

ACTIVITY RECORD FOR BILLING

Name : **BAH-00651533 IP5-00175936**
Baby ARKE TRISHIKA YADAV
10-12-2023 2 Y 6 M 23 D (F)
UHID No. **Dr. DR.V.V.R.SATYA PRASAD** 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
3/7/20	7:10 pm	ER	Ward	Abhishek

Cross Consultation Visit

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

IP5-00175936

BAH-00651533
Baby ARKE TRISHIKA YADAV
2 X 6 M 24 D

10-12-2023

2 Y 6 M 24 D

(F)

10-12-2023
Dr. DR.V.V.R.SATYA PRASAD

INVI

[illegible]

[illegible]

BAH-00651533 IP5-00175936
Baby ARKE TRISHIKA YADAV
10-12-2023 2 Y 6 M 24 D (F)
Dr. DR.V.V.R.SATYA PRASAD

PRO



Date	Procedure	Quantity	Order No.	Signature
3/7/26	IV placement	1	6089	Chona
3/7/26	ca thekitation	1	634240	cl
4/7	NHA	1	984436176	Priyanka

ANY OTHER INFORMATION

x-ray - (1)

Date : 6/7/26

Time : 12pm

Prepared By : Sushma

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Sushma	VIRGATOR		

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175936

Admit Date : 03-Jul-2026

Admit Time : 05:28 PM UHID : BAH-00651533

Patient Details :

Patient Name : Baby ARKE TRISHIKA YADAV

Age : 2 Y 6 M 23 D

Guardian : Mr ARKE SURESH YADAV

DOB : 10-12-2023

Gender : Female

Religion :

Occupation :

Martial Status : Single

Address (H) : H NO 12-13-9, JANATHA NAGAR, MOOSAPET
Borabanda Hyderabad Telangana INDIA
500018

Phone No : 7680841827/ 7032480829

E-mail : MOUNIKARAAJI@GMAIL.COM

Admission Details :

Bed Type : SEMI PRIVATE

Bed No : SPVT 107

Ward Name : 1F-VIBGYOR

Room No : SPVT 107

Admission Type : First Visit

Contact Details :

Name : Mr ARKE SURESH YADAV

Relationship : Father

Contact Address : H NO 12-13-9, JANATHA NAGAR,
MOOSAPET Borabanda Hyderabad Telangana
INDIA 500018

Phone No : 7680841827 / 7032480829

Asuresh Yadav
Signature

Doctor Details :

Doctor Name : Dr. DR.V.V.R.SATYA PRASAD

Specialisation : PEDIATRIC NEPHROLOGY

Referral Doctor : Self

Phone No :

Co-Consultant : Dr. SRUTHI BALLA

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.27

Payor Name : ICICI LOMBARD GENERAL
INSURANCE CO LTD



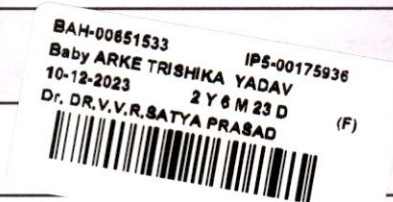
PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: Arke Trishika

UHID ID: _____

Department: _____

Consultant: _____



- 40 fever - 1 week, mod. grade; a/cne chills
reducing on radiation?
- 40 suppurative - 5 days
- 40 urinary - 5 days
self curing
- 40 poor intake ⊕
dull activity ⊕.

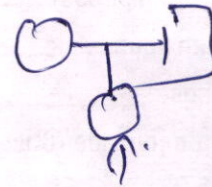


Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Term / Apgar / F / UAB



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

As per age

Immunization History :

As per age.

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Baby ARKE TRISHIKA YADAV

10-12-2023

2 Y 6 M 23 D

(F)

Dr. DR.V.V.R.SATYA PRASAD

**Pediatric Multiorgan History & Physical Examination****Anthropometry :**

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

Weight (kgs)) 12.5 kg (Centile _____)**On Examination :**Temperature : 99.0 F Pulse Rate : 128/m B.P. 118/60 SPO2 96%Resp. rate and type of breathing : 24/m

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): ANANA**Respiratory System :**

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : soft, non tender

Ausculation : _____

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : 20

Motor System:

Nutriton : _____

Tone: _____ Power 20

Co-ordinator : _____

Posture : _____

Involuntary Movements : 20

Reflexes :

DTR

Superficials: 20

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

sepsis

Desired goals of the treatment : _____

Hemodynamic stability

Planned Labs:

CBP

CRP

AP-2

Blood cfs

Urine cfs

US abdomen

Planned Management

- DMS full maintenance
nurse

- Ini - Piptag

- Ini - Esomeprazole

- Foley's catheterization

Signature of the Doctor: _____

Name of the Doctor: Dr. Nandani

Date & Time: 03/07/26, 5:45 PM

Signature of the Consultant: _____

Name of the Consultant: DR. V.V.R. SATYA PRASAD

Date & Time: _____

Registration No: 43595



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



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date & Time	Progress Notes	Doctor's Order
5/7/26 9:30 AM	SIB Resident A: UTI no fever no new issues O/E - Child alert vitals stable C/S M PIA normal	Plan. (1) Continue piptaz (2) Trace Blood C/S urine C/S (3) monitor vitals (4) Inform cos
verbal Blood C/S - so far sterile urine C/S - further incubation		dradhu
		die today Rv on Tuesday - cwe Amikacin 100mg BD piptaz 1.5g BD smth x sweets mount LANTOL
		DR. VVR SATYA PRASAD Registration No: 43599



CROSS CONSULTATION FORM

Doctor Name : Dr. Harish Jayaram Date : 4/7/26 Time : 4:50pm

Diagnosis : UTI

Hospital : RCH Bangalore

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:

B/L VUR Grade IV
UTI

Signature: Mashuri

Findings and Recommendations :

2 yrs. 6 month / FCH

plan:

with Bilateral grade IV VUR
S/o dribbling of urine / frequency
urgency & leak / micturition
2 prev. admissions on past - for UTI
(Breakthrough)
→ marlin-2026 → E. coli
→ may-2026 → Enterococcus faecium

1) Plan DMSA after
~~2-3~~ weeks (after UTI
settles)

2) Bilateral Open Ureter
Reimplantation
on follow up

on Bacem Prophylones
On Mucut powder for constipation.

3PT26
USG abd → mid left renal
calyceal fullness
internal E. coli in VB

3PT26
MC → loaded pm cells
CRP → 29

P/A - soft, Spine - (N)
Ext genitalia - no
labial adhesions

Consultant :

Name : Dr. Harish

Signature :

DR. HARISH JAYARAM
Registration No: 66254

Date & Time : 4/7/26
4:50pm

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RESULT SHEET

Date	13/7	5/7/2026			
Time					
Hb	12.1	12.7			
PCV	37	41.8			
RBC	5	5.25			
WBC	15.06k	17.280			
N/L	(36/59)	25/70.8			
Platelets	4053L	4.48/10 ⁶			
CRP	29	9 ↓			
ESR					
PCT					
RBS					
Na	140				
K	4.7				
Cl	106				
Ca/Mg					
Phosphate					
Urea	21				
Creatinine	0.4				
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	HCO ₃	20			

Date	<u>26/6</u>	27				
Time						
CUE - Alb	0	2+				
CUE - Sugar	0	0				
CUE - Ketones	0	0				
CUE - PUS Cells	70-80	loaded				
CUE - RBC Cells	2-3	18-20				
CUE	leucocytes 3+					
	Nitrite One					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI

 Others (ECG, Contrast Studies etc..) :

MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER

Shifted to: ward

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Nandan

Date & Time : 31/12/26 @ 6:25 pm

Nurse Name & Signature: poorja

Date & Time : 31/12/26 @ 6:30 pm



DRUG CHART

Date of Admission: 03/07/2026 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

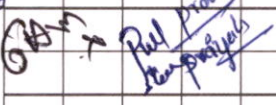
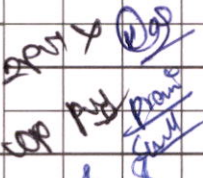
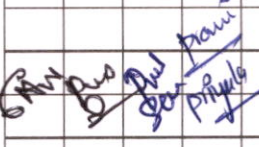
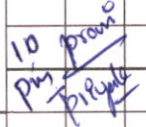
SOS / PRN (As Required Medication)

DRUG : <u>SYP. PARACETAMOL</u>				Date Time															
Dose	Route	Frequency	Start Date																
<u>3.5ml</u>	<u>PO</u>	<u>SOS</u>	<u>03/07/26</u>																
Doctor's Signature		Valid Period	Pharm.																
<u>Dr. Nanda</u>																			
Additional Instructions: <u>240mg/5ml</u>																			
<u>If temp > 100°S, minimum 6 hours gap between 2 doses.</u>																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			



REGULAR PRESCRIPTIONS

Weight. 12.5 Kg Ward.

DRUG : <u>IND. PIPITAZ</u>				Date Time	<u>8/7</u>	<u>4/7 5H</u>
Dose	Route	Frequency	Start Date			
<u>1.25g</u>	<u>IV</u>	<u>TID</u>	<u>03/07/24</u>			
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandan</u>				 		
Additional Instructions: <u>12</u>						
Daily Doctor's Endorsement by a Sign						
DRUG : <u>IND. ESOMEPRAZOLE</u>				Date Time	<u>3/7</u>	<u>4/7 5H</u>
Dose	Route	Frequency	Start Date			
<u>12mg</u>	<u>IV</u>	<u>OD</u>	<u>03/07/24</u>			
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandan</u>						
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						
DRUG : <u>MUOUT POWDER</u>				Date Time	<u>4/7</u>	
Dose	Route	Frequency	Start Date			
	<u>P/O</u>	<u>OD/HS</u>	<u>4/7/26</u>			
Name & Signature of the Doctor Starting the Drugs: <u>Madhus</u>						
Additional Instructions: <u>1 1/2 scoop to mix in some water</u>						
Daily Doctor's Endorsement by a Sign						
DRUG : <u>SYRUP. SMUTH</u>				Date Time		
Dose	Route	Frequency	Start Date			
<u>7.5ml</u>	<u>P/O</u>	<u>OD</u>	<u>5/7/26</u>			
Name & Signature of the Doctor Starting the Drugs: <u>Madhus</u>						
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						



		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
4/7/26	12 PM	NEOTOMIC ENEMA	10ml	P/R	[Signature]	[Signature] Saini

Weight. 12.5 kg Ward.

Signature

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/12/23	Time : 6 am	10 am	12:30 pm	6 pm	10 pm	2 AM	6 AM
Doctor / Nurse / Family Concern?							
Today wt - 12.3 kg Temperature (F) Heart Rate (bpm) 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							
98.5 F 97.5 F 97.5 F 97.5 F 98.0 F 97.5 F 98.5 F							
110/60 108/60 108/60 92/60 96/60 101/60 108/60							
120 bpm 116 bpm 112 bpm 110 bpm 106 bpm 100 bpm 96 bpm							
28 bpm 28 bpm 27 bpm 27 bpm 26 bpm 21 bpm 26 bpm							
100% 100% 99% 98% 100% 100% 99%							
15/15 15/15 15/15 15/15 15/15 15/15 15/15							
1 0 0 0 1 1 1							
0 0 0 0 0 0 0							
15/15 15/15 15/15 15/15 15/15 15/15 15/15							

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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Dr. DR.V.V.R.SATYA PRASAD
IPS-00175936
2 Y 6 M 24 D
(F)

No. : RCH/ FRM / CLINICAL / 125

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

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

BirthRight™
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/12/2023	Time: 2:00 PM
Doctor / Nurse / Family Concern?	
Temperature (F)	104 103 102 101 100 99 98 97 96 95 94
Heart Rate (bpm)	190 180 170 160 150 140 130 120 110 100 90 80 70 60 50
Blood Pressure (mmHg) *	110 100 90 80 70 60 50
Note: BP does not score in early warning scoring	
Heart Rate (Number)	130 bpm 120 bpm
Resp. Rate (bpm) (Over 1 Minute) *	70 60 50 40 30 20 10
Resp Rate (Number)	28 bpm 28 bpm
Resp Distress	Mod/ Severe None / Mild
Receiving O ₂ (l/min) O ₂ Saturations (%)	09x 100x
Conscious Level	Normal Altered
GCS *	14/15 15/15
TOTAL SCORE	
Number of shaded boxes	1 1
Pain Score	0 0
Observer's Initials	D S

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FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm	1	45ml									
	09:00 pm	1	45ml									
	10:00 pm	DNS	45ml						200ml			
	11:00 pm	1	45ml									
	12:00 am	1	45ml									
	01:00 am	1	45ml						300ml			
Total Intake :						Total Output :						
	02:00 am	1	45ml									
	03:00 am	1	45ml									
	04:00 am	DNS	45ml						200ml			
	05:00 am	1	45ml									
	06:00 am	1	45ml									
	07:00 am	1	45ml						300ml			
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								
4/12	08:00 am		12ml	45ml		/			/		0	J. Arora	
	09:00 am			45ml		/					0		
	10:00 am	Oral		45ml		/					0		
	11:00 am			45ml		/					0		
	12:00 pm			45ml		/				230ml	0		
	01:00 pm					/	✓				0		
Total Intake :					Total Output :								
4/12	02:00 pm		45ml			/			/		0	Mishra	
	03:00 pm		45ml			/					0		
	04:00 pm		45ml			/					0		
	05:00 pm	Oral		45ml		/				205ml	0		
	06:00 pm			45ml		/					0		
	07:00 pm			45ml		/					0		
Total Intake :					Total Output :								
4/12	08:00 pm	↑		45ml		/			/	270ml	0	P. Singh	
	09:00 pm					/					0		
	10:00 pm	Oral				/				170ml	0		
	11:00 pm					/					0		
	12:00 am			45ml		/				60ml	0		
	01:00 am	↓		45ml		/					0		
Total Intake :					Total Output :								
5/12	02:00 am	↑		45ml		/			/	105ml	0	P. Singh	
	03:00 am			45ml		/					0		
	04:00 am	Oral		45ml		/				20ml	0		
	05:00 am			45ml		/					0		
	06:00 am					/					0		
	07:00 am	↓				/				270ml	0		
Total Intake :					Total Output : U = 1380 ml								

Total 24 hrs. Intake

Total 24 hrs. Output 4.3 cc/kg

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/2026

Assessment: baby is having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	⇒ Assess the general condition of the baby	8:10am	⇒ Assessed the general condition of the baby	the baby condition is improving slowly
11pm	⇒ provide comfortable bed and position	11:10am	⇒ provided comfortable bed and position	
2pm	⇒ monitor vital signs	2:10am	⇒ monitored vital signs	
4am	⇒ continue IV fluids	4:10am	⇒ continued IV fluids	
6am	⇒ Administered medication as per doctor order	6:10am	⇒ Administered medication as per doctor order	

Re-Assessment: Baby is feeling uncomfortable

Special Notes:

Nurse Signature: shanthi

Nurse Name: shanthi

Date & Time: 4/7/2026 2am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 4/7/26

Assessment: Baby having discomfort at catheter 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
10am	→ Assessed the Baby General condition, monitor vital & Record	10:30am	→ Assessed the Baby General condition, monitored vital & Recorded	By Ankle's done pt condition
11am	→ Continue iv fluids	11:30am	→ Continued iv fluids	
12pm	→ monitor I/O chart		→ monitored I/O chart	
	→ plan to do x-ray Abdomen & surgical consultation	12:10pm	→ planned to do x-ray Abdomen & surgical consult	
1pm	→ Administer medication as per doctor order	2pm	→ administered medication as per doctor order	

Re-Assessment:

Special Notes: CRP, Cef Tim

Nurse Signature: Ap

Nurse Name: Aparajitha (021266)

Date & Time: 4/7/26 @ 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/26

Assessment: Poor intake

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 PM	Assess general condition of the patient.	8:10 PM	Assessed general condition of the patient.	By sincere implementation, as per doctor's order.
10 PM	Monitor vital signs.	10 PM	Monitored vital signs.	
11 PM	Monitor urine output strictly	11 PM	Monitored urine output	
6 AM	Administer medication as per doctor's order.	6:5 AM	Administered medication as per doctor's order.	
7 AM	Maintain fluid balance.	7:30 AM	Maintained fluid balance.	

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

Special Notes: Daily vit checking, urine output Monitoring strictly

Nurse Signature: P.B.

Nurse Name: Priyanka

Date & Time: 5/7/26 8 AM

BAH-00651533 IP5-00175936
 Baby ARKE TRISHIKA YADAV
 10-12-2023 2 Y 6 M 24 D (F)
 Dr. DR.V.V.R.SATYA PRASAD



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: 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
- ☐ Any Others. Specify.....

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	Assess the pt general condition.	8.30 AM	Assess the pt general condition.	Implemented all the procedure
9 AM	monitor vital sign	9.30 AM	monitor vital sign	
10 AM	monitor IO chart	10.30 AM	monitored IO chart	
11 AM	provide comfortable position	12 PM	provided comfortable position	
	Administered medication		Administered medication as per order	

Re-Assessment:

Special Notes:

Nurse Signature: (Signature)

Nurse Name: Sushma 01/7/26

Date & Time: 5/7/26



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Satya prasad Department: ER Date of Admission: 3/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	<u>UTD</u> <u>Acute Febrile Illness</u>							
BACKGROUND	Area	Shift Time	<u>ER</u> <u>7:10 pm</u>	<u>1st floor</u> <u>8am</u>	<u>1st floor</u> <u>8am-2pm</u>	<u>1st floor</u> <u>2pm-8pm</u>	<u>1st floor</u> <u>8am-12pm</u>	<u>1st floor</u> <u>12pm-2pm</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>98.2F</u>	<u>98.4F</u>	<u>98.2F</u>	<u>98F</u>	<u>98.4F</u>	<u>98.4</u>
	Res:	<u>24b/m</u>	<u>28b/m</u>	<u>26b/m</u>	<u>26b/m</u>	<u>21b/m</u>	<u>21</u>	
	SpO ₂ :	<u>96%</u>	<u>99%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	
	Pulse:	<u>128b/m</u>	<u>126b/m</u>	<u>112b/m</u>	<u>112b/m</u>	<u>105b/m</u>	<u>100</u>	
	BP:	<u>118/60</u>	<u>110/70</u>	<u>100/62</u>	<u>92/50</u>	<u>100/67</u>	<u>100/72</u>	
	Fall Risk Score:	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>		
Recommendations	Safety Needs:		<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>Side rails</u>	<u>yes</u>
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Post Operative Procedure Special Orders:			<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Handed Over By Name :			<u>Abhishek</u>	<u>Shanthy</u>	<u>Aparanjita</u>	<u>Merlin</u>	<u>Poojanta</u>	<u>Eusheng</u>
Signature :			<u>Abhishek</u>	<u>Shanthy</u>	<u>Aparanjita</u>	<u>Merlin</u>	<u>Poojanta</u>	<u>Eusheng</u>
Date:			<u>3/7/26</u>	<u>4/7/2026</u>	<u>4/7</u>	<u>4/7</u>	<u>5/7</u>	<u>5/7</u>
Time:			<u>7:15 pm</u>	<u>8am</u>	<u>8pm</u>	<u>8pm</u>	<u>8am</u>	<u>5/7</u>
Taken Over By Name :			<u>Shanthy</u>	<u>Aparanjita</u>	<u>Merlin</u>	<u>Poojanta</u>	<u>Eusheng</u>	<u>Eusheng</u>
Signature :			<u>Shanthy</u>	<u>Aparanjita</u>	<u>Merlin</u>	<u>Poojanta</u>	<u>Eusheng</u>	<u>Eusheng</u>
Date:			<u>3/7/26</u>	<u>4/7</u>	<u>4/7</u>	<u>4/7</u>	<u>5/7</u>	<u>5/7</u>
Time:			<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</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:								



Pat

THE HUMPTY DUMPTY SCALE

3/7 4/7 5/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	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					
	Female	1	1	1	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		
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1		
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2		
	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		
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		
TOTAL			11	11	11		

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 :		Abhishek Ram				
Signature :		Abhishek Ram				
Date :		3/7/24				
Time :		6:10 PM				



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	5/7 DAY-1			4/7 DAY-2			5/7 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			
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 cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-	-	-	-			
Signature of the Nurse				Shanti Appu Nalini Anjana Susha									

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 : SOURAV Name : SOURAV brother

Signature of Ward In Charge :

Signature : NEERAJA SR Name : NEERAJA SR

BRADEN 'Q' SCALE

					Date :	3/7/20	4/7/20	5/7/20	
					Time :	6 PM	8 AM	6 AM	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4		
"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		
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		
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		
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4		
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 of 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	3		
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					20	22	27		
Evaluator's Name					Abhishek Kumar Prasad				

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-00651533
Baby ARKE TRISHIKA YADAV
10-12-2023 2 Y 6 M 23 D
Dr. DR.V.V.R.SATYA PRASAD (F)

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
3/7/26	6pm	0	NEP	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Abhishek
4/7/26	2AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shanthi
4/7/26	10am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Appu
4/7/26	3pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Merlin
5/7	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Priyanka
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

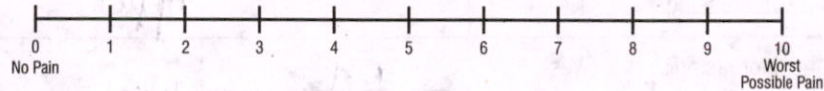
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 drawn 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

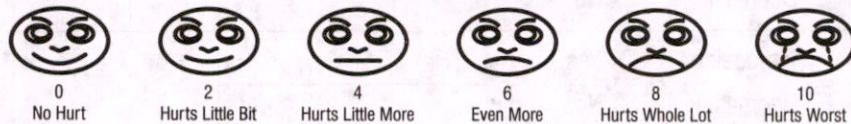
Numerical Pain Scale (Obstetric and Gynecology)



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





INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Patient / Learner Language: *Telegu*Patient / Learner Literacy: ☒ Read ☐ Write ☒ SpeakWillingness to Learn: ☒ Yes ☐ NoHealthcare Literacy: ☒ Yes ☐ No**Identified Education Needs:**

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
3/7/26	6:10pm	7	Infection Control measures	M	1	0	1	1	NA	Abhishek
4/7/26	9am	9	soft diet - plenty of oral liquids	M	1	0	1	1	-	manics

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:	<table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								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	
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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:	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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Understanding:	<table border="0"> <tr> <td>1. Verbalizes Understanding</td> <td>2. Demonstrates Understanding</td> <td>3. Needs Review</td> </tr> </table>								1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review												
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MULTI-DISCIPLINARY PLAN OF CARE FORM

UTI

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
03/07/26 6:30 pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Urinary Tract Infection	Hemodynamic Stability	IV antibiotic	[Signature]	☒ Nursing ☐ Others:
3/7/26 6:35 pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	UTI	U - Stability	2u antibiotics	[Signature]	☒ Medical ☐ Others:
4/7/26 9am	☐ Medical ☐ Nursing ☒ Others: Dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	UTI	soft diet & plenty of oral liquids	RDA E:- 1250 kcal/d P:- 2191g	[Signature]	☐ 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:

BAH-00651533
Baby ARKE TRISHIKA YADAV
10-12-2023 2 Y 6 M 24 D
Dr. DR.V.V.R.SATYA PRASAD (F)

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Hospital
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DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: as per doctor order

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☒ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication	☐ Yes	☐ No
☐ Bathing	☐ Yes	☐ No
☐ Eating	☐ Yes	☐ No
☐ Walking	☐ Yes	☐ No
☐ Dressing	☐ Yes	☐ No
☐ Toileting	☐ Yes	☐ No

explained family members

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: hand hygiene

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: Rama

Nurse Name: Rama

Date and Time: 3/7/2026 7:30pm

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00651533 IP5-00175936 Baby ARKE TRISHIKA YADAV 10-12-2023 2 Y 6 M 23 D (F) Dr. DR.V.V.R.SATYA PRASAD 		Date & Time of Admission 3/7/26 at 5:28 pm	Date & Time of Transfer Order 3/7/26 at 7:10 pm
		Transfer Ordered by Dr. Nandan	Reason for Transfer Admission
From Unit ER	To Unit 107 ward	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 25	Number of Imaging Films 1	Personal belongings including clinical documents. If any handed over to attendant OP Film Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring Mr. Abhishek		Name of Person Ordered Transfer Dr. Nandan	
Patient & Clinical Records Received by : chandana			
Date & Time of Patient Received : 3/7/2026 7:15 PM			

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

- ☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 03/07/26 Date of Removal: 03/07/26

Parameters	Date	Shift Time						
Need for the Catheter			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse			Shruti					
Signature of the Nurse			[Signature]					

BAH-00651533 IP5-00175936
Baby ARKE TRISHIKA YADAV
10-12-2023 2 Y 6 M 23 D (F)
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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Baby Arke Trishika Age : 2y Gender: ☐ Male ☒ Female
Date : 3/7/26 Time of Arrival : 4:42pm Triage Completion Time : 4:44pm
Allergies: ☐ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): Nil ☐ Not known any drug Allergies
Source of Information : ☐ Parents ☐ Others (Specify) Nil
Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance

☒ Normal

☐ Sick Looking

Circulation / Colour

☐ Normal

☐ Abnormal

☐ Bleeding

Work of Breathing

☒ Normal

☐ Decreased

☐ Increased

☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

☒ Stable

☐ Unstable :

☐ Not - Life - Threatening

☐ Life - Threatening

Vital Signs: Temp: 97.8 PR: 128b/m BP: 118/60(70) RR: 24b/m SpO₂: 96% RA

Chief Complaints: Fever 1 week

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☒ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☐ 60 min
☐ Level 5 : NON - URGENT : May receive care when convenient	☐ 120 min

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

* CTAS - Canadian Triage and Acuity Scale

G. Manik
Signature of Parent / Guardian

Communicable Disease Triage Screening

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

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

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

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☐ No
If yes, State Location:
2. Are your parents / close contacts at home healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☐ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : NR Subbar

Signature of Triage Nurse [Signature]

Date & Time : 3/7/26 at 4:44pm

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



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 3/7/26 Time of arrival : 4:45 pm
Chief Complaints: Fever x 1 week RBS: NA
Height : 90 cms Weight : 12.5 kg BMI : NA Head Circumference (<2 years) : NA
Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: NA
If yes, identify NA
Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 9/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker
☐ Character: nil ☐ Location: nil ☐ Frequency: nil ☐ Duration: nil

RISK FOR FALL:

☐ If patient is < 6 years
tick below fall risk intervention directly

☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☐ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☐ No
• Uses furniture for support ☐ Yes ☐ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☐ No
• Weak ☐ Yes ☐ No
• Impaired ☐ Yes ☐ No

Mental Status: Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- ☐ Escort while ambulating
☒ Assist Patient
☒ Educate patient and family on fall precautions/prevention

Functional Screening: ☒ No Abnormalities Detected

- ☐ Mobility Problem
☐ Walking Problem
☐ Developmental Delay
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

- ☐ Underweight
☐ Overweight
☐ Feeding Problem
☐ Special diet
☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☒ No

If Yes Consultant Notified: NA (Date/Time): NA

Social History: Lives With: parents

Siblings in household ☐ Yes ☒ No (if yes How Many?) NA

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify NA Inform consultant for positive criteria.

Time of Initial assessment completed by ER Nurse : 4:47 pm

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

Time	Nursing Notes
4:42pm	Assess the child condition
	- monitored vitals & recorded
	- teen Dr. Nandan
	- shifted to ward

Samples collected by: NR-pannag
Samples sent by :

Time: 6:15 pm
Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :	Details of Shift - out
HR: 110 bpm BP: 118/60 CFT: 12 sec RR: 28 bpm SPO ₂ : 100% GCS: 4/5/6 Temperature: 98.2°F Pain Score: 0 Repeat RBS (if applicable): NA	Shift - out from ER to: ward Time of Shift - out: 7:10 pm Handover given to: [Signature] (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):
2x placement done

Name of the Nurse : [Signature] Signature of the Nurse : [Signature]
Date & Time : 3/7/20

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 4/7/26 Time: 9am

Weight: 12.5 kgs Centile: 325th

Height: 90 cms Centile: 50th

Inference: Well child

RDA: - Calories: 1250 kcal/d Protein: 21g/d

Diet Recommendations: soft diet & plenty of oral liquids

Re-Assessment: Avoid spicy, chilled & outside foods.

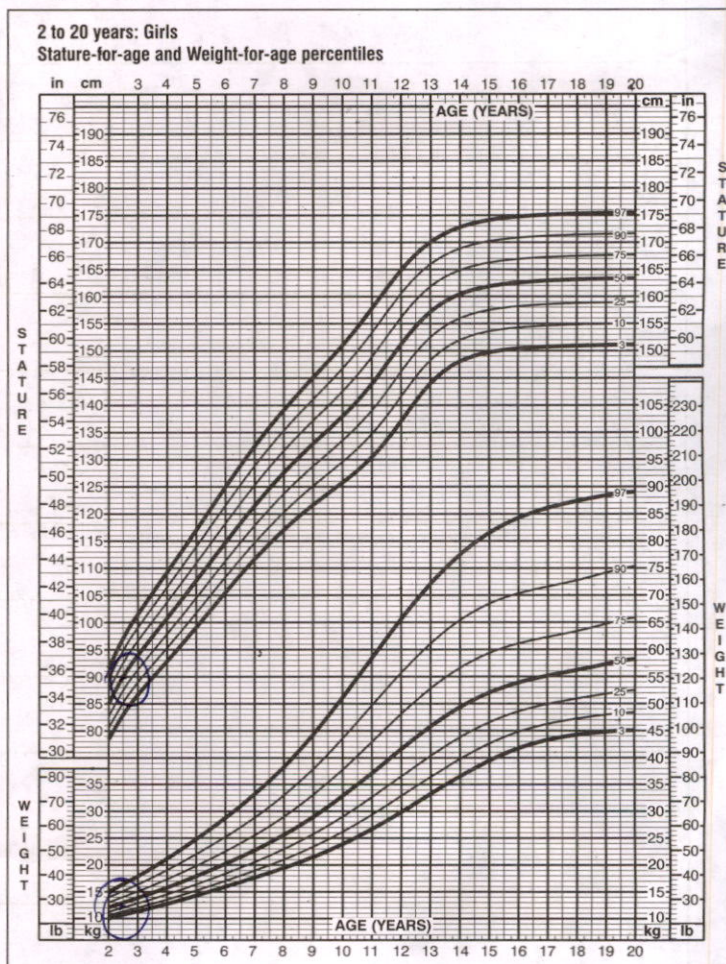
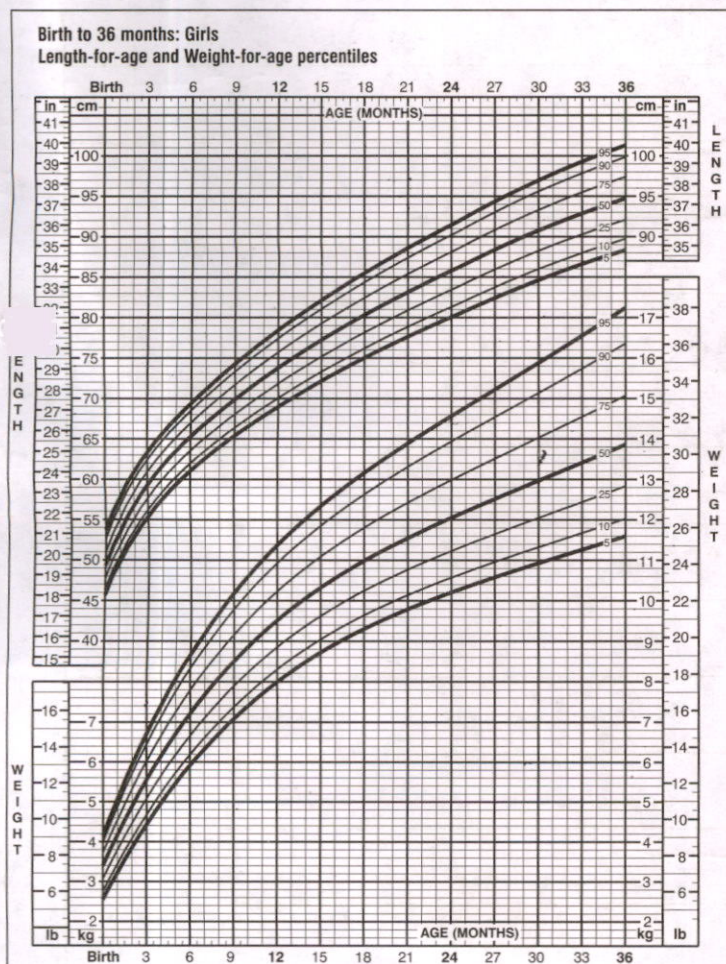
Food Allergies: NO Veg/Non-veg Non-veg

Diagnosis: UTI

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: *[Signature]*

GROWTH CHART (GIRLS)



Dietician's Name: manica

Dietician's Signature: manica

Child is stable. Entake is fair
continue = soft diet

1956