

BAH-00306262 IP5-00176616
 Master B ABHILASH
 26-12-2014 11 Y 6 M 23 D (M)
 Dr. NABEEL ALAM QADRI



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ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No. : _____ Consultant: _____ Dept : _____

Date of Admission: _____ Time : _____ Date of Discharge : 20/7/26 Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
19/7/26	11:50 PM	ER	114	IS

Cross Consultation Visit

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

[illegible]

2

[illegible]

Signature

Qul

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
19/5/26	IV Placement	1	11666	<i>[Signature]</i>
20/7/26	NHA	(1)	9712242	<i>[Signature]</i>

ANY OTHER INFORMATION

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Date : 20/7/26 Time : 11/00 Prepared By : Rama

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
<i>Rama</i>	<i>Hy Discharge</i>		

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176616

Admit Date : 19-Jul-2026

Admit Time : 10:51 PM UHID : BAH-00306262

Patient Details :

Patient Name : Master B ABHILASH

Age : 11 Y 6 M 23 D

Guardian : Mr B.MADHAVACHARY

DOB : 26-12-2014

Gender : Male

Religion : Hindu

Occupation :

Marital Status : Single

Address (H) : H NO 44-168/8,RAMNAGAR COLONY ,
Wanaparthy Wanaparthy Telangana INDIA
110005

Phone No : 9849980841/ 9398764864

E-mail : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : SEMI PRIVATE

Bed No : SPVT 114

Ward Name : 1F-VIBGYOR

Room No : SPVT 114

Admission Type : First Visit

Contact Details :

Name : Mr B.MADHAVACHARY

Relationship : Father

Contact Address : H NO 44-168/8,RAMNAGAR COLONY ,
Wanaparthy Wanaparthy Telangana INDIA
110005

Phone No : 9849980841 / 9398764864


Signature

Doctor Details :

Doctor Name : Dr. NABEEL ALAM QADRI

Specialisation : PEDIATRIC SURGERY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.01

Payment Mode : Cash

Payor Name : SELFPAY



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PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00306262 IP5-00176616
Master B ABHILASH
26-12-2014 11 Y 6 M 23 D (M)
Dr. NABEEL ALAM QADRI



Patient Name:

B
Abhilash

UHID ID:

BAH-00306262

Department:

Pediatric Surgery

Consultant:

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

clb fever :: morning .

→ clb pain & swelling on (L) side of scrotum :: morning .

History of present illness :

Kidney B/L VUR, 0 Sp B/L open ureteric reimplantation
Sp-cystoscopy + DJ stent removal done on 13.07.2026 .

Now presented c

Fever - high grade i.e. continuous, every 4-6th hly,
not a/w chills & rigors

pain & redness over (L) scrotal region :: morning

No a/w burning micturition,

No H/o difficulty in stream of urine/dribbling

No H/o seizers



Pediatric Multiorgan History & Physical Examination

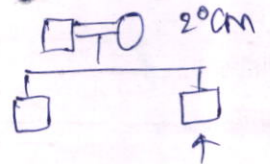
Past History : (Including details of any previous investigation or treatment)

H/o recurrent UTI ~~at~~ ^{at} 1 yr of age

↓
Aged as B/L VUR after NCVG.

Birth & Neonatal History:

Term / 2.5 kg / CIAB



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Normal till date

Immunization History : immunized till date



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile _____)

Weight (kgs) _____ (Centile _____)

On Examination :

Temperature : 100.8°F Pulse Rate : 92/min B.P. 114/80 SPO2 98%

Resp. rate and type of breathing : _____

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any addles sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen : Soft, no tenderness

Inspection _____

Palpation : _____

Auscultation : _____

Spine : _____ External Genitalia : _____

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

Genital Exam : Swelling & Redness (+) over (+) scrotal
region ; mild tenderness to touch.



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

GCS - 15/15

Level of Consciousness : AVPU/GCS score :

Cranial Nerves :

Motor System:

Nutriton :

Tone:

Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR

Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

? Epididymo-Orchitis 2° to UTI.

f/u - B/L Grade III VUR (L) scarred kidney

s/p B/L open ureteric reimplantation

s/p - cystoscopy + DJ stent removal on 13/7/26.



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment: _____

Planned Labs:

CUE

CRP ✓

Urine cells

USG B/L inguinoscrotal
eeg'00.

Planned Management

1) IV Augmentin 1.2gm iv | BD.

2) CUE, Urine e/s

3) CRP

4) USG. B/L inguino-scrotal region

5) Inj paracetamol 580mg iv | TID.

Signature of the Doctor: *[Signature]*

Name of the Doctor: *Benjaniya*

Date & Time: *19/7/26* *11:00*

Signature of the Consultant: *[Signature]*

Name of the Consultant: *Dr. Nabeel*

Date & Time: *20/7/26* *8:30am*

Dr. NABEEL ALAM QADRI
Reg. No: 75241



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/2026 8:10 AM	cf/s/r Dr Nikhita 2 (L) epididymo-orchitis E 071 8/P DJ stent removed on 13/7/2026 - 2 episodes of fever spikes. o/e temp: 99°F Vitals - stable P/A - soft u/e - (L) scrotum, enlarged, erythema (+)	Adv (L) USG B/L inguino-scrotal region + USG Abd pelvis today. 20/7/2026 - trace reports. (CUE).
	CRP-29 Shay 20/7/26 8:30 AM Dr Nikhita 20/7/2026 8:10 AM Dr. NABEEL ALAM QADRI Reg. No: 75241	

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Master B ABHILASH (M)
26-12-2014 11 Y 6 M 24 D
Dr. NABEEL ALAM QADRI



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

IP5-00176616

26-12-2014

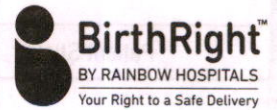
11 Y 6 M 24 D

(M)

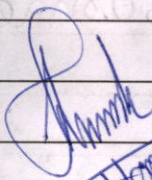
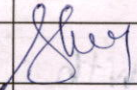
Dr. NABEEL ALAM QADRI

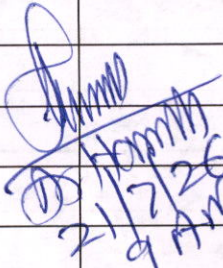


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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26 4:35pm	c/s/B Dr. Shreega	
	(L) epididymo-orchitis	<u>Advice</u>
	Afebrile -	- Send CBP
	Vitals stable.	
	L/E - Redness & tend.	
	2 fever spikes	
	 Dr. Hemant 20/7/26 DR. HEMANT JAYARAM Registration No: 66254	 20/7/26 Dr. Shreega 4:35pm.

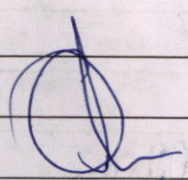
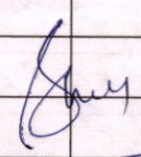
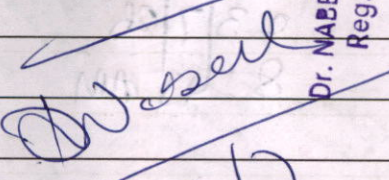
Date & Time	Progress Notes	Doctor's Order
21/7/26.	C/S/B Dr. Maliha	
8:30 AM		
\$	High Fever spikes. Vitals stable	<u>Adv.</u>
P/A - soft		1) Full feeds.
L/E -		2) Continue w fluids.
		3) Trace Urine c/s.
		4) USG Abdomen. (HOLD)
	Urine c/s - no growth after 24 hrs.	
<u>Labs</u>	WBC - 14 k.	
 DR. HARISH JAYARAM Registration No: 66254		Maliha 21/7/26 8:30 AM



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Date & Time	Progress Notes	Doctor's Order
21/7/26 4:30pm	C/S/B Dr. Maliha No fever spikes Vitals stable. P/A - soft L/E - DR. HARISH JAYARAM Registration No: 96254 Harish 21/7/26 5 PM	Adv 1) Full feeds. 2) Plan discharge tomorrow Maliha 21/7/26 4:30 PM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/12/26 5pm	C/S/B Dr. Smeyla	Advise
	① epididymo orchitis afebrile vitals stable No fever spikes.	- Full feeds - Tomorrow discharge
	 Dr. NABEEL ALAM QADRI Reg. No: 75241	 22/12/26 5pm Dr. Smeyla
	 22/12 5pm	
		AC

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/7/26, 8:45 AM	C/S/B Dr. Malika	
	No fever spikes Vitals stable	Adv
	P/A - soft	1) Full feeds
		2) Plan discharge today
23/7/26 9:05 AM	DR. JAYARAM Registration No: 66254	Malika 23/7/26 8:45 AM



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						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Soujanya

Date & Time : 19/12/20 11pm

Nurse Name & Signature: Shreya B

Date & Time : 19/12/20 11pm

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RESULT SHEET

Date	19/7/26	2017/26				
Time						
Hb		11				
PCV		34.3				
RBC		4.38				
WBC		14780				
N/L		69123				
Platelets		3.62				
CRP	29					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date	2017					
Time						
CUE - Alb	Nil					
CUE - Sugar	Nil					
CUE - Ketones	19 Negative					
CUE - PUS Cells	2-3					
CUE - RBC Cells	0					
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

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 26-12-2014 11 Y 6 M 23 D (M)
 Dr. NABEEL ALAM QADRI



DRUG CHART

Date of Admission: 19/7/20 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name _____ Signature _____



REGULAR PRESCRIPTIONS

Weight. 39.06 kg Ward.

DRUG : <u>Inj. AUGMENTIN</u>				Date Time	<u>19/7</u>	<u>20/7</u>														
Dose	Route	Frequency	Start Date																	
<u>1.2g</u>	<u>IV</u>	<u>Q12H</u>	<u>19/7</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Sanjanya</u>				<u>10am X (13)</u> <u>10pm X (13)</u> <u>changed</u> <u>Saintini</u> <u>20/7/26</u>																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Inj. PARACETAMOL</u>				Date Time	<u>19/7</u>	<u>20/7</u>	<u>21/7</u>	<u>22/7</u>												
Dose	Route	Frequency	Start Date																	
<u>580mg</u>	<u>IV</u>	<u>TID</u>	<u>19/7</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Sanj</u>				<u>6am X (14)</u> <u>2pm X (14)</u> <u>10pm X (14)</u> <u>stop</u> <u>malina</u> <u>22/7/26</u> <u>8:50 AM</u>																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Inj PIPERACILLIN TAZOBACTAM</u>				Date Time	<u>20/7</u>	<u>21/7</u>	<u>22/7</u>	<u>23/7</u>												
Dose	Route	Frequency	Start Date																	
<u>3.9g</u>	<u>IV</u>	<u>TID</u>	<u>20/7</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Saintini</u>				<u>6am X (14)</u> <u>2pm X (14)</u> <u>10pm X (14)</u> <u>stop</u> <u>malina</u> <u>22/7/26</u> <u>8:50 AM</u>																
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																				

VERIFIED

VERIFIED



Weight. Ward.

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.	

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

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Weight. Ward.

[illegible]

Signature

VERIFIED BY : Name

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26-12-2014 11 Y 6 M 26 D (M)
Dr. NABEEL ALAM QADRI


Doc. No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart



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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 4:40 6 AM

Doctor / Nurse / Family Concern?

Temperature
(°F)Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score in early warning scoring

Heart Rate (Number)

Resp. Rate (bpm)
(Over 1 Minute) *

Resp Rate (Number)	21 bpm	28 bpm
--------------------	--------	--------

Resp	Mod/ Severe
Distress	None / Mild

Receiving O ₂ (l/min)	O ₂ Saturations (%)
0	95.0
1	95.0
2	95.0
3	95.0
4	95.0
5	95.0
6	95.0
7	95.0
8	95.0
9	95.0
10	95.0
11	95.0
12	95.0
13	95.0
14	95.0
15	95.0
16	95.0
17	95.0
18	95.0
19	95.0
20	95.0
21	95.0
22	95.0
23	95.0
24	95.0
25	95.0
26	95.0
27	95.0
28	95.0
29	95.0
30	95.0
31	95.0
32	95.0
33	95.0
34	95.0
35	95.0
36	95.0
37	95.0
38	95.0
39	95.0
40	95.0
41	95.0
42	95.0
43	95.0
44	95.0
45	95.0
46	95.0
47	95.0
48	95.0
49	95.0
50	95.0
51	95.0
52	95.0
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59	95.0
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61	95.0
62	95.0
63	95.0
64	95.0
65	95.0
66	95.0
67	95.0
68	95.0
69	95.0
70	95.0
71	95.0
72	95.0
73	95.0
74	95.0
75	95.0
76	95.0
77	95.0
78	95.0
79	95.0
80	95.0
81	95.0
82	95.0
83	95.0
84	95.0
85	95.0
86	95.0
87	95.0
88	95.0
89	95.0
90	95.0
91	95.0
92	95.0
93	95.0
94	95.0
95	95.0
96	95.0
97	95.0
98	95.0
99	95.0
100	95.0

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

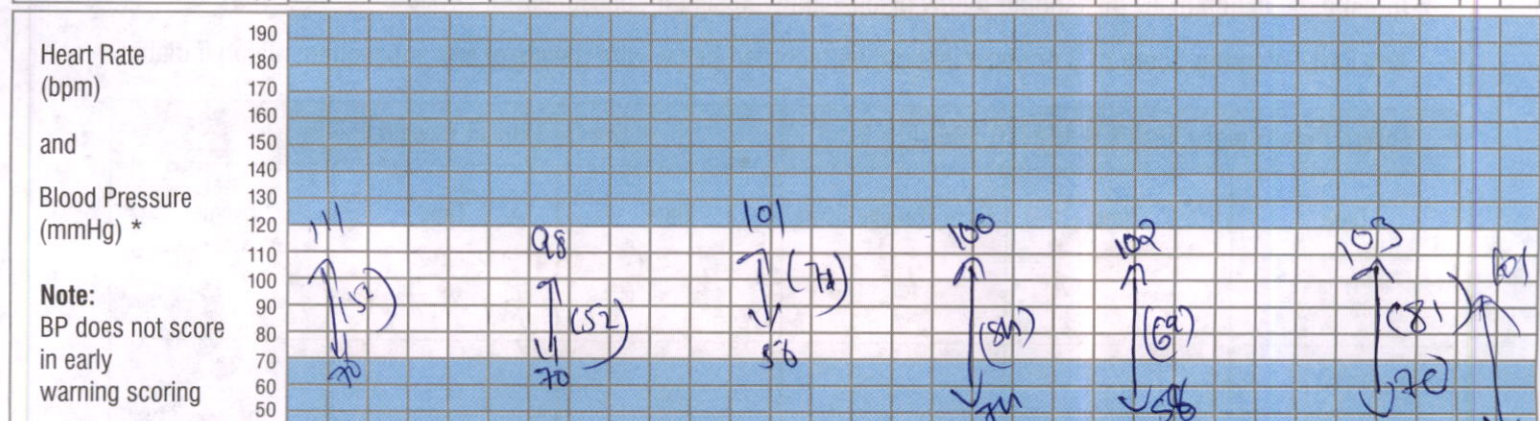
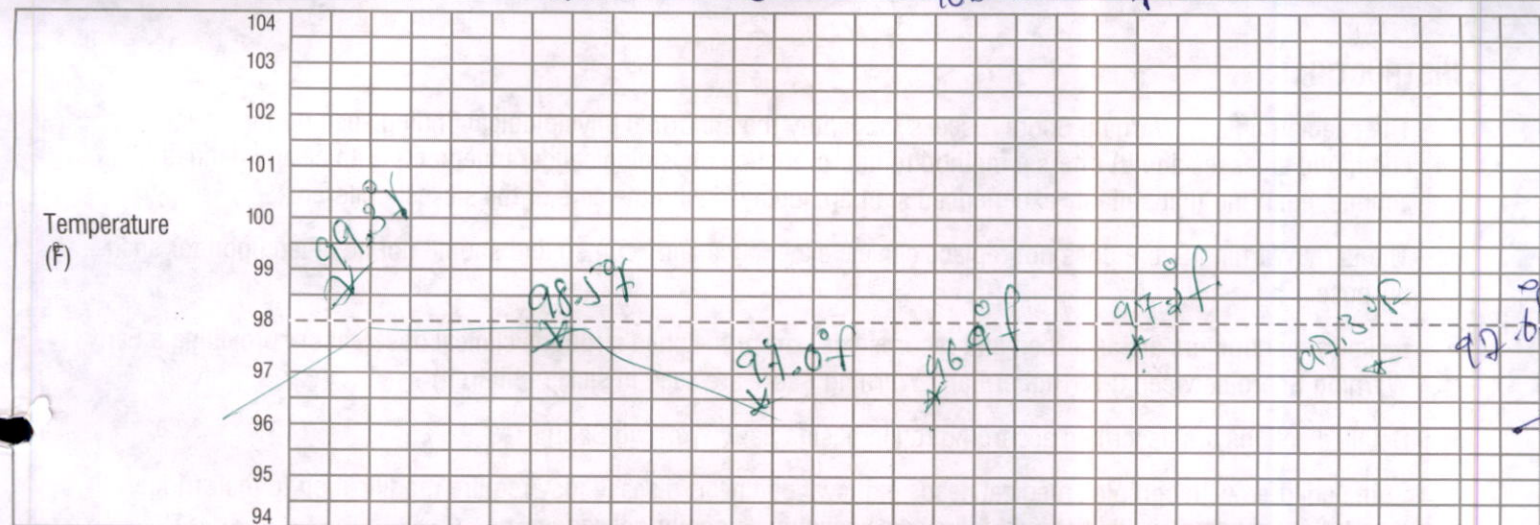
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- Following a Early Warning Score assessment, senior help may be required

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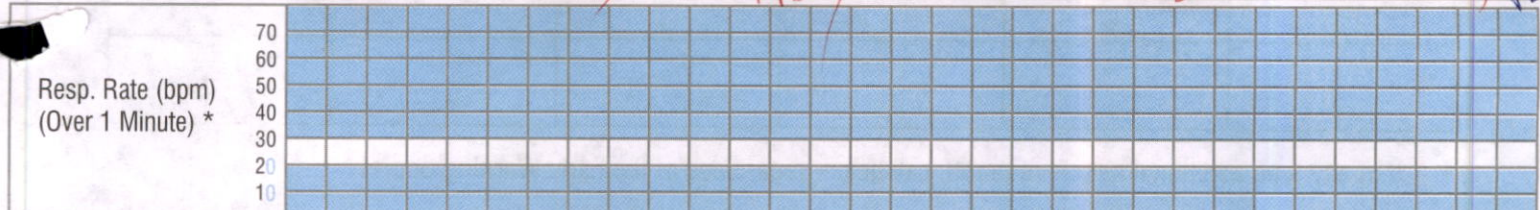
I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). 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)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/12/14 Time: 22/4
Doctor / Nurse / Family Concern? 10pm 2am 6am 10am 1pm 6pm 10pm



Heart Rate (Number) 135b/m 120b/m 74b/m 90b/m 100b/m 102b/m 101b/m



Resp Rate (Number) 26 26 26 28 29 28 28

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 99% 99% 99% 98% 100% 100% 100%

Conscious Level Normal Altered

GCS * 15/15 15/15 10/15 15/15 15/15 15/15 15/15

TOTAL SCORE Number of shaded boxes 1 1 1 1 1 1 1

Pain Score 0 0 0 0 0 0 0

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:

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- 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

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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)

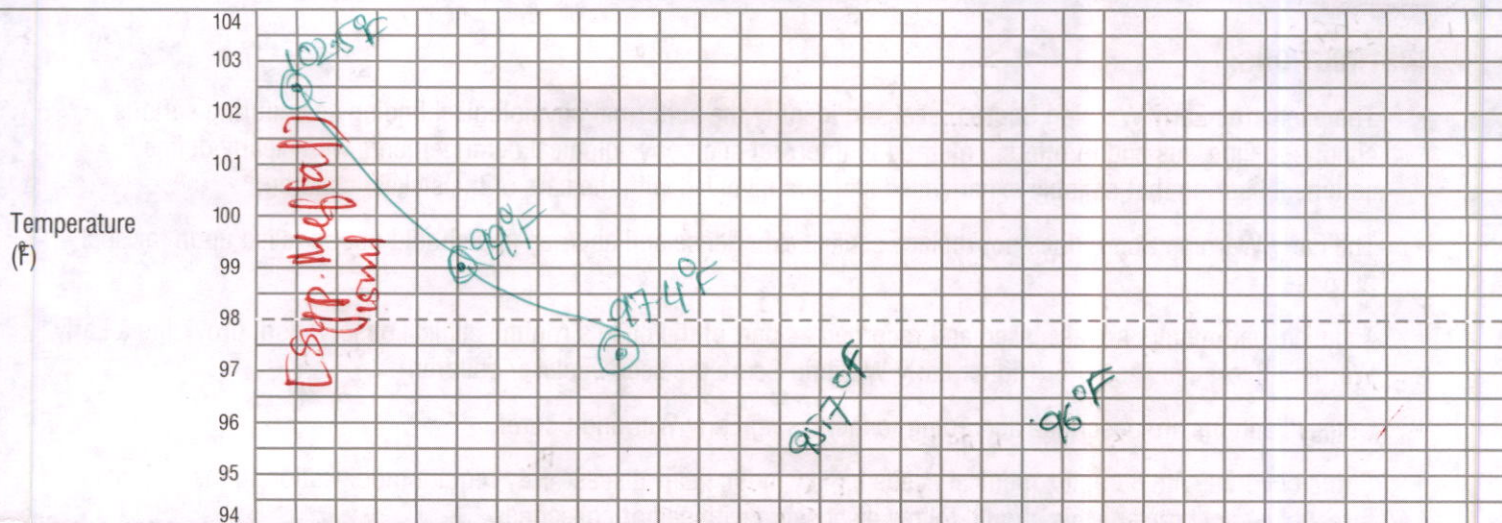


SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 2/12 Time: 2:50pm 4am 6am 10am 1pm 6pm 10pm
Doctor / Nurse / Family Concern?



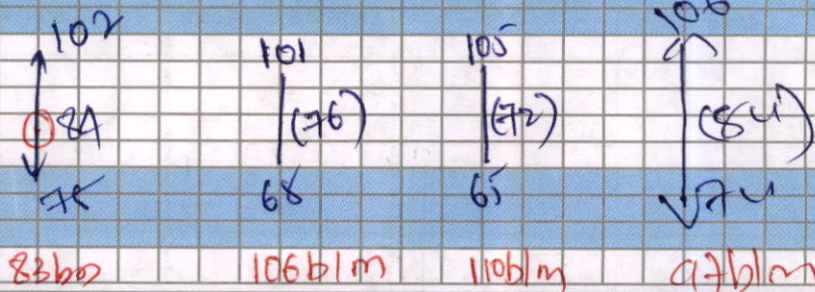
Heart Rate (bpm)

and

Blood Pressure (mmHg) *

Note:
BP does not score in early warning scoring

Heart Rate (Number)



Resp. Rate (bpm) (Over 1 Minute) *

Resp Rate (Number)

25bpm 24bpm 26bpm 23bpm

Resp Mod/ Severe Distress None / Mild

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

28l/min 28% 28% 100%

Conscious Level Normal / Altered

GCS *

15/15 15/15 15/15 9/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

1 1 1 1
0 0 0 0
m o o o

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:

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Date	Time	Early Warning Score	Date	Time	Name

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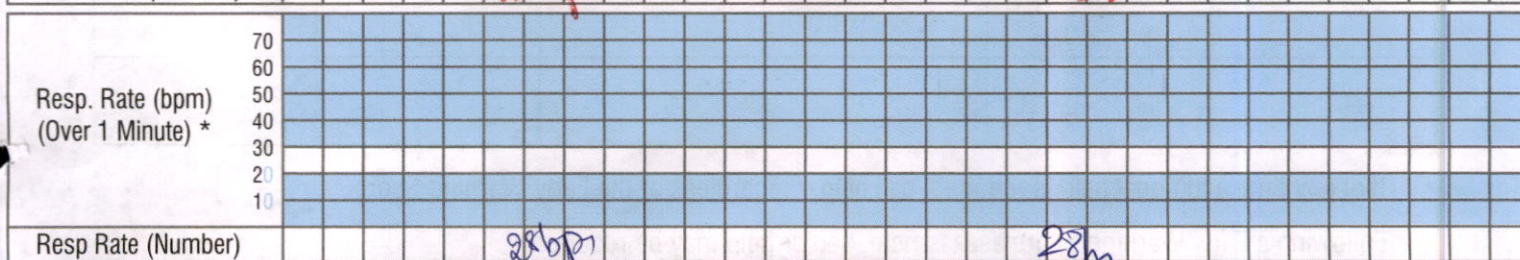
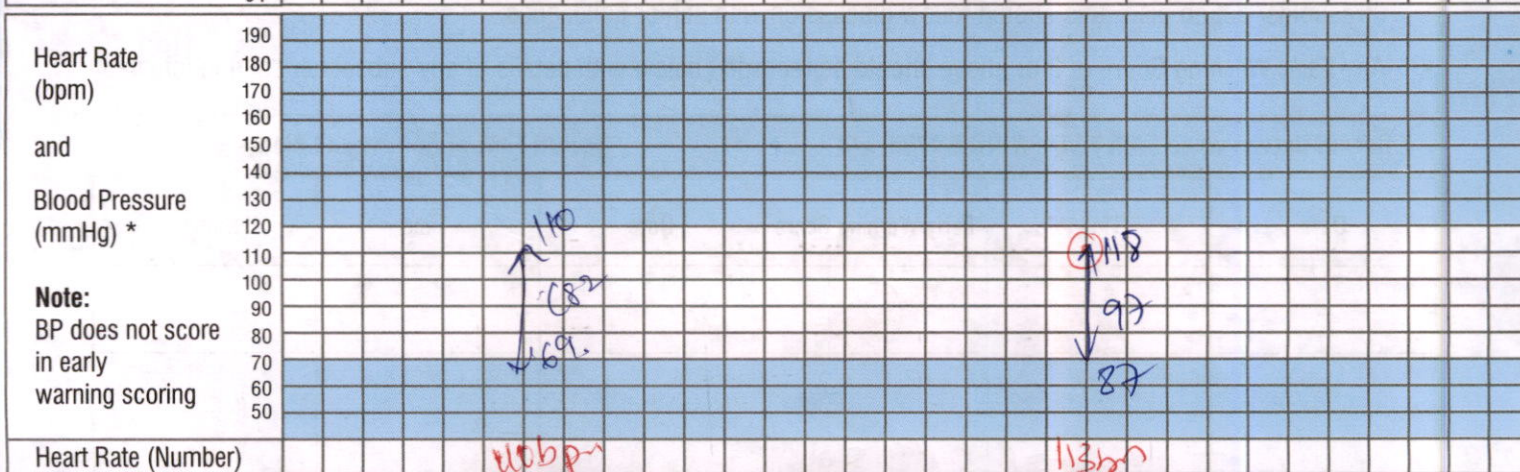
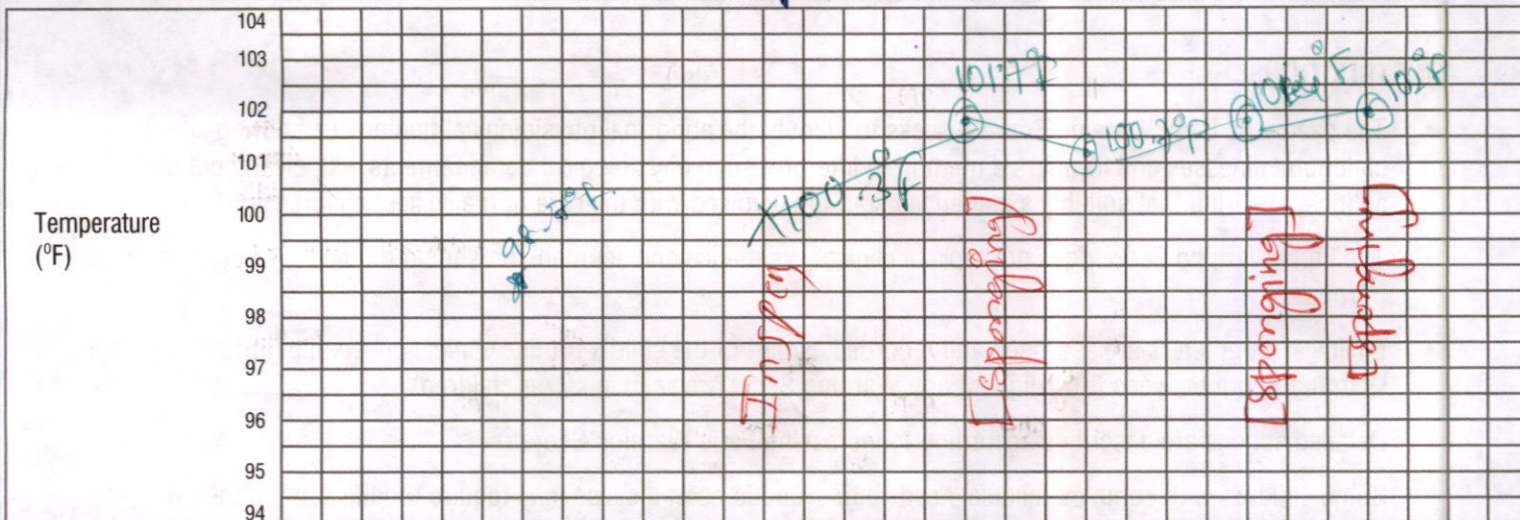
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B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
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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)



SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 20/12 Time: 8PM 9PM 10PM 12PM 1PM 2PM
Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		
Conscious Level	Normal	
	Altered	
GCS *		

TOTAL SCORE	
Number of shaded boxes	0
Pain Score	0
Observer's Initials	yo

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

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Date	Time	Early Warning Score	Date	Time	Name

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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)

Dr. NABEEL ALAM QADRI



Children's Observation & Early Warning Scoring Chart

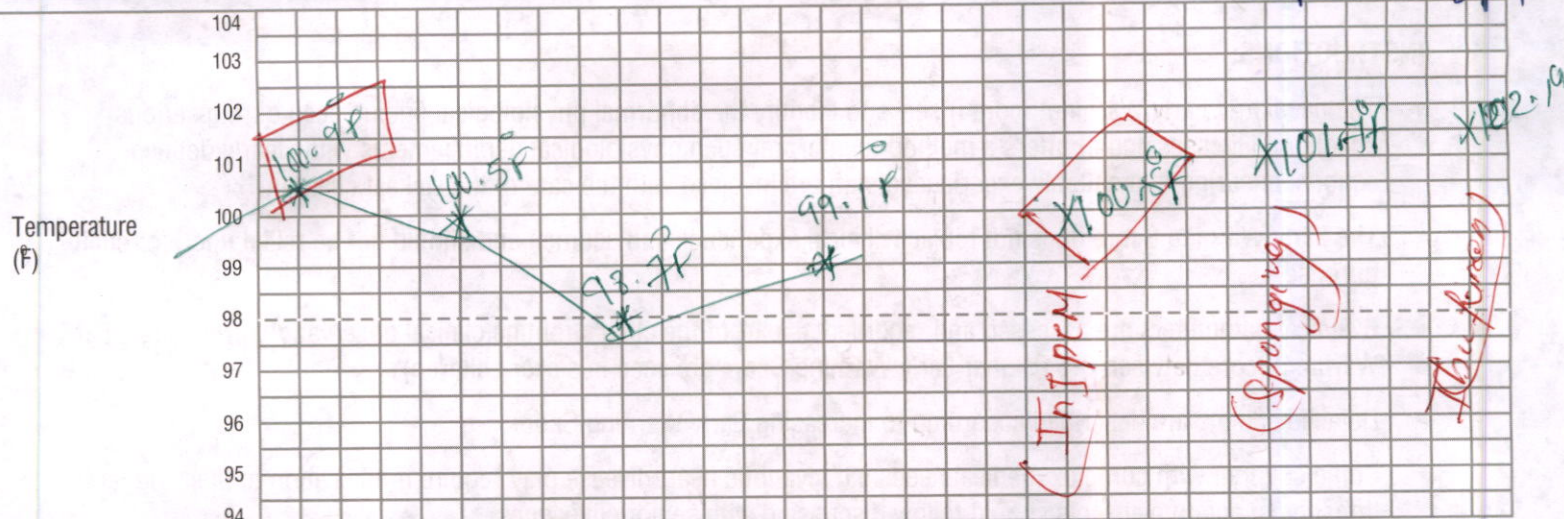


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EARLY WARNING SCORE: CHILDREN'S UNIT

[illegible]Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

Resp. Rate (bpm)
(Over 1 Minute) *

Resp Rate (Number)

Resp	Mod/ Severe
Distress	None / Mild

Receiving O ₂ (l/min)	O ₂ Saturations (%)
0	95.0
1	95.0
2	95.0
3	95.0
4	95.0
5	95.0
6	95.0
7	95.0
8	95.0
9	95.0
10	95.0
11	95.0
12	95.0
13	95.0
14	95.0
15	95.0
16	95.0
17	95.0
18	95.0
19	95.0
20	95.0
21	95.0
22	95.0
23	95.0
24	95.0
25	95.0
26	95.0
27	95.0
28	95.0
29	95.0
30	95.0
31	95.0
32	95.0
33	95.0
34	95.0
35	95.0
36	95.0
37	95.0
38	95.0
39	95.0
40	95.0
41	95.0
42	95.0
43	95.0
44	95.0
45	95.0
46	95.0
47	95.0
48	95.0
49	95.0
50	95.0
51	95.0
52	95.0
53	95.0
54	95.0
55	95.0
56	95.0
57	95.0
58	95.0
59	95.0
60	95.0
61	95.0
62	95.0
63	95.0
64	95.0
65	95.0
66	95.0
67	95.0
68	95.0
69	95.0
70	95.0
71	95.0
72	95.0
73	95.0
74	95.0
75	95.0
76	95.0
77	95.0
78	95.0
79	95.0
80	95.0
81	95.0
82	95.0
83	95.0
84	95.0
85	95.0
86	95.0
87	95.0
88	95.0
89	95.0
90	95.0
91	95.0
92	95.0
93	95.0
94	95.0
95	95.0
96	95.0
97	95.0
98	95.0
99	95.0
100	95.0

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 1	: Continue hourly observations and hourly documentation
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

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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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-00306262
Master B ABHILASH
26-12-2014
Dr. NABEEL ALAM QADRI

IP5-00176616

11 Y 6 M 24 D (M)



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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 Thrombophlebitis 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							

Date & Time: 17/1/2016 8:27

BAH-00306262 IP5-00176616

Master B ABHILASH

26-12-2014 11 Y 6 M 24 D (M)

Dr. NABEEL ALAM QADRI



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/7/26

Assessment: Baby having pyrexia

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 general condition of the baby.	8:20pm	Assessed the general condition of the baby.	It reduce by giving medicine & sponging.
10pm	Administer medication as per doctor order.	10:20pm	Administered medication as per doctor order.	
12AM	Monitor vital signs.	12:30AM	Monitored vital signs.	
2AM	Give sponging to the baby.	2AM	Given sponging to the baby.	
4AM	Continue w fluids	5AM	Continued w fluids	
6AM	Administer antipyretic drugs.	7AM	Administered antipyretic drugs.	

Re-Assessment:

Special Notes: Monitor vital signs

Nurse Signature: Meelin

Nurse Name: Meelin

Date & Time: 21/7/26 @ 8am

BAH-00306262
Master B ABHILASH
26-12-2014 11 Y 6 M 24 D (M)
Dr. NABEEL ALAM QADRI

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NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 21/7/26

Assessment: Baby having poor intake.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	Assess the general condition of the baby	8AM	Assessed the general condition of the baby	by done all these to improve
9AM	Dr. Nabeel sir advis continuous same.	9AM	Dr. Nabeel sir advised continuous same.	baby condition.
11AM	monitor vital signs & record IVF. DNS. 75ML/hr ongoing	11AM	monitored vital signs & record IVF. DNS 75ML/hr ongoing	
4PM	Administer medication as per doctor orders.	4PM	Administered medication as per doctor orders.	

Re-Assessment:

Special Notes:

Nurse Signature: Aruna

Nurse Name: Aruna

Date & Time:

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 21/7

Assessment: Baby having dull activity

Goals

- ☒ Maintain Airway and Oxygenation
☒ Maintain Personal Hygiene
☐ Identify Potential Complications

- ☐ Relieve Pain & Discomfort
☒ Prevent Infection
☐ Any Others. Specify

- ☒ Maintain Fluid Balance
☐ Meet Elimination Needs

- ☐ Improve Activity Tolerance
☒ Ensure Safety

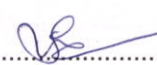
- ☒ Maintain Good Nutritional Status
☐ Early Ambulation Reduce Anxiety

- ☐ Maintain Skin Integrity
☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
3pm	→ Assess the baby general condition	3:10pm	→ Assessed the baby general condition	baby condition is stable
4pm	→ monitor the vital's	4:10pm	→ monitored the vital's	
5pm	→ maintain Dr fluid's	5:10pm	→ maintained Dr fluid's	
6pm	→ Provide comfortable position	6:10pm	→ provided comfortable position	
7pm	→ Administer medication as per doctor order's	7:10pm	→ Administered medication as per doctor order's	

Re-Assessment:

Special Notes:

Nurse Signature: 

Nurse Name: 

Date & Time: 21/7 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 21/07/26

Assessment: baby condition now normal

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 pt general condition.	8:10M	Assessed pt general condition.	by done above over the case pt condition is normal
10pm	provide comfortable position.	10:10M	provided comfortable position.	
12am	monitor vital signs.	12:11am	monitored vital signs & recorded.	
	maintain I/O chart		Maintained I/O chart	
2am	Ensure safety.	2:11am	Ensured safety.	
6am	Administer medications	6:10am	Administered medications	
8am	per chart	8:11a	per chart	

Re-Assessment: Monitored vitals & maintained I/O chart (w/ft fever spikes)

Special Notes: plan d/c tm

Nurse Signature: [Signature] Nurse Name: Ankitha Date & Time: 20/7/26 (@8am)



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 22/7/26

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
8:00 am	Assess PT general condition	8:10 am	Assessed PT general condition	BJ doing all these procedures PT condition is improving normally
9:00 am	Monitor vitals & record	9:10 am	monitored vitals & recorded	
11:00 am	Maintain I/O chart	11:10 am	Maintained I/O chart	
12:00 pm	Administer IV fluids as per doctor's order	12:10 pm	Administered IV fluids as per doctor's order	
1:00 pm	Ensure PT safety	1:10 pm	ensured PT safety	
2:00 pm	Encourage PT to intake food	2:10 pm	encouraged PT to intake food	

Re-Assessment:

Special Notes: Plan D/C T/m

Nurse Signature: Surekha

Nurse Name: Surekha

Date & Time: 22/7/26 @ 2 pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 22/7/26

Assessment: Baby having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2:00 pm	Assess pt general condition	2:40 pm	Assessed pt general condition	By doing all these procedures pt condition improving slowly?
3:00 pm	Monitor vitals & record	3:10 pm	Monitored vitals & recorded	
4:00 pm	Maintain DLO chart	4:10 pm	maintained DLO chart	
5:00 pm	Administer medications as per doctor's order	5:10 pm	Administered medication as per drug chart	
7:10 pm	Ensure pt safety	8:10 pm	Ensured pt safety?	

Re-Assessment:

Special Notes:

Nurse Signature: shirisha Nurse Name: shirisha Date & Time: 22/7/26 @ 8 pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 22/12/26

Assessment: pt 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
9pm	=> Assess the pt general condition	9:30pm	=> Assessed the pt general condition	By doing above all the procedures pt is improving
12Am	=> provided comfortable position	12:30pm	=> provided comfortable position	
2pm	=> maintain I/O chart	2:30pm	=> maintain I/O chart	
4pm	=> monitor vitals signs	4pm	=> monitor vitals signs	
6pm	=> ensure safety		=> ensure safety	
6pm	=> Administer all medication as per doctors order	6:30pm	=> Administer all medication as per doctors order	

Re-Assessment:

Special Notes: Plan Discharge T.O.
Inform duty doctor if sas

Nurse Signature: Jamuna

Nurse Name: Jamuna

Date & Time: 23/12/26 at 8Am



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Nabeel Alam Department: ER Date of Admission: 19/7/20

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	OTF							
BACKGROUND	Area	Shift Time	ER 11:45pm to 12:30am	1st Floor 12:30am to 8pm	2nd Floor 8pm to 11:45pm	3rd Floor 11:45pm to 8pm	4th Floor 8pm to 11:45pm	5th Floor 11:45pm to 8pm
	Medical Condition (Any special condition to be noted):		NA	NA	NA	NA	NA	NA
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: 98.2°F	98°F	98°F	98°F	97.5°F	98.0°F
	Res:		24 b/m	22h	22	24 b/m	25	26h
	SpO ₂ :		100%	99%	99	99%	99	99%
	Pulse:		132 b/m	120h	120	100 b/m	122	112h
	BP:		103/73	100/69	107/61	101/65	111/62	98/70
	Fall Risk Score:		10	10	10	10	10	10
Pain Score:		0/10	0/10	0/10	0/10	0/10	0/10	
Recommendations	Safety Needs:		yes	yes	yes	yes	yes	yes
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		yes	NA	NA	NA	NA	NA
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		NA	NA	NA	NA	NA	NA
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Bhavani	Nikita	Neel	Anura	Bisesh	Ankitha	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		19/7	20/7	21/7	21/7	21/7	22/7	
Time:		11:45pm	8am	8am	8pm	8pm	8am	
Taken Over By Name :		Nikita	Anura	Anura	Bisesh	Ankitha	Surekha	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		19/7	20/7	21/7	21/7	21/7	22/7	
Time:		11:55pm	8am	6am	2pm	8pm	8am	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. Nabeel Alam Qadri Department: ER Date of Admission: 19/1/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known				
	<u>UTI</u>		If Yes Specify:				
BACKGROUND	Area	Shift Time	<u>1st Shift 8am-2pm</u>	<u>2nd Shift 2pm-8pm</u>	<u>3rd Shift 8pm-8am</u>		
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>		
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:	<u>98.2°F</u>	<u>98.0°F</u>	<u>96.7°F</u>		
	Res:	<u>22</u>	<u>25b/m</u>	<u>25b/m</u>			
	SpO ₂ :	<u>99.1</u>	<u>99</u>	<u>99.6</u>			
	Pulse:	<u>100</u>	<u>105</u>	<u>105</u>			
	BP:	<u>100/69</u>	<u>107/60</u>	<u>101/62</u>			
	Fall Risk Score:	<u>10</u>	<u>10</u>	<u>10</u>			
Pain Score:	<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	☐ Yes ☐ No
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>			
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>			
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>			
Handed Over By Name :		<u>Sweetha</u>	<u>SPRINGER</u>	<u>Jannu</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>21/1/26</u>	<u>22/1</u>	<u>23/1</u>			
Time:		<u>2pm</u>	<u>@ 8pm</u>	<u>@ 8 Am</u>			
Taken Over By Name :		<u>SPRINGER</u>	<u>Jannu</u>	<u>Rama</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>22/1</u>	<u>22/1</u>	<u>23/1/26</u>			
Time:		<u>@ 2pm</u>	<u>@ 8pm</u>	<u>8am</u>			

BAH-00306262
Master B ABHILASH IPS-00176616
26-12-2014 11 Y 6 M 26 D (M)
Dr. NABEEL ALAM QADRI



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					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	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					
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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					
TOTAL							

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

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



THE HUMPTY DUMPTY SCALE

19/12/2017 20/12/2017 22/12/2017 23/12/2017

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	2	2	2
	13 years old and above	1					
Gender	Male	2	2	2	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	1	1	1
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	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	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1		1	1	1
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
TOTAL			10	10	10	10	10

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		yes	yes	yes	yes	yes
Call device within reach		yes	yes	yes	yes	yes
Wheels Locked		yes	yes	yes	yes	yes
Room free of clutter		yes	yes	yes	yes	yes
Adequate Lighting		yes	yes	yes	yes	yes
Wheel Chair Support		no	no	no	no	no
Other Intervention(s) Specify		no	no	no	no	no
Nurse's Name :		Shamir	Nikh	manu	Anish	Shaf
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :		19/12	20/12	22/12	22/12	23/12
Time :		11pm	6pm	6pm	6pm	8pm

Patient ID

BRADEN 'Q' SCALE

				Date : 23/7			
				Time : 2:30 PM			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: Responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4		
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4		
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		
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 mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4		
				TOTAL SCORE	28		
				Evaluator's Name	Farid		

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

BAH-00308262
Master B ABHILASH
26-12-2014 11 Y 6 M 23 D (M)
Dr. NABEEL ALAM QADRI



BRADEN 'Q' SCALE

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	19/12	20/12	21/12	22/12
					Time :	11pm	5m	6m	6a
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	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	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	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	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	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	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	28	28
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Bhavan	Bhavan	Bhavan	Bhavan

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

BAH-00306262 IP5-00176616
Master B ABHILASH
26-12-2014 11 Y 6 M 23 D (M)
Dr. NABEEL ALAM QADRI



PAIN ASSESSMENT FORM

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

(U / IO)			Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
19/7	11pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Shovai
20/7	9am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NO	Milk
20/7	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	neel's
21/7	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	neel's
21/7	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	AD
21/7	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	AD
22/7	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Andha
22/7	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Such
23/7	@ 8am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Jamir
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

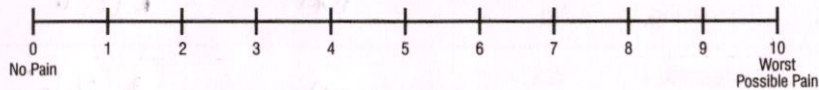
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - slow recovery - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



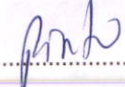


CHECKLIST FOR THROMBOPHLEBITIS

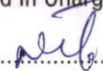
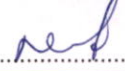
S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	19/12 DAY-1			20/12 DAY-2			21/12 DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0		0	0	0		
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV 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	CR		-	-		-	-	-		
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			-	-		-	-	-		
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-		-	-	-		
Signature of the Nurse						24	Amu		Maeh	Amu	Amu		

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 :  Name : 

Signature of Ward In Charge:

Signature :  Name : 



CHECKLIST FOR THROMBOPHLEBITIS

22/07/21

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				<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>							

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 of Ward In Charge :

Signature : Name :

Signature : Name :

BAH-00306262 IP5-00176616
Master B ABHILASH
26-12-2014 11 Y 6 M 23 D (M)
Dr. NABEEL ALAM QADRI



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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relugu

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		
19/12	11pm	7	Infection control measures	M	1	0	1	1	-	Shivani
20/12/16	8am	9	Normal diet	F	1	0	1	1	-	Nikitha

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
19/12/26	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Rever Scrotal pain	Hemodynamic stability	2v Antibiotics	Reetiba	☐ Nursing ☐ Others:
19/12/26 11pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	fever	Hemodynamic stability	Iv fluids	Shwair	☐ Medical ☒ Others:
20/12/26 8am	☐ Medical ☐ Nursing ☒ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	2 Depididymo orchitis & UTI	Normal diet & plenty of oral liquids	RDA E! - 4700 kcal/d P! - 3681g	Nikitha	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

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Master B ABHILASH
26-12-2014 11 Y 6 M 24 D (M)
Dr. NABEEL ALAM QADRI

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 12pm Mode of Arrival: with family Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Body Weight: 39.6 Kg

Height: cm

No Allergy

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

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

Family History: Nil

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

Observations: Weight: 39.6 kg Length: Head Circumference (< 2 years):

Temp.: 98.8 HR: 110b/m RR: 23b/m BP: 102/70/89

Pain Score: 0 Specify Site: 0/1/0 (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☐ Yes ☐ No Score: 10 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 23) (Document in the Braden Q Assessment Sheet)

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

Character of Pain Nil Location Nil Frequency Nil Duration Nil

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

Inform consultant for positive criteria

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

Inform consultant for positive criteria

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

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☒ Yes ☐ No if Yes specify Inform consultant for positive criteria.**Social History:** Lives WithSiblings in household ☐ Yes ☐ No (if yes How Many?)All Information Obtained From ☐ Patient ☒ Mother ☒ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach : ☒ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump : ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ No

Information given to

Nurse Signature: NilNurse Name: NikitaDate: 19/7/26 @

Time:

BAH-00306262 IP5-00176616
Master B ABHILASH
26-12-2014 11 Y 6 M 24 D (M)
Dr. NABEEL ALAM QADRI



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 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 Hygiene

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: Ab

Nurse Name: Nikita

Date and Time: 19/12/20 @ 12pm

Docu. No. : RCHBH /FRM / CLINICAL / 191

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00306262 IP5-00176616 Master B ABHILASH 26-12-2014 11 Y 6 M 23 D (M) Dr. NASEEL ALAM QADRI 		Date & Time of Admission 19/7/26 @ 10:51pm	Date & Time of Transfer Order 19/7/26 @ 11:50p
		Transfer Ordered by Dr. Sowjanya	Reason for Transfer Admission
From Unit ee	To Unit 114	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 21	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what? op file	Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films No			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	EDS A	(1)	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring NR. Bhavani		Name of Person Ordered Transfer Dr. Sowjanya	
Patient & Clinical Records Received by : Nikita 12pm 20/7/26			
Date & Time of Patient Received :			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready



114

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 2017/12/26 Time: 8 am

Weight: 39.06 kg Centile: 250th

Height: 160 cm Centile: 97th

Inference: well child

RDA: — Calories: 1700 kcal/d Protein: 30 g/d

Diet Recommendations: Normal diet & plenty of oral liquids

Assessment: Avoid spicy, chilled & outside foods.

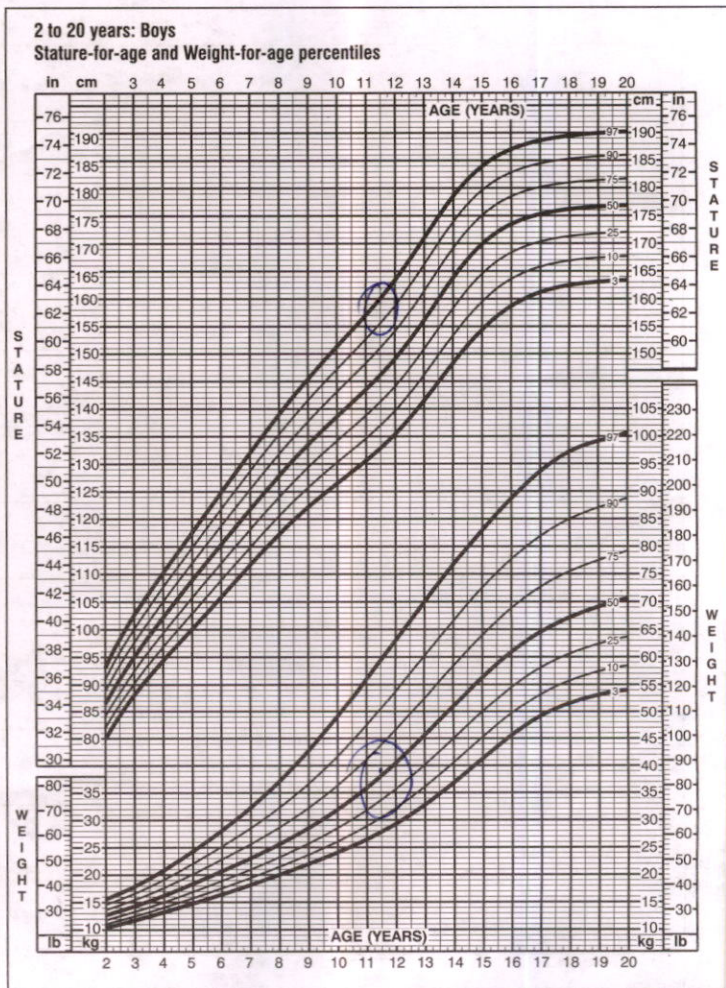
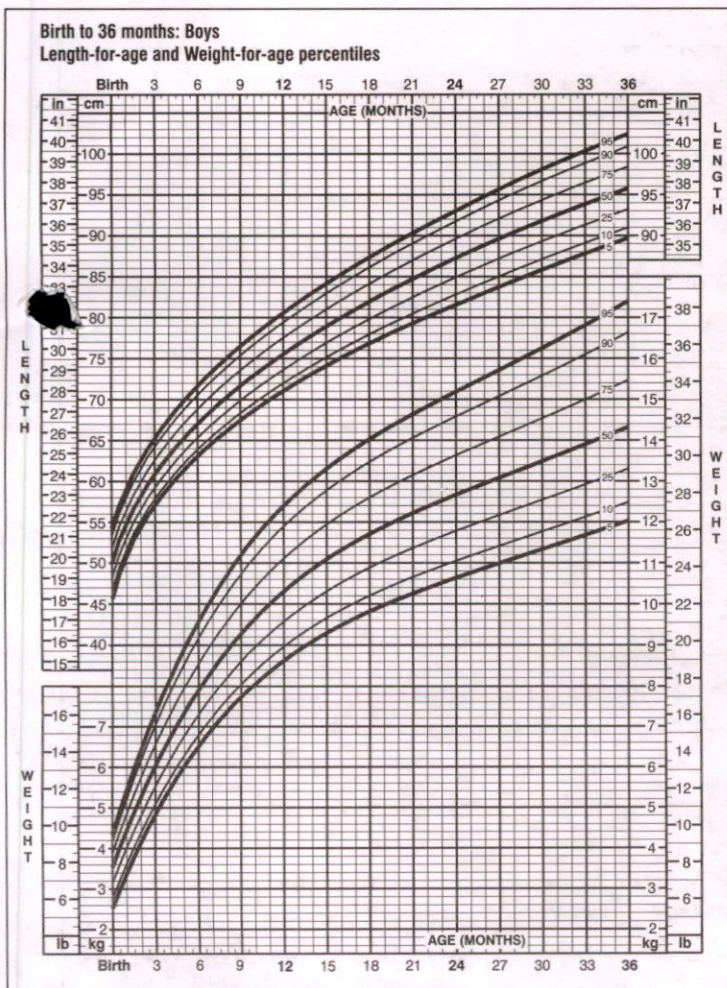
Food Allergies: No Veg/Non-veg: Non-veg

Diagnosis: ? Epididymo-orchitis & UTI & persistent removal

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha

Daily Notes:

2/18/26
sum

child is stable. oral intake is fair

continue $\bar{c}$ Normal diet $\bar{c}$ plenty of oral liquids - likely

BAH-00306262 IP5-00176616
Master B ABHILASH
26-12-2014 11 Y 6 M 24 D (M)
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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											
19/12	12:00 am											
	01:00 am	No IVF										
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
20/12	05:00 am	No IVF										
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

BAH-00306262

IP5-00176616

Master B ABHILASH

26-12-2014

11 Y 6 M 24 D

(M

Dr. NABEEL ALAM QADRI



FLUID CHART

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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 :									
20/12	08:00 pm	↑	rice	70ml		/					0				
	09:00 pm	↑	rice	70ml		/					0		mal		
	10:00 pm	↑	rice	70ml		/					0		mal		
	11:00 pm	↑	rice	70ml		/					0		mal		
	12:00 am	↑	rice	70ml		/					0		mal		
	01:00 am	↑	rice	70ml		/					0		mal		
Total Intake :						Total Output :									
21/12	02:00 am	↑				/							mal		
	03:00 am	↑				/							mal		
	04:00 am	↑				/							mal		
	05:00 am	↑				/							mal		
	06:00 am	↑				/							mal		
	07:00 am	↑				/							mal		
Total Intake :						Total Output :									
Total 24 hrs. Intake						Total 24 hrs. Output									

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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								
21/7	08:00 am						✓						
	09:00 am			75ml						✓	0	Aruna	
	10:00 am	DNS		-							0	Aruna	
	11:00 am			75ml			✓				0		
	12:00 pm			75ml						✓	0	Aruna	
	01:00 pm			-							0		
Total Intake :						Total Output :							
21/7	02:00 pm			-							0		
	03:00 pm	DNS		75ml						✓	0	Aruna	
	04:00 pm	DNS		75ml							0	Aruna	
	05:00 pm			30ml							0	Aruna	
	06:00 pm			30ml						✓	0	Aruna	
	07:00 pm			-							0		
Total Intake :						Total Output :							
21/7	08:00 pm	↑									0	Aruna	
	09:00 pm	↑		30ml						✓	0	Aruna	
	10:00 pm	DNS		30ml							0	Aruna	
	11:00 pm	DNS		30ml						✓	0	Aruna	
	12:00 am	↓		-							0	Aruna	
	01:00 am	↓		-							0	Aruna	
Total Intake :						Total Output :							
22/7	02:00 am	↑		-							0	Aruna	
	03:00 am	↑		30ml						✓	0	Aruna	
	04:00 am	DNS		30ml							0	Aruna	
	05:00 am	↓		-						✓	0	Aruna	
	06:00 am	↓		-							0	Aruna	
	07:00 am	↓		-						✓	0	Aruna	
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.
3. 24 hrs. total to be entered in the kardex in RED.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
22/12	08:00 am										0	J. Sufi	
	09:00 am	1	200								0		
	10:00 am	1									0		
	11:00 am	1									0		
	12:00 pm	NO IVF									0		
	01:00 pm										0		
Total Intake :						Total Output :							
22/12	02:00 pm	2	Rice								0	J. Sufi	
	03:00 pm	1									0		
	04:00 pm	NO IVF									0		
	05:00 pm	1									0		
	06:00 pm	1									0		
	07:00 pm										0		
Total Intake :						Total Output :							
	08:00 pm	1									0	J. Sufi	
	09:00 pm										0		
	10:00 pm	NO IVF									0		
	11:00 pm	1									0		
	12:00 am	1									0		
	01:00 am										0		
Total Intake :						Total Output :							
	02:00 am	1									0	J. Sufi	
	03:00 am										0		
	04:00 am	NO IVF									0		
	05:00 am	1									0		
	06:00 am	1									0		
	07:00 am										0		
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							