

B3

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No. _____

BAH-00661266 IP5-00176238
Master SYED AAHIL
06-09-2021 4 Y 10 M 4 D (M)
Dr. SANDEEP REDDY

Date of Admission: _____ Discharge : _____ Time: _____



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
10/7/20	10:20 AM	ER	PLW	Anil

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Parth	11/07/20	9697870	Parth
2				
3				
4				
5				
6				
7				
8				
9				
10				

2

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
10/7/26	IV placement	①	9696951	} <u>Kain</u>
10/7/26	NHC charges	①	9697263	

ANY OTHER INFORMATION

.....

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.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

PROGRESS NOTES AND DOCTOR'S ORDER

Dr. I and Deep

Date & Time	Progress Notes	Doctor's Order
11/7/26	<u>Counselling notes</u> → Child is stable, CT was normal, there is mild fracture over (R) forehead, which was superficial - not requiring any immediate treatment → It heals on its own, by itself → Neurosurgeon opinion was taken, advised conservative management → Risk is high in initial 2-3 days, if vomiting, pain, seizure activity occur that should be advised (warning signs were explained) → And child is being discharged today. → Can review after 3 days	
		<u>Fattu</u> <u>Ilyas</u>

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

		Rainbow Children's Hospital - Banjara Hills 8-2-120/103/1,2,3,4 and 5, Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034. TEL NO :+91-40-4466 5555 WEB : https://rainbowhospitals.in													
ADMISSION SHEET															
															
Registration Details : Admission No : IP5-00176238 Admit Date : 10-Jul-2026 Admit Time : 09:41 PM UHID : BAH-00661266															
Patient Details : <table border="0"> <tr> <td>Patient Name : Master SYED AAHIL</td> <td>Age : 4 Y 10 M 4 D</td> </tr> <tr> <td>Guardian : Mr SYED ILIYAS</td> <td>DOB : 06-09-2021</td> </tr> <tr> <td>Gender : Male</td> <td>Religion :</td> </tr> <tr> <td>Occupation :</td> <td>Martial Status : Single</td> </tr> <tr> <td>Address (H) : #8-3-228/1216/B JAWAHAR NAGAR YOUSUFGUDA Krishna Nagar Hyderabad Telangana INDIA 500045</td> <td>Phone No : 7981157300/ 6303354115</td> </tr> <tr> <td></td> <td>E-mail : nomailid@gmail.com</td> </tr> </table>				Patient Name : Master SYED AAHIL	Age : 4 Y 10 M 4 D	Guardian : Mr SYED ILIYAS	DOB : 06-09-2021	Gender : Male	Religion :	Occupation :	Martial Status : Single	Address (H) : #8-3-228/1216/B JAWAHAR NAGAR YOUSUFGUDA Krishna Nagar Hyderabad Telangana INDIA 500045	Phone No : 7981157300/ 6303354115		E-mail : nomailid@gmail.com
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Payment Details : <table border="0"> <tr> <td>Payment Mode : Cash</td> <td>Deposit Amount : 0.00</td> </tr> <tr> <td></td> <td>Payor Name : SELFPAY</td> </tr> </table>				Payment Mode : Cash	Deposit Amount : 0.00		Payor Name : SELFPAY								
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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: *Dr. Naveen* Date & Time: *10/9/26 10:40 PM*

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Master SYED AAHIL
06-09-2021 4 Y 10 M 4 D (M)
Dr. SANDEEP REDDY

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DISCHARGE CRITERIA – PICU

Discharge to:

☐ HDU / Step down ICU ☐ Ward ☐ Outside Facility ☐ Others: D/S

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: Jayashree

Name of the Doctor: Jayashree

Date & Time: 11/07/2016 @ 01. pm

PEDIATRIC INTENSIVE CARE ADMISSION RECORD

Date: 10/7/26 Time: 10:25pm.

Patient Assessment Form:

Informant: ☐ Father ☒ Mother ☐ Other

Presenting Complaints / Chief Complaints : Alleged history of fall of
wooden almanac on head on 10/7/26 3:00pm at home
near yusufsada.

No loss of consciousness, bleeding from nose, mouth, ear
No seizures.

+/- vomiting 3 episodes post incident.

+/- headache post incident

went to local hospital advised CT scan

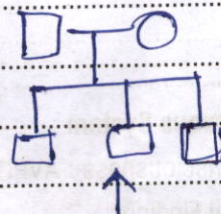
Referred to higher center for further management.

Past History (Including previous treatment and investigations) :

No previous hospitalization in past.

Birth and Developmental History :

Term | LCCS | Btwt 2-7kg | No NICU admission.



Immunization History :

attained milestones as per age.

H / O Allergy :

Family History :

varicella free age.

INITIAL ASSESSMENT

RBS : Temperature : Weight (kg) : 15 kg

Respiratory System Findings:

Air Way: ☒ Open ☒ Maintainable ☐ Not Maintainable Intubated, If Intubated, size & position of ETT :

Respiratory Examination Finding: (Air entry, breath sounds, s/o distress etc.): BAECP Respiratory Rate :

SPO₂ : 98% O by NC / FM / NRB mask / Oxyhood, at Room Air L / min

Ventilatory Support : Yes ☒ No ☐ Day # of Vent : Respiratory Efforts :

Ventilatory Settings : Leak around ETT : Delivered Vt :

ABG : EtCO₂ : P/F ratio : O.I. :

Any Nebs : ICD? Yes ☐ No, if Yes, details :

CXR :

Cardio Vascular System Clinical Exam : Heart Rate : 90 Cardiac Rhytho : sinus

(Heart sounds, murmur etc.) : good

Quality of Pulses : good cap refill Time : ~ 2 sec Liver Edge : cm below Rt costal margin

Blood Pressures : NIBP : 90/60/60 mmHg IBP : CVP :

Infusion of any Inotropes? : Yes ☐ No ☒ If yes, then details :

Any Other Infusions :

Last 2D Echo Findings :

Size of the heart and lung fields in latest CXR :

Arterial line in Situ : Yes ☒ No ☐ Place of art, line & its condition :

Central line in Situ : Yes ☒ No ☐ Place of central line & its condition :

Infection and Antibiotics :

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

Cultures Done outside? Yes ☐ No ☒ If yes, details :

Describe c/s Reports :

Other Labs (Latex, Serology, etc) : left eye bow swelling lateral side

Ongoing Antibiotics : 1x1 cm

Abdominal Exam : soft

ENT Exam :

Central Nervous System :

Level of Consciousness : AVPU / GCS score : alert, active

Neurological Findings : GCS 15/15

no focal defect

Relevant data from outside (Neuro imaging any ongoing medications etc) : pupil 2mm 2mm

reactive reactive

Special Needs Screening: (If any of the below are Positive, Please fill "Cross Consultation Form" to Concerned Department)
(Please select and 'tick mark' [✓] the boxes as applicable)

- a. Nutritional Screening Criteria: Screening is ☐ Positive ☒ Negative
- | | | | |
|--|--|---|---|
| ☐ Diabetes Mellitus | ☐ Needs Therapeutic Diet. | ☐ Diarrhoea > 4days | ☐ Food Allergy |
| ☐ Overweight | ☐ Psychological Eating Disorder | ☐ Major Surgery | ☐ Patient in ICU |
| ☐ Under Weight | ☐ Difficulty swallowing / Chewing | ☐ Hyperemesis gravidarum | ☐ Tube Feeding |
| ☐ Poor Appetite > 3days | ☐ Unplanned Change in Weight | | |

- b. Psychological Screening Criteria: Screening is ☐ Positive ☒ Negative
- ☐ Non-compliance to offered treatment Over weight ☐ Suspected Drug Abuse
- ☐ Emotional / Behavioural Problem (Tearful, uncooperative)

- c. Functional Screening Criteria: Screening is ☐ Positive ☒ Negative
- ☐ Patient cannot position himself in bed ☐ Change in Muscle Power
- ☐ Restricted ROM ☐ Impaired Daily Living Activities

- d. Socio-economic Screening Criteria: Screening is ☐ Positive ☒ Negative
- ☐ Living alone ☐ Suspected abuse or neglect
- ☐ Cultural or religious background that would need to know for the plan of care ☐ Unable to assess due to lack of family

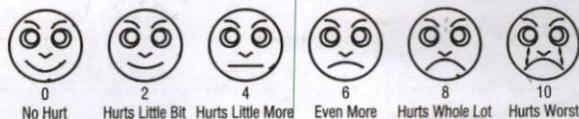
e. Need for Interpretar Screening is ☐ Yes ☐ No If Yes then plan

6. Patient needs additional specialized assessments: ☐ Yes ☒ No
- If yes, Please fill Individualized Initial Assessments Form for Special Populations
- Others

Pain Screening:

Pain Scale used Wong Baker (Scale 0-10) FLACC (Scale 0-10)

Pain Score "Whenever Applicable"



Location:

Duration: days / weeks / months (Strike Out that is not applicable)

Character: ☐ localized ☐ diffuse ☐ sharp ☐ aching ☐ referred - ☒ vague ☐ burning / soreness

Frequency: ☐ constant ☒ intermittent ☐ occasional

Pain Management done ☒ Yes ☐ No

Nutritional Evaluation: well nourished.

Current Medications:

Provisional Diagnosis : mild TBI .

Prism III score at 24 hrs of admission : 0 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 : AS per Rota .

Indication for PICU referral : mild TBI

PLAN OF CARE

Preventive aspects of the treatment : Seizures .

Desired goals of the treatment : hemodynamic stability .

PLANNED INVESTIGATIONS

✓ CBP, RR₂ .

Noted by
Dr. Nithin
10/12/26
@
10:30pm

PLANNED MANAGEMENT

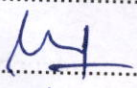
~~DRG~~ ~~DRG~~ .

iv levetiracetam
iv paracetamol .
iv ondansetron

Noted by
Helen

10/12/26
@10:30pm

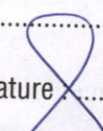
Final Diagnosis : mild TBI .

Doctor's Signature : 

Name : Dr. Nithin

Date : 10/12/26 .

Time : 10/12/26 @10:30pm

Consultant's Signature : 

Name : Dr. Karri Venkata Sandeep Reddy

Date : Reg. No: TSMC/FMR/15713

Time : 11/12/26 @ 01Am

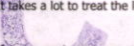
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/2026 8:10pm	<u>C/S/B Plan Team</u> Alleged history of fall of wooden algebra on head on 10/7/2026 @ 3:00pm at home near Yungpales. History of 3 episodes of vomiting post injury. No H/o seizure / loss of consciousness + No bleed / focal deficit O/E child is Alert/Active HR - 90/min SpO ₂ - 100% & Room air RR - 20/min. BP - 96/60 mmHg Cals: GC - 15/15 pupls - BL 2mm & Reacting to light No focal deficit p/a - soft, Abdomen Abnormally CVC - S/S (+) mo Respir: SAE (+) No added sound No other external injuries	<u>Plan</u> To discuss CT head Send CBP RP2 Tij - Esomeprazole Supp - Paracetamol (A) w/F Danger signs (B) counsel parents (C) Rx Indication. Noted by Athen 10/7/2026 @ 10:30pm AA Dm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/2021 8:10pm	History explained CT videos shared	clerk Dr. Vineeth (Radiologist)
		Physician
		No obvious fractures or intracranial Bleeds.
10/7/2021 2:10pm	History explained CT videos shared.	clerk Dr. Praneeth (Neurosurgeon)
		dem
		No Active intervention from neurosurgical side
		Noted by Aiven 10/7 10:35pm
		Dr. Praneeth



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Dr. Vikas

Dr Mathew.

Date & Time	Progress Notes	Doctor's Order
10/2/26 11:15 PM	<u>counseling notes:</u> patient had alleged history of fall of almaray on head followed by 3 episodes of vomiting with headache. CT brain discussed with radiologist no obvious fracture no hemorrhage is seen. If there are no further vomiting and patient is stable, patient can be discharged in 24 hours. patient condition explained to attendants in their own language.	
	<u>Wieder</u> (MATH)	<u>1st</u> to mother



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[illegible]

BAH-00661266
Master SYED AAHL
06-09-2021 4 Y 10 M 4 D (M)
Dr. SANDEEP REDDY
IP5-00176238



DAILY ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 10/7/26 Day of Admission : Day-2 Today's Date & Time : 11/7/26 8AM
PRISM - III Score in first 24hrs. of Admission : 0 Today's SOFA Score :

OVERVIEW	Diagnosis : mild TBI.	Current Issues : = Nil-
	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 : 98% O ₂ by NC / FM / NRB mask / Oxyhood, at Room Air 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 :	
CARDIO VASCULAR SYSTEM	Cardio Vascular System Clinical Exam (Heart sounds, murmur etc.) : Spurs HR - 90	
	Quality of Pulses : good cap refill Time : 2.2 sec. Liver Edge : cm below Rt costal margin	
	Blood Pressures : NIBP : IBP : 100/60 CVP : 70 mm Hg	
	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 :	
	Neuro Exam : alert, active GCS 15/15	
	Pupils : 2mm 2mm reacting Sedation Used ? ☐ Yes ☒ No Any paralysis ? ☐ Yes ☒ No	
Types of Sedation : Types of Paralysis :		
Relevant CT Scan, MRI EEG, Neurosonogram etc. : CT - Brain - (N)		
Plan of Care : Ramsay Sedation Score :		

FLUIDS STATUS NUTRITION AND G.I	☐ NPO ☒ PO feeds ☐ NG Feeds ☐ NJ Feeds ☐ GT Feeds I / O / Balance : / (+/-) Input : ml/k/d UO : ml/kg/hr Stools : NG output : PO intake : Feed Formula : <i>soft diet</i> Feed Schedule : 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 <i>141</i> K <i>4.1</i> Cl <i>103</i> Ca Mg P HCO3 Sr. Amylase : Sr. Lipase : Latest LFT : Abd Exam : <i>soft</i> 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 : Other Labs (Latex, Serology, etc) : Ongoing Antibiotics :	
	Sr. Creat : <i>0.3</i> Bld. Urea : <i>41</i> 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) : <i>10/2</i> <i>12.7</i> <i>12850</i> <i>2.54 lakn</i> Any Coagulopathy : <i>76</i> Relevant Transfusion History : <i>20</i> 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 :	
	Review soft to room .	

Doctor's Name (Handover given) : *Dr. Nathan*
 Signature : *[Signature]*
 Date & Time : *11/7/26 8 AM*

Doctor's Name (Handover taken) : *Suby*
 Signature : *[Signature]*
 Date & Time : *11/7/26 8 AM*

MLC

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ES AND DOCTOR'S ORDER



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
07/26 2:30pm	cls/B Dr. Sandeep Reddy sis	
	Asin - Mild TBI	
	current glue - Nil -	<u>Plan</u>
	on Room A6	Discharge today
	HR - 81/min	
	SpO ₂ - 99%	
	RR - 18/min	Teoh!



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SS NOTES AND DOCTOR'S ORDER

[illegible]



CROSS CONSULTATION FORM

Doctor Name: Dr Partha Date: 11 Time: @ 10 AM

Diagnosis: TBI

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:

Head injury → 3 episodes of Vomiting

Signature: [Signature]

Findings and Recommendations :

Plan

CT head (report awaited)

No obvious intraparenchymal bleed

No obvious extra-axial bleed

Right frontal undrained dural fracture noted

① Danger has explained

② Continue Anti emetics and Analgesics

③ Parents counselled.

④ Review on Monday

Consultant: Dr. Partha

Name: [Signature] Signature: [Signature]

Date & Time: 11/7/2020

@ 10 AM

BAH-00661266 IP5-00176238
Master SYED AAHIL
06-09-2021 4 Y 10 M 4 D (M)
Dr. SANDEEP REDDY



MLC

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RESULT SHEET

Date	10/2/26				
Time	11:30pm				
Hb	12.7				
PCV	38.5				
RBC	5.10				
WBC	12850				
N/L	76/20				
Platelets	2.54 lakh				
CRP					
ESR					
PCT					
RBS					
Na	141				
K	4.1				
Cl	103				
Ca/Mg					
Phosphate					
Urea	41				
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					

11003

20

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MEDICATION RECONCILIATION FORM

Drug Allergies:

☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER

Shifted to: Ward / PICU

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Ramya

Date & Time : 10/11/26 ; 9:10pm

Nurse Name & Signature: Anneel

Date & Time : 10/11/26

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06-09-2021

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4 Y 10 M 4 D

(M)



DRUG CHART

Date of Admission: 10/7/26 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG : <u>Syp. CROCI-N-DS</u>				Date Time
Dose <u>5ml</u>	Route <u>PO</u>	Frequency <u>SOS</u>	Start Date <u>10/7/26</u>	
Doctor's Signature <u>Dr. Ranga</u>		Valid Period	Pharm.	
Additional Instructions:				

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

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



REGULAR PRESCRIPTIONS

Weight. 15.06kg Ward. P100

DRUG : <u>Syr ESOMEPRAZOL</u>				Date Time	<u>10/7/21</u>
Dose	Route	Frequency	Start Date		
<u>15mg</u>	<u>IV</u>	<u>OD</u>	<u>10/7</u>		
Name & Signature of the Doctor Starting the Drugs:				<u>S. Santhi</u> <u>6 am</u> <u>10/7/21</u> <u>10/7/21</u>	
Additional Instructions:					
<u>@ 1mg/kg/dose.</u>					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>Syr PARACETAMOL</u>				Date Time	<u>10/7/21</u>
Dose	Route	Frequency	Start Date		
<u>5ml</u>	<u>PO</u>	<u>TID</u>	<u>10/7</u>	<u>6 am</u>	<u>X</u> <u>10/7/21</u>
Name & Signature of the Doctor Starting the Drugs:				<u>S. Santhi</u> <u>2 pm</u> <u>X</u>	
Additional Instructions:					
<u>@ 15mg/kg/dose.</u>				<u>10 pm</u> <u>10/7/21</u>	
Daily Doctor's Endorsement by a Sign					
DRUG : <u>Syr ONDANSETRON</u>				Date Time	<u>10/7/21</u>
Dose	Route	Frequency	Start Date		
<u>2.5mg</u>	<u>IV</u>	<u>TID</u>	<u>10/7</u>	<u>6 am</u>	<u>X</u> <u>10/7/21</u>
Name & Signature of the Doctor Starting the Drugs:				<u>S. Santhi</u> <u>2 pm</u> <u>X</u>	
Additional Instructions:				<u>10 pm</u> <u>10/7/21</u>	
Daily Doctor's Endorsement by a Sign					
DRUG :				Date Time	
Dose	Route	Frequency	Start Date		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

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4 Y 10 M 4 D

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Weight. Ward.

Master SYED AAHIL 06-09-2021 4 Y 10 M 4 D (M) Dr. SANDEEP REDDY 		Date Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
		Dose		Dose		Dose		Dose			
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.			
Route		Start Date		Dose		Dose		Dose			
				Dr. Sign.		Dr. Sign.		Dr. Sign.			
Name & Signature of the Doctor				Dose		Dose		Dose			
				Dr. Sign.		Dr. Sign.		Dr. Sign.			
Additional Instructions:				Dose		Dose		Dose			
				Dr. Sign.		Dr. Sign.		Dr. Sign.			

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

STAT / ONCE ONLY DRUGS[illegible]

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4 Y 10 M 4 D

06-09-2021

4 Y 10 M 4 D

(M)

Weight. 75.06 kg Ward. 940

Dr. SANDEEP REDDY



1 of I.V. Fluid
/hr = Mcg/kg/min. etc)

Route

Flow Rate
ml/hr

Doctor
Sign

Nurse
Sign

Date of Stopping

Doctor
Sign

Nurse
Sign

10/9/20

DNS

(1/2 mint)

IV

35

2

Doneb

10/7

W

Am Haler	
---	--

VERIFIED BY: Name:

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INITIAL ASSESSMENT FOR PICU

Date of Admission: 10/12/20 @ 10:25 PM
Source of Admission: ☒ OPD ☐ Ward ☐ Other: ER
Reason for Admission: head injury due to fall from upboard
Admission Diagnosis: Mild TBI
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	No past hospitalization	no past surgical history	-
	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: _____ 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: 15kg Length: - Head Circumference (< 2 years): - Temp.: 98.6 F HR: 85 RR: 23 BP: - Pain Score: 0 Specify Site: NA (Follow Pain Assessment Sheet & Document) Fall Risk Assessment: ☒ Yes ☐ No Score: 11 (Document in the Humpty Dumpty Sheet) Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)			

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☐ 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): 10/7/26

Social History: Lives With

Siblings in household ☒ Yes ☐ No (if yes How Many?) 2

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: Aiven

Nurse Signature: Aiven

Date & Time: 10/7/26 @ 10:45pm

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: Mild TBI

Nurse Name: Aiven

Nurse Signature: Aiven

Date & Time: 10/7/26 @ 10:30pm

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NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA : 10/7/26		Diagnosis : Mild TBI		Surgery / Procedures : -	
	Allergies : -				Post OP Day : -	
	Date :	10/7/26				
	Area					
	Shift Time	PICU Night				
	Diet :	orally				
INVASIVE LINES	Ventilation (RA, NP, NIV, VENTI)		RA			
	1.					
	2.	cannula				
	3.					
	4.					
ASSESSMENT	Infusions / Transfusions		no			
			infusions			
	PU Prophylaxis		NA			
	DVT Prophylaxis		NA			
	Vitals	BP	91/69			
		PR	78			
		RR	20			
		SpO ₂	100			
		Temp	98.6F			
	Pain Score		0			
	LOC (Alert, Conscious, Confusion, Unconscious)		Alert			
	Skin Integrity (Intact / Bedsore / Any other condition)		Intact			
	Restraints If any	Physical	NA			
		Chemical				
	Fall Risk (Vulnerable (Y/N) if yes score)		yes			
(Ambulation, walking, moving with assistance, bed ridden)		mainly				
ADL (Dependent / Non-Dependent)		dependent				
Critical Lab Test / Values (if any)		nil				

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

RECOMMENDATIONS	Investigations Procedures	Date :	10/7												
		Area	Shift Time	11:00 night											
		Ordered / Planned								Followed doctor's order					
		Due	no due												
									Reports Pending						
										Referrals (If any)	no Referrals				
		Remarks (Special Interventions like, Drainage Tube flushing etc.)	no Remarks												
									Handed Over By Name :						
										Signature :	Arver				
		Date :	10/9/26												
									Time :						
										Taken Over By Name :	Vandana				
		Signature :	Vandana												
									Date :						
										Time :	@8am				

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 10/11/20

Assessment: Pain

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
10pm	To Assess the Baby condition	10pm	Assessed Baby condition	All plans are implemented
12Am	To monitor vitals of baby	12Am	Monitored vitals of baby	
2Am	Plan to send CBP, RP2	3Am	Sended CBP, RP2	
4Am	Administer medicine as Plan.	5Am	Administered medicine as Plan.	
6Am	Provide comfortable position	7Am	Provided comfortable position	

Re-Assessment: Re-Assessment done

Special Notes: wlf pain, Bleedings.

Nurse Signature: [Signature]

Nurse Name: Aiven C. Ma

Date & Time: 11/11/20 5Am

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NURSING CARE RECORD

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:

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3			
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1			
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1			
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
TOTAL			11	4			

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓				
Call device within reach		✓				
Wheels Locked		✓				
Room free of clutter		✓				
Adequate Lighting		✓				
Wheel Chair Support		NA				
Other Intervention(s) Specify		NA				
Nurse's Name :		Rishi				
Signature :		Rishi				
Date :		10/17				
Time :		10pm				

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MULTI-DISCIPLINARY PLAN OF CARE FORM

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Di:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
10/1/26	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Mild TBI	Hemodynamic stability	PIV observation		☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☒ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I.

Patient's

Patient / Learner Literacy:

☐ Read☐ Write☐ SpeakWillingness to Learn: ☐ Yes ☒ NoHealthcare 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		
10/11	10:00	10	Fire Risk Education	mob	1	2	1	1	NO	

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: <table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>									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	
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: <table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>									1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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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BRADEN 'Q' SCALE

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				Date :	10/9/20	11/7/20		
				Time :	10:30	6:45		
Mobility	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.	9	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.	9	4		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	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.	4	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	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	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.	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	23		
Docu. No. : RCHBH /FRM / CLINICAL / 119				Evaluator's Name	Amit	Amit		

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



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							
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						Anu							

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 : [Signature] Name : [Signature]

Signature of Ward In Charge :

Signature : [Signature] Name : [Signature]

BAH-00661266

IP5-00176238

Master SYED AAHIL

06-09-2021

4 Y 10 M 4 D

(M)

Dr. SANDEEP REDDY



PAIN ASSESSMENT FORM

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

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Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
10/7	10:20	0/10	WB	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NO N	Amb
11/7	1am	0	WA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	AMC
11/7	4am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	AMC
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

1. Every eight hours for all hospitalized patients.

2. For post-surgical patients, patients with chronic pain, patient with severe pain:

- a) At least every 2 hours for the first 24 hours
c) Prior to pain pain-relieving intervention.

b) Then every 4 hours.

d) Within 30 – 60 minutes after relief intervention.

Docu.No: RCHBH /FRM / CLINICAL / 152

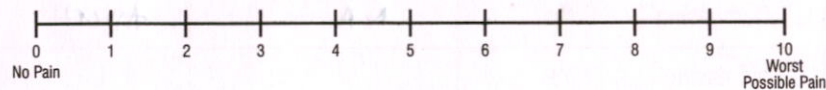
(P.T.O)

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 - slow recovery - 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



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Date & Time : 11/07/20

BAH-00661266 IP5-00176238
Master SYED AAHIL
06-09-2021 4 Y 10 M 4 D (M)
Dr. SANDEEP REDDY



DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor: Dr. As per Rote (PICU)

Date: 10/7/26

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

Start Time of Assessment: 9pm

Weight: 15.06 kg

Allergic History: _____

Chief Complaints:

Accidental fall of cupboard on left
side of head on 10/7/26 @
Sustained head injury
3 episodes of vomiting, headache

Pediatric Assessment Triangle

A Appearance - TICLS _____

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

Significant Past History: _____

2. High level (N) transition NO H/O NICU stay

Medication History: _____

Family H/O

Relevant Investigations: _____

H/O Paternal grandfellow - peritonitis (P)

Primary Assessment

Airway

☒ Open

☐ Maintainable

☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____

Breathing

Rate: 25/min SpO₂ on FiO₂ 100% on RA

Rhythm: Regular

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR

☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: BILAE (P)

Palpation Findings (If necessary): _____

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____



Circulation

HR: 82/min

CFT ☐ Central
☐ Peripheral

Any urgent interventions needed: ☐ Yes ☒ No

BP: 97/67 (72) mmHg

Pulse Volume: ☐ Central
☐ Peripheral

If in Shock: ☐ Compensated
☐ Hypotensive

Muffled Heart Sound: ☐ Yes ☒ No

Engorged Neck Veins: ☐ Yes ☒ No

Murmurs: ☐ Yes ☒ No

Liver Span:

ECG:

Any Signs of Heart Failure: ☐ Yes ☒ No

If Yes



Disability

GCS: 8.15/15 AVPU:

Pupils: ☐ Responsive ☒ Non-Responsive ☐

Size ☐ Right
☐ Left

Active Seizures: ☐ Yes ☒ No Sugars:

Signs of Neurological compromise

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

Exposure



Temp.: 98.1 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:

Labs Planned: CBP, CRP, S. Electrolytes

CT Head plain done on OPD basis

Treatment Planned:

• IV Fluids (Normantamine)
• Admit in PICU

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

High Flow ☐ PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): Mild Trauma Brain injury

Assessment done by

Name of the Doctor: Dr. Ramya

Signature: [Signature]

Date & Time: 10/7/26; 9:10pm

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor:

Signature:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. S.R Department: picu Date of Admission: 10/7/20

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
BACKGROUND	Area	<u>CA</u>					
	Shift Time						
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>NA</u>					
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:	<u>98.3</u>				
		Res:	<u>24</u>				
		SpO ₂ :	<u>100%</u>				
		Pulse:	<u>82bpm</u>				
		BP:	<u>94/67</u>				
		Fall Risk Score:	<u>10</u>				
Pain Score:	<u>0/0</u>						
Recommendations	Safety Needs:	<u>yes</u>					
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	<u>NO</u>					
	Special Diet:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>NO</u>					
Post Operative Procedure Special Orders:		<u>NO</u>					
Handed Over By Name :		<u>Aneel</u>					
Signature :		<u>[Signature]</u>					
Date:		<u>10/7/20</u>					
Time:		<u>10/20</u>					
Taken Over By Name :		<u>Aiven</u>					
Signature :		<u>[Signature]</u>					
Date:		<u>10/7</u>					
Time:		<u>10:25pm</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						
BACKGROUND	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:					
	Res:						
	SpO ₂ :						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

CONSENT FOR ADMISSION IN PEDIATRIC INTENSIVE CARE UNIT

MILC

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to treat the little.

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BAH-00661266
Master SYED AAHIL
06-09-2021 4 Y 10 M 4 D (M)
Dr. SANDEEP REDDY
IP5-00176238

Name:

Gender: Male ☒ Female ☐

UHID.No :

Date: 10/7/26

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

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

mild TBI.

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 :

Signature: Vajeda

Name: Vajeda

Relationship with Patient: Mother

Date & Time: 10/7/26 @ 10:40pm

Witness :

Signature: Vajeda Arun

Name: Arun

Date & Time: 10/7/26 @ 10:40pm

Doctor (who is taking the consent) :

Signature: Dr. Sandeep Reddy

Name: Dr. Sandeep Reddy

Date & Time: 10/7/26 @ 10:40pm

**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.హెచ్.డి.

నేను s/o. d/o. w/o.

..... అనే బాలుడు / బాలిక యొక్క చికిత్స మేరకు రెయిన్ బో పిల్లల అనుపత్తి లోని పిల్లల ఇంటెన్సివ్ కేర్ యూనిట్
తేదీ నాడు పూర్తి సమ్మతితో చేర్చితిని.

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

రెయిన్ బో చిల్డ్రన్స్ హాస్పిటల్ లోని పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో చేరింది జడ్డకు 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 సిర మరియు ధమనుల కాథెటర్ వంటి. పెరిఫెరల్ ఇన్ఫర్స్ చేయబడిన సెంట్రల్ కాథెటర్ లైన్ మరియు ఆర్థో లైన్ ప్లేస్ మెంట్స్, ఛాతీ డ్రైయిన్ లేదా పెరిటోనియల్ డ్రైయిన్ ఇన్ఫర్స్ 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 జడ్డ ప్రాణాన్ని కాపాడేందుకు ఇతర వైద్య ప్రక్రియలకు నేను సమ్మతి ఇస్తున్నాను.

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

ఒక జడ్డ 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 కలిగవచ్చు 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 ధృవపరుస్తున్నాను.

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

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సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము