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Your Right to a Safe Delivery

ACTIVITY RECORD FOR BILLING

Name :_____

BAH-00656408 IP5-00176081
Master ZACH PAUL
22-04-2024 2 Y 2 M 15 D (M)
Dr. ANUPAMA Y

UHID No. : _____ nsultant: _____ Dept : _____

Date of Admission: ____ te of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
7/7/26	11:30pm	ER	~~ER~~ 12/	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
07/07	CBP, CRP, s/E	68073	
	X-ray chest	33782	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
7/7	Infusion Pump	6.30 Pm	Stop	92216	Sanjay
7/7	Oxygen	7.30 Pm	Stop	92273	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
07/07	IV Placement	1	92206	Sam
	Nebulization	4	92215	
08/07/26	NHA	1	2400358	

ANY OTHER INFORMATION

1 X-ray

Date : 08/07/26 Time : 01:00am Prepared By : [signature]

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
[signature]	MW-I		

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176081 **Admit Date** : 07-Jul-2026 **Admit Time** : 06:24 PM **UHID** : BAH-00656408

Patient Details :

Patient Name	: Master ZACH PAUL	**Age**	: 2 Y 2 M 15 D
Guardian	: Mr RAYNOLD PAUL	**DOB**	: 22-04-2024
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: FLAT NO 201, HOME GREEN RESIDENCY, PADMAVATHI NAGAR COLONY Khairatabad Hyderabad Telangana INDIA 500004	**Phone No**	: 9849892949/ 9502576861
		E-mail	: ALEXANDER.RAYNOLD@GMAIL.COM

Admission Details :

Bed Type : GENERAL WARD **Bed No** : GW 121 **Ward Name** : 1F-GENERAL WARD I

Room No : GW 121 **Admission Type** : First Visit

Contact Details :

Name	: Mr RAYNOLD PAUL	**Relationship**	: Father
Contact Address	: FLAT NO 201, HOME GREEN RESIDENCY, PADMAVATHI NAGAR COLONY Khairatabad Hyderabad Telangana INDIA 500004	**Phone No**	: 9849892949

Signature

Doctor Details :

Doctor Name	: Dr. ANUPAMA Y	**Specialisation**	: GENERAL PEDIATRICS
Referral Doctor	: DR RAKESH (KHAIRATHABAD)	**Phone No**	:
Co-Consultant	: Dr. JAPA AVINASH		

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 10000.00

Payor Name : SELFPAY

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NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
07/07/26	00.00 4:00pm	Nebulization c̄ Levolin	[illegible]	
07/07/26	01.00 4:30pm	Nebulization c̄ Levolin	Bhavani	
07/07/26	02.00 5:00pm	Nebulization c̄ Levolin	Bhavani	
07/07/26	03.00 5:30pm	Nebulization c̄ Budecort	[illegible]	
07/07/26	04.00 7:20pm	Nebulization c̄ Levolin	[illegible]	
	05.00			
	06.00			
	07.00			
	08.00			
	09.00			
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Anupama. Date : 07/7/24

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

Start Time of Assessment: ..... Weight: 10.98 kg

Allergic History: .....

Chief Complaints:

C/O cough, cold : 2 days
Hurried breathing : morning today

Pediatric Assessment Triangle

A Appearance - TICLS (N)

B Breathing
- ☑ ↑ WOB
- ☐ ↓ WOB
- ☐ Normal
- ☐ Gasping / Apnea

C Circulation
- ☑ Normal
- ☐ Abnormal
  - 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: 42/min SpO₂ ~~on FIO₂~~ 92% c RA.

Rhythm: .....

Retractions: ☑ Suprasternal ☑ ICR ☑ SCR
☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☑ Wheezing ☐ Grunting

Air Entry: Bl. AE Equally (+)

Palpation Findings (If necessary) .....

Any urgent interventions needed: ☐ Yes ☑ No
If Yes .....

Circulation

HR: 176/min. CFT — Central .... — Peripheral ....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes ....

BP: .... mmHg

Pulse Volume: — Central .... — Peripheral ....

If in Shock: — Compensated .... — Hypotensive ....

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: ....

ECG: ....

Any Signs of Heart Failure: ☐ Yes ☐ No

Disability

GCS: .... AVPU: ....

Pupils: — Responsive ☐ Non-Responsive ☐ — Size — Right .... — Left ....

Active Seizures: ☐ Yes ☐ No Sugars: ....

Signs of Neurological compromise ....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes ....

Exposure

Temp.: 99.3°F

Any Rash: ☐ Yes ☐ No,

If yes describe the rash ....

Active bleed ....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: ....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes ....

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☐ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings: ....

Labs Planned:

CBP, CRP, S. Electrolytes

CXR.

N.B. Chethan

Treatment Planned:

IV Fluids

Inj. Hydrocortisone

Neb c̄ Levolin, Duolin, Budecort

~~[illegible]~~

N.B. Chethan

Need for Oxygen: ☐ Yes ☐ No if yes Low Flow ☐ High Flow ☐ PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): LRTI with wheeze ⊕

Assessment done by

Name of the Doctor: N. Perumal

Signature: N.Pr

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

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: ....

Signature: ....

Date & Time: ....

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: Z-ACH DAVE.

UHID ID: _____

Department: _____

Consultant: _____

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: Mother Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

c/o Cough, cold :- 2 days
Heard breathing :- Morning

History of present illness :

Apparently normal child. Developed cough, cold :- 2 days
Heard breathing from Early morning.
No H/o fever.

Patient Sticker

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Normal neonatal transition

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History :

Normal for age

Immunization History :

Immunized till date

(P.T.O.)

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Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 10.98 (Centile ________)

On Examination :

Temperature : 99.3°F Pulse Rate : 176/min B.P. 98/79 (72) SPO2 92% c RA

Resp.rate and type of breathing : 42/min

Rash —

Lymphadenopathy —

Oedema : —

Allergies (if any): —

Inj. Hydrocort, Neb c Levolin, Neb c Budecort } given in ER.

RR – 38/min.

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds :

Any addes sounds :

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

B/L wheeze ⊕
B/L Air entry ⊕
Tachypnea ⊕
SCR ⊕, ICR ⊕.

Cardiovascular System :

Inspection of procordium :

Heart Sounds :

Any murmur :

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

S1S2 ⊕.

Per Abdomen :

Inspection

Palpation :

Ausculation :

Spine :________ External Genitelia :

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

Soft
non tender
No organomegaly.

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Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Alert

Cranial Nerves : _____

_____

_____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR **Superficials:**

Plantars _____

Sensory System :

_____

_____

_____

Bladder / Bowel : _____

Clinical Summary & Diagnostic: LRTI c wheeze c mild PD.

_____

_____

_____

_____

(P.T.O.)

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22-04-2024 2 Y 2 M 15 D (M)
Dr. ANUPAMA Y

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: education

Desired goals of the treatment : Resolution of symptoms

Planned Labs:

CBP
CRP
S.Electrolytes
✓ CXR.

Noted by
[illegible]

Planned Management

IV Fluids
Inj. Hydrocort-sp? → TID
Neb c Levolin
Neb c Duolin
Neb c Budecort.
Vitals monitoring @ 3 hourly

DR. ANUPAMA Y
Registration No: 50853

Signature of the Doctor: N [signature]
Name of the Doctor: N. Prathibha
Date & Time: 07/7/26. 10:30pm.

Signature of the Consultant: [signature]
Name of the Consultant: D. Anupama
Date & Time: 7/7/26

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/24 6 pm	Seen by Dr. Anupama mam	10.98 kg
		Plan
		- Admission - Daycare / if wheeze not controlled Full Day
	+RTI c wheeze (SCR +, ICR +)	
		- Inj. Hydrocort stat
		~~stat~~ IV Fluids -
		- Neb. Levolin 6th hourly
		Duolin @ 8H
		Budecort @ 8H
		- CXR
		- CBP, CRP, S. Electrolytes.
		~~[illegible]~~
		- Informed Dr. Anupama at 10 pm
	RR = 34/m ; ICR ; SCR + wheeze +.	[signature] DR. ANUPAMA Y Registration No: 50858 [signature]

Docu. No. : RCHBH /FRM / CLINICAL / 088

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26 10:15pm	c/d/w Dr. Anupama	
	-> Clinical condition explained	PLAN
		- Advised admission
		- Inj. HYDROCORTISONE TID
		- Nebulizations to contin
		monitor saturations
		Q3H.
		RAHUL
08/07/26 8:00a	S/B	
	Δ: WALRTI	
		ADV
	-> No fever spikes	
	-> Cough ↓ed	1) Ct IVfluid till today
	-> No ↑ WOB	afternoon &
		decide based on
	occas^nl wheeze (+)	oral intake
	on Auscultation	
		2) Ct Nebulisation

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/24 10am	SB Dr. Anupama	
	Under 5 wheezer. Acute exacerbation afebrile wheeze better	Plan
		- 5 viral Panel (Nasopharyn)
		- Discharge
		- Levolin nebs 1:2 8 hrly x 3 days
		Budecort BD x 3 days
		Duolin UD BD x 1 day.
		Oral steroids (1mg/kg/day) x 2 days
		12mg OD
		Plan ē Dr. Rakesh.
		[signature]

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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RESULT SHEET

Date	7/7/26					
Time						
Hb	13.2					
PCV	39.5					
RBC	4.89					
WBC	16,720					
N/L	81/12					
Platelets	271L					
CRP	5					
ESR						
PCT						
RBS						
Na	139					
K	4.5					
Cl	105					
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						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

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22-04-2024 2 Y 2 M 15 D (M)
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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☑ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ..... ER ..... Shifted to: ..... ER .....

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 : N Pavankumar DRO

Date & Time : 7/7/24. 6:30pm

Nurse Name & Signature: Bhavani B

Date & Time : 7/7/24 @ 7:40pm

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DRUG CHART

Date of Admission: 2/2/26 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:				

VERIFIED BY : Name ..... Signature .....

22-04-2024 2 Y 2 M 15 D (M)
Dr. ANUPAMA Y

REGULAR PRESCRIPTIONS

Weight. 10.98kg Ward. ....

DRUG: Inj NEB c DUOLIN				Date/Time	7/7
Dose	Route	Frequency	Start Date		
1 Respule	NEB	8H	07/7	2am	Priyanka
Name & Signature of the Doctor Starting the Drugs: N. Pearwibu				10am	
Additional Instructions:				6pm	
Daily Doctor's Endorsement by a Sign					

DRUG: NEB c LEVOLIN				Date/Time	7/7	8/7
Dose	Route	Frequency	Start Date			
0.63	NEB	6H	7/7	12AM	X	1:45 am Priyanka
Name & Signature of the Doctor Starting the Drugs: N. Pearwibu				6AM	X	Priyanka
				12pm	X	
Additional Instructions:				6pm	4:45 pm ER	
Daily Doctor's Endorsement by a Sign						

DRUG: NEB c BUDECORT				Date/Time	7/7	8/7
Dose	Route	Frequency	Start Date			
0.5mg	NEB	8H	7/7	7am	X	
Name & Signature of the Doctor Starting the Drugs: N. Pearwibu				3pm	5:30 pm ER	
Additional Instructions:				11pm	1 AM Priyanka	
Daily Doctor's Endorsement by a Sign						

DRUG: Inj. HYDROCORTISONE				Date/Time	7/7	8/7
Dose	Route	Frequency	Start Date			
25mg	I.V	TID	7/7	6AM	X	Priyanka
Name & Signature of the Doctor Starting the Drugs: [signature]				2pm	6:5 pm ER	
Additional Instructions:				10pm	12:15 AM Priyanka	
Daily Doctor's Endorsement by a Sign						

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Dr. ANUPAMA Y

Weight. .... Ward. ....

	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
7/7/24.	6:05 pm	Inj. Hydrocort	50 mg	IV	N. [illegible]	[illegible] [illegible]
		DC				

VERIFIED BY : Name .... Signature ....

22-04-2024 2 Y 2 M 15 D (M)
Dr. ANUPAMA Y

I.V. FLUIDS CHART

Weight. 10.98 kg Ward. ....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
7/7/24.	7pm	DNS	IV	20	N.[illegible]	[signature] Sthalo	Not Conne[illegible]		

VERIFIED BY : Name .... Signature ....

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Master ZACH PAUL
22-04-2024 2 Y 2 M 15 D (M)
Dr. ANUPAMA Y

Doc. No. : RCHBH / FRM / CLINICAL / 125

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

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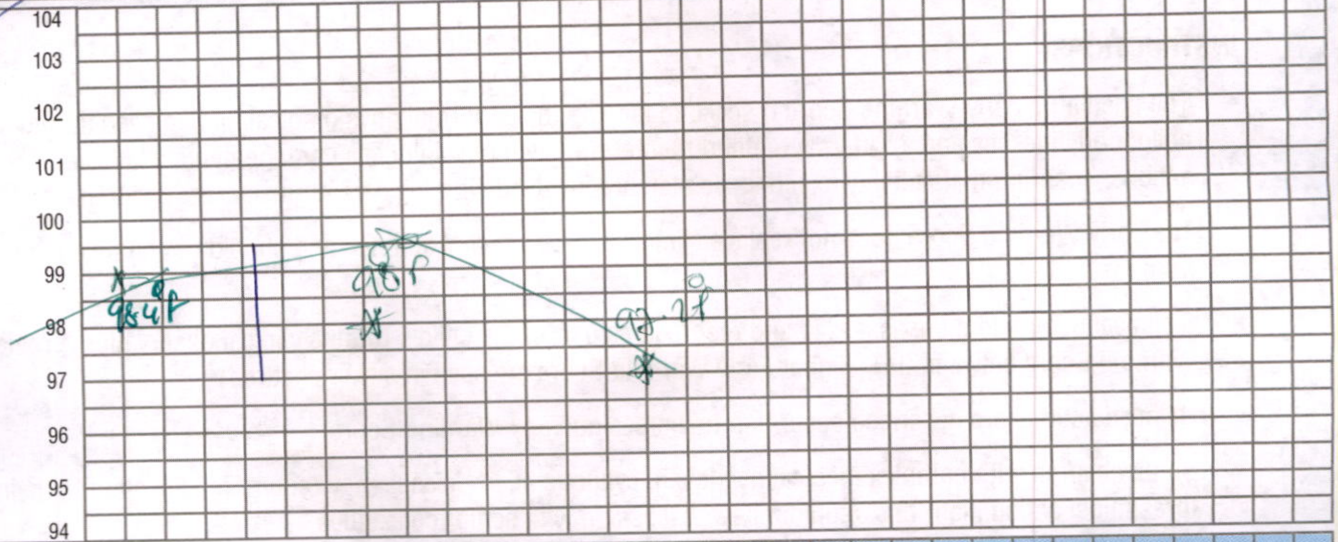
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 7/7/24

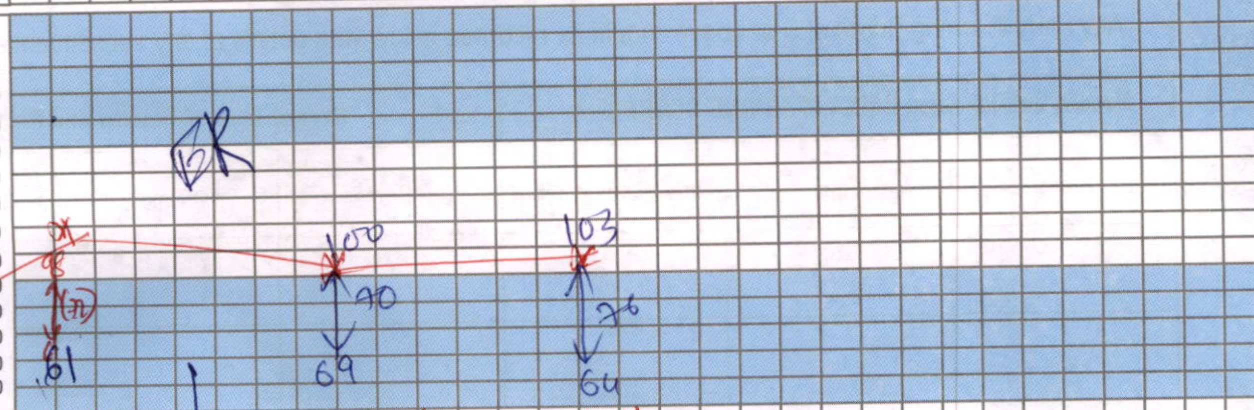
Parameter			
Time:	7pm	2am	6am
Doctor / Nurse / Family Concern?			
Temperature (F)	98.4F	98F	97.2F
Blood Pressure (mmHg) *	98/61 (72)	100/69 (70)	103/64 (76)
Heart Rate (Number)	142bm	100bm	121bm
Resp Rate (Number)	40/M	28bm	27bm
Resp Distress (Mod/ Severe; None / Mild)			
Receiving O_2(l/min) / O_2Saturations (%)	97/RA	97%	98%
Conscious Level (Normal / Altered)			
GCS *	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes		1	1
Pain Score	0	0	3
Observer's Initials			

Temperature (F)



Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring



ACTIONS	Score	
ACTIONS	Score 1	: Continue normal observation by staff nurse
NB: Scores 3 should be recorded overleaf	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.

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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)

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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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			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	DNS		20ml						✓	0	
al Intake :						**Total Output :**						
	08:00 pm	DNS		20ml			1				1	
	09:00 pm	DNS		20ml			1				0	
	10:00 pm	DNS		20ml			NP			✓	1	
	11:00 pm			—								
	12:00 am	DNS		~~20ml~~			1				0	P.B
	01:00 am			~~20ml~~							0	P.B
Total Intake :						**Total Output :**						
	02:00 am	1		20ml							0	P.B
	03:00 am			20ml			1				0	P.B
	04:00 am	DNS		20ml						✓	0	P.B
	05:00 am	1		20ml			NP				0	P.B
	06:00 am			20ml							0	P.B
	07:00 am			—			1				0	P.B
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			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**	

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☑ Night

Date: 7/7/26

Assessment: cold- cough, ↑ WOB

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
12am	assess the general health condition of the patient	12am	Assessed the patient's health condition	After providing all these care now patient stable
1am	plan to check vitals	1am	checked vitals signs	
2am	Maintain I/o chart	2am	Maintaing I/o chart	
3am	encourage orally	3am	encouraged orally	
4am	Provide nebulisation as per drug chart	4am	Provided nebulisation as per drug chart	
6am	Provide medicine as per doctor's order	6am	Provided medications as per drug chart	

Re-Assessment: assess for distress

Special Notes: SOS O_2

Nurse Signature: P.P Nurse Name: Priyanka Date & Time: 8/7/26 @ 8am

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NURSING CARE RECORD

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Shift: ☐ [illegible] ☐ Afternoon ☐ Night

Date: .....

Assessment: .....

.....

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

Re-Assessment: .....

.....

Special Notes: .....

.....

Nurse Signature: ..... Nurse Na[illegible] ..... Date & Time: .....

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 7/7	DATE 8/7	DATE	DATE	DATE
Age	Less than 3 years old	4	4	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	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1			
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1			
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
	TOTAL		12	12			

Intervention : -Fall Risk : Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position		yes	yes			
	Call device within reach		yes	yes			
	Wheels Locked		yes	yes			
	Room free of clutter		yes	yes			
	Adequate Lighting		yes	yes			
	Wheel Chair Support		No	No			
	Other Intervention(s) Specify		No	No			
	Nurse's Name :		Bhagya	Pratyusha			
	Signature :		B	P.B			
	Date :		7/7	8/7			
	Time :		8pm	8am			

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Anupama Y Department: ER Date of Admission: ER

SITUATION

Diagnosis: LRTI

Any Infection: ☐ Yes ☐ No ☐ Not Known
If Yes Specify: .....

BACKGROUND

Area / Shift Time	ER 5pm	1st F 12am-8am				
Medical Condition (Any special condition to be noted):	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	97.8°F					
Res:	<4 c/m	29 b/m					
SpO_2:	100%	98%					
Pulse:	132 b/m	118 b/m					
BP:	100/78	108/58					
Fall Risk Score:	12	12					
Pain Score:	0/10	0					

Recommendations

Safety Needs:	yes	side rails	DC			
Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Others Specify:	yes	NO				
Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Special Orders / Medications:	NA	NO				
Post Operative Procedure Special Orders:	NA	NO				
Handed Over By Name :	Bhavani	Priyanka				
Signature :	B	P.P				
Date:	7/7/26	8/7/26				
Time:	11:30	8am				
Taken Over By Name :	Priyanka	Shub				
Signature :	P.P	S				
Date:	7/7/26	8/7/26				
Time:	8pm	8am				

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

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BRADEN 'Q' SCALE

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					Date : 7/7	8/7		
					Time : 8pm	8am		
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 extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4		
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4		
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4		
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4		
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	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	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4		
				TOTAL SCORE	20	28		
				Evaluator's Name	Bhavani	Priya		

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

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PAIN ASSESSMENT FORM

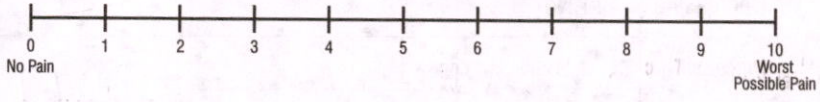
		ore)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
7/7	5pm	0/10	/	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	nil	Bhavani
7/7	11pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	P.B
8/7	6am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	P.B
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

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

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, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

BAH-00656408 IP5-00176081
Master ZACH PAUL
22-04-2024 2 Y 2 M 15 D (M)
Dr. ANUPAMA Y

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CHECKLIST FOR THROMBOPHLEBITIS

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

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 : Anirban .....

Signature of Ward In Charge :

Signature : ..... Name : .....

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I.

Patient's ..... Patient / Learner Literacy: ☐ Read ☐ Write ☐ Speak Willingness to Learn: ☐ Yes ☐ No Healthcare Literacy: ☐ Yes ☐ No

Identified Education Needs:

1. Diagnosis
2. Treatment and Care Plan
3. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights
13. Risk / Safety
14. Activity / Exercise
15. Social & Rehabilitation Needs
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		
7/7/26	8 Am	7	Infection control measures	M	4	0	1	1	—	BENCH
8/7/26	8 Am	9	Soft High protein diet	M	1	0	1	1	—	Mounika

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
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify .....

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:

1. None
2. Obtain translator
3. Reassurance & Support
4. Teach Family / Others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify .....

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

Patient Sticker

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MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagno

Date / Time			Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
7/7/26 8:00	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	LRTI	H-stability	IV fluids	[illegible]	☐ Nursing (ticked) ☐ Others:
7/7/26 2pm	☐ Medical ☐ Nursing (ticked) ☐ Others:	☐ Initial (ticked) ☐ Modified ☐ Per-Op ☐ Post Op	cold, cough x 2 days	Hemodynamic stability	IV fluids	Bhavani	☐ Medical ☐ Others: (ticked)
8/7/26 8AM	☐ Medical ☐ Nursing ☐ Others: (ticked) Dietitian	☐ Initial (ticked) ☐ Modified ☐ Per-Op ☐ Post Op	LRTI	Soft High Protein diet	RDA E:- 1250kcals/d P:- 21g/d	Mounika	☐ Medical ☐ Nursing ☐ Others: (ticked)
	☐ 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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DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: 10/07/26

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	explain to mother
☐ Walking	☑ Yes	☐ No	
☐ Dressing	☐ Yes	☑ No	
☐ Toileting	☑ Yes	☐ No	

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: about patient care
   ☐ Patient's Educational Topic/s discussed with the:
   ☐ Patient ☑ Family Member ☐ Others: .....

Nurse Signature: .....
Nurse Name: Priyanka
Date and Time: 7/7/26 @11:50 pm

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22-04-2024
Dr. ANUPAMA Y

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Zach paul Age : 2y/2m Gender: ☑ Male ☐ Female

Date : 7/7/26 Time of Arrival : 4:40pm Triage Completion Time : 4:42pm

Allergies: ☐ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): ☑ Not known any drug Allergies

Source of Information : ☑ Parents ☐ Others (Specify)

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance: ☑ Normal ☐ Sick Looking
Work of Breathing: ☐ Normal ☐ Decreased ☑ Increased ☐ Gasping / Apnea
Circulation / Colour: ☐ Normal ☐ Bleeding

INITIAL PHYSIOLOGICAL STATUS

☐ Stable
☑ Unstable :
☑ Not – Life – Threatening
☐ Life – Threatening

Vital Signs: Temp: 99.5 PR: 176bpm BP: 91/79 (72) RR: 42bpm SpO₂: 88-90% CRA 90-9...

Chief Complaints: cold, cough x 2days. ↑ WOB x Today morning 5:00AM

Triage Classification

☐	Level 1 :	Resuscitation
☐	Level 2 :	EMERGENT : Life or limb threatening
☐	Level 3 :	URGENT : Significant illness / injury with potential to become life or limb threatening
☐	Level 4 :	LESS URGENT : Significant illness but not life threatening
☐	Level 5 :	NON – URGENT : May receive care when convenient

CTAS

☐ Immediate
☐ < 15 min
☑ 30 min
☐ 60 min
☐ 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / ... Rajmohan

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☐ No
2. Have you had cough or a rash in the past 2 weeks ☑ Yes ☐ No
3. Have you had shortness of breath or difficulty breathing in the past 2 weeks ☑ Yes ☐ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☑ Not applicable

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☐ No

If yes, State Location: ....

2. Are your parents / close contacts at home healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☐ No

Name of Triage Nurse : Ramadevi

Date & Time : 7/7/26 at

Docu. No. : RCHBH /FRM / CLINICAL / 085

PART C. A positive communicable disease tr... considered for any patient who m... following criteria:

☐ Any patient with Fever / Rash / Ves... and Cough
☐ Any patient with fever and respi... "YES" to any of the question... "PART B" of the triage scre...

PART D. ACTION / INTERVEN... communicable disea...

☐ Patients should be im... room or a single ro...
☐ The patient should ... already wearing or...
☐ If patient ...

Inform consultant for positive...

Date ... Chief C... Height : ... Allergies: ... If ye... Pain Screening: ... Character ... FOR FALL: ...patient is < 6 years ...below fall risk inter... ...nt is > 6 years ...he below paramet... within past 3 m... ...port ... FALLIN... 1:30pm

Nursing Notes (Including Labs / Medications / Other Care):

Time	Nursing Notes
	* Dr. Anupama Sen | advised Day Care admission
	* Observe in ER Over 6 hours Re-assess
	Ei informed Dr.
	* Shifted to 121

Time: | @ 8pm

Time:

Samples collected by: | Nr. Sambhu

Samples sent by :

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign
4:45 am.	NEB. LEVOLIN	NEB	0.63mg 3 doses back to back	[signature]	[signature]
7/7/26 5:30pm	NEB. BUDECORT	NEB	0.5mg x 1 dose	[signature]	
6:05pm	INJ. HYDROCORTISONE	IV	50mg	[signature]	
6:07pm	INJ. PANTOPRAZOLE	IV	10mg	[signature]	

Condition of patient at time of shift - out :

HR: 126 b/m BP: 98/79 CFT: < 2 sec
RR: 26 b/m SPO₂ : 100%
GCS: 15/15 Temperature : 98.2 °F
Pain Score: 0/10
Repeat RBS (if applicable): NA

Details of Shift - out

Shift - out from ER to: [illegible]
Time of Shift - out: [illegible]
Handover given to: (Nurse's Name) [illegible]

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV placement

Name of the Nurse : Bhavani

Signature of the Nu

7/7/26 @ 4:47pm

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
BAH-00655408 IP5-00176081 Master ZACH PAUL 22-04-2024 2 Y 2 M 15 D (M) Dr. ANUPAMA Y	7/7/26 @ 6:24pm	7/7/26 @ 11:30pm
	Transfer Ordered by Dr. prathibha	Reason for Transfer Admission
From Unit ER	To Unit 121	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 20	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant OP File Yes ☐ No ☐ If yes, what ? Any

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Neb chamber	(1)
2.	ONS	(1)
3.	Intrafix	(1)
4.	Nasal cannula	(1)
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Nr. Rachel	Dr. prathibha.

Patient & Clinical Records Received by : priyanka

Date & Time of Patient Received : 7/7 11.35pm

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

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Master ZACH PAUL
22-04-2024 2 Y 2 M 15 D (M)
Dr. ANUPAMA Y

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 8/6/26 Time: 8AM

Weight: 10.9kg Centile: <5th

Height: 85cms Centile: >16th

Inference: underweight child

RDA: — Calories: 1200kcals/d Protein: 21g/d

Diet Recommendations: Soft High Protein diet

Re-Assesment: Avoid spicy, chilled and outside foods

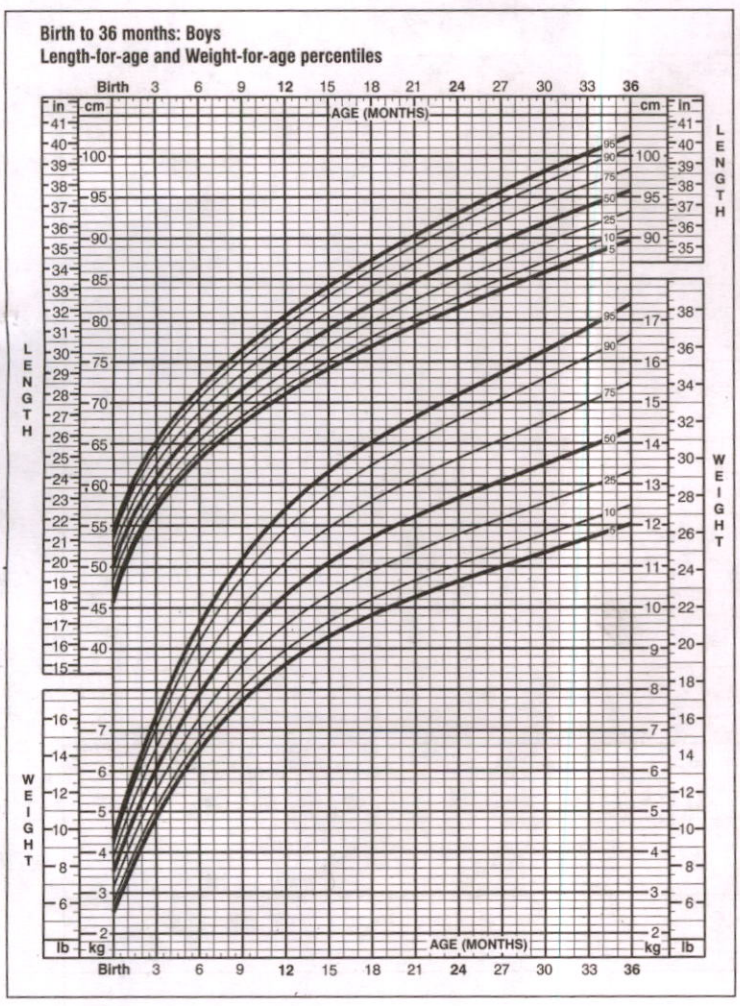
Food Allergies: NO Veg/Non-veg veg

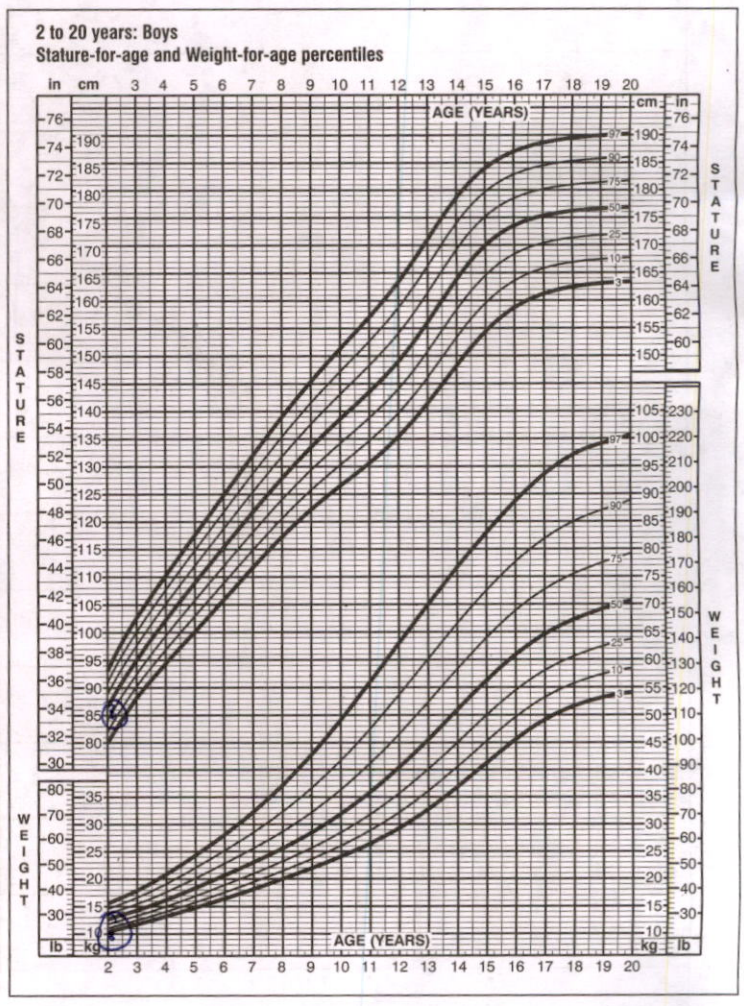
Diagnosis: LRTI & wheezing & mild RD

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Raynold Paul

GROWTH CHART (BOYS)





Dietician's Name Mounika Dietician's Signature Mounika

Daily Notes: