

ADMISSION SHEET

Registration Details :


Admission No : IP5-00174354 **Admit Date** : 26-May-2026 **Admit Time** : 09:30 PM **UHID** : BAH-00607743

Patient Details :

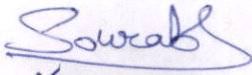
Patient Name : Baby Of KEERTI GUPTA (SHREY AGARWAL)	Age : 1 Y 6 M 10 D
Guardian : Mr SOURABH JODHANI	DOB : 16-11-2024 02:53 PM
Gender : Male	Religion :
Occupation :	Martial Status : Single
Address (H) : FLAT NO 301, BLOCK B, HIMA SAI APARTMENT, NEAR PILLAR NO 135 Attapur Hyderabad Telangana INDIA 500048	Phone No : 8222916726/ 7838661717
	E-mail : SOURABH.JD@GMAIL.COM

Admission Details :

Bed Type : SEMI PRIVATE **Bed No** : SPVT331-(1) **Ward Name** : 3F-ZONE C
Room No : SPVT331-(1) **Admission Type** : First Visit

Contact Details :

Name : Mr SOURABH JODHANI **Relationship** : Father
Contact Address : FLAT NO 301, BLOCK B, HIMA SAI
APARTMENT, NEAR PILLAR NO 135 Attapur
Hyderabad Telangana INDIA 500048 **Phone No** : 7838661717 / 7838661717


Signature

Doctor Details :

Doctor Name : Dr. SANDEEP REDDY **Specialisation** : GENERAL PEDIATRICS
Referral Doctor : SELF **Phone No** :
Cc-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00
Payor Name : VIDAL HEALTH INSURANCE TPAPVT LTD

ACTIVITY RECORD FOR BILLING

Name : _____

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

Date of Admission: _____ T _____ Charge : _____ Time: _____

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

BAH-00607743 IP5-00174354
Baby Of KEERTI GUPTA (SHREY)
16-11-2024 1 Y 6 M 10 D (M)
Dr. SANDEEP REDDY



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
26/5	10:30 / 14	CR	331-1	Kanadey

Cross Consultation Visit

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

BAH-00607743 IP5-00174354
 Baby Of KEERTI GUPTA (SHREY)
 16-11-2024 1 Y 6 M 10 D (M)
 Dr. SANDEEP REDDY



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor: Dr. Sandeep

Date: 26/5/26

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

Start Time of Assessment: 8:30 PM

Weight: 11 kg

Allergic History: 0

Chief Complaints:
no fever since evening
alw. ep. of paroxysmal activity - head bobbing
cy jerky movements and jaw clenching - 2 min
Alert now

Pediatric Assessment Triangle

A Appearance - TICLS 1

B Breathing

C Circulation

Normal
 Abnormal

↑ WOB
 ↓ WOB
 Normal
 Gasping / Apnea

Pallor
 Cyanosis
 Mottling
 Bleeding

Initial Physiological Status: Stable Unstable
 Life Threatening
 Non Life Threatening

Any urgent interventions needed: Yes No
 If Yes

Significant Past History: 0

Medication History: 0

Relevant Investigations: 0

Primary Assessment

Airway Open
 Maintainable
 Not Maintainable

Breathing

Rate: 20/min SpO₂ on FiO₂: 98%
 Rhythm: regular IRA
 Retractions: Suprasternal ICR SCR
 Sternal Supraclavicular Nasal Flaring
 Respiratory Noises: Stridor Wheezing Grunting
 Air Entry: BAE ⊕
 Palpation Findings (if necessary)

Any urgent interventions needed: Yes No
 If Yes



Circulation

HR: 26/min

CFT [Central] 22 sec
Peripheral

Any urgent interventions needed: Yes No

If Yes

BP: mmHg

Murmurs: Yes No

Pulse Volume: [Central] good
Peripheral

Liver Span:

If in Shock: [Compensated]
[Hypotensive]

ECG:

Muffled Heart Sound: Yes No

Any Signs of Heart Failure: Yes No

Engorged Neck Veins: Yes No



Disability

GCS: 15/15

AVPU: Alert

Any urgent interventions needed: Yes No

If Yes

Pupils: [Responsive Non-Responsive]
Size [Right] equal
Left

Active Seizures: Yes No Sugars:

Signs of Neurological compromise

Exposure



Temp.: 100.1°F

Any urgent interventions needed: Yes No

If Yes

Any Rash: Yes No

If yes describe the rash

Active bleed

Lacerations Abrasions bruises

Describe:

Final Physiological Status: Respiratory Distress Respiratory Failure Respiratory Arrest
 Shock - Compensated Hypotensive
 Cardiopulmonary Arrest Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings: (N)

Labs Planned: CBP
CRP
S. Calcium, Magnesium, Phosphorus
Rz
Blood U/S
S. Electrolytes
RBS

Treatment Planned: 1g CEFTRIAXONE
Am. Pcm QID
Am. PANTOPRAZOLE
Am. ONDENSETRON
T. Syp. FRISIUM

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

Final Diagnosis with possible Differential Diagnosis (If necessary): febrile Seizure

Assessment done by
Name of the Doctor: Sainthi

Sr. Doctor on Duty (If necessary)
Name of the Sr. Doctor: Dr. Anurag

Signature: [Signature]

Signature: [Signature]

Date & Time: 26/5/26

Date & Time: 26/5/26



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00607743 IP5-00174354
Baby Of KEERTI GUPTA (SHREY
16-11-2024 1 Y 6 M 10 D (M)
Dr. SANDEEP REDDY



Patient Name:

B/o Keerthi Gupta

UHID ID:

Department:

Consultant:

BAH-00607743

IP5-00174354

Baby Of KEERTI GUPTA (SHREY

16-11-2024 1 Y 6 M 10 D (M)

Dr. SANDEEP REDDY



Pediatric Multiorgan History & Physical Examination

Name : B/o Keerthi Age/Sex 6M 1yr/M.

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

c/o fever: 1 day
also rep of paroxysmal activity

History of present illness :

Premorbidly well child,
c/o fever since today evening.
not documented, not also chills.
not also cough, cold, vomitings, loose stools.

c/o episode of paroxysmal activity -
head bobbing, jerking movements of the body
and clenching of jaw.
not responding to parents, no LOC.
episode lasted for 2 minutes, subsided on its
own. no post ictal confusion or drowsiness.

No family H/o Seizures.
No H/o previous such episodes.
Sw Now, interacting with parents.



Pediatric multiorgan history & Physical Examination

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

②

Birth & Neonatal History:

FT/Ⓜ perinatal transition



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Developed as per age

Immunization History :

Immunised as per age.



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 10kg (Centile _____)

On Examination :

Temperature : 100.1°f Pulse Rate : 140/min B.P. _____ SPO2 98%

Resp. rate and type of breathing : 26/min

Rash _____
Lymphadenopathy ⊖ throat healthy
Oedema : _____
Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____
Air entry & breath sounds : B.A.G. ⊕ clear
Any added sounds : cr. ⊖
Relevant data from outside (Chest X-Ray, ABG, etc.,) /

Cardiovascular System :

Inspection of precordium : _____
Heart Sounds : S₁S₂ ⊕
Any murmur : ⊖
Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : _____

Per Abdomen :

Inspection _____
Palpation : Soft, NT
Auscultation : Bowel sounds ⊕
Spine : ⊖ External Genitalia : _____
Relevant data from outside (CT, USG etc.,) /



Systemic multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15/15

Cranial Nerves : (N)

*no meningeal signs
no s/o focal neurological deficit.
sensory Normal.*

Motor System:

Nutrition : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

NAD.

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : Regular

Clinical Summary & Diagnostic:

AF 12 1st episode of febrile seizure.



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: to prevent further seizures.

Desired goals of the treatment: Hemodynamic stability.

Planned Labs:
CBP
CRP
Blood C/S
S. Electrolytes
S. Calcium, magnesium
Phosphorus
AP2
RBS
MB Amud
26/05/20

Planned Management
Aug Ceftriaxone
Aug PCM QID
Aug Pantoprazole
Aug Ondansetron
T. folicium
MB Amud
26/05/20

Signature of the Doctor: [Signature]
Name of the Doctor: Sahiltri
Date & Time: 26/5/20 8:45 AM

Signature of the Consultant: [Signature]
Name of the Consultant: [Signature]
Date & Time: [Signature]

Dr. Venkat Sandeep Reddy, K
Reg. No: TSMC/FMR/15713
26/5/20



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/26 11:45 PM	Seen by Resident	
	Aft 1st episode of febrile seizures.	
O/E	child asleep, afebrile hemodynamically stable.	Plan:
No focal neurological deficits.	labs reviewed.	1. Continue medications as charted.
K → 5.1 mmol/L.	Bicarbonate → 16 mmol/L.	2. LEVOLIN nebulisation 0.6g mg stat. (x2)
		3. IV fluids @ 2/3rd maintenance.
		4. Monitor vitals & watch for further episodes of seizures noted by Phys 12 AM Sathini
27/5/26	C/S/B Resident (Dr. Nandan)	
9 AM	D: Simple febrile seizure (1st episode)	Plan
On Room Air	Hemodynamically stable	- Continue ceftriaxone (C ₂)
No fresh rashes.	No fever spikes	- Continue Medications as per chart.
No seizures		- W/S fever / seizure
		- STOP Ondansetron, Paracetamol
		- SOS Paracetamol - Monitor vitals

BAH-00607743 IP5-00174354
 Baby Of KEERTI GUPTA (SHREY)
 16-11-2024 1 Y 6 M 11 D (M)
 Dr. SANDEEP REDDY



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/05/2026 12pm	C/S/B Dr. sandeep sir	
	D- 1st episode of Simple febrile seizure	Plan = send CXR now
	- on Room Air - Hemodynamically stable	- Plan discharge in the evening if stable
	- No fresh issues - 1 fever spikes at 11 AM	- Monitor vitals
		- watch for fever spikes
		Noted by stlyr @12:10pm
		(Dr. Sandeep)
		Dr. Venkat Sandeep Reddy. K Reg. No. TSMC/EMR/15713



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/05/26 5pm	C/S/B	Dr. Nandan (Resident)
	D: AFI (D ₂) - First episode of simple febrile seizure	Plan - send CUE, ^{urine} C/S ^{now}
	2 fever spikes since morning 100.2°f at 11AM 101.5°f at 4PM	- Continue medication as per chart INS. CEFTRIAXONE - D ₂
	Hemodynamically stable on Room Air Active & alert	- Monitor vitals - w/o fever spikes/seizures
		<p><u>Nanda</u> (Dr. Nandan)</p> <p>Dr. Prater</p>
		<p>Noted by chilpa. 8.10pm.</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/05/2026 8.30AM	C/S/B Resident (Dr. Nandan)	
	<p>10: AFI (Acute febrile illness - D3) / First episode of simple febrile seizure</p> <ul style="list-style-type: none"> - Probable UTI - On Room Air - Hemodynamically Stable - Ongoing fever spikes & fever spikes in last 24 hrs 100.2°f - 11AM 103.5°f - 7.40 AM 102.1°f - 12.30 AM 100.8°f - 6 AM - Good oral intake - Active child 	<p><u>Plan</u></p> <ul style="list-style-type: none"> - Continue CEFTRIAXONE-D₃ CLOBAZAM-D₃ - continue medications as per chart - Monitor vitals - Watch for fever spikes/seizure - Trace final bloods, Urine c/s
		<p><u>Dr. Nandan</u> (Dr. Nandan)</p>

BAH-00607743 IP5-00174354
 Baby Of KEERTI GUPTA (SHREY
 16-11-2024 1 Y 6 M 12 D (M)
 Dr. SANDEEP REDDY



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/05/2024 11 AM	C/S/B Dr. Sandeep sir	
	D. Acute febrile illness (D3) with simple febrile seizure	<p>Plan</p> <p>- continue medications as per chart</p>
	on room air Hemodynamically Stable	<p>- Use abdomen now to look for cystitis</p>
	- Ongoing fever spikes @	<p>- Plan Discharge in the evening if stable & no high grade fever spikes</p>
	- NO fresh issues.	<p>- Trace final blood & urine c/s</p>
		<p>Noted by Shilpa @ 11:20 AM</p>
		<p>Dr. Venkat Sandeep Reddy - K Reg No: TSMC/FMR/15713</p>
		<p><i>[Handwritten signature]</i></p>

BAH-00607743 IP5-00174354
 Baby Of KEERTI GUPTA (SHREY)
 16-11-2024 1 Y 6 M 12 D (M)
 Dr. SANDEEP REDDY



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/11/26	D/w Dr. Sandeep SIB Resident	plan.
2:30pm	4: febrile seizure prophylaxis	1) Discharge at Request
	USG Abdomen - few GB calculi rest normal	on
	vitals stable	Symp. Augment oral BP
	child alert / active / playful.	Lanzol
		febrile seizure prophylaxis
		Follow up with Dr. Sandeep.
		with pediatric surgeon } after 3 days.
		Noted by shelpa
		@ 2:40pm Madhu

BAH-00607743 IP5-00174354
 Baby Of KEERTI GUPTA (SHREY
 16-11-2024 1 Y 6 M 10 D (M)
 Dr. SANDEEP REDDY



Pati



RESULT SHEET

Date	26/5/26			
Time	11pm			
Hb	11.7			
PCV	35.9			
RBC	5			
WBC	8.89k			
N/L	53/34			
Platelets	3.13L			
CRP	5			
ESR				
PCT				
FBS	97			
Na	141			
K	5.1			
Cl	106			
Ca/Mg	10/2.5			
Phosphate	6.9			
Urea	31			
Creatinine	0.5			
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	HCO3	16		

BAH-00607743 IP5-00174354
 Baby Of KEERTI GUPTA (SHREY
 16-11-2024 1 Y 8 M 10 D (M)
 Dr. SANDEEP REDDY



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						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Savitri S

Date & Time : 26/05/26. 8:30pm.

Nurse Name & Signature : Annab

Date & Time : 27/05/26 10:30pm

BAH-00607743 IP5-00174354
 Baby Of KEERTI GUPTA (SHREY)
 16-11-2024 1 Y 6 M 10 D (M)
 Dr. SANDEEP REDDY



Weight ... 10.8 Kg Ward ... 3rd floor

She

REGULAR PRESCRIPTIONS

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

B/201

BAH-00607743
IP5-00174354
Baby Of KEERTI GUPTA (SHREY)
16-11-2024 1 Y 6 M 10 D (M)
Dr. SANDEEP REDDY

DRUG CHART

Date of Admission: 26/05/20 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG : <u>Syp IBUPROFEN</u>				Date/Time																	
Dose	Route	Frequency	Start Date																		
<u>5ml</u>	<u>PO</u>	<u>SOS</u>	<u>26/5</u>	<u>11 AM</u>	<u>27/5</u>	<u>12:30 PM</u>															
Doctor's Signature		Valid Period	Pharm.																		
<u>Sahithi</u>		<u>4 hrs</u>																			
Additional Instructions: <u>temp > 102</u> <u>max 8th hrly</u> <u>(5ml/100mg)</u>																					
DRUG : <u>Syp. PARACETAMOL</u>				Date/Time																	
Dose	Route	Frequency	Start Date																		
<u>3ml</u>	<u>PO</u>	<u>SOS</u>	<u>27/5</u>	<u>11 AM</u>	<u>27/5</u>	<u>12:30 PM</u>															
Doctor's Signature		Valid Period	Pharm.																		
<u>Dr. Nanda</u>		<u>7 hrs</u>																			
Additional Instructions: <u>if temp > 101°</u> <u>240mg/15ml</u> <u>Min 6 hrs gap between 2 doses</u>																					
DRUG :				Date/Time																	
Dose	Route	Frequency	Start Date																		
Doctor's Signature		Valid Period	Pharm.																		
Additional Instructions:																					

VERIFIED Signature
VERIFIED Name



REGULAR PRESCRIPTIONS

Weight 10.8kg Ward 3rd floor

DRUG : <u>500mg CEFTRIAXONE</u>				Date/Time
Dose	Route	Frequency	Start Date	<u>26/5</u> <u>27/5</u> <u>28/5</u>
<u>500mg</u>	<u>IV</u>	<u>BD</u>	<u>26/5</u>	<u>11AM</u> / <u>8PM</u> / <u>12PM</u> / <u>5PM</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Sanithi</u>				
Additional Instructions: <u>@ 50 mg/kg/dose</u>				<u>11PM</u> / <u>12PM</u> / <u>1PM</u> / <u>2PM</u>
Daily Doctor's Endorsement by a Sign				<u>(S)</u> <u>(S)</u> <u>(S)</u>

DRUG : <u>150mg PARACETAMOL</u>				Date/Time
Dose	Route	Frequency	Start Date	<u>26/5</u>
<u>150mg</u>	<u>IV</u>	<u>QID</u>	<u>26/5</u>	<u>12AM</u> / <u>12PM</u> / <u>6PM</u> / <u>12PM</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Sanithi</u>				
Additional Instructions: <u>@ 15 mg/kg/dose</u>				<u>12PM</u> / <u>6PM</u>
Daily Doctor's Endorsement by a Sign				<u>(S)</u>

Stop 27/5/26
9 AM
Dr. Nanda

DRUG : <u>10mg PANTOPRAZOLE</u>				Date/Time
Dose	Route	Frequency	Start Date	<u>26/5</u> <u>27/5</u> <u>28/5</u>
<u>10mg</u>	<u>IV</u>	<u>OD</u>	<u>26/5</u>	<u>6AM</u> / <u>11PM</u> / <u>12PM</u> / <u>12PM</u> / <u>12PM</u>
Name & Signature of the Doctor Starting the Drugs: <u>Sanithi</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				<u>(S)</u> <u>(S)</u> <u>(S)</u>

DRUG : <u>1.5mg ONDANSETRON</u>				Date/Time
Dose	Route	Frequency	Start Date	<u>26/5</u> <u>27/5</u> <u>28/5</u>
<u>1.5mg</u>	<u>IV</u>	<u>TID</u>	<u>26/5</u>	<u>7AM</u> / <u>3PM</u> / <u>11PM</u> / <u>12PM</u> / <u>12PM</u>
Name & Signature of the Doctor Starting the Drugs: <u>Sanithi</u>				
Additional Instructions: <u>@ 0.15 mg/kg/dose</u>				<u>11PM</u> / <u>12PM</u> / <u>1PM</u> / <u>2PM</u>
Daily Doctor's Endorsement by a Sign				<u>(S)</u> <u>(S)</u> <u>(S)</u>

Stop 27/5/26
4PM
Dr. Nanda

VERIFIED

VERIFIED

VERIFIED

VERIFIED

BAH-00607743 IP5-00174354
 Baby Of KEERTI GUPTA (SHREY)
 16-11-2024 1 Y 6 M 10 D (M)
 Dr. SANDEEP REDDY

Weight. 10.8kg Ward.



Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
	Dose		Dose		Dose		Dose	
Dr. Sign.		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.	
	Dose		Dose		Dose		Dose	
Dr. Sign.		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
27/5/24	12 AM GAM	Neb LEVOLIN	0.63 mg	Neb.	\$	Shilpa Supriya
27/5/24	12 AM:10 AM GAM	LEVOLIN	0.63 mg	Neb	\$	Shilpa Supriya
27/5/24	7-30 PM	INS. PARACETAMOL	150mg	IV	Nalt	Shilpa Supriya

VERIFIED

Signature
VERIFIED BY: Name

BAH-0060743 IP5-00174354
 Baby Of KEERTI GUPTA (SHREY
 16-11-2024 1 Y 6 M 11 D (M)
 Dr. SANDEEP REDDY



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

26/05/26

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time:

Doctor / Nurse / Family Concern? 11:00 2:00 6:00

Temperature (F)	104			
	103			
	102			
	101			
	100			
	99	97.5F	98.1F	98.0F
	98	*	*	*
	97			
	96			
	95			
	94			R

Heart Rate (bpm) and Blood Pressure (mmHg) *	190			
	180			
	170			
	160			
	150			
	140			
	130		*	
	120			
	110	95		
	100			

Heart Rate (Number) 138b/m 130b/m D

Resp. Rate (bpm) (Over 1 Minute) *	70		
	60		
	50		
	40		
	30		
	20		
	10		
	0		

Resp Rate (Number) 30b/m 28b/m

Resp Mod/ Severe Distress None / Mild N N

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

Conscious Level Normal / Altered N N

GCS * 15/15 15/16

TOTAL SCORE		
Number of shaded boxes	0	0
Pain Score	0	0
Observer's Initials	<u>D</u>	<u>D</u>

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

* 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

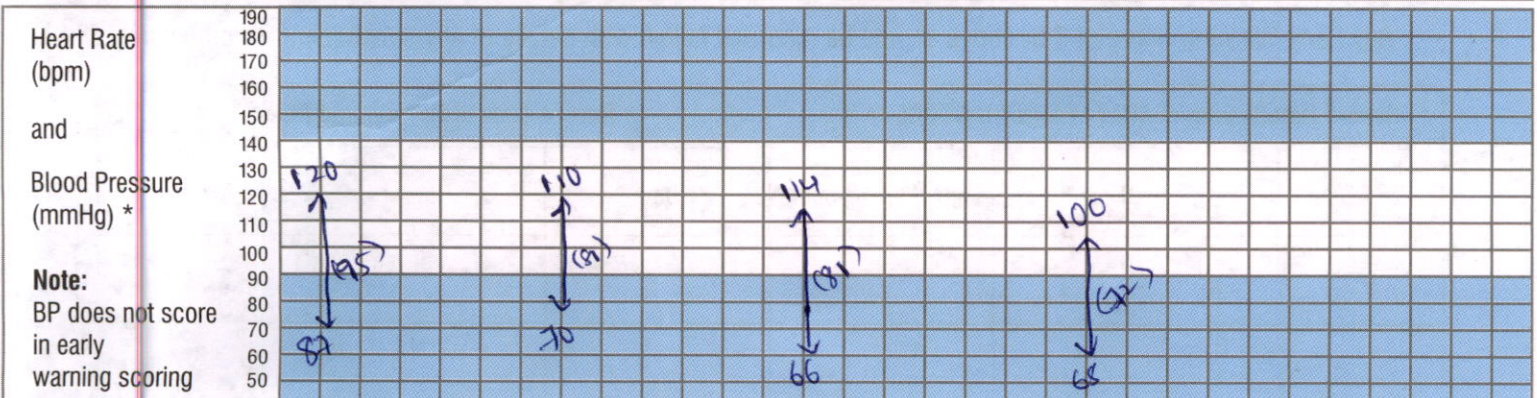
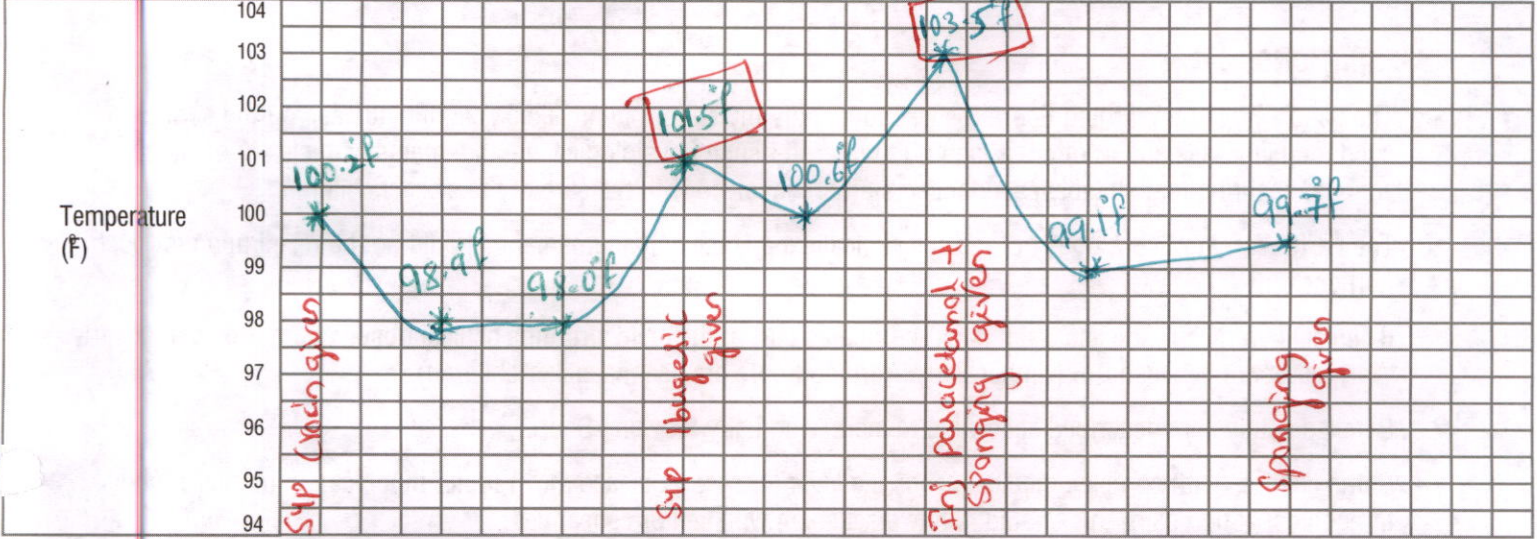
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 27/5/26 Time: 11AM 12pm 2pm 4pm 5pm 7:30pm 10pm 11:30pm

Doctor / Nurse / Family Concern?



Note:
 BP does not score in early warning scoring

Heart Rate (Number) 140b/m 110b/m 138b/m 126b/m

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

Resp Rate (Number) 30b/m 28b/m 32b/m 28b/m

Resp Mod/ Severe Distress None / Mild

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

Conscious Level Normal / Altered

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

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

ACTIONS
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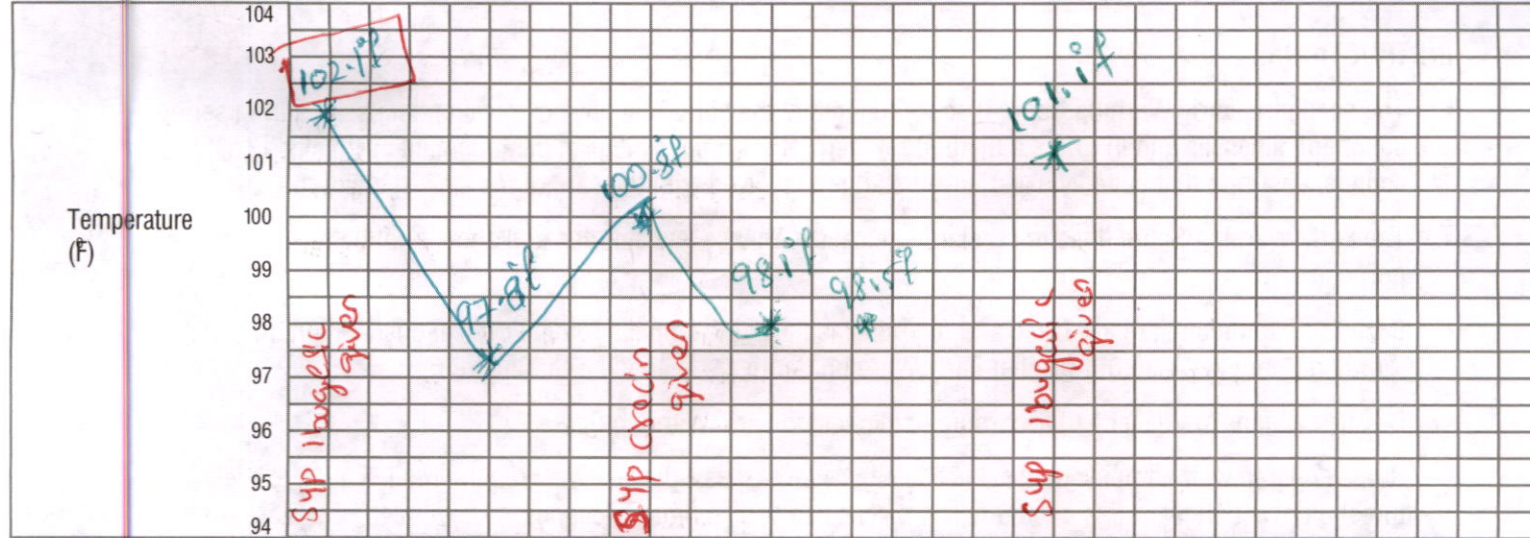
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 28/5/26 Time: 12:30 1:30 6AM 8AM 10AM 2PM

Doctor / Nurse / Family Concern? Am Am



Heart Rate (bpm)	
and	
Blood Pressure (mmHg) *	
Note: BP does not score in early warning scoring	

Heart Rate (Number) 100b/m 126b/m 119b/m 110b/m

Resp. Rate (bpm) (Over 1 Minute) *	
Resp Rate (Number)	28b/m 30b/m 42b/m 40b/m

Resp Mod/ Severe Distress None / Mild

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

Conscious Level Normal Altered

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

TOTAL SCORE

Number of shaded boxes 0 0 1 1

Pain Score 0 0 0 0

Observer's Initials S S S S

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Patient S

BAH-00807743 IP5-00174354
 Baby Of KEERTI GUPTA (SHREY)
 16-11-2024 1 Y 6 M 10 D (M)
 Dr. SANDEEP REDDY



FLUID CHART

Sheet No. :

26/05/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am	DNS									0	Phys	
	01:00 am	DNS milk									0	Phys	
Total Intake : Taken Ford						Total Output : 0 0 0							
	02:00 am	DNS									0	Phys	
	03:00 am	DNS milk									0	Phys	
	04:00 am	DNS									0	Phys	
	05:00 am	DNS									0	Phys	
	06:00 am	DNS milk									0	Phys	
	07:00 am	DNS									0	Phys	
Total Intake : Taken 180ml						Total Output : 0 1 0							
Total 24 hrs. Intake			Taken			Total 24 hrs. Output			0 1 0				



FLUID CHART

Sheet No. :

27/5/24

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
27/5/24	08:00 am	DNS		30ml						✓	0	Shirpa
	09:00 am	DNS water		30ml						✓	0	
	10:00 am	DNS		30ml							0	
	11:00 am	DNS water		30ml							0	
	12:00 pm	DNS		30ml						✓	0	
	01:00 pm	DNS milk		30ml							0	
Total Intake : 210ml			Total Output : U-2 N-0									
	02:00 pm	DNS		30ml							0	Shirpa
	03:00 pm	DNS water		30ml						✓	0	
	04:00 pm	DNS milk		30ml							0	
	05:00 pm	DNS		30ml							0	
	06:00 pm	DNS water		30ml						✓	0	
	07:00 pm	DNS		30ml							0	
Total Intake : 180ml			Total Output : U-2 N-0									
	08:00 pm										0	Shirpa
	09:00 pm	milk									0	
	10:00 pm										0	
	11:00 pm	milk									0	
	12:00 am									✓	0	
	01:00 am	milk		30ml							0	
Total Intake : 90ml			Total Output : N-1 U-1									
	02:00 am			30ml							0	Shirpa
	03:00 am	milk		30ml							0	
	04:00 am			30ml							0	
	05:00 am			30ml							0	
	06:00 am	water								✓	0	
	07:00 am										0	
Total Intake : 120ml			Total Output : N-1 U-1									

Total 24 hrs. Intake 600ml

Total 24 hrs. Output N-2 U-6

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 16-11-2024 1 Y 6 M 11 D (M)
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FLUID CHART

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28/5/26

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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			
	08:00 am			30ml							0	Shety	
	09:00 am	D	milk	30ml							0	Shety	
	10:00 am			30ml					✓		0	Shety	
	11:00 am	N	I.V	20ml							0	Shety	
	12:00 pm	S	contd								0	Shety	
	01:00 pm										0	Shety	
Total Intake :						Total Output : U-							M-
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

Patient Sticker

FLUID CHART



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	08:00 am													
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	04:00 am													
	05:00 am													
	06:00 am													
	07:00 am													
Total Intake :						Total Output :								

Total 24 hrs. Intake

Total 24 hrs. Output

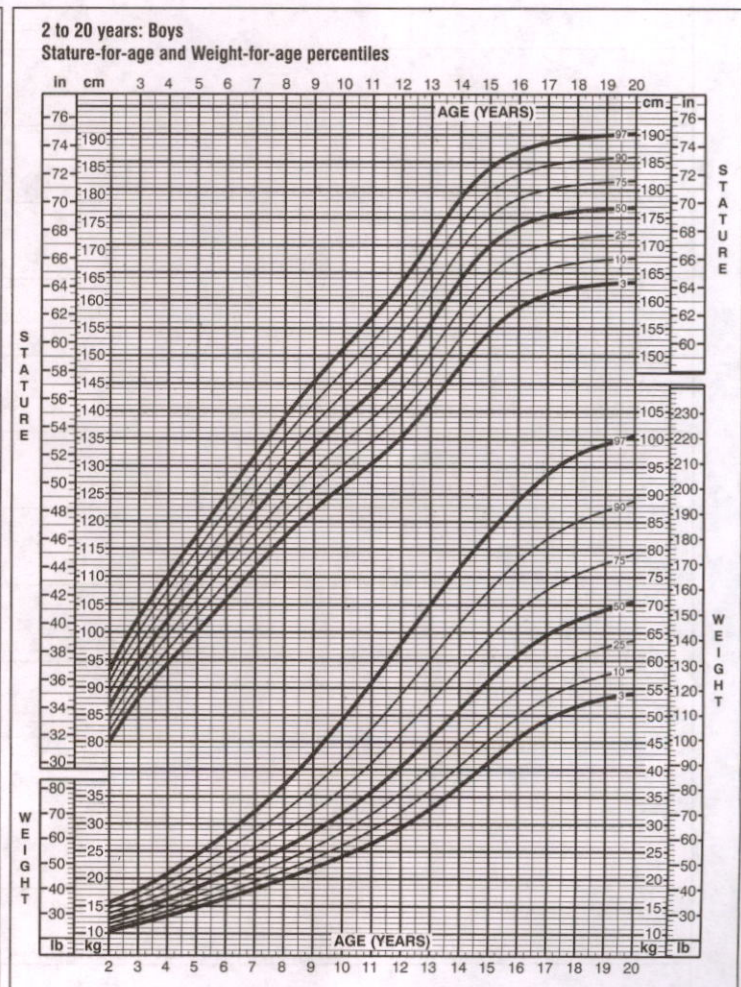
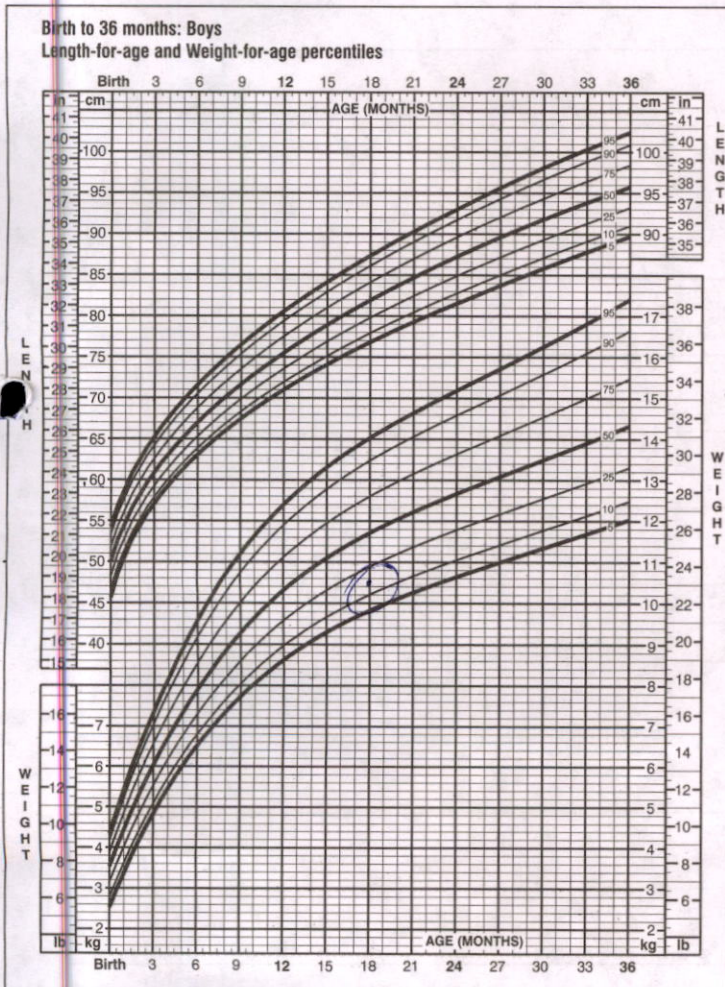
331-I

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 27/5/26 Time: 9am

Weight: 10.8kg Centile: 7th 10th
 Height: 60cm Centile: 7th 10th
 Inference: Underweight child
 RDA: — Calories: 1200kcal/d Protein: 20g/d
 Diet Recommendations: Soft diet
 Re-Assesment: Avoid Spicy, Chilled & outside foods
 Food Allergies: NO Veg/Non-veg: veg.
 Diagnosis: Age + 1st episode of febrile seizures
 Nutritional Intervention - Oral Enteral Parenteral
 Patient's Signature: *Sourabh*

GROWTH CHART (BOYS)



Dietician's Name: *Raina*

Dietician's Signature: *Raina*

