↓ no fresh complaint hemodynamically stable	<u>Trace</u> - CUE - 5 Viral Panel - Bld & Uric c/s
	<u>O/E</u> Child is alert, active vitals stable	noted by RJS JAM <u>Sohel</u>

Date & Time	Progress Notes	Doctor's Order
6/7 9:30 am	O/S/B Resident. A: AFI (D4). afebrile. good oral intake O/E: alert stable vitals no rash chest clear. abd soft	Adv: F) (D) today. gastrodiet x 3d oral Zipmax x 3d R/v 3d. Shihle
		DR. VENKAT LAKSHMI A Registration No: 50115

BAH-00604852 IP5-00175975
 Baby CHENNOJI AARAADHYA
 16-10-2024 1 Y 6 M 18 D (F)
 Dr. VENKATA LAKSHMI A



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RESULT SHEET

Date	04/04/26				
Time					
Hb	10.9				
PCV	33				
RBC	4.10				
WBC	14.210				
N/L	84/11.7				
Platelets	4.03L				
CRP	28				
ESR					
PCT					
RBS					
Na	137				
K	4.4				
Cl	104				
Ca/Mg					
Phosphate					
Urea	22				
Creatinine	0.3				
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L	Bicarb 17				

Date	5/2					
Time						
CUE - Alb	⊖					
CUE - Sugar	⊖					
CUE - Ketones	+++					
CUE - PUS Cells	2-3					
CUE - RBC Cells	6-8					
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : flu A, B, Rsv, Covid, Adeno - Negative !

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

BAH-00604852
Baby CHENNOJI AARADHYA
16-10-2024 1 Y 8 M 18 D
Dr. VENKATA LAKSHMI A

IPS-00175975
(F)



Aaradhya



MEDICATION RECONCILIATION FORM

Drug Allergies: _____ ☒ Not known any Drug Allergies

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

Shifting From: ER Shifted to: 3rd floor

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
-						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Sohile C Dr

Date & Time : 04/10/26

Nurse Name & Signature: Murshid

Date & Time : 04/10/26 @ 9:30pm



DRUG CHART

Date of Admission: 4/11/26 Drug Allergies: — ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG : IBUGESIC SYP				Date Time
Dose	Route	Frequency	Start Date	
6ml	P/O	SOS	04/07	
Doctor's Signature <i>Sobhi</i>		Valid Period	Pharm.	
			<i>[Signature]</i>	
Additional Instructions: Temp > 101°F max 3 times (orally)				

DRUG : Eyp PARACETAMOL				Date Time
Dose	Route	Frequency	Start Date	
3.5ml PO		6H	5/7	
Doctor's Signature <i>Sainthi</i>		Valid Period	Pharm.	
			<i>[Signature]</i>	
Additional Instructions: temp > 100 (5/240 mg) max 6H				

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



REGULAR PRESCRIPTIONS

Weight. 11.8kg Ward.

VERIFIED

DRUG : <u>Sij CEFTRIAXONE</u>				Date Time	<u>4/7/24</u>	<u>6/7</u>
Dose	Route	Frequency	Start Date			
<u>600mg</u>	<u>I.V</u>	<u>BID</u>	<u>04/07</u>	<u>10AM</u>	<u>X</u>	<u>6/7</u>
Name & Signature of the Doctor Starting the Drugs: <u>Sohela</u>				<u>10pm</u>		
Additional Instructions: <u>50 mg/kg/dose</u>				<u>Pu</u>		
Daily Doctor's Endorsement by a Sign				<u>g g</u>		

VERIFIED

DRUG : <u>Sij ONDENSETRON</u>				Date Time	<u>4/7/24</u>	<u>5/7</u>
Dose	Route	Frequency	Start Date			
<u>2mg</u>	<u>I.V</u>	<u>OTID</u>	<u>04/07</u>	<u>6AM</u>	<u>X</u>	<u>5/7</u>
Name & Signature of the Doctor Starting the Drugs: <u>Sohela</u>				<u>2pm</u>		
Additional Instructions:				<u>10pm</u>		
Daily Doctor's Endorsement by a Sign				<u>g g</u>		

