

IAH-00652633
Baby Of HARI PRIYA
15-11-2025 0 Y 7 M 26 D (M)
Dr. HARISH JAYARAM

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

BirthRight™
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Your Right to a Safe Delivery

ACTIVITY RECORD FOR BILLING

Name : _____

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
1.7.26.	10:15pm	ER	OT III	
2/7/26	7:30 AM	III	OT	
2/7/26	1:30pm	OT	ICU	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Bhargavi	5/7/26	9641931	Chandan
2	Dr:- Anupama.y	02/07/26	9689920	Shaiyaf
3	Dr:- Anupama.y	03/07/26	9689925	Shaiyaf
4	Dr:- Anupama.y	04/07/26	9689928	Shaiyaf
5	Dr:- Anupama.y	05/07/26	9689931	Shaiyaf
6	Dr:- Anupama.y	06/07/26	9689934	Shaiyaf
7				
8				
9				
10				

[illegible]

Investigations

Order No.

Signature

107

CBP, $\frac{8E}{INR}$

65577

Samy

31 7

CBP, SIE

6807 JB

82

317126

CXR - 1

653 219

— Divya

4/7/26

S. R.

6532913

2

 $\frac{5}{7}$

2DECH ①

033370



[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
Samohy	IR placement	①	683130	Samohy
4/17/26	PAC	①	9632106	Samohy
2/7	NHA	①	603352	Samohy

ANY OTHER INFORMATION

2 ray @
lab report

Date : 4/07/26

Time : @ 9am

Prepared By : Rawina

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Rawina	Spot		

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175841

Admit Date : 01-Jul-2026

Admit Time : 07:58 PM UHID : BAH-00652633

Patient Details :

Patient Name : Baby Of HARI PRIYA

Age : 0 Y 7 M 26 D

Guardian : Mr VINAY KANIYA

DOB : 05-11-2025 06:38 PM

Gender : Male

Religion :

Occupation :

Marital Status : Single

Address (H) : H NO - 23, STREET NO - 2, RAJIVNAGAR
Raipur CHHATTISGARH INDIA 492001

Phone No : 7440711404/ 9981411404

E-mail : vinaykaniya@gmail.com

Admission Details :

Bed Type : SEMI PRIVATE

Bed No : SPVT 111

Ward Name : 1F-VIBGYOR

Room No : SPVT 111

Admission Type : First Visit

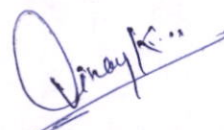
Contact Details :

Name : Mr VINAY KANIYA

Relationship : Father

Contact Address : H NO - 23, STREET NO - 2, RAJIVNAGAR
Raipur CHHATTISGARH INDIA 492001

Phone No : 7440711404 / 9981411404


Signature

Doctor Details :

Doctor Name : Dr. HARISH JAYARAM

Specialisation : PEDIATRIC SURGERY

Referral Doctor : SELF

Phone No :

Co-Consultant :

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

IAH-00652633 IP5-00175841
Baby Of HARI PRIYA
5-11-2025 0 Y 7 M 26 D (M)
Dr. HARISH JAYARAM



Patient Name: B/o Hari priya

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

post NEC stricture transverse colon
SIP Resection and colostomy in April 2024
now for colostomy closure

History of present illness :

post nec stricture transverse colon
SIP Resection and colostomy in April 2024
now for colostomy closure

~~no~~ Runny nose / cold
no cough / fever.



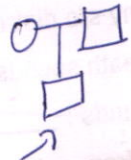
Pediatric Multiorgan History & Physical Examination

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

laparotomy + Resection of strichured segment + colostomy
on 02.04.2026

Birth & Neonatal History:

Term/ B.W- 2.5 kg/ NVD/ new stay x 25 days
sph. ^{CHD} balloon valvuloplasty



Birth & Socio Economic History:

About Father : middle
About Mother :
Any additional Information :

Developmental History :

appropriate for age

Immunization History :

vaccinated per date

now for colostomy closure

Pediatric Multiorgan History & Physical Examination

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: complications

Desired goals of the treatment: Resolution of symptoms

Planned Labs:

CBS
Serum electrolytes

NB
Blowout
1/11/26

Planned Management

- 1) PAC to do
- 2) Reserve PRBC 100ml
- 3) to give pre-op pepfar
- 4) to give PEHLEC 180ml
through NG tube over 2 hours
(8pm to 10pm).

Signature of the Doctor: Madhu

Name of the Doctor: Madhu

Date & Time: 1/11/26 3/

DR. HARISH JAYARAM
Signature of the Consultant: Dr. Harish

Name of the Consultant: Dr. Harish

Date & Time: 2/11/26 8:30 AM

Date & Time	Progress Notes	Doctor's Order
2/7/26 4:10 PM	C/S/B Dr. Malika POD - (0) Fever spike 100°F Vitals stable P/A - soft.	Adv 1) NPO until further orders 2) NG Aspiration 2nd hourly and continuous drainage 3) Urine Output monitoring by diaper weight.
 Dr. Harish Jayaram 2/7/26 4:55 AM	DR. HARISH JAYARAM Registration No: 60254	Malika Dr. Malika 2/7/26 4:10 PM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/26 7PM	C/S/B < Dr. Anupama post nec structure ASPS: - 1/2 colostomy closure POD-0 on room < APx hemodynamically stable one fever spike 100°. chest-clear.	plan. 1. Add Ivg tramadol. 2. IVF Fluids DNS 20mg/hr 3. Monitor vitals 4. w/t fever spikes. DR. ANUPAMA Y Registration No: 50853
3/7/26 8:30 AM	C/S/B Dr. Malika POD - ① No fever spikes Vitals stable P/A - soft did not pass stool dressing - intact, no leakage NG - 1.5ml. GRBS - 98 mg/dl. U.O - 0.9 cc/kg/hr	Adv 1) NPO 2) GRBS 8th hourly. 3) Trace CBP, Serum Electrolytes report Malika 3/7/26 8:30 AM DR. HARISH JAYARAM Registration No: 60254

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 2:45 pm	POP - (1) No fever spikey Vitals stable. P/A - soft did not pass stool U-O - adequate.	C/S/B Dr. Maliha. Adv 1) NPO 2) NG aspiration 4 th . hourly and continuous drainage.
3/7/26 5 PM	DR. HARISH JAYARAM Registration No: 06254	Maliha 3/7/26 2:45 pm
03/07/2026 7:40 pm	Δ POD-1 laproscopy & colotomy done O/E Intermittent Cushing (+) Nasal sounds (+), wheeze (+) No r/rku (-) P/A - soft.	Plan: 1) St. Nace + Adrenaline Q8H 2) Levamisole 150mg Q8H 3) Budecort nebs Q8H 4) DNS + 5ml KCl IV 5) Paracetamol T/m 6) Chest xray now

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26 9:10 AM	POD - 2	
	No fever spikes Vitals stable	<u>Adm</u>
	P/A - soft did not passed stool.	1) Remove NG tube
	NG - 1.3ml (yellow)	2) Can start sips of water/ORS (5ml 2nd hourly)
4/7/26 9:10 AM DR. HARISH JAYARAM Registration No: 66254		Maliha Dr. Maliha 4/7/26 9:10 AM
4/7 9:40 AM	S/B Dr. Anupama	<u>Plan</u>
	Cough (+)	- 2nd Betas
	Wheez & hyper	- continue Kci in ivf
	CXR - upturned apex	- start acipic for PnLia
		- Stop Trumadol
		DR. ANUPAMA Registration No: 50853



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26 4:50 PM	SIB Dr. Harish POD - 2 etc	
	No fever spikes Vitals stable P/A - soft passing stools	<u>Adv</u> 1) To give 5ml ORS 2 nd hourly.
4/7/26 4:50 PM		Dr. Malika Malika 4/7/26 4:50 PM
5/7/26 9:30 AM	C/S/B Dr. Lavanya POD - (3)	<u>Adv</u> 1) To give 20 ml milk 2 nd hourly 2 nd 2) Continue IV fluids.
	No fever spikes Vitals stable P/A - soft passing stools	
		malika 5/7/26 9:30 AM

DR. HARISH JAYARAM
 Registration No: 00254

PROGRESS NOTES AND DOCTOR'S ORDER

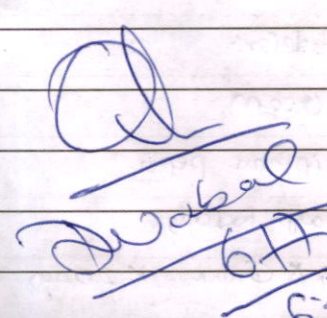
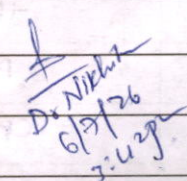
Date & Time	Progress Notes	Doctor's Order
5/7/26 11:30 AM	S/B Dr. Anupama cough better Wheezing better child on Room air Hemodynamically stable	Plan 1) Stop Adrenaline nebs 2) Continue levodopa Budecort 2) Monitor Vitals Dr. Jayash
6/7/26 8:50 AM	e/S/B Dr. Malika POD - (4) No fever spikes Vitals stable P/A - soft passing stools	Adv 1) Can increase oral feeds
6/7/26 8:50 AM	DR. HARISH JAYARAM Registration No: 66254	

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 05-11-2025 0 Y 7 M 29 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7 10:15am	S/B Dr. Anupama	
	cover heater whee heater	Plan
		1) Make parenteral and order (inform Surgical team)
		2) make coversin + Rudocort 1200
		
6/7/26 3:42pm	C/S/B Dr. Nikhita	
	[POD-4] No c/o fever spikes, abd. distension,	Adm
	O/E - Afebrile vitals - stable	① Full feeds as tolerated
	I/A - soft passing stool	
	 6:30pm	 6/7/26 3:42pm

Dr. NABEEL ALAM QADRI
 DR. H. REG. No: 75241
 Registration No: 66254



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26 8:05 AM	POD - (5) No fever spikes Vitals stable P/A - soft passed stools diaper rash (+)	<u>ClS/B</u> Dr. Maliha / Dr. Nikhita <u>Adv</u> 1) Full feeds 2) Stop IV fluids 3) Plan discharge today 4) Review on Thursday with Dr. Nabeel Maliha Dr. Maliha 7/7/26 8:20 AM
	DR. HARISH JAYARAM Registration No: 66254	<u>Cl&lb</u> Dr. Anupama
07/07/2026 10:30 AM	Post-OP Laproscopy & Colonoscopy Clome O/E: Hemodynamically stable PLA - soft Chest - clear	<u>Plan:</u> 1) Remove PICC line 2) Stop BudeCort 3) Dentin cream 4) Continue Aplanis pepti 5) Discharge today 6) Lendin X Contin X 20 days

IP5-00175841

OF HARI PRIYA

11-2025

0 Y 7 M 28 D

(M)

11-2025
HARISH JAYARAM



8th hour



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GASTRO MONITORING FORM

[illegible]

BAH-00852633 IP5-00175841
Baby Of HARI PRIYA
05-11-2025 0 Y 7 M 29 D (M)
Dr. HARISH JAYARAM

2D echo
Rainbow Children's Hospital
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CROSS CONSULTATION FORM

Doctor Name : Date : 5/7/26 Time :

Diagnosis :

Hospital :

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

Referred for : ☐ Opinion ☐ Co-Management ☐ Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

Findings and Recommendations :

Neonatal PBPV @ day 6 of life.
stricture of transverse colon

Operated

SpO₂ - 100%

ECHO

s/p PBPV

PV got 18mmHg

PR +

RV → Normal

tricuspid TR

PFO L → R

GBV

lv - 6mmHg

Consultant :

BHARUJI

Signature :

Date & Time : 5/7/26





INFORMED CONSENT FOR SURGERY / PROCEDURE

Authorization By: ☐ Patient ☒ Patient Attendant

I, the undersigned do hereby agree to undergo the following surgery(s), Procedure(s) on patient / myself at Rainbow Children's Hospital. (Avoid technical terms and leave no blank space)

1. LAPAROTOMY AND COLOSTOMY CLOSURE

2. _____

I acknowledge the following:

- I have been made aware of the benefits and reasons of the surgery / procedure as indicated by the clinical observations and / or diagnostics performed.
- The benefits and risks of this surgery / procedure have been explained to me. I have also been told about the alternatives available for this surgery / procedure including the advantages and disadvantages of the alternatives.

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
Restoration of continuity of colon.	Nil

- As with any procedure, I am aware that risks such as blood loss, infection, cardiac arrest, anesthetic allergic reactions, paralysis, Deep Vein thrombosis (DVT), Pulmonary thromboembolism (PTE) etc may arise necessitating attention. Therefore, in addition to consenting to the performance of the above-mentioned surgery/procedure(s), I also consent and authorize the rendering of such other care and treatment as patient/my surgeon or his / her designee reasonably believes necessary should one or more of these and or other unforeseeable events occur.

Apart from the listed above, I have also been explained about the possible complications of the surgery / procedure are as follows:

- Bleeding, Infection, Adhesive Intestinal Obstruction
- Anastomotic leak, Anastomotic stricture

- I authorize Dr. Harish Jayaram and his / her team to perform the procedural sedation upon the patient / myself.
- I recognize that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes.
- 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: Harish Jayaram

Name: Mother: HARI PRIYA

with patient: Mother

Date & Time: 2/7/26, 8:11 AM

Witness:

Signature: Vinay Kaniya

Name: Vinay Kaniya

Date & Time: 2/7/26 8:11 AM

Dr. Malika

Date 2/7/26 Time: 8:11 AM

శస్త్రచికిత్స / ప్రాసీజర్కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్బో చిల్డ్రెన్ హాస్పిటల్లో చేయబడబోయే క్రింది శస్త్రచికిత్స(లు) / ప్రాసీజర్(లు) చేయడానికి అంగీకరిస్తున్నాను. (టెక్నికల్ పదాలు వాడవద్దు మరియు ఖాళీ స్థలం వదిలివేయకండి)

1

2

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

- క్లినికల్ పరిశీలనలు మరియు/లేదా చేసిన పరీక్షల ఆధారంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
- ఈ శస్త్రచికిత్స / ప్రాసీజర్కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి.
ఈ శస్త్రచికిత్స / ప్రాసీజర్కు ఉన్న ప్రత్యామ్నాయాల గురించి, వాటి ప్రయోజనాలు మరియు నష్టాలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

- ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్లోలాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీషియా వల్ల అలెర్జిక్, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు.
అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్కు నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినపుడు, రోగి/నా కోసం అవసరమని వైద్యుడు భావించే ఇతర చికిత్సలను చేయడానికి కూడా నేను అనుమతిస్తున్నాను.

అదనంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ వల్ల సంభవించగల ఇతర సమస్యలు కూడా నాకు వివరించబడ్డాయి:

a.	
b.	

- డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్ను చేయడానికి నేను అనుమతిస్తున్నాను.
- వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
- పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భాష సమాధానం ఇచ్చారు.
ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో, స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

(26)

LIST

Surgeon : Dr. Harish Jayaram
Asst. Surgeon :
Anaesthetist : Dr. Akhilesh
Scrub Nurse : Akhil

Patient Name : B/o Hari Priya Age : 7m Gender : M
UHID No. BAH-00652633 Surgery Name : Laparotomy & colostomy closure
Date : 02/07/26 In-time : 8:40am Out-time :

Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN		Time: <u>8:30AM</u>
Patient Has Confirmed		
Identity	☒ Yes ☐ No	
Site	☒ Yes ☐ No	
Procedure	☒ Yes ☐ No	
Consent	☒ Yes ☐ No	
Site Marked	☐ Yes ☐ No ☒ NA	
Anaesthesia Safety Check Completed	☒ Yes ☐ No	
Pulse Oximeter on Patient & Functioning	☒ Yes ☐ No	
Does Patient have a:		
Known Allergy?	☐ Yes ☒ No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	☐ Yes ☒ No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☒ No ☐ NA	
Blood Units Reserved	☒ Yes ☐ No ☐ NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?		
	☒ Yes ☐ No ☐ NA	
Signature : <u>[Signature]</u>		
Name : <u>Dr. Akhilesh K.</u>		

TIME OUT		Time: <u>10:03AM</u>
Confirm all team members have introduced themselves by Name and Role ☒ Yes ☐ No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	☒ Yes ☐ No	
Correct Site	☒ Yes ☐ No	
Correct Procedure	☒ Yes ☐ No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, <u>2hr</u> Anticipated Blood Loss? <u>5ml</u> ☐ Yes ☒ No ☐ NA		
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns? ☐ Yes ☐ No ☐ NA		
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☒ Yes ☐ No ☐ NA		
Is Essential Imaging Displayed? ☐ Yes ☐ No ☒ NA		
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☒ Yes ☐ No		
Signature : <u>[Signature]</u>		
Name : <u>S. Sata</u>		

SIGN OUT		Time: <u>11:50am</u>
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	☒ Yes ☐ No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☒ Yes ☐ No ☐ NA	
The Specimen is Labelled (including patient name)	☐ Yes ☐ No ☒ NA	
Whether there are any Equipment Problems to be addressed	☐ Yes ☒ No ☐ NA	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient? ☐ Yes ☒ No		
Signature : <u>[Signature]</u>		
Name : <u>DR. HARISH JAYARAM</u>		

Patient Sticker

BAH-00652633 IP5-00175841
 Baby Of HARI PRIYA (M)
 05-11-2025 0 Y 7 M 27 D
 Dr. HARISH JAYARAM



BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 02/07/26

Department : OT Duration of Procedure : 2hr
 Name of Surgeon : Dr. Harish Jayaram Date of Admission : 02/07/26

Bundle Care Criteria : (Tick (✓) if done)

		Staff Signature
1.	Antibiotic given prior to surgery ? ☒ Yes ☐ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☒ Yes ☐ No Name of the Antibiotic : Inj. Piptax 1gm	Sugata
2.	Hair Removal ☐ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : Skin preparation done (cleanse surgical area with antiseptic agent)? ☒ Yes ☐ No	Sugata
3.	Patient's body temperature immediately post operation (Recovery Room) _____ °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Srs. Teena Date & Time of antibiotic administration : 02/07/26 @ 7Am Date & Time procedure started : 02/07/26 @ 10:05Am	Sugata

- Ensure form is filled in completely by assigned staff whenever patient had surgery
- If any bundle care criteria has not been observed or unmet, assigned staff must inform infection control nurse for management
- All forms (Bundle care and when required SSI form) are completed properly
- Forms must always be kept in Infection Control folder in respective department



OPERATION THEATER NOTES

Patient's Name : B/o Hari Priya Age : 7m Gender : ☒ Male ☐ Female
UHID No.: BAH-00652633 Weight : 10 kgs Height :

Surgeon : Dr. Harish Jayaram Asst. Surgeon : Dr. Maliha
Anesthetist : OT Nurse: Akhil OT Technician: Sirisha

Pre-Operative Diagnosis: S/P TRANSVERSE COLONIC STRICTURE

Surgical Procedure : COLOSTOMY

LAPAROTOMY + COLOSTOMY CLOSURE

Indications for Surgery :

S/P COLOSTOMY FOR TRANSVERSE COLONIC STRICTURE

Date : 02/07/26 Start Time : 10:05 Am End Time : 10:30 am

Pre Operative Preparations:

Post Operative Diagnosis: S/P COLOSTOMY FOR TRANSVERSE COLONIC STRICTURE

Peri-Operative Complications:

Operation Notes:

FINDINGS:-

1) Flimsy interbowel adhesions present.

Procedure

- 1) Incision made around the stoma. Incision deepened upto subcutaneous tissues.
- 2) Rectus abdominis and peritoneum opened.
- 3) Above findings noted.

