

ACTIVITY RECORD FOR BILLING

Name : BAH-00632536 IP5-00176032
Baby SINGARAJU SAANVITHA
20-08-2024 1 Y 10 M 16 D (F)
Dr. SIRISHA RANI

UHID No. : _____



Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/7/26	2 PM	ER	ONEG	DOOIS

Cross Consultation Visit

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

[illegible]

06/07	CBP, CRP, Blood chs (Done on op bases)	T. snare
-------	--	----------

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
06/07	iv placement	1	(q Basis)	Tammy

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : 6/26 Time : 2:30 PM Prepared By : Tammy

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Tammy	6:00-11		

S. Saurwite
 DSH-00632536
 Dr. S. Saurwite
 Patient Sticker

148

DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	1+1			
7	Nursing plan of care and handover sheets	1			
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				
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	1			
43	BP Monitoring chart				
44	RBS monitoring chart				
	Other	5			
	Total No. of Pages	22			

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 : IP5-00176032 Admit Date : 06-Jul-2026 Admit Time : 01:02 PM UHID : BAH-00632536

Patient Details :

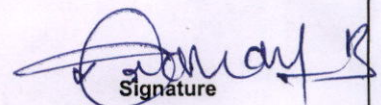
Patient Name	: Baby SINGARAJU SAANVITHA	Age	: 1 Y 10 M 16 D
Guardian	: Mr SINGARAJU RAVI KUMAR	DOB	: 20-08-2024 11:55 AM
Gender	: Female	Religion	:
Occupation	:	Marital Status	: Single
Address (H)	: H NO 5-64 Veldanda Mahabubnagar Telangana INDIA 509360	Phone No	: 8712571821/ 9912547847
		E-mail	: SINGARAJU.RAVIKUMAR@GMAIL.CO

Admission Details :

Bed Type : SHARED WARD Bed No : SW 148 Ward Name : 1F-VIBGYOR
Room No : SW 148 Admission Type : First Visit

Contact Details :

Name : Mr SINGARAJU RAVI KUMAR Relationship : Father
Contact Address : H NO 5-64 Veldanda Mahabubnagar Phone No : 9912547847 / 8688615771
Telangana INDIA 509360


Signature

Doctor Details :

Doctor Name : Dr. SIRISHA RANI Specialisation : HEMATO ONCOLOGY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

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



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Sirisha Rani

Date : 6/7/26

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

Start Time of Assessment: 12 pm

Weight: 8.7kg

Allergic History: _____

Chief Complaints: _____

Post MVD HsCT for B-ALL

with fever since 3 days

Cough since 3 days

No H/o vomiting, loose stools, other complaints

Pediatric Assessment Triangle

A Appearance - TICLS _____



B

C

Circulation

☒ Normal

☐ Abnormal

Breathing

☐ ↑ WOB

☐ ↓ WOB

☒ Normal

☐ Gasping / Apnea

☐ Pallor

☐ Cyanosis

☐ Mottling

☐ Bleeding

Initial Physiological Status: ☒ Stable ☐ Unstable

☐ Life Threatening

☐ Non Life Threatening

Any urgent interventions needed: ☐ Yes ☒ No

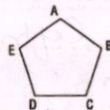
If Yes _____

Significant Past History: _____

Medication History: _____

Relevant Investigations: _____

Primary Assessment



Airway

☒ Open

☐ Maintainable

☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____

Breathing

Rate: 38/min

SpO₂ on FiO₂ 98% on RA

Rhythm: Regular

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR

☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: _____

Palpation Findings (If necessary): _____

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____



Circulation

HR: 120/min

CFT ☐ Central
☐ PeripheralAny urgent interventions needed: ☐ Yes ☒ No

BP: 89/47 (52) mmHg

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

Liver Span:

ECG:

Any Signs of
Heart Failure: ☐ Yes ☒ No

If Yes



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.: 99.6°F

Any Rash: ☐ Yes ☒ No,

If yes describe the rash

Active bleed

Lacerations ☐ Abrasions ☐ bruises ☐

Describe:

Any urgent interventions needed: ☐ Yes ☐ NoIf Yes Syp. acacin DSFinal Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest
☐ Shock - Compensated ☐ Hypotensive ☐
☐ Cardiopulmonary Arrest ☒ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings:

Labs Planned:

CBP, CRP, Blood Gs
Extra plain N/B
Island

Treatment Planned:

Ij Cephazone 6
Ij Amikacin
Ij Hydrat long esterNeed for Oxygen: ☐ Yes ☒ No if yes Low Flow ☐ High Flow ☐ PPV ☐Final Diagnosis with possible Differential Diagnosis (If necessary): Post MVD HSC T Erythrocyte neutropenic

Assessment done by

Name of the Doctor: Dr. RanySignature: [Signature]Date & Time: 6/21/26; 12:10 pm

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor:

Signature:

Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/8/24 4 PM	febrile illness	1) <u>ASA</u> Ceftriaxone Amoxicillin
CAP - 178 CSP - Hb - 9.7 WBC 28000 CRP - 148.4 Pulse 142	No further fever mild cough feeding well Vitals (10) perfusion good S/E - CXR nl S/P (10)	15 f 2) (RW) D/C @ request on IV ASA
		<u>Shankar</u>
	<u>CSIS Dr. Sindhya</u>	
		<u>ASA</u> 1) D/C. Ceftriaxone Amoxicillin 105 8/9/24 CAP, URP 2) have Uls on fuc. <u>Shankar</u>

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

DRUG CHART

Date of Admission: 6/7/26 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG :				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:																			



REGULAR PRESCRIPTIONS

Weight. 8.7kg Ward.

DRUG : <u>Inj CEFTRIAXONE</u>				Date Time	<u>6/7</u>															
Dose	Route	Frequency	Start Date																	
<u>450mg</u>	<u>IV</u>	<u>BD</u>	<u>6/7/24</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Dr Remya</u>				<u>GAM X</u>																
Additional Instructions:				<u>3:13pm</u> <u>6pm - Pratik</u> <u>Jawad</u>																
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Inj AMIKACIN</u>				Date Time	<u>6/7</u>															
Dose	Route	Frequency	Start Date																	
<u>67.5mg</u>	<u>IV</u>	<u>BD</u>	<u>6/7/24</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Dr Remya</u>				<u>GAM X</u>																
Additional Instructions:				<u>3:13pm</u> <u>6pm - Pratik</u> <u>Jawad</u>																
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

IPS-00176032

20-08-2024

1 Y 10 M 16 D

(F)

Dr. SIRISHA RANI



Weight. 8.7 kg Ward.

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

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

STAT / ONCE ONLY DRUGS[illegible]

Weight. 8.7kg Ward.

[illegible]



MEDICATION RECONCILIATION FORM

Drug Allergies:

☐ Not known any Drug Allergies

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

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

Shifting From: ER

Shifted to: Ward

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	Syp Septran	2.5ml	PO	BD		☒ C ☐ DC
2	Teb Voriconazole	1/4 tab	PO	OD	5/2/26	☒ C ☐ DC
3	Teb Vancomycin	1/4 tab	PO	BD		☒ C ☐ DC
4	Ruxo Teb	1/2 tab	PO	OD		☒ C ☐ DC
5	Teb Lenrol	1/2 tab	PO	OD		☒ C ☐ DC
6	Teb Faropenem	1/2 tab	PO	BD		☒ C ☐ DC
7	Teb Amelodipine	1/2 tab	PO	OD		☒ C ☐ DC
8	Teb Budesonide CR	1/2 tab	PO	OD		☒ C ☐ DC
9	Syp. omnicotril	6ml	PO	BD		☒ C ☐ DC
10	Syp. Colistin	3ml	PO	BD		☒ C ☐ DC

11. Syp. Azee 4ml PO OD *C-Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Rani

Date & Time: 6/7/26 12:30pm

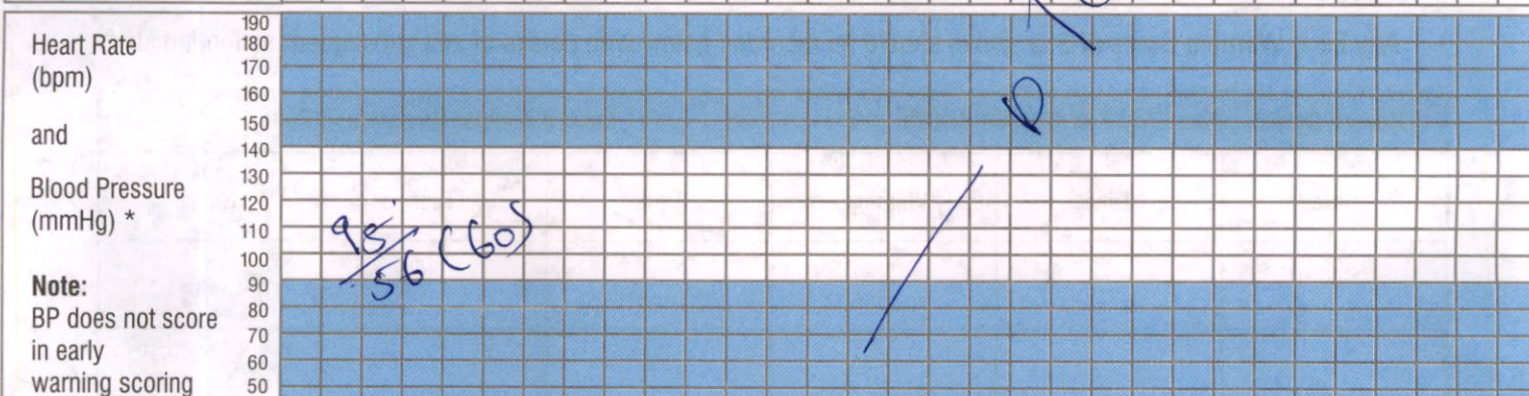
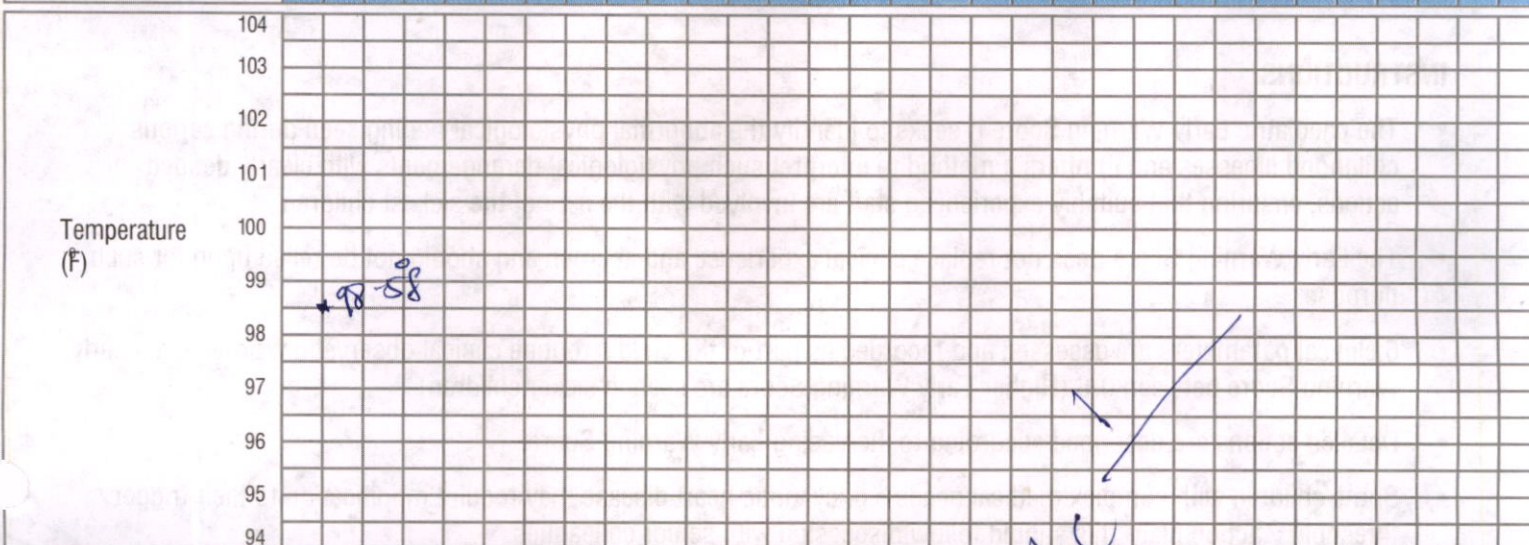
Nurse Name & Signature: T. Jenthine

Date & Time: 6/7/26 @ 12:34

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 6.17.26 Time: 3pm

Doctor / Nurse / Family Concern?



Heart Rate (Number)



Resp Rate (Number)

Resp Distress Mod/ Severe None / Mild

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

Conscious Level Normal Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1	: Continue normal observation by staff nurse
	Score 2	: Shift in charge nurse to be informed and continue hourly observations
	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)

BAH-00632536 IP5-00176032
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 20-08-2024 1 Y 10 M 16 D (F)
 Dr. SIRISHA RANI

Patient

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

BirthRight™
 BY RAINBOW HOSPITALS
 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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	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						

Patient Sticker

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											
	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						

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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: _____

☐ Night

Date: _____

Assessment: _____

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
	=> pt Received from ER => Assess the general condition of pt => pt vitals monitor => pt provided comfortable position => medication given as per doctor order.		=> pt Assessed the general condition => vitals monitored => pt provided comfortable position => medication given as per doctors order.	pt well Improving.

Re-Assessment: _____

Special Notes: _____

Nurse Signature: _____

Nurse Name: _____

Date & Time: 6/12/28 / 3:30pm

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time: