

Patient

BAH-00657854 IP5-00176085
 Master SAMARTH TANAJI BORADE
 04-10-2019 6 Y 9 M 3 D (M)
 Dr. SRIPARTHA KRISHNA



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JRGERY DETAILS

verbal

Date : 8/7/2026

Patient Name: Samarth Tanaji Borade Date of Birth: 4-10-2019 Age: 6 Y 9 m

Gender: Male Ward: P-OT UHID No.: BAH-00657854

Date of Surgery: 8/7/2026 ☒ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery: L3-L4 LAMINECTOMY AND DETETHERING

Time in : 8:10 AM

Time Out : 11:00 AM

	NAME	AMOUNT
1. Surgeon	Dr. SRIPARTHA	
2. Anaesthetist	Dr. Ravichander	
3. Assistant Surgeon		
4. OT Technician	Shivaleela	
5. Circulating Nurse	Thijas	
6. Assistant Nurse	Jyothi, Sujata	

Special Equipment: ☐ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator

☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa

☐ Neuro Cusa ☐ Others : Neuro microscope, Neuro drill

Signature of the Surgeon: SRIPARTHA

Signature of Circulating Nurse: Thijas

Order No: 9692997

Order by: Sujata

master - Samaritan

Patient Sticker

64716-8109

6549

657854

Laminectomy AND DETHETRING OF CORD CONSUMABLES OF OT

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Circulating staff :

Technician :

Date :

8/7/26

Time :

8:00am

Anaesthesia Disposables			Surgical Disposables			Disposables (Baby Side)		
Issued	Qty	Used	Issued	Qty	Used	Issued	Qty	Used
ET tube	1	1	Major Pack	1	1	Inj Vit.K	2	2
LMA	0	0	Sutures	2	2	Cord Clamp	2	2
ECG leads : A P N	5	1	2437, Boreline 5-0	2	2	Suction Catheter	1	1
HME filter : A P N	0	1	6-0, 8-0	2	2	Feeding Tube	1	1
Syringes : 10 cc	15	5	5087, Monoclon 3-0	2	2	Vaccum Suction Set		
05 cc	15	5	Gloves	2	2	Surgical Gloves	1	1
02 cc	15	0	6-16, 5-17, 5-18	2	2	Gauze Pack	2	2
01 cc	10	0	16-5 (17) 5-17, 5-18	2	2	Syringe 1ml / 2ml	1	1
Cautery plate : A P N	0	1	(pds- 4-0, 3-0)	1	1	Surgical Blade # 20		
IV set	0	1	Surgical blade	1	1	Koochies (S)	1	1
RL + 3.1 NS + Monoclon	1	1	NG tube	1	1	Monoclon 2-0, 4-0, 3-0	2	2
NS : 10ml / 100ml / 500ml / 1000ml	5	2	Cautery pencil	1	1	Horizon clip	2	2
monoclon + Transfix	2	1	Koochies	1	1	multitube hooks	1	1
O2 Mask + Nasal prongs	1	1	Ointments					
Fentanyl	0	1	Suction Catheter					
Morphine			Cap, Mask					
Ketamine			Gauze Pack	3	2			
Propofol	0	5	Mop Pack	1	1			
Rocuronium	0	1	Steristrip					
Glycopyrolate	0	1	Underpad	1	1			
Myopyrolate + Neostigme	0	2	Draw sheet	1	1			
Ondansetron	0	1	Abgel	1	1			
Pencan 25g/ Spinal Needle 22			Foleys catheter	1	1			
Bupivacaine 0.25%	0	1	Urobag	1	1			
Bupivacaine 0.25%(Heavy)			Chest Drainage Catheter					
Antibiotics Amikam 250mg	0	1	Romodrain bag					
Cefalorone + Cefazolin	1	1	Bandage					
Suppositories 250	0	1	Tegaderm					
Anamol : 80mg / 250mg / 170 mg			Ioban	1	1			
Supridol : 100mg			Double J Stent					
Justin : 12.5 mg 25mg / 100mg	0	1	Vaccum Suction set	2	0			
Tab. Misoprost : 200mg	0	1	Plastic Bed Sheet	1	1			
Vaccum set	0	2	Betadine Solution 10%	1	1			
Snarays 10 + 100 in	3	3	Microshield	1	1			
Amway (2112)	1	1	Cotton Balls					
Nasal Airways (22+24)	2	2	Latex Gloves	10	10			
IV Cambe (20+24)	3	3	Ramdone Scrub	1	1			
			Saral					

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. :

Ordered by :

Doc. No. : RCH / FRM / GENERAL / 125

ACTIVITY RECORD FOR BILLING

Name : _____

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

BAH-00657854 IP5-00178085
Master SAMARTH TANAJI BORADE
04-10-2019 6 Y 9 M 3 D (M)
Dr. SRIPARTHA KRISHNA

Date of Admission: _____ Tim _____ rge : _____ Time: _____



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
7/12/26	8:45 pm	CR	120	Laila
8/7	7:35 AM	120	OT	Pmijank
8/7/26	12:45 pm	OT	120	Quel

Cross Consultation Visit

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

[illegible]

Investigations

Signature

CBP, SE, RFT, BGT
PT-ANR

8089

Chetan



[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
7/7/26	Dv placement	①	2310	Choran
8/7/26	Pac	①	92062	NS
8/7/26	Catheterisation	①	92964	Thyas.
8/7	NHA	①	9693530	CEP

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : 10 am

Time : 10/2

Prepared By : SL

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Amishu	G.W.I		

ADMISSION SHEET
Registration Details :


Admission No : IP5-00176085 Admit Date : 07-Jul-2026 Admit Time : 07:41 PM UHID : BAH-00657854

Patient Details :

Patient Name	: Master SAMARTH TANAJI BORADE	Age	: 6 Y 9 M 3 D
Guardian	: Mr TANAJI NAVNATH BORADE	DOB	: 04-10-2019
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: PLOT NO 129, VAISHNAVI NAGAR, SAIFUL, NEAR GANAPATI TEMPLE Indira Nagar Sholapur Maharashtra INDIA 413004	Phone No	: 8669011567/ 8411845507
		E-mail	: MANISHAJAGTAP997@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 TANAJI NAVNATH BORADE	Relationship	: Father
Contact Address	: PLOT NO 129, VAISHNAVI NAGAR, SAIFUL, NEAR GANAPATI TEMPLE Indira Nagar Sholapur Maharashtra INDIA 413004	Phone No	: 8669011567

Manish
Signature

Doctor Details :

Doctor Name	: Dr. SRIPARTHA KRISHNA YERRAMILLI	Specialisation	: PEDIATRIC NEURO SURGERY
Referral Doctor	: Self	Phone No	:
Co-Consultant	: Dr. KOKKULA PRANEETH		

Payment Details :

Payment Mode	: Cash	Deposit Amount	: 0.00
		Payor Name	: MEDI ASSIST INSURANCE TPA PVT LTD



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PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00657854 IP5-00176085
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Dr. SRIPARTHA KRISHNA



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Case of Spina bifida Sun type 2
Tethered cord.

↳ Suspected neurogenic bladder.

↳ Drooling.

History of present illness :

↳ Straining @. ↳ Constipation.

↳ Hb pvr @.

↳ Right to Ulcer - now healing.

Postop for Detethering tomorrow.

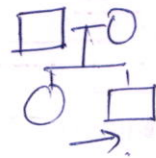
02/06/26 - 62 cc - Post void residue @.

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

USG / No NICU stay



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Normal for age

Immunization History :

Immunized upto 3 years of age.

(P.T.O.)

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Spina bifida

sent type 2, L4-L5, Neurogenic bladder/bowel

Admitted for Debridement of abscess.

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 16.94 (Centile _____)

On Examination :

Temperature : 98.4°F Pulse Rate : 116/min B.P. 104/61 ⁽⁷⁰⁾ SP02 98% RA

Resp.rate and type of breathing : 24/min

Rash _____

Lymphadenopathy _____

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Aspiration

Desired goals of the treatment : _____

surgical resolution of symptoms

Planned Labs:

CBC, S-Electrolytes, T
BFT, PT-INR, Blood glucose
Extra EDTA

NR
Chetan
7/7/26 @ 8 AM.

Planned Management

NPO from 12am On 08/7/26.
IVF DNS (Maintain full from 12am)
- Lys-Cepotaxin stat T/m at 7 am
- Sp+ Detumbling of cord.

Noted by
Dr. Chetan

Signature of the Doctor: _____

Name of the Doctor: _____

Date & Time: _____

Signature of the Consultant: _____

Name of the Consultant: _____

Date & Time: _____



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Date & Time	Progress Notes	Doctor's Order
8/7/26 7:30pm	C/S/B Neuroteam <u>POD - 0</u> No pain over surgical site No discharge around suture fever - low grade - 99°F (+) Accepting feeds (N) No vomiting.	
O/E	Child conscious Oriented EOM full Tone - (N) moving both U&L vitals - stable DTR - to be reassessed	Adv Vital monitoring Pain management
	Signature	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
09/07/25 9am	<u>CL/B Neuroteam</u> Klco Split Cord malformation type 2 C low lying tethered cord C ? Neurogenic bladder S/P L3-L4 detethering laminectomy & detethering <u>POD-1</u> • No fever spikes • No FND • ? Neurogenic bladder - Dribbling Ulcer <u>+</u> over <u>+</u> Great toe <u>O/E:</u> Child conscious Oriented EDM - full B/L pupils normal size RTL Tone - <u>N / N</u> <u>W / N</u> vitals - stable UL - moving both limbs against Gravity lower limbs - <u>separate</u> antigravity movements <u>+</u> restricted due to pain DTR - LL - hyporeflexia	<u>Ad:</u> • vital • monitoring • Mobilize • Encourage orally <i>Abhishek</i> <i>Sriparth</i>



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7	CLP/B Neuroteam POD - 2 No fresh complaints Weight Bearing (+) Urine passed No pain @ surgical site	
	O/E: Child conscious weight bearing (+) vitals - stable Tone, power, DTR - (N) A lumbar lordosis } Pressers walking (+) EOM - full	Plan ① plan ① after discussion
	Plan • Discharge today • Continue - Syp Ziprox (5ml/50mg) 6ml BD x 3 days → STOP - Syp PCM 250mg BD x 2 days ↳ SOS Abhishek - Syp Smuth 100mg HS - To continue • Review on MONDAY 13.07.26 Sripa	

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RESULT SHEET

Date	7/7/26				
Time					
Hb	11.3				
PCV	33.2				
RBC	4.15				
WBC	8.12				
N/L	46.9/46.4				
Platelets	352000				
CRP					
ESR					
PCT					
RBS					
Na	136				
K	4.2				
Cl	106				
Ca/Mg					
Phosphate					
Urea	22				
Creatinine	0.3				
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR	14/1.0				
APTT	41				
CSF Protein / Sugar					
Cells					
N/L					

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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: *CR*

Shifted to: *ICU*

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : *N. Prashant N. Pr*

Date & Time : *21/7/26, 7:30pm*

Nurse Name & Signature: *Lachel*

Date & Time : *21/7/26 @ 8pm*

BAH-00657654 IP5-00176085
Master SAMARTH TANAJI BORADE
04-10-2019 6 Y 9 M 3 D (M)
Dr. SRIPARTHA KRISHNA



DRUG CHART

Date of Admission: 21/2/26 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 : <u>2mg TRAMADOL</u>				Date Time
Dose <u>30mg</u>	Route <u>IV</u>	Frequency <u>SOS</u>	Start Date <u>08/07</u>	
Doctor's Signature <u>Sriparkha</u>		Valid Period <u>FOR 3 DAYS</u>	Pharm.	
Additional Instructions: <u>For PAIN</u>				

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

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

Weight. 16.94 kg Ward.

Page: 2/4



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
8/1/26	7am	Inj. CEFOTAXIME	850 mg	IV	P. Paw	P. Paw
8/1/26	10:15 AM	Inj. PARACETAMOL	250 mg	IV	A	N. K. S.
						Bohi

Weight. 16.94 kg. Ward.

BAH-00657854 IP5-00176085
Master SAMARTH TANAJI BORADE
04-10-2019 6 Y 9 M 4 D (M)
Dr. SRIPARTHA KRISHNA



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 : 10/11/26... Time:

Doctor / Nurse / Family Concern? 2 AM 6 AM

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

Heart Rate (Number)

101bpm 116bpm

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

70
60
50
40
30
20
10

Resp Rate (Number)

28bpm 29bpm

Resp Mod/ Severe
Distress None / Mild

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

98% 100%

Conscious Level
Normal
Altered

GCS *

15/15 15/15

TOTAL SCORE

Number of shaded boxes

1

1

Pain Score

0

0

Observer's Initials

0

0

ACTIONS

NB: Scores 3 should be
recorded overleaf

Score 1 : Continue normal observation by staff nurse

Score 2 : Shift in charge nurse to be informed and continue hourly observations

Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see

Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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

SCHOOL AGE (5-12 years)

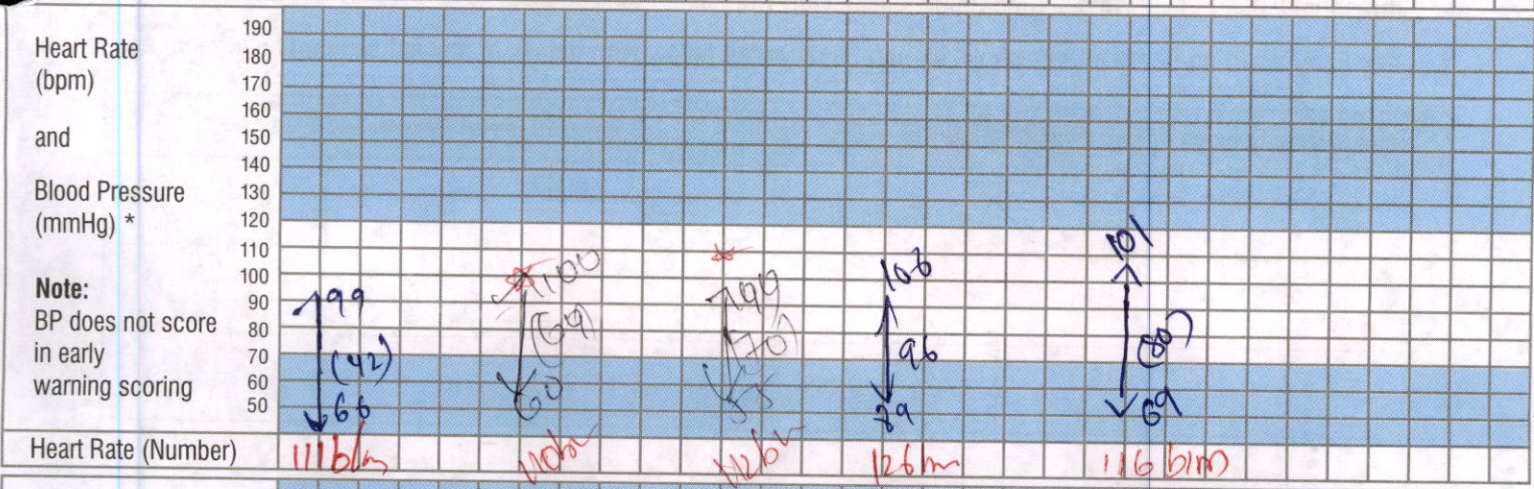
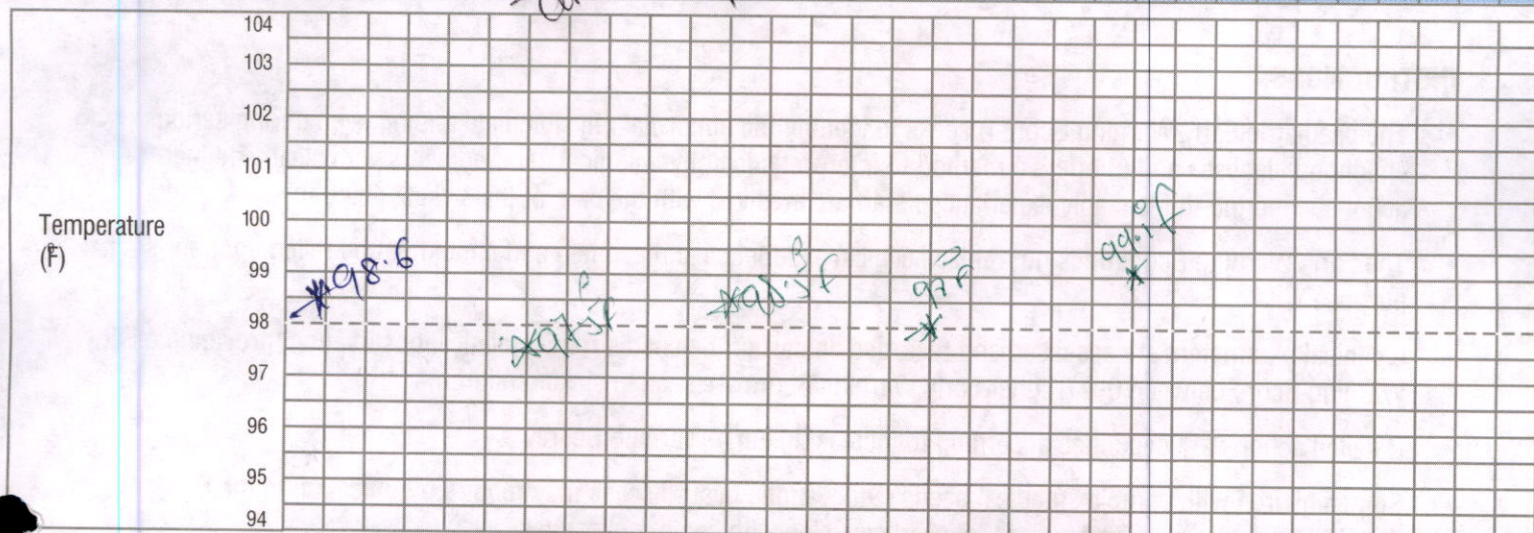
Children's Observation &
Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9/10/2019 Time: 6am 10am 1pm 6pm 10pm
Doctor / Nurse / Family Concern? 6am 10am 1pm 6pm 10pm



Resp. Rate (bpm) (per 1 Minute) *	70	60	50	40	30	20	10
Resp Rate (Number)	26	28	28	22	28		
Resp Mod/ Severe Distress None / Mild							
Receiving O ₂ (l/min) O ₂ Saturations (%)	100%	99%	100%	97%	98%		
Conscious Level Normal Altered	15/15	15/15	15/15	15/15	15/15		
GCS *	15	15	15	15	15		
TOTAL SCORE	0	1	1	1	1		
Number of shaded boxes	0	1	1	1	1		
Pain Score	0	0	0	0	0		
Observer's Initials	8y	0	0	0	0		

ACTIONS

NB: Scores 3 should be
recorded overleaf

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- 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)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 08/7	Time: 5:30 pm	6 pm	10 pm	2 am
Doctor / Nurse / Family Concern?				
Temperature (F)	99.1 F	99.2 F	98.3	97.9
Heart Rate (bpm)	128 bpm	121 bpm	115 bpm	
Blood Pressure (mmHg) *	90/50 (59)	98/60 (42)	100/65 (51)	
Resp. Rate (bpm) Over 1 Minute *	28 bpm	28 bpm	21 bpm	
Resp Mod/ Severe Distress None / Mild				
Receiving O ₂ (l/min) O ₂ Saturations (%)	99%	100%	100%	
Conscious Level Normal Altered				
GCS *	15/15	15/15	15/15	
TOTAL SCORE	1	0	0	
Number of shaded boxes				
Pain Score				
Observer's Initials				
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.			

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 27/10/26	Time: 10pm	8/7	6am	10pm	2am	4am
Doctor / Nurse / Family Concern?						
Temperature (F)	104					
	103					
	102					
	101					
	100					
Heart Rate (bpm)	190					
	180					
	170					
	160					
	150					
Blood Pressure (mmHg) *	140					
	130					
	120					
	110					
	100					
Note: BP does not score in early warning scoring	90					
	80					
	70					
	60					
	50					
Heart Rate (Number)	101bpm	110bpm	107bpm	111bpm		
Resp. Rate (bpm) Over 1 Minute *	70					
	60					
	50					
	40					
	30					
Resp Rate (Number)	20bpm	20bpm	20bpm	20bpm		
Resp Mod/ Severe Distress None / Mild						
Receiving O ₂ (l/min) O ₂ Saturations (%)	90%	98%	100%	97%		
Conscious Level Normal / Altered	15/15	15/15	15/15	15/15		
GCS *	15/15	15/15	15/15	15/15		
TOTAL SCORE	1	1	1	0		
Pain Score	0	0	0	0		
Observer's Initials	15/15	15/15	15/15	15/15		

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00657854 IP5-00176085
 Master SAMARTH TANAJI BORADE
 04-10-2019 6 Y 9 M 3 D (M)
 Dr. SRIPARTHA KRISHNA

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

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 Your Right to a Safe Delivery

FLUID CHART

Sheet No. : 6

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										0	Nishi	
	09:00 pm										0		
	10:00 pm										0		
	11:00 pm							NP			0	Nishi	
	12:00 am			SSM							0		
	01:00 am		NPO	SSM							0		
Total Intake :						Total Output :							
	02:00 am			SSM							0	Nishi	
	03:00 am		N	SSM							0		
	04:00 am			SSM							0		
	05:00 am		P	SSM				NP			0	Nishi	
	06:00 am			SSM							0		
	07:00 am										0		
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

FLUID CHART

Sheet No. : 6

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			
8/7	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm	H											
	01:00 pm	H											
Total Intake :						Total Output :							
8/7	02:00 pm	↑	RP4										
	03:00 pm	↑	RP4										
	04:00 pm	NO											
	05:00 pm	IVF							200ml				
	06:00 pm												
	07:00 pm	↓											
Total Intake :						Total Output :							
8/8	08:00 pm	↑											
	09:00 pm												
	10:00 pm	NO											
	11:00 pm	IVF											
	12:00 am								100ml				
	01:00 am	↓											
Total Intake :						Total Output :							
9/8	02:00 am	↑											
	03:00 am												
	04:00 am	NO											
	05:00 am	IVF							250ml				
	06:00 am												
	07:00 am	↓											
Total Intake :						Total Output :							
Total 24 hrs. Intake													
Total 24 hrs. Output		4-550ml											

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 Master SAMARTH TANAJI BORADE
 04-10-2019 8 Y 9 M 5 D (M)
 Dr. SRIPARTHA KRISHNA

FLUID CHART

Sheet No. : 3

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			
9/10/27	08:00 am	NO I.V	✓	/	/	/	/	/	/	/	0	/	
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
9/11/27	02:00 pm	NO I.V	/	/	/	/	/	/	/	/	0	/	
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
9/17/28	08:00 pm	NO I.V	/	/	/	/	/	/	/	/	0	/	
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
10/7/28	02:00 am	NO I.V	/	/	/	/	/	/	/	/	0	/	
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake			Total 24 hrs. Output										

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04-10-2019 6 Y 9 M 5 D (M)
Dr. SRIPARTHA KRISHNA



FLUID CHART

Rainbow Children's Hospital
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Sheet No. : 15

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		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

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Master SAMARTH TANAJI BORADE
04-10-2019 8 Y 9 M 3 D (M)
Dr. SRIPARTHA KRISHNA



NURSING CARE RECORD

Rainbow Children's Hospital
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BirthRight
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Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/7/28

Assessment: Baby having

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 general condition of the patient	10pm	Assessed the general condition of the patient	Baby condition is good
11pm	monitor the vitals signs	12am	monitored the vitals signs	
2am	maintain I/O chart	3am	maintained I/O chart	
4am	maintain fluid balance	5am	maintained fluid balance	
6am	Administer medication as per chart	7am	Administered medication as per chart	

Re-Assessment:

Re - Assessment

Special Notes:

Delirium of food NPO 12am

Nurse Signature:

Nurse Name: Nikita

Date & Time: 8/7/28 @ 2am

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Master SAMARTH TANAJI BORADE
04-10-2019 6 Y 9 M 3 D (M)
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NURSING CARE RECORD


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BirthRight™
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Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

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 Master SAMARTH TANAJI BORADE
 04-10-2019 8 Y 9 M 3 D (M)
 Dr. SRIPARTHA KRISHNA



NURSING CARE RECORD

Rainbow Children's Hospital
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BirthRight
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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 8/7/20

Assessment: *Our Baby*

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 AM	Assess the pt General Condition. Relieve pain & Discomfort monitor vital signs monitor for bleeding maintain I/O chart maintain NPO status pt shift to the ward	8 AM	Assess the pt General Condition. Relieved pain & Discomfort monitored vital signs monitored for bleeding maintained I/O chart NPO broken, water given pt shifted to the ward	pt is Conscious & oriented vital Reorder no bleeding maintained no vomiting shifted
2 PM		2 PM		

Re-Assessment:

Special Notes:

Nurse Signature: *[Signature]*

Nurse Name: *Quig*

Date & Time: 8/7/20 2 PM



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 08/12/20

Assessment: Pain & Discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the baby General Condition	2pm	→ Assessed the baby general Condition	By doing the all procedures the baby condition is improved slowly.
3pm	→ provide comfort position.	3pm	→ provided comfort position	
4pm	→ monitor the vitals & Recorded it.	4pm	→ monitored the vitals & Recorded it	
5pm	→ administer the all drugs as per doctor orders	5pm	→ administered the all drugs as per doctor orders	
6pm		6pm		
7pm		7pm		
8pm		8pm		

Re-Assessment: Inj: paracetamol given

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Shailaja (BORADE)

Date & Time: 08/12/20 (8pm)

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Master SAMARTH TANAJI BORADE
04-10-2019 6 Y 9 M 3 D (M)
Dr. SRIPARTHA KRISHNA



NURSING CARE RECORD

Rainbow Children's Hospital
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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/12/20

Assessment: pt having dm. 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
8pm	→ Assess the pt General Condition	8:10pm	→ Assessed the pt General Condition	pt is stable
10pm	→ Check the Vital Signs	10:10pm	→ Checked the Vital Signs	
2am	→ plan for Administration medication	12:10am	→ providing medication as per doctor Order	
	→ plan for strictly I/O Chart	2:10am	→ strictly I/O Chart	
8am	→ plan for Ensure safety	8am	→ providing Ensuring safety	

Re-Assessment: Re-Assessment Every 4th hrly

Special Notes: Strictly I/O Chart

Nurse Signature: @

Nurse Name: Chandana

Date & Time: 9/12/20 @ 8am

BAH-00657854 IP5-00176085
Master SAMARTH TANAJI BORADE
04-10-2019 6 Y 9 M 5 D (M)
Dr. SRIPARtha KRISHNA



NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 9/07/24

Assessment: pt having some 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
8am	* Assess the pt General condition	8:30 am	* Assessed the pt General condition	
9am	* check the pt all vitals	9:30 am	* checked the pt all vitals	
10am	* maintain I/O chart	10:30 am	* maintained I/O chart	pt is well
11am	* provide comfortable position	11:30 am	* provided comfortable position	
12pm	* administer all medication given as per doctor order	12:30 pm	* administered all medication given as per doctor order	

Re-Assessment:

Special Notes:

Nurse Signature: _____

Nurse Name: shanthi

Date & Time: 9/07/24 8am

BAH-00657854 IPS-00176085
 Master SAMARTH TANAJI BORADE
 04-10-2019 6 Y 9 M 4 D (M)
 Dr. SRIPARTHA KRISHNA

NURSING CARE RECORD

Rainbow Children's Hospital
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BirthRight™
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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/7/26

Assessment: Baby having pain at surgical site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the general condition of the patient	2:30 PM	Assessed the general condition of the patient	Baby condition is good.
3pm	Monitor the vitals signs		monitored the vitals signs	
4pm	maintain I/O chart	3:30 pm	maintained I/O chart	
	maintain personal hygiene	4:30 pm	maintained personal hygiene	
5pm	Administer medication as per as chart	5:30 pm	Administered medication as per as chart	
6pm	Ensure the patient safety	7pm	Ensured the patient safety	

Re-Assessment: Re - Assessment

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Nikita

Date & Time: 9/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/11/26

Assessment: Baby having pain at Surgical Site.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the baby general condition. monitor vital signs	8pm	* Assessed the baby general condition. monitored vital signs	. Baby condition is improving slowly
10pm	* provide comfortable position.	10pm	* provided comfortable position	
12Am	* encourage take orally well	12Am	* Encouraged take orally well	
4Am	* maintain I/O charting	4Am	* maintained I/O charting	
6Am	* Administer medication as per doctor orders	6Am	* Administer medication as per doctor orders	
8Am	* Ensure safety side rails	8Am	* Ensured safety side rails.	

Re-Assessment: Given inj. paracetamol for pain.

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Sweetha (021086)

Date & Time: 10/11/26 (same)



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Krishna Department: pediatric Date of Admission: 2/7/26

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known		If Yes Specify:	
BACKGROUND	Area	spina bifida					
	Shift Time	ER 8:45 PM	1st floor 2pm to 4pm	OT 8am to 4:30 pm	2nd floor 8:45 PM to 10:00 PM	1st floor 8pm - 8am	2nd floor 8am to 4pm
ASSESSMENT	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	NA	NA
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
ASSESSMENT	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp: 98.4°F	98°F	98.6°F	98.0	98.3°F	98.2°F
	Res:	24b/m	22b/m	25b/m	26b/m	26b/m	28b/m
	SpO ₂ :	98%	99%	98%	98%	99%	99%
	Pulse:	116b/m	110b/m	105b/m	106b/m	101b/m	110b/m
	BP:	102/68 (AS)	100/64	105/61	106/70	99/60	100/60
	Fall Risk Score:	12	12	12	12	12	12
Pain Score:	0/10	0/10	1/10	0/10	0/10	0/10	
Recommendations	Safety Needs:	side rails	yes	yes	yes	yes	yes
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:	NA	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 :		Rahul	Nikita	Shreyas	Shatish	Chandana	Shubh
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		2/7/26	8/7/26	8/7/26	8/7/26	9/7/26	9/7/26
Time:		8:45 PM	7 PM	8 PM	8 PM	2:00 AM	9 PM
Taken Over By Name :		Nikita	Shreyas	Shatish	Chandana	Shanthi	Nikita
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		7/7	8/7	8/7	8/7	9/7/26	9/7
Time:		9 PM	2 PM	2 PM	2:00 PM	2:00 AM	2 PM

BAH-00657854
Master SAMARTH TANAJI BORADE
04-10-2019 6 Y 9 M 5 D
Dr. SRIPARTHA KRISHNA (M)

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BirthRight™
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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	1st floor 2pm to 8pm	1st floor 8pm to 8pm			
	Medical Condition (Any special condition to be noted):		NA	NA			
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	98.5	98.9			
		Res:	22	29			
		SpO ₂ :	99	100			
		Pulse:	112	110			
		BP:	99/69	100/70			
		Fall Risk Score:	12	12			
Pain Score:	0/10	0/10					
Recommendations	Safety Needs:	Yes	Yes				
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	NA	NA				
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	NA	NA				
Post Operative Procedure Special Orders:		NA	NA				
Handed Over By Name :		Nikita	Sneha				
Signature :		[Signature]	[Signature]				
Date:		8/7/26	10/7/26				
Time:		8pm	8pm				
Taken Over By Name :		Sneha	Sprick				
Signature :		[Signature]	[Signature]				
Date:		9/7/26	10/7/26				
Time:		8pm	8pm				



THE HUMPTY DUMPTY SCALE 2/2 2/2 9/2 0/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	3	3	
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	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	
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2	2	2	2	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	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	
TOTAL			12	12	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	Yes	Yes
Call device within reach	Yes	Yes	Yes	Yes
Wheels Locked	Yes	Yes	Yes	Yes
Room free of clutter	Yes	Yes	Yes	Yes
Adequate Lighting	Yes	Yes	Yes	Yes
Wheel Chair Support	No	No	No	No
Other Intervention(s) Specify	No	No	No	No
Nurse's Name :	Dachal Niki Chandu Sahu			
Signature :	[Signatures]			
Date :	2/2 2/5 9/5 10/6/24			
Time :	8:30pm 6:00am 6:00am			

BAH-00657854 IP5-00176085
Master SAMARTH TANAJI BORADE
04-10-2019 8 Y 9 M 3 D (M)
Dr. SRIPARTHA KRISHNA

BRADEN 'Q' SCALE

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					Date :	25/12/20	8/1/21	9/2/21	10/3/21
					Time :	8:20pm	6pm	6am	6am
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity 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	
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	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	
TOTAL SCORE					28	28	28	28	
Evaluator's Name					Ch	Ch	Ch	Ch	

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

Docu. No. : RCHBH / FRM / CLINICAL / 119

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
10/7/26	6am	1/10	s/s	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inf. paracetamol given	Swetha
10/7/26	7am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Swetha
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

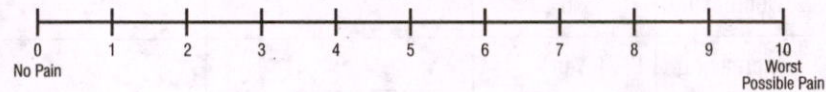
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

Date	Time	Score (u/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
7/7/26	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Lachel
8/7	uam	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Nikhil
8/7	11:55 AM	1/10	SS	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Ding
8/7	10pm	1	S/S	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	Inj. pcm Given	Chondam
8/7	11pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chondam
9/7	6am	1	S/S	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	Inj. pcm Given	Chondam
9/7	7am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	NA
9/7	3pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Nikhil
9/7/26	10pm	1/10	S/S	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☒ Increasing ☒ Decreasing	☒ Yes ☐ No	Inje: paracetamol given	Surekha
9/7/26	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Surekha

Re-assessment Frequency:

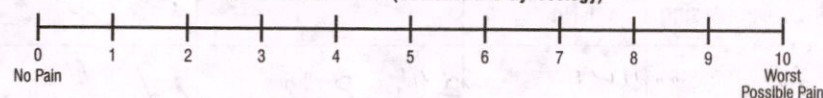
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 - At least every 2 hours for the first 24 hours
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 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

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CATEGORY	SCORING		
	0	1	2
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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
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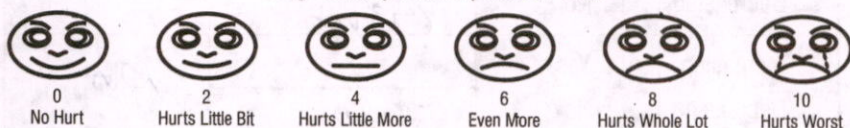
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Wong - Baker (Pediatrics) Above 7 Years



BAH-00657854
Master SAMARTH TANAJI BORADE
04-10-2019 8 Y 9 M 3 D
Dr. SRIPARATHA KRISHNA (M)



CHECKLIST FOR THROMBOPHLEBITIS

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

BirthRight
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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	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													

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 :

BAH-00657854 IP5-00176085
Master SAMARTH TANAJI BORADE
04-10-2019 6 Y 9 M 3 D (M)
Dr. SRIPARtha KRISHNA



OPERATION THEATER NOTES

Patient's Name : Samarth Tanaji Borade Age : 6.4.9m Gender : ☒ Male ☐ Female

UHID No.: BAH-00657854 Weight : 16.84 Height :

Surgeon :		Asst. Surgeon :	
Anesthetist : <u>Dr. Pavi</u>	OT Nurse: <u>Jyothi, Sujata</u>	OT Technician: <u>Shivaleela</u>	
Pre-Operative Diagnosis: <u>SCM TYPE II WITH LOW-LYING TETHERED CORD</u>			
Surgical Procedure : <u>L3-L4 LAMINECTOMY AND DETETHERING</u>			
Indications for Surgery : <u>PROGRESSIVE NEUROLOGICAL DEFICIT</u>			
Date : <u>08/07/26</u>	Start Time : <u>9.03 AM</u>	End Time : <u>10.45 AM</u>	
Pre Operative Preparations:			
<u>3 X BETADINE</u>			
Post Operative Diagnosis: SCM TYPE II <u>SCM TYPE-II WITH LOW-LYING TETHERED CORD</u>			
Peri-Operative Complications: <u>NONE</u>			
Operation Notes: 1) Patient laid prone under GA. Pressure points padded.			
2) Midline incision made at L3-L4 Level.			
3) Bilid Laminae at L3 and L4 level with muscle invaginating into spinal canal noted. Posterior bony elements dysplastic.			
4) Bony compression of thecal sac noted at L3 level and decompressed.			
5) Dura opened at L4-L5 interspace.			
6) Taut Filum terminale identified and divided. No other dorsal adhesions noted.			

