

ACTIVITY RECORD FOR BILLING

Name : _____
UHID No. : _____
Date of Admission: _____
Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

BAH-00531145 IP5-00176180
Master SHRIYAN RATAN
08-10-2021 4 Y 9 M 2 D (M)
Dr. UJJWALA DESAI

Physician: _____
of Discharge : _____ Time: _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
10/7	3:18A	ICU	PICU	[Signature]
10/7/26	10:30AM	PICU	144 A	[Signature]

Cross Consultation Visit

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

[illegible]

Investigations

Signature

CBP, Rpa; CRP.

Respiratory viral.

CXR .

26068827

34182

Aslma

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
10/2	2v Placement	(1)	9695564	[Signature]
11/2	nebulization	(2)	9697377	See
11/2	NHD	(1)	9697377	See

ANY OTHER INFORMATION

x-ray /
shifting summary

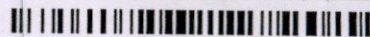
Date : 11/2/20

Time : 10 am

Prepared By : Meel

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Meel	9W II		

ADMISSION SHEET

Registration Details :


Admission No : IP5-00176180 Admit Date : 10-Jul-2026 Admit Time : 04:32 AM UHID : BAH-00531145

Patient Details :

Patient Name : Master SHRIYAN RATAN	Age : 4 Y 9 M 2 D
Guardian : Mr RATAN SATISH	DOB : 08-10-2021
Gender : Male	Religion :
Occupation :	Martial Status : Single
Address (H) : H NO 13-2-267/A/51 Karwan Sahu Hyderabad Telangana INDIA 500006	Phone No : 9963340499/ 6300830497
	E-mail : nomailid@gmail.com

Admission Details :

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

Contact Details :

Name : Mr RATAN SATISH	Relationship : Father
Contact Address : H NO 13-2-267/A/51 Karwan Sahu Hyderabad Telangana INDIA 500006	Phone No : 9963340499 / 6300830497

Signature

Referring Doctor Details :

Doctor Name : Dr. UJJWALA DESAI	Specialisation : GENERAL PEDIATRICS
Referral Doctor : Self	Phone No :
Co-Consultant : Dr. FAISAL B NAHDI	

Payment Details :

Payment Mode : DC/CC Card	Deposit Amount : 15000.00
	Payor Name : SELFPAY

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 an 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 > 4seconds.
☐ Children Blood pressure (Syst.) < [70 + (2 × age "Years")].
Respiratory failure or high risk of failure or airway obstruction:
☐ Respiration rate < 5 per minute below the normal or > 10-15 per minute above the normal range for age.
☐ O2 Saturation < 90 % or need for O2 > 4 Litres per minute by normal face mask. Abnormal ABG: PH < 7.25, PaO2 < 60 torr, PaCO2 > 50 torr.
☐ Distress and risk of exhaustion
☐ **Change of level of consciousness: GCS < 13.**
☐ **Persistent oliguria with acidosis.**

Signature of the Doctor:

Name of the Doctor:

Date & Time:

DISCHARGE CRITERIA – PICU

Discharge to:

☐ HDU / Step down ICU

☒ Ward

☐ Outside Facility

☐ Others:

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

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

Signature of the Doctor: *Madhu*

Name of the Doctor : *Madhu*

Date & Time: *10/8/2016 @ 9.58am*

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176180 Admit Date : 10-Jul-2026 Admit Time : 04:32 AM UHID : BAH-00531145

Patient Details :

Patient Name	: Master SHRIYAN RATAN	Age	: 4 Y 9 M 2 D
Guardian	: Mr RATAN SATISH	DOB	: 08-10-2021
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H NO 13-2-267/A/51 Karwan Sahu Hyderabad Telangana INDIA 500006	Phone No	: 9963340499/ 6300830497
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type : GENERAL WARD Bed No : GW 144 A Ward Name : 1F-GENERAL WARD II
 Room No : GW 144 A Admission Type : First Visit

Contact Details :

Name : Mr RATAN SATISH Relationship : Father
 Contact Address : H NO 13-2-267/A/51 Karwan Sahu Hyderabad Phone No : 9963340499 / 6300830497
 Telangana INDIA 500006


 Signature

Doctor Details :

Doctor Name : Dr. UJJWALA DESAI Specialisation : GENERAL PEDIATRICS
 Referral Doctor : Self Phone No :
 Co-Consultant : Dr. FAISAL B NAHDI

Payment Details :

Deposit Amount : 0.00
 Payment Mode : Cash Payor Name : SELFPAY

BAH-00531145
Master SHRIYAN RATAN
08-10-2021 4 Y 9 M 2 D
Dr. UJJWALA DESAI
IP5-00176180
(M)

PEDIATRIC INTENSIVE CARE ADMISSION RECORD

Date: 10/07/21 Time: 4:00am.

Patient Assessment Form:

Informant: ☒ Father ☐ Mother ☐ Other

Presenting Complaints / Chief Complaints :

child was Irritable ~ 2:00am Early
morn today @ 10/07/21. Father noted to have drooling
of saliva, noisy breathing.

Was brought to Emergency of Rainbow BH

child was given INT. Hydrocortisone
Nebz Adrenaline

Admitted to PICU.

Past History (Including previous treatment and investigations) :

→ Hx similar illness @ 2yr of Age was given
adrenaline & relieved then.

Birth and Developmental History :

FT (AGA) CI AB (DNAR) No NIW adn

Normal Development
As per age

Immunization History :

H / O Allergy :

Family History :

□ T O

INITIAL ASSESSMENT

RBS : Temperature : Weight (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.): Respiratory Rate :

ASTH chest clear

SPO₂: RAE 98+ O by NC / FM / NRB mask / Oxyhood, at 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 : 158/min Cardiac Rhytho : regular

(Heart sounds, murmur etc.): no murmur

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

Blood Pressures: NIBP 109/68 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) :

Ongoing Antibiotics :

Abdominal Exam :

Soft NT No organomegaly,

ENT Exam : blc Grade II Pharyngitis (+)

Central Nervous System:

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

Neurological Findings : blc Pupils R (+)

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

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

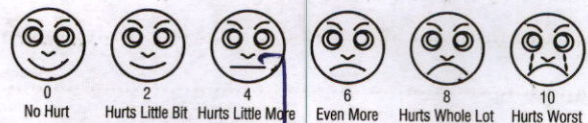
- e. Need for Interpretar Screening is ☐ Yes ☒ No If Yes then plan

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

Not applicable

Nutritional Evaluation: *well built*

Current Medications: *INT. Hydrocortisone*

web 2 Adrenaline

Provisional Diagnosis : Δ: ALTB (mup)

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

☐ Referred Patient - ☐ Self Referral - ☒ Rainbow Patient "

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

Referring Consultant :

Admitting Consultant : Arpuhota,

Indication for PICU referral : → Respiratory monitoring,

PLAN OF CARE

Preventive aspects of the treatment : → to prevent worsening of stridor

Desired goals of the treatment : → Normal respiratory noises

PLANNED INVESTIGATIONS

→ CBC, Rf, CRP
→ Viral Panel

PLANNED MANAGEMENT

→ ceftriaxone IV
→ oral dexamethasone

Final Diagnosis:

Doctor's Signature : Dr. Ujjwala

Name : Dr. Ujjwala

Date : 10/07/20

Time : 4:15pm

Consultant's Signature : Dr. Ujjwala

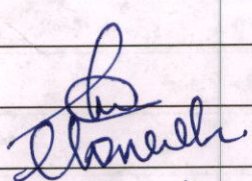
Name : Dr. Ujjwala

Date : 10/07/20

Time : 9:30am

Dr. Ujjwala Desai
Reg. No: 90550

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/02/23 4:45 PM	S/B Pwteam Stridor under evaluation / 2 CROUP	
	Examine ① Acute onset stridor	Adx ① Send CBP, AP2, CAP, Blood clt, 5 viral panel Qr
	On exam air about a/c & apical chest B/L creackles stridor	② Start Cephtriaxone, Azithromycin, Abx E Adx Neb $\bar{c}$ 3% $\bar{c}$ $\bar{c}$ $\bar{c}$ 8mly
	pt soft Bony Snd cm B/L pupils equal and RR	③ Parental counselling ④ watch for Rx
	HR 146/min RR 28/min SpO ₂ : 99% OPA	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/10/2021 @ 4:30 AM	Counselling room 2	Dr. Manish Dr. Vamsi
	child parents been explained in detail that child is having acute injury of airways and it caused significant distress which settled with nebulisation. But still a rebound and workup is expected. monitor the child in ward and two tonight and a shift will plan to shift to ward.	
	- Followed Taken by	4 parties



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26 9:30 AM	SIB Dr. Ujjwala / shifting note A: Group	plan. (1) cont. same (2) shift to room (3) Trace sputal panel - neg Adeno - acute
	no no COB / cough / fever at 2:30 AM - cough	
	on Room air comfortable vital stable	Acute over- stressed - can be shifted out in ward
		Dr. Ujjwala
10/7 8 PM	CLB Resident A: Group.	ga.
	Accepting orally well Improved activity vital - stable	plan Continue same
	Adeno - Acute panel - neg Stop	Trace Adeno - neg - monitor vitals Adeno - Acute panel - neg 1000 Dr. Ujjwala SP



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26	cl/8 @ 2:00pm	
8:30am	85% Croup. NO fever, NO breath complaints ↑ oral acceptance o/r	Agm - 1/2 Ceftriaxone (D2) Stop Azithromycin (D2) 1/2 Hydrocort (D2) - monitor vitals - w/ fever spikes, send for
	Active, alert vitals - stable Hemodynamics nicely - stable Admission - neg	
		Stop ceftriaxone ^{Pup}
	Discharge	Azithromycin 3/5
	# Croup	Lorazepam Nebulizer Budesonide - 500 stop steroids Hydrocort
	Review - Monday	DDW Stop Relentplus Dmgw 24
		Martin 11/7/26

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Master SHRIYAN RATAN
08-10-2021 4 Y 9 M 2 D (M)
Dr. UJJWALA DESAI



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RESULT SHEET

Date	10/07				
Time	4:00am				
Hb	14.4				
PCV	35.0				
RBC	5.55				
WBC	12200				
N/L	5237				
Platelets	436K				
CRP	5.0				
ESR					
PCT					
RBS					
Na	134				
K	3.9				
Cl	103				
Ca/Mg					
Phosphate					
Urea	24				
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					

D110



MEDICATION RECONCILIATION FORM

Drug Allergies: Nil ☒ 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: PICU Shifted to: Ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Inj. CEFTRIAXONE	600mg	IV	Q12H	10/7 6am	☒ C ☐ DC
2	Syrup AZITHROMYCIN	3ml	PO	OD	10/7 10am	☒ C ☐ DC
3	Inj ESOMEPRAZOLE	12mg	IV	OD	10/7 6Am	☒ C ☐ DC
4	Neb C 3/- NS Adrenaline	3ml + 3ml (Am) adrenaline	Neb	TID	10/7 6am	☒ 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: Jayabhi (JY)

Date & Time: 10/07/20 @ 10Am

Nurse Name & Signature: Navaneeth

Date & Time: 10/07/20

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Sheet No:

REGULAR PRESCRIPTIONS

Weight 11.35 Ward

DRUG : Di HYDROCOET				Date Time	10/7/17
Dose	Route	Frequency	Start Dt.		
25mg	Oral	TID	10/7	6 AM	
Name & Signature of the Doctor Starting the Drugs:				Am 8/10/17	
Additional Instructions:				2. Prn 10/7/17	
				Pm 10/7/17	
Daily Doctor's Endorsement by a Sign					

DRUG : NOBT BUDAL				Date Time	10/7/17
Dose	Route	Frequency	Start Dt.		
1mg	Oral	TID	10/7	6 AM	
Name & Signature of the Doctor Starting the Drugs:				2. 2/30 PM	
Additional Instructions:				Pm 10/7/17	
				10 PM 10/7/17	
Daily Doctor's Endorsement by a Sign					

DRUG :				Date Time	
Dose	Route	Frequency	Start Dt.		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

DRUG :				Date Time	
Dose	Route	Frequency	Start Dt.		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

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Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG :				Date Time																	
Dose	Route	Frequency	Start Dt.																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

VERIFIED BY : Name Signature



DRUG CHART

Date of Admission: 10/01/21 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>SUP PARACETAMOL</u>				Date Time
Dose <u>3.5ml</u>	Route <u>PO</u>	Frequency <u>405</u>	Start Date <u>10/01</u>	
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm.	
Additional Instructions: <u>(1ml = 250mg)</u>				

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:				

Signature
VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 11.89, Ward.

VERIFIED

DRUG: INJ CEFTRIAXONE				Date Time	10/07 11/7
Dose 600mg	Route IV	Frequency BD	Start Date 10/07		
Name & Signature of the Doctor Starting the Drugs: Dr VAMSHI				6AM (Signature)	
Additional Instructions: @ 10am/ed				6AM (Signature)	
Daily Doctor's Endorsement by a Sign					

VERIFIED

DRUG: SUP AZITHROMYCIN				Date Time	10/07
Dose 3ml	Route PO	Frequency OD	Start Date 10/07		
Name & Signature of the Doctor Starting the Drugs: Dr VAMSHI				10AM (Signature)	
Additional Instructions: (5ml=200mg)					
Daily Doctor's Endorsement by a Sign					

VERIFIED

DRUG: INJ CLMERAZOLE				Date Time	10/07 11/7
Dose 12mg	Route IV	Frequency OD	Start Date 10/07		
Name & Signature of the Doctor Starting the Drugs: Dr VAMSHI				6AM (Signature)	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

VERIFIED

DRUG: NEB 34NS + Adrenaline				Date Time	10/07
Dose Neb	Route TID	Frequency TID	Start Date 10/07		
Name & Signature of the Doctor Starting the Drugs: Dr VAMSHI				6AM (Signature)	
Additional Instructions: 3ml 34NS + 2ml Adrenaline				2PM 230 (Signature) 10PM (Signature)	
Daily Doctor's Endorsement by a Sign					

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

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

[illegible]



I.V. FLUIDS CHART

Weight. Ward.

10/07/26

u:00a

Composition of I.V. Fluid
 (if infusion, mention ml./hr = Mcg/kg/min. etc)

Route

Flow Rate
ml/hr

Doctor
Sign

Nurse
Sign

Date of
Stopping

Doctor
Sign

Nurse
Sign

IVF DNS

IV

25

W. Ashma

Rahul

11/7

8

u:00a

Signature

VERIFIED BY : Name



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/07	Time: 6pm	10pm	11/07	2am	6am	
Doctor / Nurse / Family Concern?						
Temperature (F)	104					
	103					
	102					
	101					
	100					
	99					
	98					
	97					
	96					
	94					
Heart Rate (bpm)	190					
	180					
	170					
	160					
	150					
	140					
	130					
	120					
	110					
	100					
Blood Pressure (mmHg) *	90					
	80					
	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
Note:	BP does not score in early warning scoring					
Heart Rate (Number)	108bpm	100bpm	103bpm	101bpm		
Resp. Rate (bpm) (Over 1 Minute) *	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	Resp Rate (Number)	22bpm	26bpm	24bpm	26bpm	
	Resp Distress	None	None	None	None	
Receiving O ₂ (l/min)						
Saturations (%)	100%	100%	100%	100%		
Conscious	Normal	Normal	Normal	Normal		
Altered						
Score	1	1	1	1		
Number of shaded boxes	1	1	1	1		
Score	1	1	1	1		
Initials						

- 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.

If 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)



FLUID CHART

Sheet No. : 1

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.

Date	Time	Nature of Fluid	Intake			NG	Diarrhoea	Vomit	Output			IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G				Drainage	Urine			
10/2	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm	DNS	25ml										
	01:00 pm		25ml										
Total Intake :			Total Output :										
10/2	02:00 pm			25ml									
	03:00 pm			25ml									
	04:00 pm			25ml									
	05:00 pm	DNS	25ml										
	06:00 pm												
	07:00 pm												
Total Intake :			Total Output :										
10/2	08:00 pm			25ml									
	09:00 pm			25ml									
	10:00 pm	DNS											
	11:00 pm												
	12:00 am			25ml									
	01:00 am			25ml									
Total Intake :			Total Output :										
11/2	02:00 am			25ml									
	03:00 am			25ml									
	04:00 am	DNS		25ml									
	05:00 am			25ml									
	06:00 am												
	07:00 am												
Total Intake :			Total Output :										

Total 24 hrs. Intake

Total 24 hrs. Output

FLUID CHART

Sheet No. :

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

		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							

BAH-00531145 IP5-00176180
Master SHRIYAN RATAN
08-10-2021 4 Y 9 M 2 D (M)
Dr. UJJWALA DESAI



NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☒ Night

Date: 10/7/26

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
4AM	Assess general condition of child	4:30AM	Assessed general condition of child	All plans are implemented.
4:30AM	send for labs, to do c-ray	5AM	Sent labs, chest x-ray done	
6AM	Administer medications as per chart	7AM	Administered medications as per chart.	

Re-Assessment: The assessment done.

Special Notes:

Nurse Signature:

Nurse Name: Ashme

Date & Time: 10/7/26 @ 7AM



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 10/7/21

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
11am	* Assess the general condition of the patient.	11am	* Assessed the general condition of the patient.	By above all the procedure the patient can be stable.
11:30a	* monitor vitals.	11:30a	* monitored vitals.	
12p	* maintain I & O fluid.	12p	* maintained I & O fluid.	
1p	* maintain personal hygiene.	1p	* maintained personal hygiene.	

Re-Assessment:

Monitor vitals

Special Notes:

Nurse Signature:

Nurse ne: Shriya

Date & Time: 10/7/21 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 10/07/2021

Assessment: Baby having dull activity

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the baby general condition and monitor the vitals and record.	2:10pm	Assessed the baby general condition and monitored the vitals and recorded.	By doing all above procedure baby condition improving well.
3:40pm	Doctor advised to continue the medication as per chart	3:10pm	Doctor advised to continue the medication as per chart.	
5pm	Trace the reports.	5:10pm	Tracing the reports	
7pm	Continue the ONS @ 25ml/hr.	6:10pm	Continued the ONS @ 25ml/hr	
	Provide the comfortable position	7:10pm	Provided the comfortable position	
8pm	Ensure the safety needs.	8:10pm	Ensured the safety needs	

Re-Assessment: Re assessment done

Special Notes: null

Nurse Signature: Nleketha

Nurse Name: Nleketha I.D. 607662

Date & Time: 10/07/2021 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/8/26

Assessment: Babyhauling Respiratory distress

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the baby General condition	8pm	→ Assessed the baby General condition	By doing the all procedures the baby condition is improved
10pm	→ provide comfort position	10pm	→ provided comfort position	
12am	→ monitor the vitals & Recorded it	12am	→ monitored the vitals & Recorded it	
2am		2am		
4am	→ administered the all drugs as per doctor orders	4am	→ administered the all drugs as per doctor orders	
6am		6am		
8am	→ ensure the safety	8am	→ ensured the safety side rails	

Re-Assessment: Done by giving by Nebulisation

Special Notes:

Nurse Signature: Shailaj

Nurse Name: Shailaja (605162)

Date & Time: 11/8/26 (8am)



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Ujjwala Department: Pediatric Date of Admission: 10/12/20

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known				
	<u>Δ: ALTB (Group)</u>		If Yes Specify:				
BACKGROUND	Area	<u>CA</u>	<u>1st</u>	<u>1st floor</u>	<u>1st floor</u>		
	Shift Time		<u>19:00-21:00</u>	<u>7:00-8:00</u>	<u>8:00-9:00</u>		
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
ASSESSMENT	Allergy:	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	<u>98.0°F</u>	<u>98.3°F</u>	<u>98.1°F</u>	<u>98.0</u>	
		Res:	<u>24b/m</u>	<u>20</u>	<u>26b/m</u>	<u>26b/m</u>	
		SpO ₂ :	<u>100%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	
		Pulse:	<u>135b/m</u>	<u>128</u>	<u>126</u>	<u>122b/m</u>	
		BP:	<u>102/60</u>	<u>101/62</u>	<u>61/63</u>	<u>100/70</u>	
		Fall Risk Score:	<u>11</u>	<u>11</u>	<u>4</u>	<u>11</u>	
	Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>		
	Recommendations	Safety Needs:	☒	<u>yes</u>	<u>yes</u>	<u>yes</u>	
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	
Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :		<u>Reet</u>	<u>Drugs</u>	<u>Neerha</u>	<u>Shalaja's</u>		
Signature :		<u>Reet</u>	<u>Drugs</u>	<u>Neerha</u>	<u>Shalaja's</u>		
Date:		<u>10/12/20</u>	<u>10/12</u>	<u>10/12</u>	<u>11/12</u>		
Time:		<u>4AM</u>	<u>2P</u>	<u>@8pm</u>	<u>(8am)</u>		
Taken Over By Name :		<u>Ashme</u>	<u>Nikita</u>	<u>Shalaja's</u>	<u>Meelin</u>		
Signature :		<u>Ashme</u>	<u>Nikita</u>	<u>Shalaja's</u>	<u>Meelin</u>		
Date:		<u>10/12/20</u>	<u>10/12</u>	<u>10/12</u>	<u>11/12</u>		
Time:		<u>4AM</u>	<u>2pm</u>	<u>@8pm</u>	<u>@8am</u>		



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area							
	Shift Time							
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:								



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	11			

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		Yes	Yes			
Call device within reach		Yes	Yes			
Wheels Locked		Yes	Yes			
Room free of clutter		Yes	Yes			
Adequate Lighting		Yes	Yes			
Wheel Chair Support		Yes	Yes			
Other Intervention(s) Specify		No	No			
Nurse's Name :		Aras	Aras			
Signature :		[Signature]	[Signature]			
Date :		10/7	11/7			
Time :		3pm	6am			

BRADEN 'Q' SCALE

					Date :	10/7	11/7		
					Time :	3am	6am		
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:tremitry position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	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	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	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	4		
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4		
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		
TOTAL SCORE						28	28		
Evaluator's Name						cut	Beep		

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

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
10/7/26	3Am	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Death
10/7	1pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
10/07	9pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sharp
11/07	7am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sharp
				☐ 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:

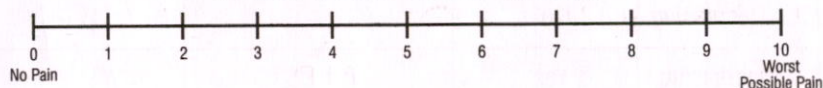
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

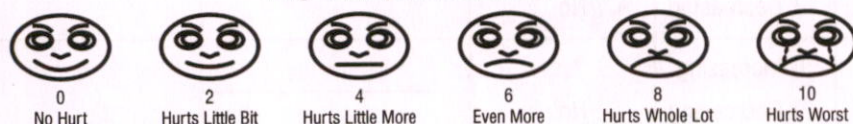
Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
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





CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-	-						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-						
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-	-						
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-	-						
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-						
Signature of the Nurse				[Signature]			[Signature]			[Signature]			

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]

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

P: Parents / Learner Language: Hindi Patient / Learner Literacy: ☒ Read ☒ Write ☐ Speak Willingness to Learn: ☒ Yes ☐ No Healthcare Literacy: ☒ Yes ☐ No

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
10/7	3Am	2	Treatment & care plan	F	1	1	1	0	-	Deeth
10/7/20	8am	9	child is on NPO	f	1	0	1	1	-	Nikita

Part - III: CODES

Who was taught:		PT: Patient	F: Father	M: Mother	S: Spouse	Sn: Son	D: Daughter	C: Caregiver	O: Other (Specify)
Learning Barriers:									
1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations		10. Financial Difficulties		13. Cultural/Religion Practice			
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home		11. Beliefs and Values		14. Others (Specify)			
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences		12. Impaired Vision/ or Hearing					
Teaching Tools Used:									
A: Audio	D: Demonstration	V: Video	O: Oral	P: Printed					
Mechanism/s to overcome barrier/s:									
1. None	3. Reassurance & Support	5. Respect values & beliefs		7. Other, Specify					
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference							
Understanding:									
1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review							

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
10/7/26 3AM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Breathing difficulty	H stability.	Ev fluids & Antibiotic	[Signature]	☐ Nursing ☒ Others:
10/7/26 3AM	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fast breathing.	H stability	IV fluids & Antibiotic	[Signature]	☒ Medical ☐ Others:
10/7/26 8AM	☐ Medical ☐ Nursing ☒ Others: <i>metformin</i>	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	croup	child is on wpo	WPO all further advise	[Signature]	☐ 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:



DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge:

2. Destination Post Discharge: ☒ Home
Family Members Notified (Person Contacted)

☒ Transfer
Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

☐ Medication ☒ Yes ☐ No

☐ Bathing ☐ Yes ☒ No

☐ Eating ☐ Yes ☒ No

☐ Walking ☐ Yes ☒ No

☐ Dressing ☐ Yes ☒ No

☐ Toileting ☐ Yes ☒ No

Supplan to mother

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Hand Hygien

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Divya

Date and Time: 10/2/26 @ 1:30pm

NURSING INITIAL ASSESSMENT FOR PICU

Date of Admission: 10/7/26

Source of Admission: ☐ OPD ☐ Ward ☒ Other:

Reason for Admission: Respiratory distress

Admission Diagnosis: Stidor under evaluation / croup.

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 Medical History	No Past Surgical History	No
	Family History: DHO		
	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: 11.29 Length: Head Circumference (< 2 years): Temp.: 98.6°F HR: 143 RR: 20 BP: 102/68 Pain Score: 0 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)			



Behavioural Status on Admission:

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

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

If Yes Consultant Notified: (Date/Time):

Social History: Lives With

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

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: Ashma

Nurse Signature: [Signature]

Date & Time: 10/7/26

DISCHARGE PLAN

Source of Information: ☒ Family ☐ Friend

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

Will Physiotherapy require at home: ☐ Yes ☒ No

Is home medical equipment anticipated: ☐ Yes ☒ No

Is home oxygen therapy anticipated: ☐ Yes ☒ No

Are dressing needs at home anticipated: ☐ Yes ☒ No

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

Discharge Medications: ☐ Yes ☒ No

Details:

Final Diagnosis:

Nurse Name: Ashma

Nurse Signature: [Signature]

Date & Time: 10/7/26



NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA : 10/7/26		Diagnosis : Croup		Surgery / Procedures :	
	Allergies :		Post OP Day :			
	Date :	10/7/26	10/7/26			
	Area	ICU Night	ICU Day			
Shift Time						
	Diet :	-				
Ventilation (RA, NP, NIV, VENTI)	RA	RA				
INVASIVE LINES	1.					
	2.	Cannula	cannula			
	3.	①	①			
	4.					
ASSESSMENT	Infusions / Transfusions		DNS	DNS		
	PU Prophylaxis	NA	NA			
	DVT Prophylaxis	NA	NA			
	Vitals	BP	107/68	104/55		
		PR	145	142		
		RR	28	25		
		SpO ₂	100%	99%		
		Temp	98.5F	98.7F		
	Pain Score	0	0/10			
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert	Alert			
	Skin Integrity (Intact / Bedsore / Any other condition)	Intact	Intact			
	Restrains If any	Physical	NA	NA		
Chemical		NA	NA			
Fall Risk (Vulnerable (Y/N) if yes score)	Yes	Yes				
(Ambulation, walking, moving with assistance, bed ridden)	moving	moving				
ADL (Dependent / Non-Dependent)	Dependent	Dependent				
Critical Lab Test / Values (if any)	Nil	Nil				

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

RECOMMENDATIONS	Investigations Procedures	Date :	10/7/26	10/7/26				
		Area	Plw	Plw				
		Shift Time	Night	Day				
		Ordered / Planned	Followed	Followed				
			by	by				
			order	order				
		Due	No	No				
			due	due				
		Reports Pending	5 Viral	5 Viral				
Panel	Panel							
Reports pending	Reports pending							
Referrals (If any)	No	No						
	Referrals	Referrals						
Remarks (Special Interventions like, Drainage Tube flushing etc.)	No	No						
Handed Over By Name :	Ashma							
Signature :	Ashma							
Date :	10/7/26							
Time :	8am							
Taken Over By Name :	Navaneetha							
Signature :	Navaneetha							
Date :	10/7/26							
Time :	@ 8am							

BAH-00531145
Master SHRIYAN RATAN
08-10-2021 4 Y 9 M 2 D
Dr. UJJWALA DESAI (M)

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

IDE CHECK LIST FOR NURSES

Date:	10/7/								
Doctor's Orders	Followed								
Carried out or not	Completed								
Bed Side									
Structured Handover done	Done								
IV Site	Yes								
Central Lines	NA								
Arterial Lines	NA								
Feeding Catheter	NA								
Urinary Catheter	NA								
Skin Care	Given								
Eye Care	Given								
Mouth Care	Given								
Sterillum Bottle, Stethoscope	Yes								
Suction Bottle (Should be clean & empty)	Empty								
Intubation Tray	NA								
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	Loaded							-D/C-	
Ventilator Tubing, (Any Water, Blood)	NA								
Humidification	NA								
Check all Infusion (Labelling, Correct Preparation)	Labelled								
Chest Physio & Neb	Yes								
Handed Over By Name :	Ashma								

Checked & Handover given by
Name of the Nurse : Ashma
Signature : Ashma
Date & Time : 10/7/2026 @ 9am

Checked & Handover taken by
Name of the Nurse : Naraneeth
Signature : Naraneeth
Date & Time : 10/07/2026
9am

Doc. No. : RCHBH/FRM/GENERAL /088

CONSENT FOR ADMISSION IN PEDIATRIC INTENSIVE CARE UNIT



Name: Age: Gender: Male ☐ Female ☐
UHID.No : Date:
IP5-00176180
BAH-00531145
Master SHRIYAN RATAN
08-10-2021 4 Y 9 M 2 D (M)
Dr. UJJWALA DESAI

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 :

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:
Name:
Relationship with Patient:
Date & Time:

Witness :

Signature:
Name:
Date & Time:

Doctor (who is taking the consent) :

Signature:
Name:
Date & Time:

**పిల్లల ఇంటర్నల్ కేర్ యూనిట్ లో
అడ్మిషన్ కిరకకు సమ్మతి**

రోగి పేరు వయస్సు లింగం ☐ పు ☐ స్త్రీ

యు.పా.బి.డి. s/o. d/o. w/o.

నేను అనే బాలుడు / బాలిక యొక్క చికిత్స మేరకు రెయిన్సీ పిల్లల అనుపత్తి లోని పిల్లల ఇంటర్నల్ కేర్ యూనిట్

..... నాడు పూర్తి సమ్మతితో చేర్చితిని.
తేదీ

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

.....
.....
.....

రెయిన్ బో చిల్డ్రన్స్ హాస్పిటల్ లోని పీడియాట్రిక్ ఇంటర్నల్ కేర్ విభాగం లో చేరించి జడ్డకు ఆరోగ్య సంబంధిత సమస్యలు ఉన్నాయని వైద్యులు నాకు అర్థమయ్యే భాషలో వివరించారు. రోగి _____ పీడియాట్రిక్ ఇంటర్నల్ కేర్ విభాగం లో ఉన్న సమయంలో అతను వివిధ వైద్య మరియు శస్త్ర చికిత్సలకు లోనవుతారని వైద్యులు నాకు స్పష్టంగా వివరించారు. ఎయిర్ చే మేనేజ్ మెంట్, మెకానికల్ వెంటిలేషన్, బొడ్డు ధమని కాథెటర్, బొడ్డు నీర మరియు ధమనుల కాథెటర్ వంటి. పెరిపెరల్లి ఇన్ఫర్ట్ చేయబడిన సెంట్రల్ కాథెటర్ లైన్ మరియు ఆర్థరో లైన్ ప్లేస్ మెంట్, ఛాతీ డ్రైయిన్ లేదా పెరిటోనియల్ డ్రైయిన్ ఇన్ఫర్డ్ 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 ఇంటర్నల్ కేర్ విభాగం లో అనారోగ్యంతో ఉన్న పిల్లవాడికి ప్రాణాంతకమైన వైద్య పరిస్థితులు ఉన్నాయని అర్థం చేసుకోవడమైనది.

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

మా బాలుడు / బాలిక ను ఇంటర్నల్ కేర్ యూనిట్ (పి.బి.సి.యు) లో చేర్చుకొని అవసరమయ్యే వైద్యం చేయుటకు నేను వైద్య బృందానికి నా సమ్మతి ధృవపరుస్తున్నాను.

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకము

పేరు

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

తేదీ మరియు సమయము

సంతకము

పేరు

PATIENT TRANSFER FORM

BAH-00531145 IP5-00176180 Master SHRIYAN RATAN 08-10-2021 4 Y 9 M 2 D (M) Dr. UJJWALA DESAI 		Date & Time of Admission 10/7/26 @	Date & Time of Transfer Order 10/7/26 @
Transfer Ordered by Dr. Ujjwala Desai		Reason for Transfer Admission	
From Unit ICU	To Unit ICU-1	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 13	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what? Optic	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	proto gown	(1)	
2.	DNB gown	(1)	
3.	Inhaler	(1)	
4.	E.C.G leads	(1)	
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Mr. Arnes		Name of Person Ordered Transfer Dr. Nandan	
Patient & Clinical Records Received by : Ashma			
Date & Time of Patient Received : 10/7/26 @ 4AM			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

- ☐ Unavailable Bed
 ☐ Nurse not Available
 ☐ Available Bed not ready

PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor: As per Rota

Date: 10/7/20

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

Start Time of Assessment: 3am

Weight: 11.8kg

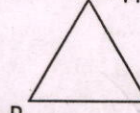
Allergic History: No

Chief Complaints:

cl. ↑ WOB: 1/2 hr.

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

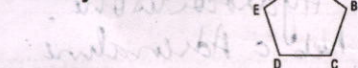
If Yes _____

Significant Past History: No similar complaints in past

Medication History: _____

Relevant Investigations: _____

Primary Assessment



Airway



- ☐ Open
- ☒ Maintainable
- ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☐ No

If Yes _____



Breathing

Rate: 27/min SpO₂ on FiO₂ 97%

Rhythm: _____

- Retractions: ☒ Suprasternal ☐ ICR ☐ SCR
- ☐ Sternal ☒ Supraclavicular ☒ Nasal Flaring

Respiratory Noises: ☒ Stridor ☐ Wheezing ☐ Grunting

Air Entry: BAE (+), louder (+) wheeze (+)

Palpation Findings (If necessary) B/L crepts (+)

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____



Circulation

HR: 137/min

CFT ☐ Central ☒ Peripheral 1 secAny urgent interventions needed: ☐ Yes ☐ No

If Yes

BP: 102/61 mmHg

Pulse Volume: ☐ Central ☒ Peripheral 10If in Shock: ☐ Compensated ☐ HypotensiveMuffled Heart Sound: ☐ Yes ☐ NoEngorged Neck Veins: ☐ Yes ☐ NoMurmurs: ☐ Yes ☐ No

Liver Span:

ECG:

Any Signs of Heart Failure: ☐ Yes ☐ No

Disability

GCS: 15/15 AVPU:

Pupils: ☒ Responsive ☐ Non-Responsive ☐Size ☐ Right ☐ LeftActive Seizures: ☐ Yes ☒ No Sugars:

Signs of Neurological compromise

Any urgent interventions needed: ☐ Yes ☐ No

If Yes

Exposure



Temp.: 98°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:

CBC
CRP

Treatment Planned:

Tri Hydrocortisone
Neb c Adrenaline
Neb c Levofloxacin
Neb c BudecortNeed for Oxygen: ☐ Yes ☐ Noif yes Low Flow ☐High Flow ☐PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary):

Assessment done by

Name of the Doctor: [Signature]

Signature: [Signature]

Date & Time: 10/7/26 @ 3:42pm

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor:

Signature:

Date & Time:



DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge:

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status:

☐ Self Care

☒ Family Home Care

☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication

☒ Yes

☐ No

☐ Bathing

☒ Yes

☐ No

☐ Eating

☒ Yes

☐ No

☐ Walking

☒ Yes

☐ No

☐ Dressing

☒ Yes

☐ No

☐ Toileting

☒ Yes

☐ No

explain to family

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s:

personal hygiene

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

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Phyllis

Date and Time: 11.01.2021

PATIENT TRANSFER FORM

BAH-00531145 IP5-00176180
Master **SHRIYAN RATAN**
06-10-2021 4 Y 9 M 2 D (M)
Dr. UJJWALA DESAI



Date & Time of Admission 10/12/26 @ 4:32 AM		Date & Time of Transfer Order 10/12/26 @ 10 AM
Treating Consultant Name Dr. Ujjwala Desai	Transfer Ordered by Dr. Ujjwala Desai	Reason for Transfer Shift to ward
From Unit PICU	To Unit 1st floor	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File 40 sheets.	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what?	Patient shifted with ID band: Yes ☒ No ☐ If No:
Number of Imaging Films x-ray - 1		
Medications / Consumables / Surgicals / Hand over		
Sl.No.	Item Name	Quantity
1.	x-ray	1
2.		
3.		
4.		
5.		
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐		
Name & Signature of Person who is Transferring Srabani		Name of Person Ordered Transfer Dr. Ujjwala Desai
Patient & Clinical Records Received by : Nikhil Hegde		
Date & Time of Patient Received : 10/12/26 5 PM		

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

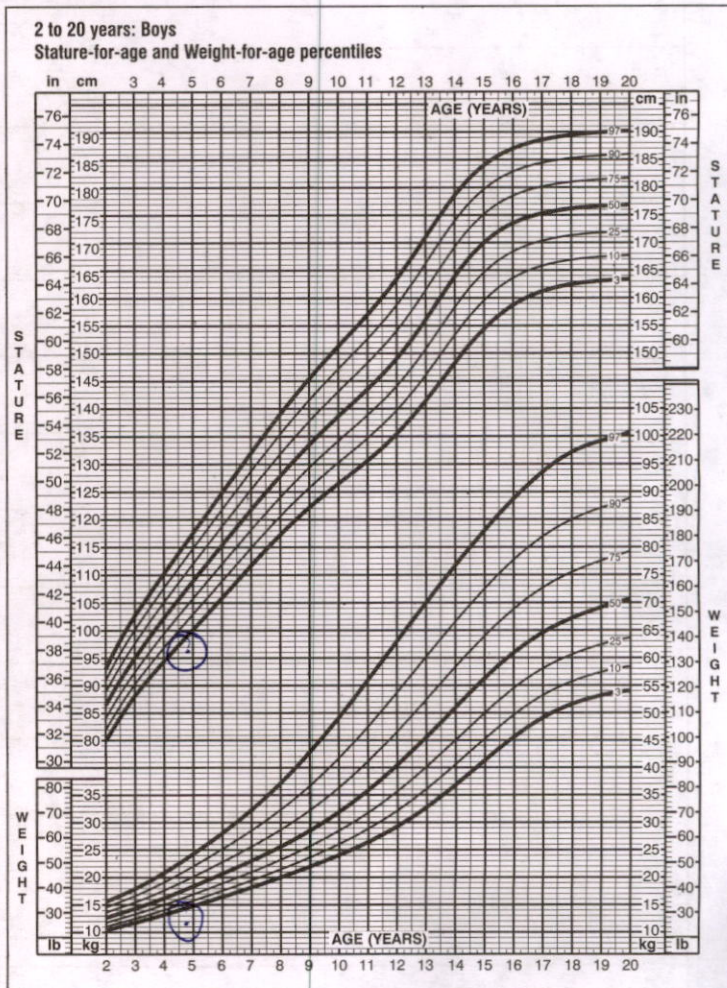
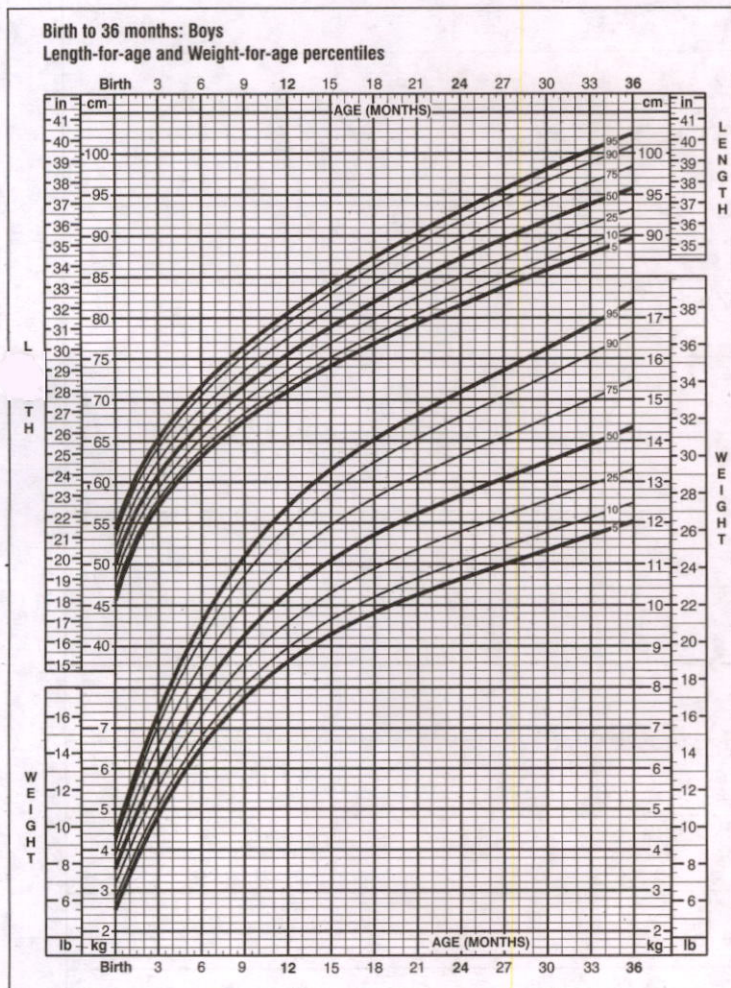


NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 10/7/26 Time: 10:30 am

Weight: 11-8 kgs Centile: <5th
Height: 96 cm Centile: <5th
Inference: Underweight child
RDA: — Calories: 1350 kcal/d Protein: 23g/d
Diet Recommendations: Soft diet
Re-Assessment: Avoid spicy, chilled, outside foods
Food Allergies: No croup Veg/Non-veg: Non-Veg
Diagnosis: croup
Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral
Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha

Daily Notes:

11/12/2020

Child is stable intake is better

Continue $\pm$ soft diet

no further