VERIFIED

DRUG : <u>Sij PANTOPRAZOLE</u>				Date Time	<u>4/7/24</u>	<u>5/7</u>
Dose	Route	Frequency	Start Date			
<u>10mg</u>	<u>I.V</u>	<u>OD</u>	<u>04/07</u>	<u>6AM</u>	<u>X</u>	<u>5/7</u>
Name & Signature of the Doctor Starting the Drugs: <u>Sohela</u>				<u>10pm</u>		
Additional Instructions:				<u>Pu</u>		
Daily Doctor's Endorsement by a Sign				<u>g g</u>		

VERIFIED

DRUG : <u>Sij PARACETAMOL</u>				Date Time	<u>4/7/24</u>	<u>5/7</u>
Dose	Route	Frequency	Start Date			
<u>120mg</u>	<u>I.V</u>	<u>TID</u>	<u>04/07</u>	<u>7AM</u>	<u>X</u>	<u>5/7</u>
Name & Signature of the Doctor Starting the Drugs: <u>Sohela</u>				<u>3PM</u>		
Additional Instructions: <u>Shely</u>				<u>11PM</u>		
Daily Doctor's Endorsement by a Sign				<u>g g</u>		

made SOS
Samir
5/7/24

Date►
Time

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

[illegible]

BAH-00604852 IP5-00175975
Baby CHENNOJI AARAADHYA
16-10-2024 1 Y 8 M 18 D (F)
Dr. VENKATA LAKSHMI A

I.V. FLUIDS CHART

Weight. 11.8 Ward.



n of I.V. Fluid
(mention ml/hr = Mcg/kg/min. etc)

Route

Flow Rate
ml/hr

Doctor
Sign

Nurse
Sign

Date of
Stopping

Doctor
Sign

Nurse
Sign

04/07

10pm

IVF DNS

I.V

45

Sohel Mathur

Piya

7/6/24

AKK

S
RB

Signature

VERIFIED BY : 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		
5/7/26	9:30 pm	5	medication.	F	1	0	1	1	W/L	Uesal
5/7/26	10:30 am	9	gastro diet	M, F	1	0	1	1	-	Saima

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
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MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

AFI

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
4/1/26	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	AFI	H. stability	medical management	Soluh	☐ Nursing ☐ Others:
4/2 9:30 P	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	AFI	H. stability	- W fluids - W meds	pusud	☒ Medical ☐ Others:
5/7/26 10:30 am	☐ Medical ☐ Nursing ☒ Others: dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	AFI	gastro diet	<u>RDA</u> E → 1200 kcal/d P → 20 gm/d.	Saima	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

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EMERGENCY ROOM TRIAGE FORM

Patient's Name: Aaraadhya Age: 2 yrs Gender: ☐ Male ☒ Female
Date: 4/7/26 Time of Arrival: 8:15pm Triage Completion Time: 8:17pm
Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): ☐ Not known any drug Allergies
Source of Information: ☒ Parents ☐ Others (Specify):
Mode of Arrival: ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance

- ☒ Normal
☐ Sick Looking

Circulation / Colour

- ☒ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing

- ☒ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

☒ Stable

☐ Unstable:

- ☐ Not - Life - Threatening
☐ Life - Threatening

Initial Vital Signs: Temp: 100.1F PR: 128bpm BP: 103/65mm RR: 26b/m SpO₂: 92% RA
Chief Complaints: do fever x 2 days (High grade), vomitings x 2 days (cupi)
4-5 Epi 4p.m.

Triage Classification	CTAS
☐ Level 1: Resuscitation	☐ Immediate
☐ Level 2: EMERGENT: Life or limb threatening	☐ < 15 min
☐ Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening	☒ 30 min
☐ Level 4: LESS URGENT: Significant illness but not life threatening	☐ 60 min
☐ Level 5: NON - URGENT: May receive care when convenient	☐ 120 min

NOTE: All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian: [Signature]

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

- Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
- Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☒ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☒ Not applicable

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☐ No
If yes, State Location:
- Are your parents / close contacts at home healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☐ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse: Mr. Lachel

Signature of Triage Nurse: [Signature]

Date & Time: 4/7/26 @ 8:17pm

Docu. No.: RCHBH / FRM / CLINICAL / 085

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

Time	Nursing Notes
9:25	Dr. Schell assessed the child w/ plant done samples sent shifted to room

Samples collected by:

Samples sent by:

Shambhu

Time:

Time:

9:30 pm

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
1044 4/17/26 8:25pm	MEPTAL P	oral	5.5ml	<i>Schell</i>	<i>Sh</i>

Condition of patient at time of shift - out :

HR: *130bpm* BP: *105/62* CFT: *23s*
 RR: *20bpm* SPO₂: *97%*
 GCS: *15/15* Temperature: *99.8°F*
 Pain Score: *0/10*
 Repeat RBS (if applicable): ☒

Details of Shift - out

Shift - out from ER to: *326*
 Time of Shift - out: *9:35 pm*
 Handover given to: *Pujn*
 (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): *w/ plant*

Name of the Nurse :

Signature of the Nurse :

Date & Time :

Neeraj
04/07/26 @ 9pm

BAH-00604852 IPS-00175975
Baby CHENNOJI AARAADHYA
16-10-2024 1 Y 8 M 18 D (F)
Dr. VENKATA LAKSHMI A



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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: Mode of Arrival: Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Body Weight: 11.8 Kg

..... MA Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>MA</u>	<u>MA</u>	<u>MA</u>

Family History:

..... Is the child or close family member had recent contact with a communicable disease? ☐ Yes ☒ No

If yes please list,

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

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

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

Observations: Weight: 11.8 kg Length: Head Circumference (< 2 years):

Temp.: 99.1 F HR: 140 bpm RR: 30 bpm BP: -

Pain Score: 0/10 Specify Site: (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☒ Yes ☐ No Score: 12 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 18) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☐ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker

Character of Pain Location Frequency Duration

FUNCTIONAL SCREENING:☒ No Abnormalities Detected☐ Mobility Problem☐ Walking Problem☐ Developmental Delay☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:☒ No Abnormalities Detected☐ Underweight☐ Overweight☐ Special Feeding Method☐ Feeding Problem☐ Special diet☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening:☒ No Significant FindingsUnusual concerns about patient's Psychological Status: ☐ Yes ☒ No

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☐ Yes ☐ No if Yes specify Inform consultant for positive criteria.**Social History:** Lives With *parents*Siblings in household ☒ Yes ☐ No (if yes How Many?)All Information Obtained From ☐ Patient ☒ Mother ☒ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach: ☒ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump: ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ NoInformation given to *parents*Nurse Signature: *Riya*Nurse Name: *Riya*Date: *04/04/2026*Time: *10pm*

r. VENKATA LAKSHMI

06/17/2026

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date :		Time:		
Doctor / Nurse / Family Concern?		GAM		
Temperature (F)	104			
	103			
	102			
	101			
	100			
	99			
	98			
	97			
	96			
	95			
94				
Heart Rate (bpm)	190			
	180			
	170			
	160			
	150			
	140			
	130			
	120			
	110			
	100			
and Blood Pressure (mmHg) *	90			
	80			
	70			
	60			
	50			
	40			
	30			
	20			
	10			
	0			
Note: BP does not score in early ing scoring				
Heart Rate (Number)		130b/m		
Resp. Rate (bpm) (Over 1 Minute) *	70			
	60			
	50			
	40			
	30			
	20			
	10			
	0			
	Resp Rate (Number)		30b/m	
	Resp Distress	Mod/ Severe None / Mild	N	
Receiving O ₂ (l/min) O ₂ Saturations (%)		100%		
Conscious Level	Normal Altered	N		
GCS *		15/15		
TOTAL SCORE		0		
Number of shaded boxes		0		
in Score		0		
NB: Score recorded over		0		
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.		
NB: If GCS is below 12 or the Oxygen		: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see		
		: Shift in charge AND PICU fellow or PICU consultant to be informed.		

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 do in the meantime ? (e.g. stop the fluid/ repeat observation)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	10 am	2 pm	6 PM	10 PM	2 AM	
Doctor / Nurse / Family Concern?							
Temperature (F)	104						
	103						
	102						
	101						
	100						
	99						
	98	97.2°F	97.7°F	97.6°F	97.5°F	97.3°F	
	97						
	96						
	95						
	94						
Heart Rate (bpm) and Blood Pressure (mmHg) *	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
	90						
Note: BP does not score in early warning scoring	80						
	70						
	60						
	50						
	Heart Rate (Number)	133b/m	138b/m	118b/m	135b/m	130b/m	
	Resp. Rate (bpm) (Over 1 Minute) *	70					
		60					
		50					
		40					
		30					
		20					
10							
Resp Rate (Number)		30b/m	30b/m	30b/m	30b/m	30b/m	
Resp Distress		Mod/ Severe					
		None / Mild	N	N	N	N	N
Receiving O ₂ (l/min)		O ₂ Saturations (%)	100%	99%	99%	100%	99%
	Conscious Level	N	N	N	N	N	
GCS *	Normal	15/15	15/15	15/15	15/15	15/15	
	Altered						
TOTAL SCORE	Number of shaded boxes	0	0	0	0	0	
	Pain Score	0	0	0	0	0	
Observer's Initials		Dr	Dr	Dr	Dr	Dr	

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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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.
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Date :		Time:	
Doctor / Nurse / Family Concern?			
10 PM		2 AM	
6 AM			
Temperature (°F)	104		
	103		
	102		
	101		
	100	100.0°F	
	99		
	98		
	97	97.1°F	
	96		
	95		
94			
Heart Rate (bpm)	190		
	180		
	170		
	160		
	150		
	140		
	130		
	120		
	110		
	100		
and Blood Pressure (mmHg) *	90		
	80		
	70		
	60		
	50		
	140		
	130		
	120		
	110		
	100		
Note: BP does not score in early warning scoring			
Heart Rate (Number)		125 bpm	
		128 bpm	
		130 bpm	
Resp. Rate (bpm) (Over 1 Minute) *	70		
	60		
	50		
	40		
	30		
	20		
	10		
Resp Rate (Number)		30 bpm	
		28 bpm	
		30 bpm	
Resp	Mod/ Severe		
Distress	None / Mild	N	N
Receiving O ₂ (l/min)			
O ₂ Saturations (%)		99%	100%
		99%	
Conscious	Normal	N	N
Level	Altered		
GCS *		15/15	15/15
		15/15	15/15
TOTAL SCORE			
Number of shaded boxes		0	0
Pain Score		0	0
Observer's Initials		Φ	Φ

NB: Scores 3 should be recorded overleaf

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

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A	ASSESSMENT : I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

BAH-00604852 IP5-00175975
 Baby CHENNOJI AARADHYA
 16-10-2024 1 Y 8 M 18 D (F)
 Dr. VENKATA LAKSHMI A

Patie

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FLUID CHART

Sheet No. :

04/07/2026

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

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm										0	} High High High High High
	09:00 pm						1				0	
	10:00 pm			45ml							0	
	11:00 pm	D		45ml			NP			✓	0	
	12:00 am	N		45ml			1				0	
	01:00 am	S		45ml			1				0	
Total Intake :						Total Output : V=1 M=0						
	02:00 am			45ml							0	} High High High High High
	03:00 am	D	45ml				1				0	
	04:00 am	N		45ml			NP			✓	0	
	05:00 am	S		45ml							0	
	06:00 am			45ml			1			✓	0	
	07:00 am			45ml							0	
Total Intake : Taken						Total Output : V=2 M=0						
Total 24 hrs. Intake			Taken									
Total 24 hrs. Output			V=2 M=0									



FLUID CHART

Sheet No. :

5/7/26

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			45ml			↑				✓	0	Lath	
	09:00 am	D	water	45ml								0		
	10:00 am											0		
	11:00 am	N					NP				✓	0		Lath
	12:00 pm											0		
	01:00 pm	S	water				↓				✓	0		Lath
Total Intake :					Total Output : 0-3-0									
	02:00 pm			45ml								0	Lath	
	03:00 pm	D	water	45ml							✓	0		
	04:00 pm	N					NP					0		
	05:00 pm	S	water	45ml								0		Lath
	06:00 pm										✓	0		
	07:00 pm											0		
Total Intake :					Total Output : 0-0-2									
5/7/26	08:00 pm			45ml								0	Lath	
	09:00 pm	D	water	45ml			✓				✓	0		
	10:00 pm	N		45ml								0		
	11:00 pm	S		45ml								0		Lath
	12:00 am		water	45ml								0		
	01:00 am			45ml								0		
Total Intake : Taken					Total Output : 1-1-1									
6/7/26	02:00 am			45ml								0	Lath	
	03:00 am	D	water	45ml			↓				✓	0		
	04:00 am	N		45ml			NP					0		Lath
	05:00 am	S		45ml								0		
	06:00 am		water	45ml							✓	0		Lath
	07:00 am			45ml								0		
Total Intake : Taken					Total Output : 2-0-0									
Total 24 hrs. Intake			Total 24 hrs. Output : 8-8-1											



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 04/11/26 09:00 PM

Assessment: Baby having fever

- 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	→ assess the general condition of the baby and check vitals.	8 AM	→ assessed the general condition of the baby and checked vitals.	Baby is Stable
10 AM	→ giving medication as advised.	10 AM	→ Given medication as advised.	
12 AM	→ Continue w fluid as advised.	12 AM	→ Continued w fluid as advised.	
4 AM	→ plan for sending sample for culture and wine culture.	4 AM	→ Sent sample for culture and wine culture.	
6 AM	→ checking urine output.	6 AM	→ checked urine output.	
8 AM	→ ensure safety.	8 AM	→ ensured safety.	

Re-Assessment: Fever reduced now

Special Notes: Trace lab reports

Nurse Signature: *[Signature]*

Nurse Name: *[Signature]*

Date & Time: 04/11/26 08 AM

BAH-00604852 IP5-00175975
 Baby CHENNOJI AARAADHYA
 16-10-2024 1 Y 8 M 19 D (F)
 Dr. VENKATA LAKSHMI A



NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/7/26

Assessment: AFI

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	* Assess the general condition of the Baby	8am	* Assessed the general condition of Baby	* Baby is stable
9:00am	* Monitor vital signs & Recorded	9:10am	* monitored vital signs & Recorded	
10:00am	* Maintain IV fluids	10:10am	* Maintained IV fluids	
11:00am	* Ensure safety	11:15am	* Ensured safety	
1:00pm	* Administer medications as per drug chart	1:00pm	* Administered medications as per drug chart.	

Re-Assessment:

Special Notes: Baby is doing well.
 Trays, labs,

Nurse Signature: latha Nurse Name: hie Date & Time: 5/7/2026 @ 2pm

BAH-00104852 IP5-00175975
Baby CHENNOJI AARADHYA
16-10-2024 1 Y 8 M 19 D (F)
Dr. VENKATA LAKSHMI A



NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/7

Assessment: Baby is here with APT

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2PM	* Assess the general condition of baby.	2:15PM	* Assessed the baby condition.	Baby is stable now
4PM	* Monitor vital signs	4:10PM	* vitals checked & documented	
	* Maintain I/O chart		* I/O chart maintained	
6PM	* Administer the medication as per chart	6:15PM	* Administered the medication as per chart.	
8PM	* Ensure safety.	8PM	* Ensured safety.	

Re-Assessment: Baby is comfortable now.

Special Notes: Take reports.

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 5/7 @ 8PM



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 06/07/26 08 PM

Assessment: Baby having dehydration

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 and check vitals.	8:00 PM	→ assessed the general condition of the baby and checked vitals.	Baby is stable
10 AM	→ Giving medication as advised.	10:20 PM	→ Given medication as advised.	
12 AM	→ Continue w fluid as advised.	12:00 AM	→ Continued w fluid as advised.	
4 AM	→ Giving Gastro diet as advised.	4:00 AM	→ Given Gastro diet as advised.	
6 AM	→ Maintaining personal hygiene. → checking urine output.	6:00 AM	→ maintained personal hygiene. → checked urine output.	
8 AM	→ Ensure safety.	8:00 AM	→ Ensured safety.	

Re-Assessment: Continued w fluid (under observation)

Special Notes: Trace Lab Reports

Nurse Signature: *Pijy*

Nurse Name: *Pijy*

Date & Time: 06/07/26 08 AM



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. V.L Department: Paed Date of Admission: 4/7/20

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	AFI						
BACKGROUND	Area	Shift Time	12-2 PM	2nd Shift 2 PM - 8 PM	3rd Shift 8 PM - 2 PM	4th Shift 2 PM - 8 PM	
	Medical Condition (Any special condition to be noted):		NA	NA	NA	NA	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	99.0 F	98.2 F	97.7 F	97.9 F	97.5 F
		Res:	30 bpm	30 bpm	30 bpm	35 bpm	30 bpm
		SpO ₂ :	98%	99%	99%	99%	100%
		Pulse:	135 bpm	130 bpm	133 bpm	138 bpm	130 bpm
		BP:	102/63	-	-	-	-
	Fall Risk Score:	13	13	13	13	13	
Pain Score:	0	0/10	0/10	0/10	0/10		
Recommendations	Safety Needs:	Yes	Yes	Yes	side rails	side rails	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	nil	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	nil	NA	NA	NA	tree Lab reports	
Post Operative Procedure Special Orders:		nil	NA	NA	NA	NA	
Handed Over By Name :		Pijy	Laksh	Pijy	Pijy	Pijy	
Signature :		Pijy	Laksh	Pijy	Pijy	Pijy	
Date:		4/7/20	5/7	5/7	5/7	5/7	
Time:		9:00 PM	8 AM	2 PM	2 PM	8 AM	
Taken Over By Name :		Pijy	Laksh	Pijy	Pijy	Pijy	
Signature :		Pijy	Laksh	Pijy	Pijy	Pijy	
Date:		4/7/20	5/7	5/7	5/7	5/7	
Time:		1:00 PM	2 PM	2 PM	8 AM	2 PM	

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	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
		Fall Risk Score:						
Recommendations	Safety Needs:							
	Physiotherapy	☐ Yes ☐ No	☐ 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	☐ 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:								

BAH-00604852 IP5-00175975
Baby CHENNOJI AARAADHYA
16-10-2024 1 Y 8 M 18 D (F)
Dr. VENKATA LAKSHMIA



BRADEN 'Q' SCALE

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

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

					Date :	5/10/24	6/10/24	5/7/24	5/7/24
					Time :	9 PM	8 AM	10 AM	8 PM - 8 PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	2	2	2	
"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	1	1	5	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	2	2	2	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	2	2	2	
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	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 or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE		28	18	18
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name		Rusny	Rusny	Latika

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

BAH-00604852
Baby CHENNOJI AARADHYA
16-10-2024 1 Y 8 M 19 D (F)
Dr. VENKATA LAKSHMI A

BRADEN 'Q' SCALE

Rainbow®
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It takes a lot to treat the little.

BirthRight™
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Your Right to a Safe Delivery

				Date : 5/7			
				Time : 8:00 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 e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	2		
"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		
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.	2		
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.	2		
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."	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 or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4		
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	18	
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Piya	

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
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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

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	17	17	17	17	
	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					
	Female	1	1	1	1	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	
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					
	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			13	13	13	13	

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	Yes	✓	✓	Yes
Call device within reach	Yes	✓	✓	Yes
Wheels Locked	Yes	✓	✓	Yes
Room free of clutter	Yes	✓	✓	Yes
Adequate Lighting	Yes	✓	✓	Yes
Wheel Chair Support	No	X	X	NA
Other Intervention(s) Specify	No	X	X	NA
Nurse's Name :	Rachal	Laksh	Rachal	Rig
Signature :	[Signature]	[Signature]	[Signature]	[Signature]
Date :	10-10-24	5/7	5/7	5/7
Time :	9m	10am	2pm	8pm-8pm



PAIN ASSESSMENT FORM

core (0/10)			Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
04/10/24	AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	anal NA	Normal -
05/10/24	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pign
5/7	10am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	better
5/7	3PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No	NA	best
5/7	10am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pign
6/10/24	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pign
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

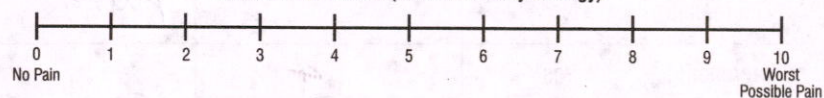
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs 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

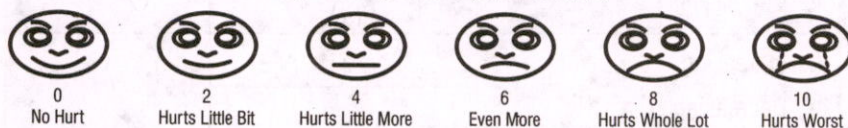
Numerical Pain Scale (Obstetric and Gynecology)



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



BAH-00604852 IPS-00175975
Baby CHENNOJI AARADHYA
16-10-2024 1 Y 8 M 19 D (F)
Dr. VENKATA LAKSHMI A



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				
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						Piya Lakshmi Suresh	Piya						

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 : Anamika Name : Anamika

Signature of Ward In Charge :

Signature : Supriya Name : Supriya

BAH-00604852 IP5-00175975
Baby CHENNOJI AARAADHYA
16-10-2024 1 Y 8 M 19 D (F)
Dr. VENKATA LAKSHMI A

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DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: 1

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

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

Need assistance

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others: _____

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others: _____

6. Patient/Family Educational Plan:

☐ Educational Topic/s: personal hygiene

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

☐ Patient ☒ Family Member

☐ Others: _____

Nurse Signature: Piy

Nurse Name: Piy

and Time: 04/10/2024 10:00 PM

TRANSFER FORM

Name & UHID No. IP5-00175975 NNOJI AARADHYA 24 1 Y & M 18 D (F) ANKATA LAKSHMI A		Date & Time of Admission 04/07/26 @ 8:54pm	Date & Time of Transfer Order 04/07/26 @ 9:30pm
		Transfer Ordered by Dr. Sohela	Reason for Transfer Admission
From Unit E12	To Unit 326	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 19	Number of Imaging Films nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ OP file - If yes, what? J. N. N. N.	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring [Signature]		Name of Person Ordered Transfer Dr. Sohela	
Patient & Clinical Records Received by : Puja 04/07/26 @ 9:45pm			
Date & Time of Patient Received :			

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

BAH-00604852 IP5-00175975
Baby CHENNOJI AARAADHYA
16-10-2024 1 Y 8 M 19 D (F)
Dr. VENKATA LAKSHMIA



327-A

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

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

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 5/7/26 Time: 10am

Weight: 11.8 kgs Centile: >25th

Height: 83 cm Centile: >25th

Inference: well child.

RDA: — Calories: 1800 kcal/D Protein: 20 gm/D

Diet Recommendations: gastro diet (avoid wheat, milk, eggs, oats,

Re-Assessment: citrus fruits & fruit Juices, nuts) can have Rice based food, sago water, poh

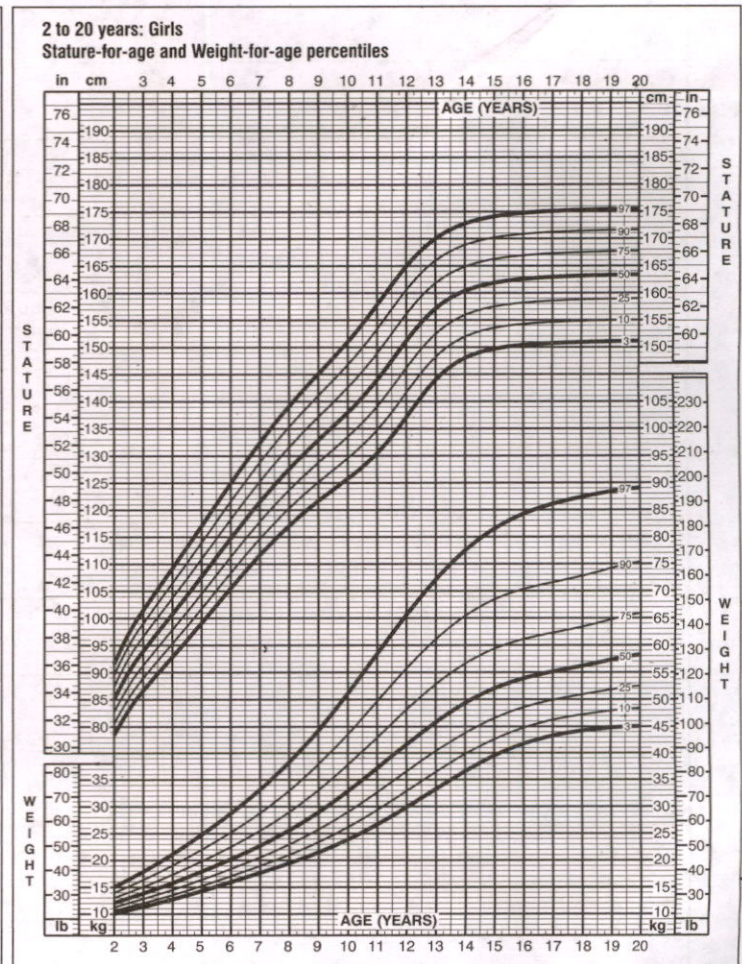
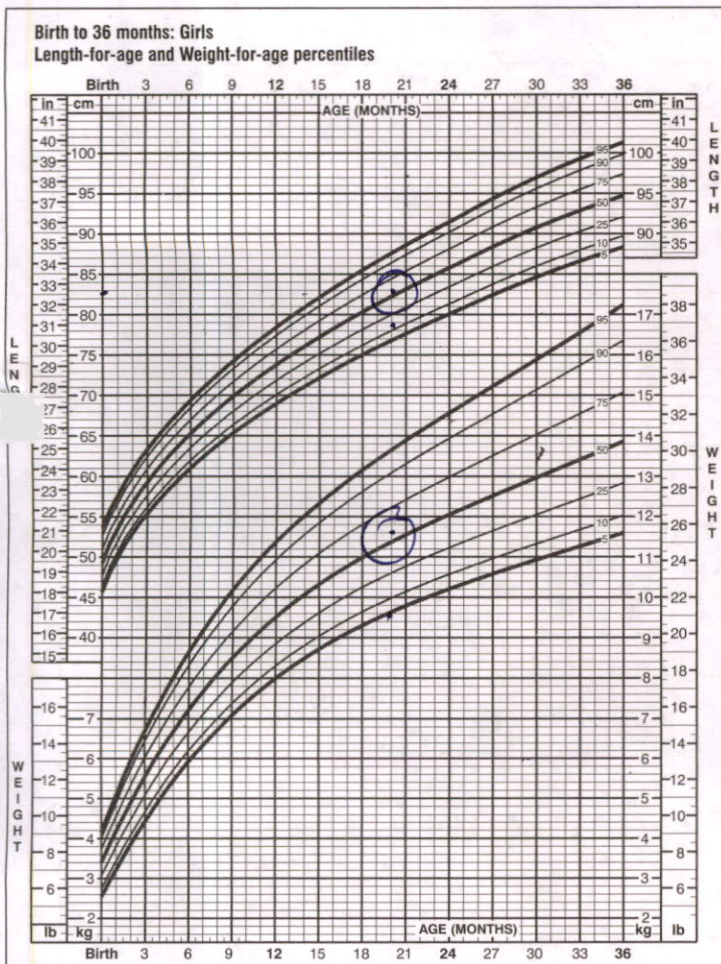
Food Allergies: No Veg/Non-veg Non-veg

Diagnosis: AFI (D2)

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: D. N. K.

GROWTH CHART (GIRLS)



Dietician's Name: Saimy

Dietician's Signature: Saimy

Docu. No. : RCHBH / FRM / CLINICAL / 161

(PT.O.)

Daily Notes:

2058

13079-13084

11/25/2009

[illegible]

with open file, but all other files are closed.

for 10/2/2

1992

10. 17. 2

⑤