

RD FOR BILLING

UHID No. : _____ II KUH-00211197 IPS-00176761 Patient: _____ Dept : _____

Date of Admission: _____ Master YADLA DEVASHISH 16-05-2023 3 Y 2 M 6 D (M) if Discharge : _____ Time: _____
Dr. NALLA ANURAG REDDY



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
22/7/26	11:30 am	ER	ON/O	Abhishek

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

[illegible][illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
22/7	Lumbar puncture	②	9716299	Veenq
	conscious sedation			

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : 22/7/26

Time : 2pm

Prepared By : Veenq

Staff Nurse Veenq	Shift / Ward Dayshift oncology	Billing Assistant	Billing Supervisor
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KUH-00211197 IPS-00176761
Master YADLA DEVASHISH
16-05-2023 3 Y 2 M 6 D (M)
Dr. NALLA ANURAG REDDY




**Rainbow
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ADMISSION CRITERIA – ONCOLOGY

Admission / Transfer from:

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

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

- ☐ For Chemotherapy-Day Care or IP Admission as per the Type of Chemotherapy
- ☐ Febrile Neutropenias (ANC <500 cells / mm³)
- ☐ Netropenic Enterocolitis
- ☐ Mucositis Induced Significant Diarrohea or Pain
- ☐ Neurological Complications (like Seizures, Bleeding, Thrombosis) that can arise while on Chemotherapy Treatment or at the Time of Presentation and also for other Systemic Problems like Pancreatitis during Chemotherapy
- ☐ Management of Oncological Emergencies
- ☐ Bleeding Problems (where it is indicated)
- ☐ Evaluation and Management of Severe Anemias
- ☐ Day Care Admissions for PRBC Transfusions
- ☐ Evaluation and Management of Sick Children who come with Hematological Problems like Severe Anemia like Autoimmune Hemolytic Anemia/ Bleeding/ Others
- ☐ Primary Immunodeficiency Disorders with Infections that Warrants Hospitalisation
- ☐ Management and Evaluation of Hemophagocytic LymphoHisticytosis
- ☐ Any Systemic Disorders with Significant Hematological issues like JRA / SLE with Secondary HLH

Signature of the Doctor:

Name of the Doctor:

Date & Time: 22/7/26 @ 11:30AM

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DISCHARGE CRITERIA – ONCOLOGY

Discharge to:

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

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

- ☐ Completion of chemotherapy, with no debilitating side effects.
- ☐ Resolution of febrile episode, with no fever > 24hrs and Absolute Neutrophil count (ANC) > 500cells/mm³.
- ☐ Admitted patients - Once the admitting problem gets resolved or made a plan to manage further on out-patient basis.

Signature of the Doctor:

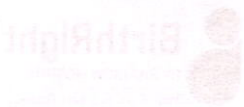
Name of the Doctor :

Date & Time: 22/7/26 @ 3pm



DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	2			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	1			
7	Nursing plan of care and handover sheets	2			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation	4			
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				
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				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Extra	6			
		(29)			
	Total No. of Pages				



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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

ADMISSION SHEET

Registration Details :


Admission No : IP5-00176761 Admit Date : 22-Jul-2026 Admit Time : 11:08 AM UHID : KUH-00211197

Patient Details :

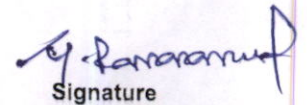
Patient Name	: Master YADLA DEVASHISH	Age	: 3 Y 2 M 6 D
Guardian	: Mr YADLA RAMANAMURTY	DOB	: 16-05-2023
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: FLAT NO 202, H NO 78, SRI SAI NILAYAM Ramachandra puram Sangareddy Telangana INDIA 502032	Phone No	: 9491876210/ 7288048218
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : DAY CARE Bed No : HO DC 3 Ward Name : 1F-HEMATO-ONCOLOGY
 Room No : HO DC 3 Admission Type : First Visit

Contact Details :

Name : Mr YADLA RAMANAMURTY Relationship : Father
 Contact Address : FLAT NO 202, H NO 78, SRI SAI NILAYAM
 Ramachandra puram Sangareddy Telangana
 INDIA 502032 Phone No : 9491876210


 Signature

Doctor Details :

Doctor Name : Dr. NALLA ANURAAG REDDY Specialisation : HEMATO ONCOLOGY
 Referral Doctor : Self Phone No :
 Co-Consultant :

Payment Details :

Deposit Amount : 0.00
 Payment Mode : Cash Payor Name : STAR HEALTH AND ALLIED
 INSURANCE CO LTD

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 11/120hr	QIC/B Dr Ramya Sammeta ER Resident OIE KICLO B cell ALL CAU+ve, CNS -ve, Standard cytogenetics / MRD -ve consolidation Now came for LP clo fever cough - cold 1wk back. treated with syp cefixime for 5 days now clo cough & cold non productive OIE - child active Temp - 98.4°F HR - 91 bpm BP - 101/53 (64) RR - 20 / min SpO₂ - 98% ERA CRT - green Re - BARE clear PLA soft non tend	Re - NPO - Dr fluids - Inj ondansetron - LP N/B Abhishek 021048 @ 11:30 AM Re

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RESULT SHEET

Date					
Time					
Hb					
PCV					
RBC					
WBC					
N/L					
Platelets					
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

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DRUG CHART

Date of Admission: Dec 24/22 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 :				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:																			

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

VERIFIED BY : Name

Weight. 14.9 kg Ward.

Page: 2/4

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]



I.V. FLUIDS CHART

Weight. 14.9 kg. Ward.

[illegible]

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ION 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: Hemat-oncology

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	TAB AMLODIPINE	5mg 1/2 tab	PO	OD BID	21/7/26 8am	☒ C ☐ DC
2	TAB VORICONAZOLE 200mg	1/2 tab	PO	OD	21/7/26 8am	☐ C ☐ DC
3	SYP SEPTRAN TRIMETHOPIM-SULFAMETHOXAZOLE	5ml	PO	BD (Mon-Wed) Fri	21/7/26 8am	☐ C ☐ DC
4	SYP MOKTEL	5ml	PO	OD	21/7/26 8am	☐ C ☐ DC
5	DOMSTAL SUSPENSION	2.5ml	PO	TID	22/7/26 (8am)	☐ C ☐ DC
6	SYP-CALCIMAX PLUS	2.5ml	PO	TID OD	21/7/26	☐ C ☐ DC
7						☐ C ☐ DC
						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

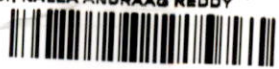
Doctor Name & Signature: Dr. Ramya Sammetla

Date & Time: 22/7/26 11:12am

Nurse Name & Signature: Abhishek Abhis

Date & Time: 22/7/26 @ 11:30am

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PAIN ASSESSMENT FORM

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Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
02/7/24	11:00 AM	0/10	NEI	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	— NA —	Abhishek
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

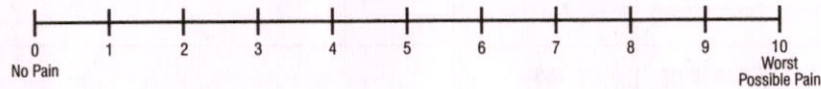
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours.
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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





PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	22/5/24	Time:	12pm	
Doctor / Nurse / Family Concern?				
Temperature (F)	104			
	103			
	102			
	101			
	100			
	99	98.6		
	98	*		
	97			
	96			
	95			
94				
Heart Rate (bpm)	190			
	180			
	170			
	160			
	150			
	140			
	130			
	120			
	110			
	100	100		
and Blood Pressure (mmHg) *	90			
	80			
	70	71		
	60	60		
	50			
	40			
	30			
	20			
	10			
	0			
Note: BP does not score in early warning scoring				
Heart Rate (Number)		106b/m		
Resp. Rate (bpm) (Over 1 Minute) *	70			
	60			
	50			
	40			
	30			
	20			
	10			
	0			
	Resp Rate (Number)		26b/m	
	Resp Distress	Mod/ Severe None / Mild	0	
Receiving O ₂ (l/min) O ₂ Saturations (%)		100%		
Conscious Level	Normal Altered	C		
GCS *		15/15		
TOTAL SCORE		0		
Number of shaded boxes		0		
Pain Score		0		
Observer's Initials		Ger		

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 11:30am Mode of Arrival: By mother Admitting From: ☒ ER ☐ OPD ☐ Direct
Allergy / Adverse Reaction No allergy reaction Body Weight: 14.30 Kg
Height: cm

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

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

Family History: Healthy family

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

es 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: 14.3 kg Length: Head Circumference (< 2 years):
Temp.: 98.6 F HR: 106 bpm RR: 26 bpm BP: 100/60 (71) mmHg

Pain Score: Specify Site: (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)

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

Character of Pain Location Frequency Duration

FUNCTIONAL SCREENING:

- ☐ Mobility Problem
☐ Developmental Delay

☒ No Abnormalities Detected

- ☐ Walking Problem
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

- ☐ Underweight
☐ Feeding Problem

- ☐ Overweight
☐ Special diet

☒ No Abnormalities Detected

- ☐ Special Feeding Method
☐ 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):

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 ☐ No

Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump : ☒ Yes ☐ No

Hand hygiene Explained: ☒ Yes ☐ No

☐ Others

Patient Rights & Responsibilities: ☐ Yes ☒ No

Information given to parents

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date: 22/7/26

Time: 11:40 AM

KUH-00211197 IP5-00176761
 Master YADLA DEVASHISH
 16-06-2023 3 Y 2 M 6 D (M)
 Dr. NALLA ANURAG REDDY



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 Your Right to a Safe Delivery

FLUID CHART

Sheet No. :

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

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

KUH-00211197 IP5-00176761
Master YADLA DEVASHISH
16-05-2023 3 Y 2 M 6 D (M)
Dr. NALLA ANURAG REDDY



FLUID CHART

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No. :

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

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
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	06:00 am												
	07:00 am												
	Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output							

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CONSENT FOR SPECIAL PROCEDURES


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Patient Name : Dewashish Gender: ☐ Male ☐ Female

UHID No : KUH-00211197 Department : Neurology Date : 22/7/21

I V. Ramana moorthy S/D/W/O Dewashish

Here by give consent for procedure of : Lp + IT chemo

For my patient, Named :

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

Pain, Headache, Bleeding

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

none

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

Name of the Doctor performing the procedure: Vishwaje

Patient Attendant :

Signature : A. Bharathi

Name : A. Bharathi

Relationship with Patient: mother

Date & Time : 22/7/26 at 11:45 AM

Witness :

Signature : A. Bharathi

Name : A. Bharathi

Date & Time : 22/7/26 at 11:45 AM

Doctor (who is taking the consent) :

Signature : Vishwaje

Name : Vishwaje

Date & Time : 22/7/26 at 11:45 AM

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

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

.....

.....

.....

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

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు (అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము



CONSENT FOR PROCEDURAL SEDATION

Authorization By: ☐ Patient ☒ Patient Attendant

I, the undersigned do hereby acknowledge the following:

- I have been made aware by the doctors in language known to me the details of sedation planned for the procedure
short sedation
- I have been made aware of the possible complications from the procedure of sedation as follows:
- Changes in heart rate, blood pressure, need for oxygen supplementation, allergic reactions, upper airway obstruction, laryngospasm, conversion to general anaesthesia
- I have been made aware that the sedation is being advised to relieve pain and anxiety during the procedure. It will help me remain calm, comfortable, and cooperative, allowing the procedure to be performed smoothly and safely.
- I have been clearly explained about the benefits, risk, and alternative of the sedation which is General Anaesthesia.
- I authorize Dr. _____ and his / her team to perform the procedural sedation upon the patient / myself.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: A. Bharathi
Name: A. Bharathi
Relationship with patient: Mother
Date & Time: 22/7/26 @ 11:45 AM

Witness:

Signature: A. Bharathi
Name: A. Bharathi
Date & Time: 22/7/26 @ 11:45 AM

Doctor (who is taking consent):

Signature: [Signature] Name: Anurag Date 22/7/26 Time: 11:45 AM

ప్రాసీజరల్ సెడేషన్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, క్రింది విషయాలను అంగీకరిస్తున్నాను:

నాకు తెలిసిన భాషలో, వైద్యులు ఈ క్రింది ప్రాసీజర్ కు ఇచ్చే సెడేషన్ గురించి పూర్తి వివరాలు నాకు తెలిపారు:

- సెడేషన్ వల్ల సంభవించగల సాధ్యమైన క్రింది సమస్యలు/ప్రమాదాలు గురించి నాకు తెలిపారు: గుండె వేగం మారడం, రక్తపోటు మారడం, ఆక్సిజన్ అవసరం, అలర్జిక్ ప్రతిచర్యలు, ఎగువ శ్వాసనాళ అడ్డంకి, లాలింజోస్పాస్మస్, జనరల్ అనస్థీషియాగా మారాల్సిన అవకాశం.
- ప్రాసీజర్ సమయంలో నొప్పి, భయం, ఆందోళన తగ్గించేందుకు సెడేషన్ ఇవ్వడం అవసరం అని నాకు వివరించారు. ఇది ప్రాసీజర్ సజావుగా, సురక్షితంగా జరగడానికి సహాయపడుతుంది.
- సెడేషన్ గురించి సంబంధించిన ప్రయోజనాలు, ప్రమాదాలు, ప్రత్యామ్నాయం (జనరల్ అనస్థీషియా) గురించి నాకు స్పష్టంగా వివరించారు.
- డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ ప్రాసీజర్ సెడేషన్ చేయడానికి నేను అనుమతిస్తున్నాను.
- పై సమాచారాన్ని నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ఉన్న ప్రశ్నలన్నీ, నాకు అర్థమయ్యే భాషలో సమాధానమిచ్చారు. ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:



Moderate Sedation Flow-Sheet

Immediate Pre-Sedation Assessment

B.P	PR	R.R	Temp	SPO ₂	Pain Score	Weight
100/70	91	20/min	98.5	98.7	.	14.9kg

Diagnosis: Bleeding

Procedure: LP + RT Chemo

Comorbidities: _____

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

ASA Physical Status

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

☐ E: Emergency procedure

GCS: E 4 M 6 V 6

☐ IV Site: Gauge:

Sedation Plan: IV

Allergies: None

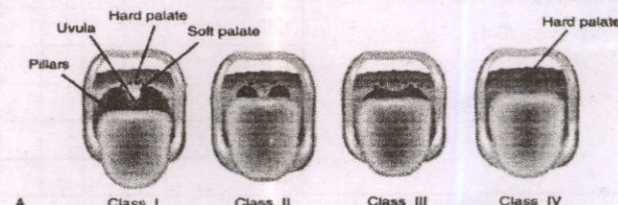
AIRWAY EVALUATION

Mouth:

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

Neck:

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



Mallampati Class: ☒ I ☐ II ☐ III ☐ IV

Monitoring of Patient Intra – Procedure

Procedure Monitoring

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

Level of Consciousness (LOC):

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

TIME	BP	PR	RR	O ₂ Sat%	O ₂ Supplementation	Comments / Initials
Baseline	100/70	100/min	22/min	99%		
11:50am	98/56	106/min	23/min	100%		

DRUG & IV Fluid: (including Nitrous Oxide)	ROUTE	DOSE	TIME GIVEN	SUBSEQUENT DOSES AND TIME
PNT. MIDAZOLAM	IV	0.5mg	11:50 pm	
PNT. LETAMINE	IV	5mg	11:50 am	

Doctor Notes: increased

Time of transportation to post sedation care room: now Case LOC: alert

Doctor Name: Dr. H. G. G. G. Signature: [Signature]

[illegible]

Activity :	Consciousness:	Respiration:	Oxygen Saturation:	Circulation:
Four extremities = 2	Fully awake = 2	Breathe Deep= 2	Sat O ₂ >92 % on room air = 2	BP +/- 20 mm hg of pre-op = 2
Two extremities = 1	Arousal on calling=1	Dyspnea, limited breathing = 1	Needs oxygen to maintain Sat O ₂ >90% = 1	BP +/- 20-50 mm hg of pre-op = 1
No extremities = 0	Unresponsive=0	Apnea = 0	Saturation <90% with oxygen = 0	Bp +/-50 mm hg of Pre-Op = 0

Patient Discharge Time: 11:55pm

Nurse Name: U. Ueng

Signature: _____

Date: 22/2/26 Time: 11:55am

Signature:

Consultant Name: Dr. S. R. She

Stamp

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PROCEDURE SAFETY CHECK LIST (TIMEOUT OUTSIDE OT)

Procedure Name: UP + 2 + Chem Date: 25/8/26 In-Time: 11:30 AM Out-Time: 11:55 AM
Doctor Performing Procedure: Ushwaj Doctor Giving Sedation: Ushwaj Assisting Nurse: Ushwaj

SIGN IN	Time: <u>11:30 AM</u>
Patient is verified using two identifiers (Name & UHID)	Yes ☒ No ☐ NA ☐
All required documents, images, studies are available	Yes ☒ No ☐ NA ☐
NPO Status Checked from Patient / Patient Attendant	Yes ☒ No ☐ NA ☐
Consent is Signed	Yes ☒ No ☐ NA ☐
Any need for blood products	Yes ☐ No ☒ NA ☐
If Yes Comment:	
Any Risk of Hemodynamic Compromise	Yes ☐ No ☒ NA ☐
If Yes Comment:	
Any drug or food allergy	Yes ☐ No ☒ NA ☐
If Yes Comment:	
Correct Site of Procedure Marked	Yes ☒ No ☐ NA ☐
All resources required are correct, available and functioning	Yes ☒ No ☐ NA ☐
Signature of the Doctor: <u>Ushwaj</u>	
Name of the Doctor: <u>Ushwaj</u>	

TIME OUT	Time: <u>11:40 AM</u>
Correct Patient	Yes ☐ No ☐ NA ☐
Correct Site	Yes ☐ No ☐ NA ☐
Correct Procedure	Yes ☐ No ☐ NA ☐
All the team members introduced	Yes ☐ No ☐ NA ☐
Signature of the Nurse: <u>Devi</u>	
Name of the Nurse: <u>Devi</u>	

SIGN OUT	Time: <u>11:55 AM</u>
Name of the Surgical / Invasive Procedure is recorded	Yes ☒ No ☐ NA ☐
Instrument, Sponge and Needle Count Completed	Yes ☒ No ☐ NA ☐
Specimens are labeled	Yes ☒ No ☐ NA ☐
Any equipment problems are addressed	Yes ☒ No ☐ NA ☐
Signature of the Nurse: <u>Ushwaj</u>	
Name of the Nurse: <u>Ushwaj</u>	

Any Adverse / Unexpected Events

0

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THE HUMPTY DUMPTY SCALE 22/7

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

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		✓					
Other Intervention(s) Specify		✓					
Nurse's Name :		Abhishek					
Signature :		Abhi					
Date :		22/7					
Time :		11 AM					

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BRADEN 'Q' SCALE

				Date :	22/7			
				Time :	11 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.	4			
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4			
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			
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			
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			
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			
TOTAL SCORE					28			
Evaluator's Name					Abhis			

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

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