Amount of Blood Loss: ~1ml

Blood Transfused (in ML) —

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications: —

- 4) Proximal and distal stoma mobilized, adhesiolysis done.
- 5) End to end colonic anastomosis done $\pm$ 4-0 vicryl sutures. Muscle layer closed with 1-0 vicryl, subcutaneous tissues and skin closed. Hemostasis ensured and counts checked.
8 Fr Suction catheter placed as subcutaneous drain

Name of the Surgeon: Dr. Hanish Jayaram

Signature of the Surgeon: 

Date & Time: 2/7/26, 12:24pm

BAH-00652533
Baby Of HARI PRIYA
Pa05-11-2025
Dr. HARISH JAYARAM
IP5-00175841
0 Y 7 M 27 D (M)

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POST-SURGICAL CARE PLAN FORM

Procedure Done: COLOSTOMY CLOSURE

Post-Surgical Diagnosis: S/P TRANSVERSE NEC STRICTURE
C END COLOSTOMY

Post-Operative Monitoring Parameters /Frequency:

TPR every 15 minutes for first 1 hour

Wound Care:

Dressing

Drain /Special Lines/Catheters:

- 1) 8 Fr Suction catheter as subcutaneous drain
- 2) NG aspiration 2nd hourly + continuous drainage.

Special Patient Positioning and Requirements:

—

Nutritional Instructions:

NPO until further orders.

When to Start Mobilization:

As early as possible

Special Referrals:

—

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

—

Treating Surgeon
(Signature & Stamp)

Date: 2/7/26 Time: 12:36pm

Note: Plan of care will be readjusted if necessary.

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 Baby Of HARI PRIYA
 05-11-2025 0 Y 7 M 26 D (M)
 Dr. HARISH JAYARAM



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RESULT SHEET

Date	4/7/26				
Time					
Hb					
PCV					
RBC					
WBC					
N/L					
Platelets					
CRP					
ESR					
PCT					
RBS					
Na	137				
K	3.1				
Cl	103				
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.,) :

BAH-00652633
Baby Of HARI PRIYA
16-11-2026 0 Y 7 M 26 D (M)
Dr. HARISH JAYARAM



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: ICU

Shifted to: Ward

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Ashile Ashile

Date & Time : 1/7/26 10pm

Nurse Name & Signature : Shavaw B

Date & Time : 1/7/26 10pm



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : INJ ESOMEPRAZOLE				Date	Time
Dose	Route	Frequency	Start Dt.	2/7	2/7
10mg	IV	Q24h	2/7/26	4/7	5/7
Name & Signature of the Doctor Starting the Drugs:				5pm	5:10pm
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : Inj TRAMADOL				Date	Time
Dose	Route	Frequency	Start Dt.	2/7	3/7
10mg	IV	TID	2/7	8:30am	9:30am
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : 3% NaCl + Adrenaline				Date	Time
Dose	Route	Frequency	Start Dt.	3/7	4/7
NEB	NEB	Q8H	03/07	9AM	10:00am
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : LEVOLIN NEBS				Date	Time
Dose	Route	Frequency	Start Dt.	4/7	5/7
0.3/wg	NEB	Q8H	03/07	9AM	10AM
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

Sheet No:

REGULAR PRESCRIPTIONS

Weight 16 kg

Ward

DRUG : BUDECORT NEB				Date Time	3/7	4/7	5/7													
Dose	Route	Frequency	Start Dt.																	
0.5	NEB	Q8H	03/07																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : LEVOLIN NEB				Date Time	6/7	7/7														
Dose	Route	Frequency	Start Dt.																	
0.31mg	NEB	BD	6/7																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : BUDECORT NEB				Date Time	6/7	7/7														
Dose	Route	Frequency	Start Dt.																	
0.5mg	NEB	BD	6/7																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : Symp PARACETMOX				Date Time	6/7	7/7														
Dose	Route	Frequency	Start Dt.																	
3ml	P/O	Q8H	6/7/20																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

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Baby Of HARI PRIYA
05-11-2025 0 Y 8 M 1 D (M)
Dr. HARISH JAYARAM




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Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : CROU N DROPS				Date	Time
Dose	Route	Frequency	Start Dt.		
1.5ml	P/O	Q8h	6/17/26	6am X	8am
Name & Signature of the Doctor Starting the Drugs: <i>Soheli</i>				2pm X	
				10pm	Some
Additional Instructions:					
Daily Doctor's Endorsement by a Sign				mal	mal

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

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

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

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

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

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

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

VERIFIED BY : Name Signature

DRUG CHART

Date of Admission: 1/7 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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



REGULAR PRESCRIPTIONS

Weight. 10kg. Ward.

VERIFIED

VERIFIED

VERIFIED

DRUG : INJ PIPERACILLIN + TAZOBACTAM				Date Time	2/7	3/7	4/7	5/7	6/7	7/7
Dose	Route	Frequency	Start Date							
1.125g	IV	Q8h	2/7/26	6am	9am	12pm	3pm	6pm	9pm	12am
Name & Signature of the Doctor Starting the Drugs: Malika Dr. Malika				12:24pm						
Additional Instructions:										
Daily Doctor's Endorsement by a Sign				mal	mal	mal	mal	mal	mal	mal

DRUG : INJ METRONIDAZOLE				Date Time	2/7	3/7	4/7	5/7	6/7	7/7
Dose	Route	Frequency	Start Date							
75mg	IV	Q8h	2/7/26	6am	9am	12pm	3pm	6pm	9pm	12am
Name & Signature of the Doctor Starting the Drugs: Malika Dr. Malika				12:24pm						
Additional Instructions:										
Daily Doctor's Endorsement by a Sign				mal	mal	mal	mal	mal	mal	mal

DRUG : INJ PARACETAMOL				Date Time	2/7	3/7	4/7	5/7	6/7	7/7
Dose	Route	Frequency	Start Date							
150mg	IV	Q8h	150mg							
Name & Signature of the Doctor Starting the Drugs:										
Additional Instructions:										
Daily Doctor's Endorsement by a Sign										

DRUG : INJ PARACETAMOL				Date Time	2/7	3/7	4/7	5/7	6/7	7/7
Dose	Route	Frequency	Start Date							
150mg	IV	Q8h	2/7/26	6am	9am	12pm	3pm	6pm	9pm	12am
Name & Signature of the Doctor Starting the Drugs: Malika Dr. Malika				12:24pm						
Additional Instructions:										
Daily Doctor's Endorsement by a Sign				mal	mal	mal	mal	mal	mal	mal



Weight. 10 kg ... Ward.

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.

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
1/7	8pm	PEGUEC	180ml	IVG	Akhil	Pramela Ravina
		mix 1/2 packet over 2h in 1L water				
2/7	7am	Inj PIPTAZ	1g			Pramela Ravina
2/7	8:55AM	Inj-PARACETAMOL	600mg	w	@Vinj	SHIRISH Sasi
2/7	8:55AM	Inj-METRONIDAZOLE	750mg	w	@Vinj	SHIRISH Sasi

Signature

VERIFIED BY : Name



I.V. FLUIDS CHART

Weight. 10kg 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
1/7	11:05 pm	IVF DNS.	IV	40			2/7		
2/7/26	8:45 AM	RINGER LACTATE	IV	100ml/hr			2/7		
2/7/26	12:24 pm	IVF DNS	IV	40 ml/hr			2/7		
2/7/26	6 pm	IV DNS	IV PICC	30			2/7		
2/7/26	7 pm	IVF DNS	PICC	20ml/hr			3/7/26		
3/7/26	5:10 pm	IVF DNS + 5cc	PICC						
03/7/26	8 pm	DNS + KCl (5ml)	IV	20 ml/hr			7/7		

Signature

VERIFIED BY : Name

BAH-00652633 IP5-00175841

Baby Of HARI PRIYA

05-11-2025

0 Y 8 M 1 D

(M)

Dr. HARISH JAYARAM

Doc. No. : RCH / FRM / CLINICAL / 124

INFANT (<1 year)

Children's Observation &
Early Warning Scoring Chart

Pratiksha
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 8/12 Time: 6:00 PM

Doctor/Nurse/Family Concern?

Temperature
(°F)

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

Heart Rate (Number)

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

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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

Conscious Level
Normal Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

Score 1 : Continue normal observation by staff nurse

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

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

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

Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU 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-00652633 IP5-00175841

Baby Of HARI PRIYA

05-11-2025 0 Y 7 M 29 D (M)

Dr. HARISH JAYARAM

Doc. No. : RCH / FRM / CLINICAL / 124

INFANT (<1 year)

Children's Observation &
Early Warning Scoring ChartPratiksha
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 06/07 Time: 10 am

6pm

10pm

2am

Doctor/Nurse/Family Concern?

Temperature
(F)Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

Heart Rate (Number)

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

Resp Rate (Number)

Resp Mod/ Severe
Distress None / MildReceiving O₂ (l/min)
O₂ Saturations (%)Conscious Normal
Level Altered

GCS *

TOTAL SCORE

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 / NICU fellow or PICU / NICU 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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Date	Time	Early Warning Score	Date	Time	Name

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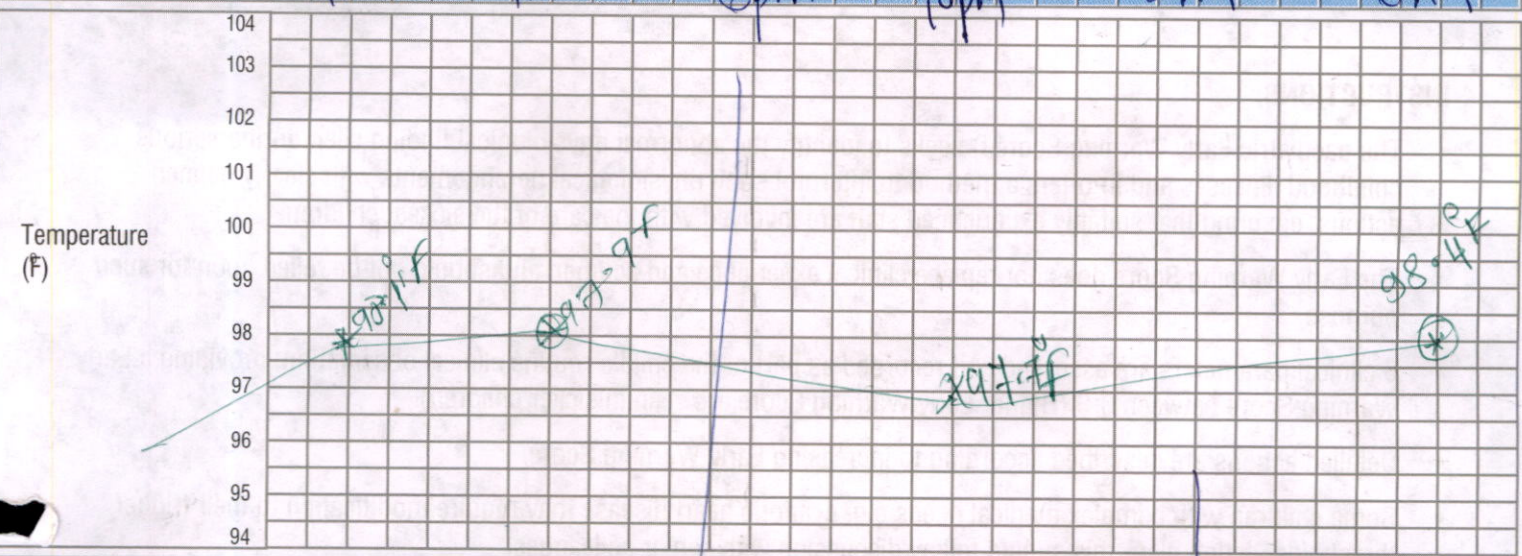
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R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



INFANT (<1 year) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 5/11/25 Time:
 Doctor/Nurse/Family Concern? 10AM 4PM 6PM 10PM 2AM 6AM



Heart Rate (bpm)

and

Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring

Time	Heart Rate (bpm)	Blood Pressure (mmHg)
10AM	120 bpm	110/60
4PM	119 bpm	100/60
6PM	120 bpm	100/60
10PM	120 bpm	100/60
2AM	120 bpm	100/60
6AM	129 bpm	92/56

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

Time	Resp. Rate (bpm)
10AM	28 bpm
4PM	28 bpm
6PM	28 bpm
10PM	28 bpm
2AM	28 bpm
6AM	24 bpm

Resp Mod/ Severe Distress None / Mild

Time	Resp Mod/ Severe Distress
10AM	None
4PM	None
6PM	None
10PM	None
2AM	None
6AM	None

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

Time	Receiving O ₂ (l/min)	O ₂ Saturations (%)
10AM	0.2	97%
4PM	0.2	99%
6PM	0.2	100%
10PM	0.2	100%
2AM	0.2	100%
6AM	0.2	100%

Conscious Level Normal / Altered

GCS *

Time	Conscious Level	GCS
10AM	Normal	14/15
4PM	Normal	14/15
6PM	Normal	15/15
10PM	Normal	15/15
2AM	Normal	15/15
6AM	Normal	15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

Time	Number of shaded boxes	Pain Score	Observer's Initials
10AM	1	0	SH
4PM	1	0	SH
6PM	1	0	SH
10PM	1	0	SH
2AM	1	0	SH
6AM	1	0	SH

ACTIONS

NB: Scores 3 should be recorded overleaf

Score	Action
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 incharge and PICU /NICU fellow or PICU/NICU 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

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



INFANT (<1 year) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 4/1/25	Time:	24 AM	6 AM	10 AM	2 PM	6 PM	10 PM	2 AM	6 AM
Doctor/Nurse/Family Concern?									
Temperature (F)	104								
	103								
	102								
	101								
	100								
	99								
	98								
Heart Rate (bpm)	190								
	180								
	170								
	160								
	150								
	140								
	130								
Blood Pressure (mmHg) *	120								
	110								
	100								
	90								
	80								
	70								
	60								
Resp. Rate (bpm)	70								
	60								
	50								
	40								
	30								
	20								
	10								
Conscious Level	Normal								
	Altered								
	GCS *								
	TOTAL SCORE								
	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 incharge and PICU /NICU fellow or PICU/NICU 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

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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)

INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 3/02	Time:	6am	10Am	11Am	1pm	6pm	10pm
Temperature (F)	104						
	103						
	102						
	101						
	100						
	99	98.6°F	99.7°F	98.6°F	98.2°F		98.3°F
	98						
	97						
	96						
	95						
	94						
Heart Rate (bpm)	190						
	180						
	170						
	160						
	150	R					
	140						
Blood Pressure (mmHg) *	130						
	120						
	110						
	100						
	90						
	80						
	70						
	60						
	50						
Note: BP does not score in early warning scoring							
Heart Rate (Number)							
	70						
	60						
	50						
	40						
	30						
	20						
	10						
Resp Rate (Number)							
	70						
	60						
	50						
	40						
	30						
	20						
	10						
Resp Mod/ Severe Distress None / Mild							
Receiving O ₂ (l/min)							
O ₂ Saturations (%)							
Conscious Level Normal / Altered							
GCS *							
TOTAL SCORE							
Number of shaded boxes							
Pain Score							
Observer's Initials							

ACTIONS

- Score 1 : Continue normal observation by staff nurse
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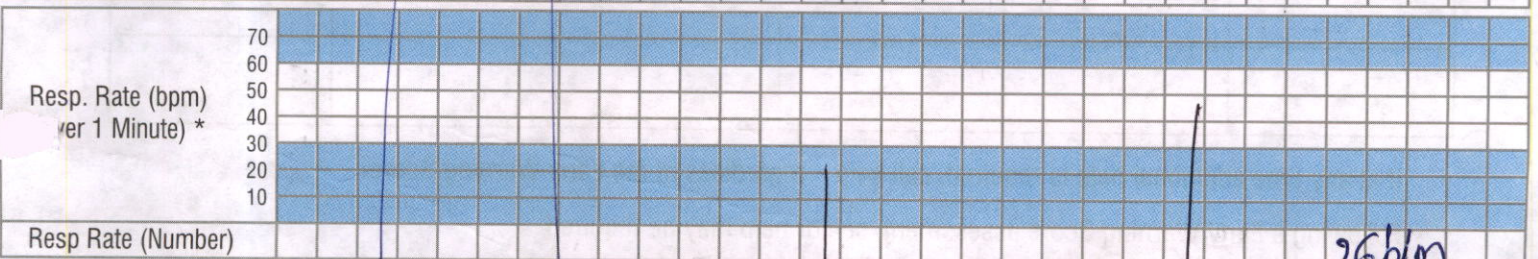
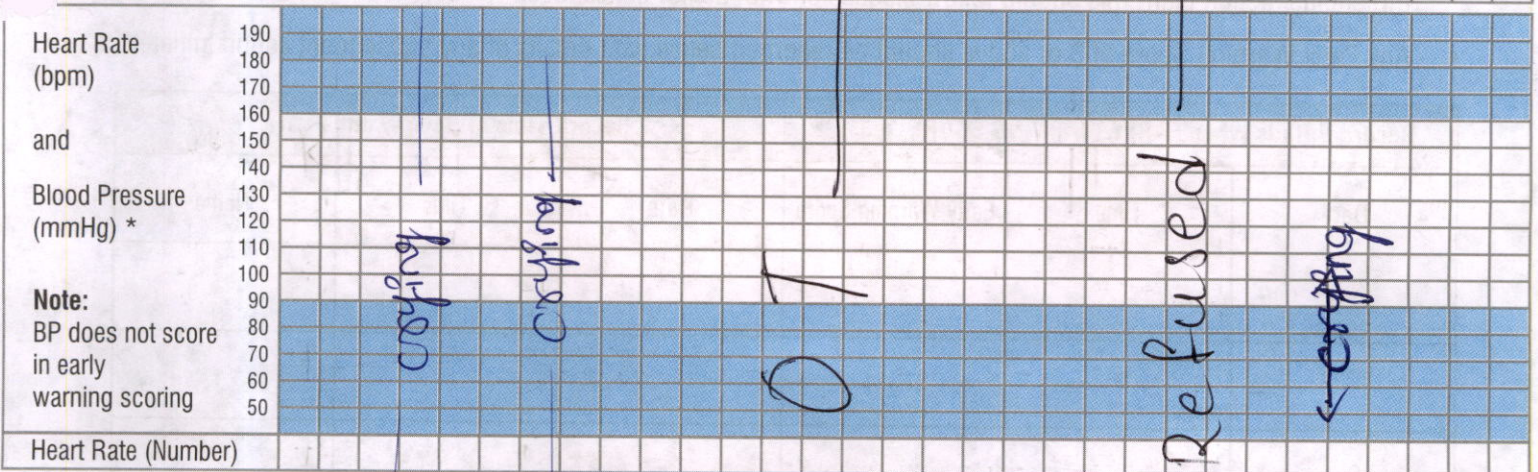
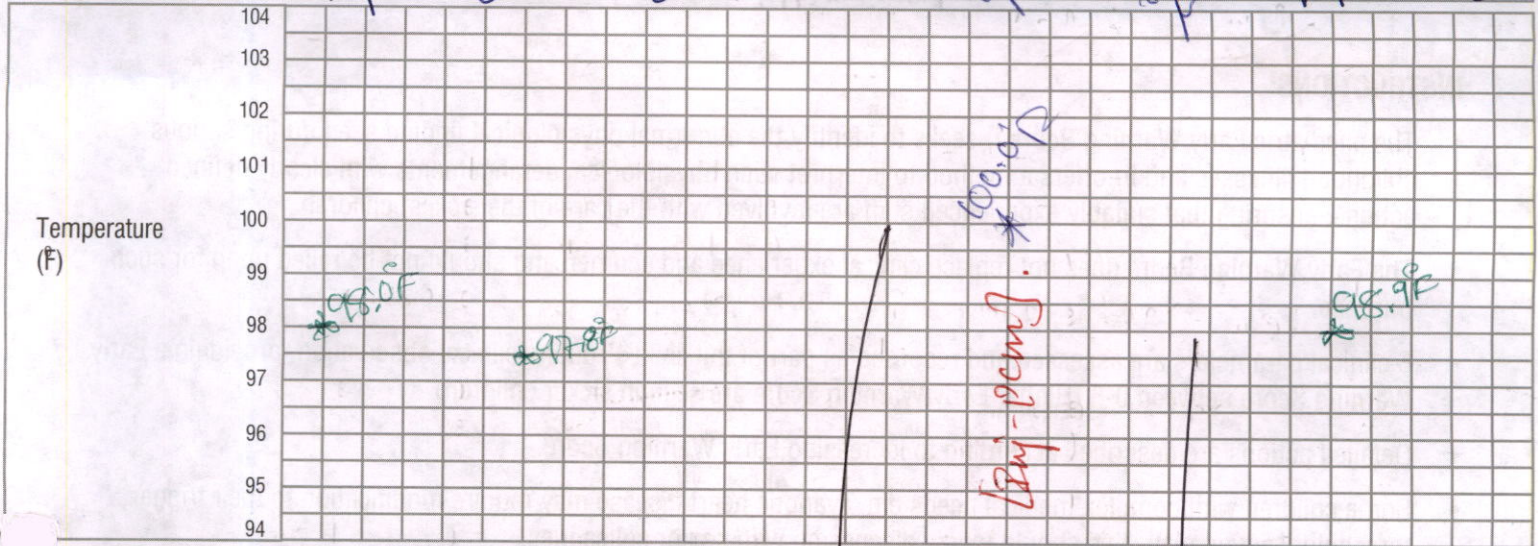
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INFANT (<1 year)
 Children's Observation &
 Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 2/7/22 Time: 10 pm 2am 6am 10 pm 2am
 Doctor/Nurse/Family Concern?



Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)		
O ₂ Saturations (%)	99%	99% 100%
Conscious Level	Normal	Altered
GCS *	15/15	15/15 15/15

TOTAL SCORE	
Number of shaded boxes	1
Pain Score	0
Observer's Initials	S

ACTIONS	Score 1 : Continue normal observation by staff nurse
	Score 2 : Shift in charge nurse to be informed and continue hourly observations
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BAH-00652633 IP5-00175841
Baby Of HARI PRIYA
05-11-2025 0 Y 7 M 26 D (M)
Dr. HARISH JAYARAM



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
01/07	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm	DNS	water	40ml								
	12:00 am			40ml								
	01:00 am			-								
Total Intake :						Total Output :						
2/7	02:00 am			40ml								
	03:00 am			40ml								
	04:00 am	DNS		40ml								
	05:00 am			40ml								
	06:00 am			40ml								
	07:00 am			-								
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						



FLUID CHART

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage			Urine
			Mouth	I.V	N.G							
9/7	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm	Das 40ml										
	Total Intake :			Total Output :								
2/7	02:00 pm	1		40ml							0	
	03:00 pm	1		45ml							6	
	04:00 pm	Das		40ml	0.1ml						0	stuge
	05:00 pm			40ml						31ml	0	
	06:00 pm	1		40ml							0	
	07:00 pm	1		40ml	0.3ml						0	stuge
	Total Intake :			Total Output :								
26/7	08:00 pm	1		20ml							0	
	09:00 pm	1		20ml	1ml						0	
	10:00 pm	Das		20ml						77ml	0	
	11:00 pm			-	Refuge						0	
	12:00 am	1		-							0	
	01:00 am	1		20ml							0	
	Total Intake :			Total Output :								
3/07	02:00 am	1		20ml							0	
	03:00 am	1		20ml	-						0	
	04:00 am	Das		20ml							0	
	05:00 am	1		20ml	0.1						0	
	06:00 am	1		20ml							0	
	07:00 am			20ml							0	
	Total Intake :			Total Output :								

Total 24 hrs. Intake	1.5ml
----------------------	-------

Total 24 hrs. Output	108ml
----------------------	-------

FLUID CHART

Sheet No. :

1. All measurements in ml.
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Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
26/11/25	08:00 am	/		20ml								} Sub	
	09:00 am	/		20ml		0.1ml				110ml			
	10:00 am	DNS		20ml			NP						
	11:00 am	/		20ml									
	12:00 pm	/		20ml		0.1ml							
	01:00 pm	/		20ml						78ml			
Total Intake :						Total Output :							
3/12/25	02:00 pm	/		20ml								} prax	
	03:00 pm	/		20ml									
	04:00 pm	DNS		20ml			NP			198ml			
	05:00 pm	/		20ml		0.3ml							
	06:00 pm	/		20ml						112ml			
	07:00 pm	/		20ml									
Total Intake :						Total Output :							
3/12/25	08:00 pm	/		20ml								} prax	
	09:00 pm	/		20ml									
	10:00 pm	DNS	NPO	20ml			NP			330ml			
	11:00 pm	5ml (K)		20ml		0.5ml				94ml			
	12:00 am	/		20ml									
	01:00 am	/		20ml									
Total Intake :						Total Output :							
9/12/25	02:00 am	/		20ml								} prax	
	03:00 am	/		20ml		Refused				107			
	04:00 am	DNS	NPO	20ml			NP						
	05:00 am	/		20ml		0.3ml							
	06:00 am	/		20ml									
	07:00 am	/		20ml						183			
Total Intake :						Total Output :							
Total 24 hrs. Intake		NG aspiration = 1.3ml light Green colour				Total 24 hrs. Output		U= 1212ml					

FLUID CHART

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		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								
04/7	08:00 am	↑		20ml		/					0	[Signature]	
	09:00 am	↑	20ml	20ml		/	✓				0		
	10:30 am	DNS +	H ₂ O	-		Removed				102ml	0		
	11:00 am	5ml		20ml		/					0		
	12:00 pm	KCL		20ml		/					0		
	01:00 pm	↓		20ml		✓				89ml	0		
Total Intake :						Total Output :							
4/7	02:00 pm	↑		20ml		/					0	[Signature]	
	03:00 pm	DNS	20ml	20ml		/					0		
	04:00 pm	+	H ₂ O	20ml		NA					EC		
	05:00 pm	5ml		20ml		/				20ml	L		
	06:00 pm	KCL		20ml		✓				32ml	1		
	07:00 pm	↓	H ₂ O	20ml		/					NB		
Total Intake :						Total Output :							
1/7	08:00 pm	↑		20ml		/	✓				↑	[Signature]	
	09:00 pm	DNS	H ₂ O	20ml		/					P		
	10:00 pm	5ml		20ml		/	✓				T		
	11:00 pm	KCL		20ml		/				68ml	E		
	12:00 am		H ₂ O	20ml		/					Line		
	01:00 am	↓		20ml		/					↓		
Total Intake :						Total Output :							
5/7	02:00 am	↑		20ml		/	✓				↑	[Signature]	
	03:00 am	DNS	H ₂ O	20ml		/					P		
	04:00 am	5ml		20ml		/				EC	motion		
	05:00 am	KCL	H ₂ O	20ml		/				100ml	P		
	06:00 am			20ml		✓					E		
	07:00 am	↓	H ₂ O	20ml		/					Line		
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

M=7

FLUID CHART

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Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
5/7	08:00 am					/				2		
	09:00 am	DNS +		20ml		/	✓			96ml		
	10:00 am	5ml		20ml		/	✓			90ml		
	11:00 am	KCL		20ml		/	✓			8300		
	12:00 pm			20ml		/	✓			43 stool		
	01:00 pm			20ml		/	✓			44ml		

Total Intake :

Total Output :

5/7	02:00 pm			20ml		/						
	03:00 pm			20ml		/						
	04:00 pm	DNS + milk		20ml		/				83ml		Chand
	05:00 pm	5ml		20ml		/	✓			33ml		Chand
	06:00 pm	1cc milk		20ml		/	✓			67ml		Chand
	07:00 pm			20ml		/	✓			18		

Total Intake :

Total Output :

5/7	08:00 pm			20ml		/	✓			94ml		
	09:00 pm			20ml		/						
	10:00 pm	DNS + milk		-		/	✓			83ml		Swara
	11:00 pm	5ml		-		/	✓			88ml		Swara
	12:00 am	KCL milk		-		/				287 stool		
	01:00 am			20ml		/						Swara

Total Intake :

Total Output :

6/7	02:00 am			20ml		/						
	03:00 am	DNS		20ml		/						Swara
	04:00 am	+ 5ml		20ml		/						
	05:00 am			20ml		/						Swara
	06:00 am	KCL		20ml		/	✓			68 stool		Swara
	07:00 am			20ml		/						Swara

Total Intake :

Total Output : V = 891 ml 2 motion.

Total 24 hrs. Intake

Total 24 hrs. Output

FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
06/7	08:00 am	↑ DNS + 5ml KCL ↓ 20ml		20ml	/	/	✓	/	/	110 motion	↑ PICC line	Shan
	09:00 am		20ml	78 motion								
	10:00 am		-	73 motion								
	11:00 am		20ml	44 motion								
	12:00 pm		20ml	0.53 motion								
	01:00 pm		20ml									
Total Intake :					Total Output :							
6/7	02:00 pm		20ml	/	/	✓	/	/	0.88 motion	/	Shan	
	03:00 pm	20ml	23+63 motion									
	04:00 pm	20ml	0.93 ml									
	05:00 pm	20ml	0.74 ml									
	06:00 pm	20ml										
	07:00 pm	20ml										
Total Intake :					Total Output :							
6/9	08:00 pm	↓ DNS + 5ml KCL /	20ml	/	/	✓	/	/	102 stool	/	Shan	
	09:00 pm		20ml						109 stool			
	10:00 pm		20ml						62 stool			
	11:00 pm		20ml									
	12:00 am		20ml									
	01:00 am		20ml									
Total Intake :					Total Output :							
6/8	02:00 am	↓ DNS + 5ml KCL /	20ml	/	/	/	/	/		/	Shan	
	03:00 am		20ml									
	04:00 am		20ml									
	05:00 am		20ml									
	06:00 am		20ml									
	07:00 am		20ml									
Total Intake :					Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

BAH-00652633 IP5-00175841
 Baby Of HARI PRIYA
 05-11-2025 0 Y 7 M 27 D (M)
 Dr. HARISH JAYARAM



NURSING CARE RECORD

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

BirthRight[™]
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 01/07/26

Assessment: Baby having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
10:20 PM	Assess the baby general condition and monitor the vitals and record.	10:30 PM	→ Assessed the baby general condition and monitored the vitals and recorded.	By doing all above procedure baby condition improving well.
12 AM	→ After the doctor review collect the history structure transverse colon slp resection and colostomy in apree	12:15 AM	→ After the doctor review collected the history structure transverse colon slp resection and colostomy in apree.	
2 AM	→ Plan for Colostomy closure. at 8:30am NPO at continue	2:10 AM	→ PAC & POC done	
3 AM	→ Reserve PRBC 15ml/kg.	2:45 AM	→ Planned for Colostomy closure at 8:30 am NPO at	
5 AM	→ Connect DMS @ 40ml/hr	3:30 AM	→ Reserved PRBC 15ml/kg	
6 AM	→ Ensure the safety needs.	5:30 AM	→ Connected DMS @ 40ml/hr	
7 AM	→ Shift to OT	6:30 AM	→ Ensured the safety needs.	
		7:30 AM	→ Shifted to OT	

Re-Assessment: Re-assessment done

Special Notes: Plan for colostomy closure @ 8:30am, NPO at, Reserve PRBC 15ml/kg, PAC and POC written.

Nurse Signature: Ravena

Nurse Name: Ravena

Date & Time: 02/07/26 @ 8am

Patient Details
 BAH-00652633 IP5-00175841
 Baby Of HARI PRIYA
 05-11-2025 0 Y 7 M 27 D (M)
 Dr. HARISH JAYARAM


NURSING CARE RECORD



☒ Day
☐ Night

Date:

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:



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 2/7/26

Assessment:

Acute 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
3pm	* Assess the pt General Condition	3pm	* Assessed the pt General Condition.	pt is Conscious & oriented
4pm	* Relieve pain & Discomfort	4pm	* Relieved pain & Discomfort	* pain reduced
5pm	* monitor vital signs	5pm	* monitored vital signs	* vital stable
6pm	* monitor for bleeding	6pm	* monitored for bleeding	* no vomiting
7pm	* maintain I/O chart	7pm	* maintained I/O chart	* maintained
	* maintain NPO status		* no vomit, water given	* no vomiting
	* provide psychological support		* provided psychological support	* supported
	* pt shifted to the ward		* pt shifted to the ward	* shifted

Re-Assessment:

Nil Operation 2nd only.

Special Notes:

Nurse Signature: *[Signature]*

Nurse Name: *Ding*

Date & Time: 17/26/26

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 02/07/26

Assessment: pt having some activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	*Assess The pt General condition	9pm	*Assessed the pt General condition	pt is stable
10pm	*check the pt vitals	11pm	*checked the pt vitals	
11pm	*maintain I/O chart	12am	*maintained I/O chart	
12am	*provide comfortable position	6am	*provided comfortable position	
7am	*administer all medication given as per doctor order	8am	*administered all medtication given as per doctor order	

Re-Assessment: N/A Aspiration 2nd hourly

Special Notes:

Nurse Signature: *

Nurse Name: Ravi

Date & Time: 03/07/26 8u

BAH-00652633
Baby Of HARI PRIYA
05-11-2025 0 Y 7 M 27 D
Dr. HARISH JAYARAM (M)
IP5-00175841

NURSING CARE RECORD

on ☒ Night

Date: 4/7/26.

Assessment:

Baby having mild infection related to his disease condition.

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.	8:05pm	⇒ Assessed the pt general condition.	By done all the procedures the baby condition is Improving.
10pm	⇒ provide the comfortable position.	10:05pm	⇒ provided the comfortable position.	
12AM	⇒ Check the vitals.	12:05AM	⇒ Checked the vitals.	
2AM	⇒ maintain I-V fluids.	2:05AM	⇒ Maintained I-V fluids DRL= 20ml/hr.	
4AM	⇒ Baby NPO continue.	4:05AM	⇒ Continued NPO.	
6AM	⇒ Continue nebulization.	6:05AM	⇒ Continued nebulization.	
	⇒ Continue NG aspiration qth hourly.		⇒ Continued NG aspiration qth hourly.	

Re-Assessment:

Re-assessment is done by checking vital signs.

Special Notes:

DRL + gail KCL = 20ml/hr, NPO continue, NG aspiration qth hourly, baby having PICC line do the picc line care.

Nurse Signature:

[Signature]

Nurse Name:

prameela (015802)

Date & Time:

4/7/26 @ 11AM.

BAH-00652633
Baby Of HARI PRIYA
05-11-2025 0 Y 7 M 27 D (M)
Dr. HARISH JAYARAM

IP5-00175841



NURSING CARE RECORD

☐ Night

Date: 04/04/26

Baby having mild pain at surgical site

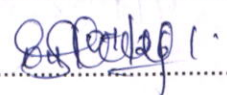
Goals

- | | | | | | |
|---|---|--|--|---|---|
| ☒ 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
8am	→ Assess the baby General condition	8am	→ Assessed the baby General Condition	By doing the all procedures's the baby condition is improved.
9am	→ provide comfort position	9am	→ provided comfortable position	
10am	→ monitor the vitals	10am	→ monitored the vitals	
11am	→ administer the all drugs as per doctor orders	11am	El Recorded it	
12pm		12pm	→ administered the all drugs as per doctor orders	
1pm	→ Baby having picc line	1pm	→ picc line care	
2pm	handle with care → ensure the safety	2pm	→ Ensured the safety & Pda & PIS	

Re-Assessment:

Special Notes: NG Removed and sponcho need to do picc line care

Nurse Signature: 

Nurse Name: Shariya (605567)

Date & Time: 04/04/26 (2pm)



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 4/7/26

Assessment: Baby having mild pain

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 baby.	2.30pm	Assessed the general condition of the baby.	Implemented all the procedure.
3pm	Administer medication as per doctor order.	3.30pm	Administered medication as per doctor order.	
4pm	Give nebulisation	4.30pm	Given nebulisation.	
5pm	check GRBS 8th hourly.	5.30pm	Checked GRBS hourly	
6pm	Monitor urine output	6.30pm	Monitored urine output	
7pm	Provide comfortable	7.30pm	Provided comfortable position	
7.30pm	Provide pice line care	7.30pm	Provided pice line care	

Re-Assessment: Implemented all the procedure.

Special Notes: GRBS 8th hourly

Nurse Signature: Merlin

Nurse Name: Merlin

Date & Time: 4/7/26 @ 8pm

BAH-00652633 IP5-00175841
 Baby Of HARI PRIYA
 05-11-2025 0 Y 7 M 29 D (M)
 Dr. HARISH JAYARAM



NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/26

Assessment: pain & 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 general condition of the patient.	8.10 pm	Assessed general condition of the patient.	By done as implementation, as per doctor's order.
10PM	Monitor vital signs.	10.5 pm	Monitored vital signs.	
12PM	To give nebulization.	12pm	Given nebulization.	
6AM	Administer medication as per doctor's order.	6AM	Administered medication as per doctor's order.	
	To give pice line care.		Given pice line care.	
7AM	Maintain I/O chart.	7.30 AM	Maintained I/O chart.	

Re-Assessment: Re-Assessment done by checking vital.

Special Notes: 2nd hourly 5ml ORS orally to give

Nurse Signature: P.B

Nurse Name: Poojanika

Date & Time: 5/7/26 8AM



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/2/25

Assessment: pt having having pain in the 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
8 AM	Assess the pt general condition.	9 AM	Assessed the pt general condition	By doc all implementation as per order
9 AM	monitor vital sign	10 AM	monitor vital sign	
10 AM	maintain IO chart	11 AM	maintained IO chart	
11 AM	provide comfortable position	12 PM	provided comfortable position	
12 PM	provide hand hygiene as per order	1 PM	provided hand hygiene Administered medication	

Re-Assessment:

Special Notes: 2nd hourly ifeed

Nurse Signature: [Signature]

Nurse Name: Sudhina 0777121

Date & Time: 5/2/25 @ 2 PM

BAH-00652633 IP5-00175841
 Baby Of HARI PRIYA
 05-11-2025 0 Y 7 M 29 D (M)
 Dr. HARISH JAYARAM



NURSING CARE RECORD

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

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 Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/7/26

Assessment: pt having dull activity

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the pt General Condition	2:10pm	→ Assessed the pt General Condition	pt is stable
4pm	→ Check the Vital Signs	4:10pm	→ Checked the Vital Signs	
6pm	→ Plan for Administration medication	6:10pm	→ Providing medication as per doctor Order	
8pm	→ Plan for I/O Chart	8:10pm	→ Maintaining I/O Chart	
	→ Plan for Comfortable Position		→ Providing Comfortable Position	

Re-Assessment: Re-Assessment Every 4th hrly

Special Notes:

Nurse Signature:

Nurse Name: Chandana

Date & Time: 5/7/26 2pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: Baby having pain 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 general condition of the baby	8:10 pm	Assessed the general condition of the baby.	By done all procedure baby condition is Improved.
10 pm	Monitor the vitals signs	10:15 pm	Monitored the vitals signs.	
2am	provide comfortable position.	5am	provided comfortable position	
6am	To give INJ PCM & maintain I & O chart	6:30 am	given INJ PCM 150mg & maintained I & O chart	
8:30 am	Administer medication as per doctor order	8am	Administered medication as per doctor order	

Re-Assessment:

After giving INJ PCM pain was reduced

Special Notes:

After giving INJ pain 8th hourly G.R.B.S -> Nebulization

Nurse Signature: 

Nurse Name: Swarna

Date & Time: 6/7/26 @ 8am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 06/07/2025

Assessment: Baby having mild pain at Surgical site and loose stools

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the baby general condition	8am	→ Assessed the baby general condition	By doing the all procedures the baby condition is improved slowly.
9am	→ provide comfort position	9am	→ provided comfortable position	
10am	→ Baby having mild pain and allow orally feeding and hourly	10am	→ Baby having orally allowed and hourly.	
11am	dom	11am	→ picc line flush going on	
12pm	→ Baby having picc line	12pm	→ administered the all drugs as per doctor orders	
1pm	→ administer the all drugs as per doctor orders	1pm		
2pm	→ Ensure the safety	2pm	→ Ensured the safety side rails	

Re-Assessment:

Special Notes:

Done by giving fluid balance and feeding and Baby having picc line and heparin flush (1ml/hr) and dressing need to do today.

Nurse Signature:

Sharuf

Nurse Name:

Sharajia (605567)

Date & Time:

06/07/25 (2pm)



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 6/7/2025

Assessment: Baby having discomfort.

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the general condition of the baby.	2.30pm	Assessed the general condition of the baby.	Implemented all the procedure
3pm	Administer medication as per doctor order.	3.30pm	Administered medication as per doctor order.	
4pm	Encourage to take orally	4.30pm	Encouraged to take orally.	
5pm	Monitor urine output	5.30pm	Monitored urine output	
6pm	Monitor vital signs.	6.30pm	Monitored vital signs.	
7pm	Give nebulisation	7pm	Refused nebulisation.	

Re-Assessment:

Special Notes: GRBS TCD.

Nurse Signature: Meshin Nurse Name: Maelin Date & Time: 6/7/2025 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6/12/26

Assessment: Pt having 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
8PM	→ Assess the pt General condition	8PM	→ Assessed pt General condition	pt condition is normal
1PM	→ monitor vital signs	1PM	→ monitored vital signs	
2AM	→ maintain I/O chart	2AM	→ maintained I/O chart	
8AM	→ Administered the medications as per doctors orders.	8AM	→ Administered the medications as per doctors orders.	

Re-Assessment: Nil

Special Notes:

Nurse Signature: (Signature)

Nurse Name: Sathya

Date & Time: 7/12/26 8AM

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Harish Jayaram Department: CR Date of Admission: 11/2/26

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known		If Yes Specify:	
BACKGROUND	Area	Taparotomy					
	Shift Time	CR 10:15pm	1st Floor 10:30 PM - 8am	OT 8am-4:30pm	ICU 8am-4:30pm	ICU 8am-4:30pm	ICU 8am-4:30pm
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
RECOMMENDATIONS	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp: 98.2°F	98.1°F	98.6°F	98.1°F	98.5°F	98.3°F
	Res:	34b/m	28b/m	25b/m	18b/m	28b/m	28b/m
	SpO ₂ :	100%	100%	100%	99%	99%	99%
	Pulse:	122b/m	110b/m	116b/m	120b/m	110b/m	110b/m
	BP:	72/63	73/62	84/42	100/60	100/60	108/62
	Fall Risk Score:	13	13	13	13	13	13
	Pain Score:	0/10	0/10	1/10	0/10	0/10	0/10
Other Special Orders / Medications:	Safety Needs:	Yes	Yes	Yes	Yes	Yes	Yes
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:	Yes	Yes	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 :		Shavani	Ravina	Ravina	Ravina	Such	Omig
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		11/2/26	11/2/26	11/2/26	11/2/26	11/2/26	11/2/26
Time:		10:15pm	@ 8am	@ 1:30pm	@ 8am	2pm	2pm
Taken Over By Name :		Ravina	Kalyan	Ravina	Such	Omig	Praveen
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		11/2/26	11/2/26	11/2/26	11/2/26	11/2/26	11/2/26
Time:		@ 10:30pm	@ 10:30pm	@ 10:30pm	@ 10:30pm	@ 10:30pm	@ 10:30pm

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. H J Department: surgeon Date of Admission: 11/4/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:						
	<u>Laparotomy.</u>								
BACKGROUND	Area	Shift Time	<u>1st Floor</u> <u>8pm - 2am</u>	<u>1st Floor</u> <u>8am - 2pm</u>	<u>1st Floor</u> <u>2pm - 8pm</u>	<u>1st Floor</u> <u>8pm - 8am</u>	<u>1st Floor</u> <u>8am - 2pm</u>	<u>1st Floor</u> <u>2pm - 8pm</u>	
	Medical Condition (Any special condition to be noted):		<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:		Temp:	<u>98.3°F</u>	<u>98.6</u>	<u>98.8</u>	<u>98.4°F</u>	<u>98.0°F</u>	<u>98.3°F</u>
			Res:	<u>24/hr</u>	<u>28/hr</u>	<u>28/hr</u>	<u>26/hr</u>	<u>27/hr</u>	<u>26/hr</u>
			SpO ₂ :	<u>100%</u>	<u>99%</u>	<u>99%</u>	<u>100%</u>	<u>99%</u>	<u>99%</u>
			Pulse:	<u>126/bm</u>	<u>123/bm</u>	<u>120/hr</u>	<u>116/bm</u>	<u>130/bm</u>	<u>116/hr</u>
			BP:	<u>93/53</u>	<u>100/60</u>	<u>100/59</u>	<u>101/67</u>	<u>89/50</u>	<u>90/60</u>
			Fall Risk Score:	<u>13</u>	<u>13</u>	<u>13</u>	<u>13</u>	<u>13</u>	<u>13</u>
Recommendations	Pain Score:		<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>1/10</u>	<u>1/10</u>	<u>0/10</u>	
	Safety Needs:		<u>side rails</u>	<u>yes</u>	<u>yes</u>	<u>side rails</u>	<u>side rails</u>	<u>yes</u>	
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:		<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:		<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :		<u>Praneel</u>	<u>Shrey</u>	<u>Merlin</u>	<u>Pratyanka</u>	<u>Sushra</u>	<u>Chandana</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7</u>	<u>5/7</u>	<u>5/7</u>	<u>5/7/26</u>		
Time:		<u>8AM</u>	<u>(2pm)</u>	<u>@8pm</u>	<u>8AM</u>	<u>2pm</u>	<u>8pm</u>		
Taken Over By Name :		<u>Shrey</u>	<u>Merlin</u>	<u>Pratyanka</u>	<u>Sushra</u>	<u>Chandana</u>	<u>Swarna</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>4/7</u>	<u>4/7</u>	<u>4/7</u>	<u>5/7</u>	<u>5/7/26</u>	<u>5/7/26</u>		
Time:		<u>@8am</u>	<u>@2pm</u>	<u>8pm</u>	<u>8AM</u>	<u>@2pm</u>	<u>8pm</u>		

RSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. HJ Department: Surgeon Date of Admission: 11/7/26

SITUATION	Diagnosis: <u>Laporaotomy +</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
	Area	Shift Time	1st Floor 8pm - 8am	1st Floor 8-10am PM	1st Floor 8am - 8pm		
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>		
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	<u>96.5</u>	<u>98.0 F</u>	<u>95.5 F</u>		
		Res:	<u>28</u>	<u>30b/m</u>	<u>28b/m</u>		
		SpO ₂ :	<u>99%</u>	<u>98%</u>	<u>100%</u>		
		Pulse:	<u>110</u>	<u>122b/m</u>	<u>105b/m</u>		
		BP:	<u>99/64</u>	<u>116/60</u>	<u>109/59</u>		
		Fall Risk Score:	<u>13</u>	<u>13</u>	<u>13</u>		
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>				
Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>yes</u>			
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>			
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>			
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>			
Handed Over By Name :		<u>Swarnag</u>	<u>Shailaja</u>	<u>Swarnathi</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>6/7/26</u>	<u>6/07</u>	<u>7/7/26</u>			
Time:		<u>8am</u>	<u>(2pm)</u>	<u>8pm</u>			
Taken Over By Name :		<u>Shailaja</u>	<u>Nerlin</u>	<u>Swarnag</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>6/07</u>	<u>6/7/26</u>	<u>7/7</u>			
Time:		<u>8am</u>	<u>8pm</u>	<u>@ 8am</u>			

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area							
	Shift Time							
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
		Fall Risk Score:						
		Pain Score:						
	Recommendations	Safety Needs:						
Physiotherapy		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Others Specify:								
Special Diet:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Other Special Orders / Medications:								
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature :								
Date:								
Time:								
Taken Over By Name :								
Signature :								
Date:								
Time:								

THE HUMPTY DUMPTY SCALE

617 217

PARAMETER	CRITERIA	SCORE	DATE	DATE	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	2	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			13	13			

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 :		Grunth	Granth			
Signature :		Grunth	Granth			
Date :		01/11/25	01/11/25			
Time :		5:00 AM	08:00 AM			

MEMORANDUM FOR THE RECORD

DATE: 1/13

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

19. [illegible]

20. [illegible]

Pat



THE HUMPTY DUMPTY SCALE

2/07 3/07 4/7 5/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	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	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2	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	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	1
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
TOTAL			13	13	13	13	13

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	no	no	no
Other Intervention(s) Specify	no	no	no	no	no
Nurse's Name :	Shwini	Ravina	Ravina	Pran	Pran
Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :	1/7	2/07	3/07	4/7	5/7
Time :	10 PM	6 AM	11	6 AM	6 AM

BAH-00652633

IP5-00175841

Baby Of HARI PRIYA

08-11-2025

0 Y 7 M 26 D

(M)

Dr. HARISH JAYARAM



PAIN ASSESSMENT FORM

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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
1/7/26	10pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Shan
02/07/26	5am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Paula
2/7/26	12:20 pm	1/10	SS	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Shan
2/07	8pm	1/10	xy	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Pen
3/07	uor	1/10	xy	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Pen
3/7	2pm	0/10	wo	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Sub
3/7	10pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NIL	prameela
4/7	6AM	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NIL	prameela
4/7	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shan
4/7	10pm	1/10	OP site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Ty . PCM	Priyanka

Re-assessment Frequency:

1. Every eight hours for all hospitalized patients.

2. For post-surgical patients, patients with chronic pain, patient with severe pain:

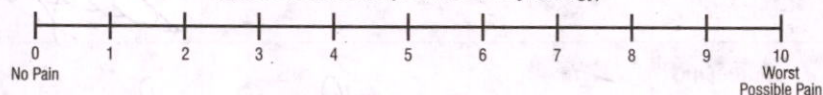
- At least every 2 hours for the first 24 hours
- Then every 4 hours.
- Prior to pain relieving intervention.
- Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

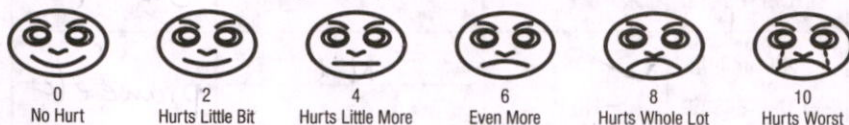
FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years



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

BAH-00652633

IP5-00175841

Baby Of HARI PRIYA

05-11-2025 0 Y 7 M 29 D (M)

Dr. HARISH JAYARAM



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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
5/7	6 AM	1/10	Sp site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Put PCM comfortable position	Priyanka
5/7	11 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sushra
5/7	6 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chandona
6/7	2 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sow
6/7	10 am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shaiyaf
6/7	6 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
7/7	2 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
	10 AM			☐ 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:

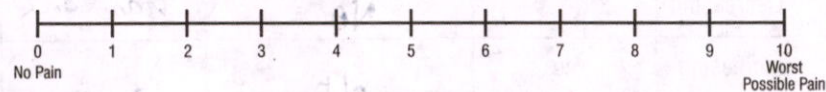
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

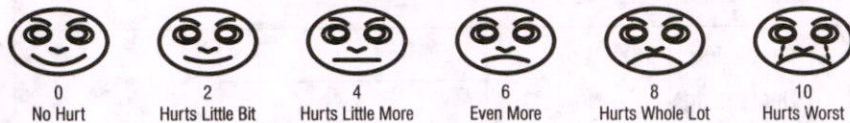
Numerical Pain Scale (Obstetric and Gynecology)



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



BAH-00652633 IP5-00175841
 Baby Of HARI PRIYA
 08-11-2025 0 Y 7 M 26 D (M)
 Dr. HARISH JAYARAM



BRADEN 'Q' SCALE

				Date :	11/11/25	02/12/25	03/01/26	04/11/25
				Time :	10 AM	10 AM	10 AM	6 AM
Mobility	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
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
TOTAL SCORE					24	28	24	28
Evaluator's Name					Shweta	Shweta	Shweta	pran

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

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

BAH-00652633

IP5-00175841

Baby Of HARI PRIYA

05-11-2025

0 Y 7 M 29 D

(M)

Dr. HARISH JAYARAM



BRADEN 'Q' SCALE

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Hospital
It takes a lot to treat the little.

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					Date :	5/7	6/7	7/7	
					Time :	6 AM	6 PM	6 PM	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:xtremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4		
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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		
					TOTAL SCORE	27	27	27	
					Evaluator's Name	Pranav			

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)
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CHECKLIST FOR THROMBOPHLEBITIS

7/7/26

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	P									
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	C									
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	C									
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	C									
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	i									
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	e									
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 : [Signature] Name : pulakesh

Signature of Ward In Charge :

Signature : [Signature] Name : neeraj



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	4/07 DAY-1			5/7 DAY-2			6/7 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	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				Sheep Malik, Priyanka, Anshu, Gopal, Sita									

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 : Pulak Name : Pulak

Signature of Ward In Charge :

Signature : Neel Name : Neel

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			3/7 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	—
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	ER		—	—	—	—	—	—	—	—
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													—

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 : Pulakesh Name : Pulakesh

Signature of Ward In Charge :

Signature : Neeraja Devi Name : Neeraja Devi

Patient Sticker

BAH-00652633 IP5-00175841

Baby Of HARI PRIYA

05-11-2025 0 Y 7 M 26 D (M)

Dr. HARISH JAYARAM



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Your Right to a Safe Delivery

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

- | | | | |
|----------------------------|--|--|---|
| 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		
1/7	10pm	2	Infection control measure	M	1	0	1	1	—	Blind
2/7/26	5pm	9	APPTAMPIL PEPTP (1:30ml) Injection. T stage 1 weaning foods.	M	1	0	1	1	—	Mander

Part - III: CODES

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

MULTI-DISCIPLINARY PLAN OF CARE FORM

BAH-00652633 IP5-00175841

Baby Of HARI PRIYA

05-11-2025 0 Y 7 M 26 D (M)

Dr. HARISH JAYARAM



Diag

TIME		ype	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
1/7/26 10pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Laparotomy	stabilis	Npo Iv fluids	Harish	☐ Nursing ☒ Others:
1/7/26 10pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Laparotomy	Hemodynamic stability	Iv fluids Npo	Shavan	☐ Medical ☒ Others:
2/7/26 12pm	☐ Medical ☐ Nursing ☒ Others: Dilution	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Colostomy Closure	Aptambl pept (1:30ml) dilution	<u>RDA</u> E:- 98 kcal/kg/d P:- 1.8g/kg/d	moan	☐ 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:

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

BAH-00652633 IP5-00175841
Baby Of HARI PRIYA
05-11-2025 0 Y 7 M 26 D (M)
Dr. HARISH JAYARAM

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Name: Age: Sex: UHID.No :
Date: 11/11/26 Time: 10-40 PM Proposed Operation: Colostomy closure.
Diagnosis: S/P Rupture + Colostomy
B.P / CRT: H.R: 138/min Weight: 10kg ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 13.7 Glucose: Protein: HIV: X-Ray:
PCV: Urea: Alb: HBS Ag: ECG:
WBC: 10750 Creat: Total Bill: HCV: 2D Echo:
Plate: 517 Na: 134 Dir. Bill: Blood group: Stress/Angio:
PT: 15 K: 4.6 LDH: T3: Other:
PTT: 44.17 Ca++: Alk phos: T4:
INR: Mg++: Amylase: TSH:
Cl: 105 SGOT/SGPT:
Breathing difficulty - severe RS

Allergies: No known allergy

Medical History: CVS: CHD - S/P balloon valvuloplasty
RESP: - no cough, cold, fever
CNS: -
Renal: -
Hepatic / GE: -
Others: -
Diabetes: term BVV 2.5 kg
NEC 1 day 20 days - 23 days

Physical Activity: -

Past Anaesthetic History: colostomy on 2/4/2026 at Rainbow for - admission 4 days

Physical Exam: S/P pul valve perforation and PRVC 10 Nov 2025 - 6 days

Airway: MP 1 2 3 4 Mouth Opening: Mentohyoid Distance: Neck: Teeth:
Lungs:
Heart:
CNS:
Pregnant: ☐ Yes ☐ No ☒ NA Venous Access Site: Spine Exam for regional:
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
 Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☐ Discussed with Patient
- Other Instructions:

Signature: Name: Dr. Ardit N

→ CBC, INR, serum electrolytes
→ Reserve 15ml/kg of PRVC

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H.R:	131	B.P/CRT:	74/46	SpO ₂ :	98%	R.R:	22/min	Last Feed:	>4hrs
Pre-OP Diagnosis:					SLP Colostomy for Stricture		Operation:		Colostomy Cleanse
Surgeon:					Dr. H. Sathish		Date:		21/5/20
Anaesthesiologist:					Dr. Sathish / Dr. Akhila		Technician:		Srishta

Antibiotic
metazyl
Suppository
—
Blood Loss

NOTES

MAR 50th

85 (53)

37



LAB Values

☒ Equipment Checked and Functional ☒ BP ☒ Cuff Site: <u>R. FL</u> ☐ Art Site: ☒ EKG Lead ☒ Temp Site: <u>oral</u> ☒ FIO ₂ Monitor ☒ Agent Monitor ☒ Pulse Oximeter ☒ Capnograph ☒ Ventilator ☐ Nerve Stimulator Position: <u>Supine</u> ☒ Pressure Points Checked	Temp: ☒ AWE ☒ Fluid Warmer ☐ Cling Film ☒ OH Warmer ☒ Hugger's ☒ Cotton Wool ☐ Other Times: Anaes Start: <u>8:45 AM</u> OP Start: <u>9:55 AM</u> OP End: Leave OR: <u>12:15 pm</u> Anaesthesia: ☒ GA ☐ Monitored Anaesthesia Care ☒ Regional Line (Size & Location) ☐ CVP: ☐ ART: ☒ IV: <u>R. UL 22g</u> ☒ IV: <u>R. UL PICC line</u> ☐ IV:	Induction ☒ IV ☒ Inhal ☒ Pre O ₂ ☐ RSI ☐ Others ☐ Mask ☐ SGA ☐ Airway ☐ Oral ☐ Nasal ETT# <u>2.5</u> at <u>10</u> cm ☒ Oral ☐ Nasal ☐ Cuff ☐ Tracheostomy ☐ Topical ☐ Drug: <u>ROCURONIUM</u> ☐ Awake ☒ Direct Vision ☐ Video Laryngoscopy ☐ Stylette / Bougie ☐ Fiberoptic Blade # <u>MAC2</u> Attempts: <u>1</u> Difficulty Why? ☒ Bilat = BS ☐ Semi-Closed Circle ☒ Closed Circle ☐ Other	Regional: Extremity Specify: ☐ Spinal ☐ Epidural ☒ Caudal Others: Position: <u>lateral</u> Site: <u>Sacral hiatus</u> Needle Size: <u>21G QB</u> Depth: <u>1cm</u> Parasthesia ☐ Yes ☒ No Catheter at skin cm Drug Name & Conc: <u>0.25% Bupivacaine</u> <u>10ml</u> Bolus: Infusion: Block Level: <u>Adequate</u> Comments: Transportation to ☒ PACU ☐ ICU ☐ Other Relaxant Reversed ☒ Yes ☐ No ☐ NA Name of the Doctor: <u>Dr. Archies - A</u> Signature of the Doctor: <u>[Signature]</u>
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POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Dr. Aravind

Time Received : 12:10 AM Time Discharged :

BLOOD PRESSURE PULSE RESP	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>376</u> ☐ O ₂ Mask ☐ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway Vomiting : ☐ Yes ☒ No Drug : NG Tube : ☐ Yes ☒ No Drain : ☐ Yes ☒ No Urinary Catheter : ☐ Yes ☒ No Chest Tube : ☐ Yes ☒ No Nil Oral ☐ Yes ☒ No IV Fluids : Oral Feeds :
	(Graph area with handwritten data points for BP, Pulse, and Resp)		

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						
Able to move 0 extremities voluntary or on command	= 0						
Able to deep breathe & cough freely	= 2	RESPIRATION	1	1	2	2	
Dyspnea or limited breathing	= 1						
Apneic	= 0						
BP ± 20 of Pre Anaesthetic level	= 2	CIRCULATION	2	2	2	2	
BP ± 20-50 of Pre Anaesthetic level	= 1						
BP ± 50 of Pre Anaesthetic level	= 0						
Fully awake	= 2	CONSCIOUSNESS	1	1	2	2	
Arousable on calling	= 1						
Not responding	= 0						
Pink	= 2	COLOR	2	2	2	2	
Pale, dusky, blotchy, jaundiced, other	= 1						
Cyanotic	= 0						
TOTAL			8	8	9	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
21/11/2025	12:20 PM	1/10	—	Dr. Aravind

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

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

Anaesthesiologist Name : Dr. Aravind

Anaesthesiologist Signature: [Signature]

Date & Time: 21/11/2025

PACU Nurse Name : [Signature]

PACU Nurse Signature: [Signature]

Date & Time: 21/11/2025

Transferred to Unit by (PACU): 10/1

Date & Time: 21/11/2025

Patient Sticker

EPIDURAL ANALGESIA RECORD

b)

[illegible]

Date and Time :