7) Wound closed in watertight fashion and covered with fibrin glue.

8) Wound closed in layers. Sterile dressing done

Amount of Blood Loss:

80 ml

Blood Transfused (in ML)

None

Name and Number of Surgical Specimen sent for examination:

None

Peri-Operative Complications:

None

Name of the Surgeon: Dr. SAIPARTHA

Signature of the Surgeon: 

Date & Time: 08/07/26 11 am

BAH-00657854 IP5-00176085
Master SAMARTH TANAJI BORADE
04-10-2019 6 Y 9 M 3 D (M)
Dr. SRIPARTHA KRISHNA



Patient S


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


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

POST-SURGICAL CARE PLAN FORM

Procedure Done: L3-L4 LAMINECTOMY AND DETETHERING

Post-Surgical Diagnosis: SCM TYPE II WITH LOW-LYING TETHERED CORD

Post-Operative Monitoring Parameters /Frequency:

VITAL Q4H

Wound Care:

DRESSING

Drain /Special Lines/Catheters:

FOLGY'S CATHETER IN SITU

Special Patient Positioning and Requirements:

PRONE / LATERAL NURSING

Nutritional Instructions:

ORALLY ALLOWED ONCE ALERT

Time to Start Mobilization:

TOMORROW MORNING

Special Referrals:

NONE

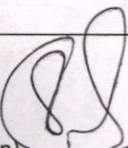
The new order for all required medications documented in the doctor order/medication sheet:

☒ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

NONE

Treating Surgeon
(Signature & Stamp)


Sripartha

Date: 08/07/26 Time: 11 am

Note: Plan of care will be readjusted if necessary.

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: MASTER SAMARTH BORADE Age: 6Y7M29 Sex: MALE UHID.No: BAH 00 657625

Date: 7/7/2026 Time: 12:06 PM Proposed Operation: Detethering of cord

Diagnosis: SPINA BIFIDA SCM Type 2

B.P / CRT: 135/90 H.R: 110 Weight: 13.15 ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 11.3 Glucose: 110mg/dl Protein: HIV: X-Ray:
PCV: 22 Urea: 0.3 Alb: HBS Ag: ECG:
WBC: 8.12 Creat: 0.3 Total Bill: HCV: 2D Echo:
Plate: 352000 Na: 136 Dir. Bill: Blood group: Stress/Angio:
PT: 14 K: 4.2 LDH: T3 Other:
PTT: 40.41 Ca++: Alk phos: T4
INR: 1.0 Mg++: Amylase: TSH
Cl-: 106 SGOT/SGPT:

Allergies: NKDA

Medical History: CVS: —

RESP: — Diabetes: —

CNS: — Reduce sensation over dorsum of foot and great toe.

Renal: Neurogenic bladder: Straining while micturition. 1 dribbling of urine.

Hepatic / GE: — Physical Activity: —

Others: Rtoe wound → non healing ulcer, Reduce sensation over dorsum of foot

Past Anaesthetic History: NRI ↓ sedation → ineffective

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Mentohyoid Distance: Neck: Teeth:

Lungs: AEBE

Heart: S1S2

CNS: NAD

Pregnant: ☐ Yes ☐ No ☒ NA Venous Access Site: LUL RUL Spine Exam for regional: acausim

Anaesthetic Plan: ☐ MAC ☐ REGIONAL ☒ GA-ETT ☐ LMA

Peri-Operative Plan Explained to the Patient: ☒ Yes ☐ No

CURRENT MEDICATIONS	DOSAGE
—	—
—	—
—	—
—	—

Pre-Operative Instructions:

- DVT Prophylaxis:
- NIL ORAL → Water / ORS 2 Hours before SOLID MEAL Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☐ Discussed with Patient
- Other Instructions:

CBC, RE HbR, APPT, RFT

→ Blood grouping
→ Reserve 5ml Idg PRBC

Signature: [Signature] Name: Dr. Abhishek N

small posterior central disc protrusion c focal anterior tear - C5-6
MRI SPINA - extensive SPINA BIFIDA L2-S1 levels
Tethered Cord syndrome c low lying conus medullaris dural ectasia
FOCAL anterior hydromelia c. D12 Lumbosacral transition of vertebra

Normal NIBP = 102/60/75
Age - 6 years
5th percentile
BP = 90/70 + 62/40

BAH-00657854 IP5-00176085
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04-10-2019 6 Y 9 M 3 D (M)
Dr. SRIPARTHA KRISHNA

MABL = EBV x $\frac{\text{Initial Hb} - \text{Final Hb}}{\text{Initial Hb}}$

for 10 Hb = 155 ml
8 Hb = 393 ml

ANAESTHESIA CHART

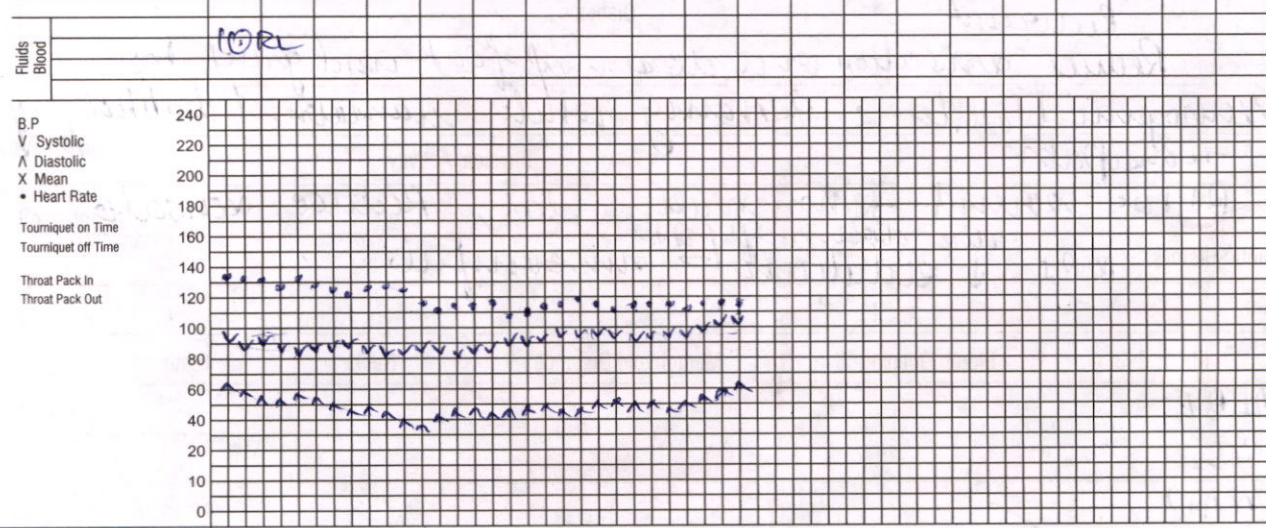


Pre Induction Assessment:

Change in Patient Condition:	☐ Yes ☒ No	Fasting Status:	Confirmed
Physical Status:	☒ Patient Identified	☒ Consent Present	☒ Chart Reviewed

H.R:	120 bpm	B.P / CRT:	100/60 mmHg	SpO ₂ :	98% on B.A	R.R:	20/min	Last Feed:	7 hrs
Pre-OP Diagnosis:					Operation:	Laminectomy & Debridement of Cord		Date:	8/7/26
Surgeon:	Dr. Sripartha		Anaesthesiologist:	Dr. Ravi Chandra / Dr. Anupam / Dr. Soma		Technician:	Nishanth		

TIME	8:10	8:20	8:30	8:45	9:00	9:15	9:30	10:00	10:30	11:00
N ₂ O (AIR) O ₂ LPM	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0
HALO 750 (SEVOMAX)	1	1	1	1	1	1	1	1	1	1
Drugs:										
MIDAZOLAM	0.6mg									
FENTANYL	36mcg									
ROPOFOL	60mg									
ROPOFOL	8mg + 2mg									
GLUCOPYRROLATE	100mcg									
DEXMEDETOMIDINE	infusion @ 8mg/ml									
FI _{O2} / SaO ₂	100	100	100	100	100	100	100	100	100	100
ETCO ₂	52	48	46	42	38	39	40	41	41	40
ECG	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR
Temperature	35.6	35.8	36.1	36.3	36.6	36.6	36.9	37.0	37.1	
Urine Output										



LAB Values	ABG	
	GRBS	
	Others	

☒ Equipment Checked and Functional ☒ BP ☒ Cuff Site: (R) lower limb ☐ Art Site: ☒ EKG Lead ☒ Temp Site: (oesophagus) ☒ FIO ₂ Monitor ☒ Agent Monitor ☒ Pulse Oximeter ☒ Capnograph ☒ Ventilator ☐ Nerve Stimulator Position: Done ☒ Pressure Points Checked Eye Care: ☐ Oint ☐ Tape ☒ Padding ☐ Awake	Temp: ☒ HME ☐ Fluid Warmer ☐ Cling Film ☐ OH Warmer ☐ Hugger's ☒ Cotton Wool ☐ Other Times: Anaes Start: 8:10 AM OP Start: OP End: Leave OR: 11:00 AM Anaesthesia: ☒ GA ☐ Monitored Anaesthesia Care ☐ Regional Line (Size & Location) ☐ CVP: ☐ ART: ☒ IV: 22G (R) hand ☒ IV: 22G (L) hand ☐ IV:	Induction ☒ IV ☐ Inhal ☐ Pre O ₂ ☐ RSI ☐ Others ☐ Mask ☐ SGA ☐ Airway ☐ Oral ☐ Nasal ETT# 4.5 at 15 cm ☒ Oral ☐ Nasal ☒ Cuff ☐ Tracheostomy ☐ Topical ☒ Drug: Rocuronium ☐ Awake ☒ Direct Vision ☐ Video Laryngoscopy ☒ Stylette / Bougie ☐ Fiberoptic Blade# 2 Attempts: 1 Difficulty Why? ☒ Bilat = BS ☐ Semi-Closed Circle ☒ Closed Circle ☐ Other	Regional: Extremity Specify: ☐ Spinal ☐ Epidural ☐ Caudal Others: Position: Site: Needle Size: Depth: Parasthesia ☐ Yes ☐ No Catheter at skin cm Drug Name & Conc: Bolus: Infusion: Block Level: Comments: Transportation to ☐ PACU ☐ ICU ☐ Other Relaxant Reversed ☐ Yes ☐ No ☐ NA Name of the Doctor: Signature of the Doctor:
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POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Dr. D. Ramadev

Time Received : 11:57 AM

Time Discharged : 12:45 PM

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site : <u>22G</u>
		☐ O ₂ Mask ☐ Tracheostomy ☐ Oral Airway ☐ Nasal Prongs ☐ T-Piece ☐ Nasal Airway Vomiting : ☐ Yes ☒ No NG Tube : ☐ Yes ☒ No Drain : ☐ Yes ☒ No Urinary Catheter : ☐ Yes ☒ No Chest Tube : ☐ Yes ☒ No Nil Oral : ☐ Yes ☒ No IV Fluids : _____ Oral Feeds : _____

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES			OUT	SCORING INTERPRETATION
				30	60	90		
Able to move 4 extremities voluntary or on command	= 2	ACTIVITY	1	1	1	2	A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:	
Able to move 2 extremities voluntary or on command	= 1		2	2	2	2		
Able to move 0 extremities voluntary or on command	= 0		2	2	2	2		
Able to deep breathe & cough freely	= 2	RESPIRATION	2	2	2	2		
Dyspnea or limited breathing	= 1		2	2	2	2		
Apneic	= 0		2	2	2	2		
BP ± 20 of Pre Anaesthetic leve	= 2	CIRCULATION	2	2	2	2		
BP ± 20-50 of Pre Anaesthetic leve	= 1		2	2	2	2		
BP ± 50 of Pre Anaesthetic leve	= 0		2	2	2	2		
Fully awake	= 2	CONSCIOUSNESS	1	1	2	2		
Arousable on calling	= 1		2	2	2	2		
Not responding	= 0		2	2	2	2		
Pink	= 2	COLOR	2	2	2	2		
Pale, dusky, blotchy, jaundiced, other	= 1		2	2	2	2		
Cyanotic	= 0		2	2	2	2		
TOTAL			8	8	9	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
8/7	11:57 AM	1/10	—	Dr. D. Ramadev

Pain Tool Used: ☐ N PASS ☒ FLACC ☐ Wong Baker ☐ NPS

Anaesthesiologist Name : Dr. D. Ramadev

Anaesthesiologist Signature: Dr. D. Ramadev

Date & Time: 8/7/26 @ 12:45 PM

PACU Nurse Name : Dr. D. Ramadev

PACU Nurse Signature: Dr. D. Ramadev

Date & Time: 8/7/26 @ 12:45 PM

Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): Dr. D. Ramadev

Date & Time: 8/7/26 @ 12:45 PM

EPIDURAL ANALGESIA RECORD

b)

[illegible]

Date and Time :



CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: DETETHERING OF CORD

Anaesthesiologist: DR. ADITI NEWASKAR Surgeon: DR. SRIPARTHA YERRAMEL

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk(s): The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders

☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease

☐ Others: DESATURATION, BRADYCARDIA, LARYNGOSPASM -

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☐ Regional Anaesthesia ☒ General Anaesthesia ☐ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: Manisha
Name: manisha tanaji borade
Relationship with patient: mother
Date & Time: 7/7/26 12.05

Witness:

Signature: Tanaji
Name: Tanaji Nannabh Borade
Date & Time: 7/7/26 12.05

Doctor (who is taking consent):

Signature: Aditi Name: Dr. Aditi N Date: 7/7/26 Time: 12.05

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్థావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

లీజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్స్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ లీజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనెస్ యాక్సెస్, ఆర్థిలయల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, లీజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

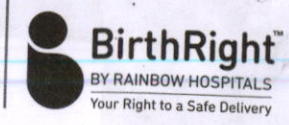
తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

SAH-00657854
Master SAMARTH TANAJI BORADE
04-10-2019 8 Y 9 M 3 D
Dr. SRIPARTHA KRISHNA (M)

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD



Part - I.

Patient's / Learner Language: 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		
7/7	8pm	7	Infection control measures	M	1	0	1	1	NA	Dr. S. K.
8/7/26	1pm	9	Normal diet	M	1	0	1	1	-	maul

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
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Patient Sticker

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 Master SAMARTH TANAJI BORADE
 04-10-2019 8 Y 9 M 3 D (M)
 Dr. SRIPARTHA KRISHNA



MULTI-DISCIPLINARY PLAN OF CARE FORM

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Diagnosis:

Spina bifida.

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
7/7/26 8 PM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	that Tethered cord.	hemodynamic stability	dethethering of cord.	<i>[Signature]</i> Sainth	☐ Nursing ☐ Others:
7/7/26 8 PM	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Dethethering of cord	H. stability	IVF NPO.	<i>[Signature]</i>	☒ Medical ☐ Others:
8/7/26 1 PM	☐ Medical ☐ Nursing ☒ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Dethethering of cord	Normal diet	ROA E: 14.50 kcal/d P: 25g/d	<i>[Signature]</i>	☐ 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:

Samon

BAH-00657854 IP5-00176085
Master SAMARTH TANAJI BORADE
04-10-2019 5 Y 9 M 4 D (M)
Dr. SRIPARTHA KRISHNA



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 8/7/26 Time: 1pm

Weight: 16.94 kgs Centile: 25th

Height: 111 cms Centile: 75th

Inference: underweight child

RDA: — Calories: 1450 kals/d Protein: 25g/d

Diet Recommendations: Normal diet

Re-Assessment: Avoid spicy, chilled and outside foods

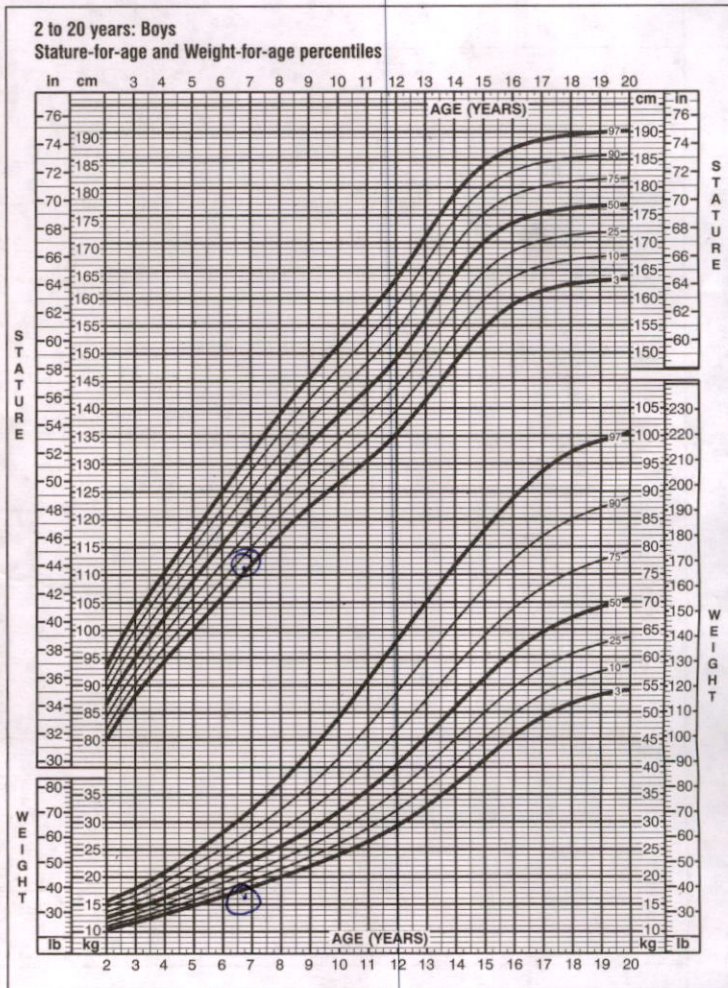
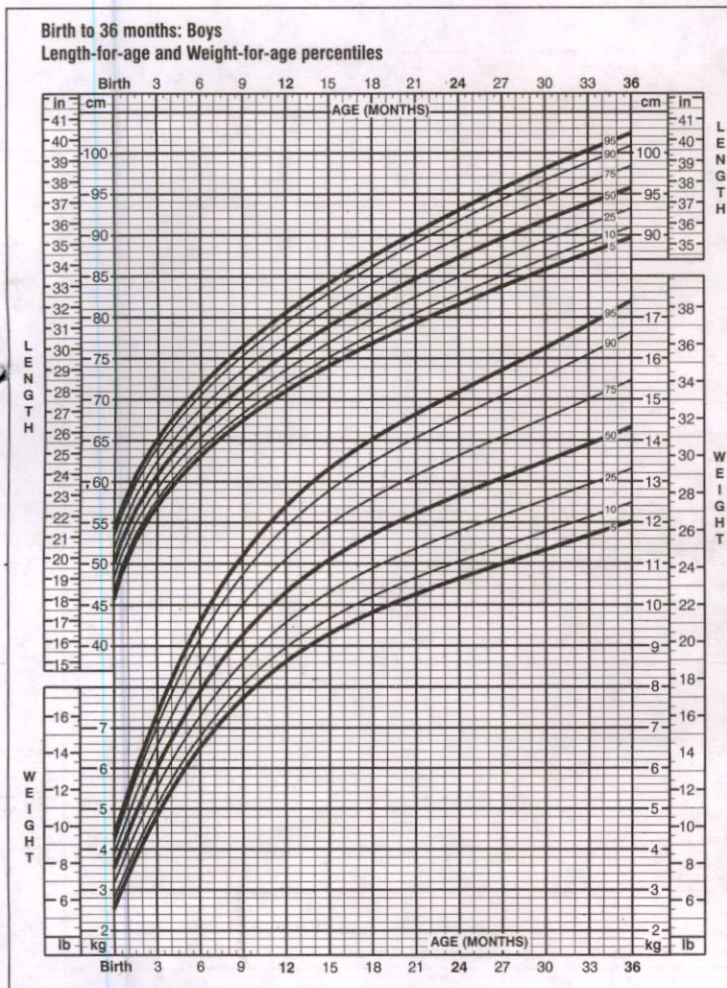
Food Allergies: No Veg/Non-veg: veg

Diagnosis: Sphibella type 2, LTC, Neurogenic bladder for Detethering of cord.

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Murish

GROWTH CHART (BOYS)



Dietician's Name: Murish

Dietician's Signature: Murish

Daily Notes:

9/2/26
sam

Child is stable Intake is better
continue to normal diet

Wittall

10/2/26
B. Sam

Child is stable Intake is optimal
Continue to Normal diet.

Wittall