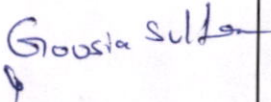


 Rainbow Children's Hospital	 BirthRight Rainbow	Rainbow Children's Hospital - Banjara Hills 8-2-120/103/1,2,3,4 and 5, Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad Telangana, India ,500034. TEL NO :+91-40-4466 5555 WEB : https://rainbowhospitals.in	
ADMISSION SHEET			
Registration Details :			
Admission No : IP5-00176178	Admit Date : 10-Jul-2026	Admit Time : 01:55 AM	UHID : CUV-00165141
Patient Details :			
Patient Name : Master PURANJEET ABRAM	Age : 1 Y 1 M 5 D	DOB : 05-06-2025 03:47 PM	
Guardian : Mr KIRAN KUMAR	Religion :		
Gender : Male	Martial Status : Single		
Occupation :	Phone No : 7673905434/ 7093053764		
Address (H) : #FLAT NO 407, SUNCITY APTS Srinagar Colony Hyderabad Telangana INDIA 500073	E-mail : nomailid@gmail.com		
Admission Details :			
Bed Type : BASINET	Bed No : CRDL-DLX308-1	Ward Name : 3F-ZONE A	
Room No : CRDL-DLX308-1	Admission Type : First Visit		
Contact Details :			
Name : Mr KIRAN KUMAR	Relationship : Father		
Contact Address : #FLAT NO 407, SUNCITY APTS Srinagar Colony Hyderabad Telangana INDIA 500073	Phone No : 7093053764 / 7673905434		
			 Signature
Doctor Details :			
Doctor Name : Dr. ANNAPOORNA TADAVARTHY	Specialisation : GENERAL PEDIATRICS		
Referral Doctor : SELF	Phone No :		
Co-Consultant : Dr. UJJWALA DESAI			
Payment Details :			
Payment Mode : Cash	Deposit Amount : 0.00		
Payor Name : STAR HEALTH AND ALLIED INSURANCE CO LTD			

ACTIVITY RECORD FOR BILLING

Name : _____

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

Date of Admission: _____ Time _____ e : _____ Time: _____

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

CUV-00165141 IP5-00176178
Master PURANJEET ABRAM
05-06-2025 1 Y 1 M 5 D (M)
Dr. ANNAPOORNA TADAVARTHY



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
10/7/26	2:38 PM	ER	308-1	Anna

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
10/7/26	IV placement	①	5797	Chasen

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor



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PEDIATRIC IN-PATIENT MEDICAL RECORD

CUV-00165141 IP5-00176178
Master PURANJEET ABRAM
05-06-2025 1 Y 1 M 5 D (M)
Dr. ANNAPOORNA TADAVARTHY



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

Pediatric Multiorgan history & Physical Examination

Preventive aspects of the treatment:

Sepsis
Shock

Desired goals of the treatment :

Hemodynamic stability

Planned Labs:

- CBP
 - CRP, RP-2
 - Blood cfs
 - 5 viral panel
 - CUE
 - Extra Plain sample
- AB
Cyan

Planned Management

- IVE DNS 80% Maintenance
 - Inj. Ceftriaxone
 - Inj. Esomeprazole
 - Syz. Fluor
 - Antipyretics
- AB
Aval
10/2/26

Signature of the Doctor: Nandani

Name of the Doctor: Dr. Nandan

Date & Time: 10/07/2026, 2 AM

Signature of the Consultant: 4

Name of the Consultant: Annapurna

Date & Time: 10/2/26 10 A

Dr. Tadvartthy Annapoornd
Reg. No. 3054

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7 9:30am	C/S/B Resident Δ: COVID illness	
	- fever - 1 spike morning	Adv:
	- cough on & off	1.) Isolation of patient
	O/E: alert stable vitals no RD chest clear	Do not give 308 A room to infants, immunosuppressed without disinfecting surfaces.
		2.) Plan (B) today
		3.) Cont current meds + nebs.
		4.) R/v Fluor
		Ashile
10pm	P/S/B w/ Annapoorna LRI.	
		P) CXR now.
		CVE.
		New order disp
		noted by Swapna

Dr. Tadavarthy Annapoorna
Reg. No: 53054

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/4 4pm	C/S/B Resident	
	<u>Δ: Covid illness</u>	<u>Adv:</u>
	- fever spikes ⊕	1) Fever management
	- no respiratory distress	2) Continue current antibiotics
	- orally accepting food	3) Do Chest X-ray
	- cough mild	Send CUE
	O/E: alert	4) Monitor vitals
	vitals stable	noted by Akhile
	Chest BAE ⊕ / clear	Swapna
	Abdomen soft	
7/4	r/s/b or Amp.	1) anti re
		Dr. Tadavorthy Annapoorna Reg. No. 53054
		Noted by Vamini @606288

CUV-00165141
Master PURANJEET ABRAM
05-08-2023 1 Y 1 M 5 D (M)
Dr. ANNAPOORNA TADAVARTHY

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7 9:30am	CS/B Resident A: COVID illness <u>adenovirus illness</u> - cp: 3 fever spikes/24h - last fever spike 12h ago - cough mild opi - based. O/E: alert vitals stable chest clear no resp distress CVS P/A / NAD	AF I (D5) <u>Adv:</u> 1) Add Ribavirin 2) Stop IVF to 1/2 maintenance 3) Stop Oseltamivir 4) R/v repeat CBP/CRP t/m 6am 5) Monitor vitals 6) continue Fluix 7) Femite lotion Shile 4A (Thumb Sucking) 8) Enterogemina 10ml BID Solich
	- R/S/B Dr Amp:	1) contiv Oseltami Ribavirin • stop iv fluid Dr. Tadavarthy Annapoorna Reg. No: 53054

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26 4:30pm	CL/B Resident	
	- No fever	
	- 3 c/o loose stools	Prn
	Oral ulcer	
	O/E	- Dengs as per chart
	detritus	- Monitor vitals / Inform so
	vitals - stable	
	S/E was	
		Noted by Jany Khan
	NGT in amp.	COX, CRP 12/7/26 Sueh
		Noted by Sueh @ 8pm 12/7/26



Date & Time	Progress Notes	Doctor's Order
12/1/20 9:30AM	4/5/6 Covid Covid - Immune. - No fresh complaints 9/5 Ardu inlets - stable S/E - NAD	<u>PLAN:</u> 1) D/C today. • F/U Wednesday. • Libavaia - Ptl 5 dgs • Paxin - 3 dgs. • Oultain - 1 dy. • Entecogin - 2 dgs • Hypernet BD - 3 dgs A.T.

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

CUV-00165141 IP5-00176178
 Master PURANJEET ABRAM
 05-06-2025 1 Y 1 M 5 D (M)
 Dr. ANNAPOORNA TADAVARTHY



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RESULT SHEET

Date	10/7/26	12/7/26			
Time	6 AM				
Hb	11	11.7			
PCV	33	36.4			
RBC	4.39	4.80			
WBC	15.98	9,460			
N/L	61.5/30	28/62			
Platelets	221	2.77L			
CRP	48	28 L			
ESR					
PCT					
RBS					
Na	133	140			
K	4.3	5.4			
Cl	106	112			
Ca/Mg					
Phosphate					
Urea	25	2			
Creatinine	0.3				
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

BICARBONATE - 15

Patient

CUV-00185141 IP5-00176178
 Master PURANJEET ABRAM
 05-06-2026 1 Y 1 M 6 D
 Dr. ANNAPOORNA TADAVARTHY (M)

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MEDICATION RECONCILIATION FORM

Drug Allergies: ☒ Not known any Drug Allergies

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

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

Shifting From: ER Shifted to: 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	SYP. FLUVER	2.5ml	PO	BD	yet to start	☒ 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: Nandhan, Dr. Nandhan

Date & Time: 10/07/2026, 2 AM

Nurse Name & Signature: Anneel

Date & Time: 10/7/2026 2:30 PM

UV-00165141 IP5-00176178
 aster PURANJEET ABRAM
 3-06-2023 1 Y 1 M 3 D (M)
 r. ANNAPOORNA TADAVARTHY

Sheet No: REGULAR PRESCRIPTIONS Weight Ward

DRUG : <u>HYPERNER</u>				Date Time	<u>10/7</u>	<u>11/7</u>	<u>12/7</u>													
Dose	Route	Frequency	Start Dt.																	
<u>1ml</u>	<u>nebs</u>	<u>Day</u>	<u>10/7</u>																	
Name & Signature of the Doctor Starting the Drugs:				<u>AAI</u> <u>10pm</u> <u>11pm</u> <u>12pm</u>																
Additional Instructions:				<u>3y. Nace</u>																
Daily Doctor's Endorsement by a Sign				<u>A</u> <u>A</u>																
DRUG : <u>Cap RIBAVIRIN</u>				Date Time	<u>10/7</u>	<u>11/7</u>	<u>12/7</u>													
Dose	Route	Frequency	Start Dt.																	
<u>2ml</u>	<u>PO</u>	<u>BID</u>	<u>11/7</u>																	
Name & Signature of the Doctor Starting the Drugs:				<u>Shihla</u> <u>10pm</u> <u>11pm</u> <u>12pm</u>																
Additional Instructions:				<u>ditute</u>																
Daily Doctor's Endorsement by a Sign				<u>Cap = 200mg in 2ml & give 2ml</u>																
DRUG : <u>ENTEROGERMINA</u>				Date Time	<u>10/7</u>	<u>11/7</u>	<u>12/7</u>													
Dose	Route	Frequency	Start Dt.																	
<u>1ml</u>	<u>PO</u>	<u>BID</u>	<u>11/7</u>																	
Name & Signature of the Doctor Starting the Drugs:				<u>Sohih</u> <u>10pm</u> <u>11pm</u> <u>12pm</u>																
Additional Instructions:				<u>10pm 2ml</u>																
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>SYN OSELTAMIVIR</u>				Date Time	<u>10/7</u>	<u>11/7</u>	<u>12/7</u>													
Dose	Route	Frequency	Start Dt.																	
<u>2.5ml</u>	<u>PO</u>	<u>BID</u>	<u>11/7</u>																	
Name & Signature of the Doctor Starting the Drugs:				<u>Sohih</u> <u>10pm</u> <u>11pm</u> <u>12pm</u>																
Additional Instructions:				<u>10pm 2ml</u>																
Daily Doctor's Endorsement by a Sign																				

Weight Ward

DRUG :				Date	Time	Weight	Ward
Dose	Route	Frequency	Start Dt.				
	4A	TID	11/7				
Name & Signature of the Doctor Starting the Drugs:							
Additional Instructions:							
Daily Doctor's Endorsement by a Sign							
DRUG :				Date	Time	Weight	Ward
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	Weight	Ward
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	Weight	Ward
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	Weight	Ward
Dose	Route	Frequency	Start Dt.				
Name & Signature of the Doctor Starting the Drugs:							
Additional Instructions:							
Daily Doctor's Endorsement by a Sign							

DRUG CHART

Date of Admission: 10/07/2026 Drug Allergies: 2 Allergic to Ibuprofen ☐ 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: SYD. PARACETAMOL				Date Time	10/7/26
Dose 3ml	Route PO	Frequency SOS	Start Date 10/7/26	2:00 PM	
Doctor's Signature Dr. Nanda		Valid Period	Pharm. Per		
Additional Instructions: 240mg 15ml if temp > 100°F, minimum 6 hrs gap between 2 doses.					
DRUG: SYD. MEFTAL-1				Date Time	
Dose 4ml	Route PO	Frequency SOS	Start Date 10/7/26		
Doctor's Signature Dr. Nanda		Valid Period	Pharm. Per		
Additional Instructions: If temp > 102°F minimum 8 hrs gap between 2 doses.					
DRUG:				Date Time	
Dose	Route	Frequency	Start Date		
Doctor's Signature		Valid Period	Pharm.		
Additional Instructions:					

VERIFIED BY: Name Sign



REGULAR PRESCRIPTIONS

Weight. 9.25 kg Ward.

VERIFIED

DRUG : <u>INS. CEFTRIAXONE</u>				Date Time	<u>10/7</u>	<u>11/7</u>	<u>12/7</u>
Dose	Route	Frequency	Start Date				
<u>450mg</u>	<u>IV</u>	<u>BD</u>	<u>10/07/26</u>				
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandani</u>				<u>6AM 3AM 11/7</u> <u>12/7</u>			
Additional Instructions:				<u>6PM 12/7</u> <u>12/7</u>			
Daily Doctor's Endorsement by a Sign				<u>10/7</u> <u>11/7</u>			

VERIFIED

DRUG : <u>INS. PANTOPRAZOLE</u>				Date Time	<u>10/7</u>	<u>11/7</u>	<u>12/7</u>
Dose	Route	Frequency	Start Date				
<u>10mg</u>	<u>IV</u>	<u>OD</u>	<u>10/07/26</u>				
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandani</u>				<u>6AM 3AM 11/7</u> <u>12/7</u>			
Additional Instructions:				<u>6PM 12/7</u> <u>12/7</u>			
Daily Doctor's Endorsement by a Sign				<u>10/7</u> <u>11/7</u>			

VERIFIED

DRUG : <u>SYN. OSELTAMIVIR</u>				Date Time	<u>10/7</u>	<u>11/7</u>	<u>12/7</u>
Dose	Route	Frequency	Start Date				
<u>2.5ml</u>	<u>PO</u>	<u>BD</u>	<u>10/07/26</u>				
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandani</u>				<u>10AM 12/7</u> <u>12/7</u>			
Additional Instructions: <u>60mg/5ml</u>				<u>STOP</u> <u>11/7</u>			
Daily Doctor's Endorsement by a Sign				<u>10/7</u> <u>11/7</u>			

VERIFIED

DRUG : <u>NASO CLEAR DROPS</u>				Date Time	<u>10/7</u>	<u>11/7</u>	<u>12/7</u>
Dose	Route	Frequency	Start Date				
<u>2/2</u>	<u>Nasal</u>	<u>TID</u>	<u>10/7</u>				
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u>				<u>6AM 12/7</u> <u>12/7</u>			
Additional Instructions:				<u>6PM 12/7</u> <u>12/7</u>			
Daily Doctor's Endorsement by a Sign				<u>10/7</u> <u>11/7</u>			

CUV-00165141 IP5-00176178
Master PURANJEET ABRAM
05-06-2025 1 Y 1 M 5 D (M)
Dr. ANNAPOORNA TADAVARTHY

Master PURANJEET ABRAM 05-06-2025 1 Y 1 M 5 D (M) Dr. ANNAPOORNA TADAVARTHY 		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		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Start Date		Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor			Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:			Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

STAT / ONCE ONLY DRUGS[illegible]



NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
10/7	00.00	Neb T 3% NS (10pm)	Janni	969681
	01.00	Neb T 3% NS (10AM)	Janni	969884
	02.00			
12/7/25	03.00	Neb T		
	04.00			
12/7/25	05.00	Neb. 3% NS 10AM	Sundar	
	06.00			
	07.00			
	08.00			
	09.00			
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

CUV-00165141 IP5-00176178
Master PURANJEET ABRAM
05-06-2025 1 Y 1 M 5 D (M)
Dr. ANNAPORNA TADAVARTHY

10/7/26

: RCH/ FRM / CLINICAL / 125

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

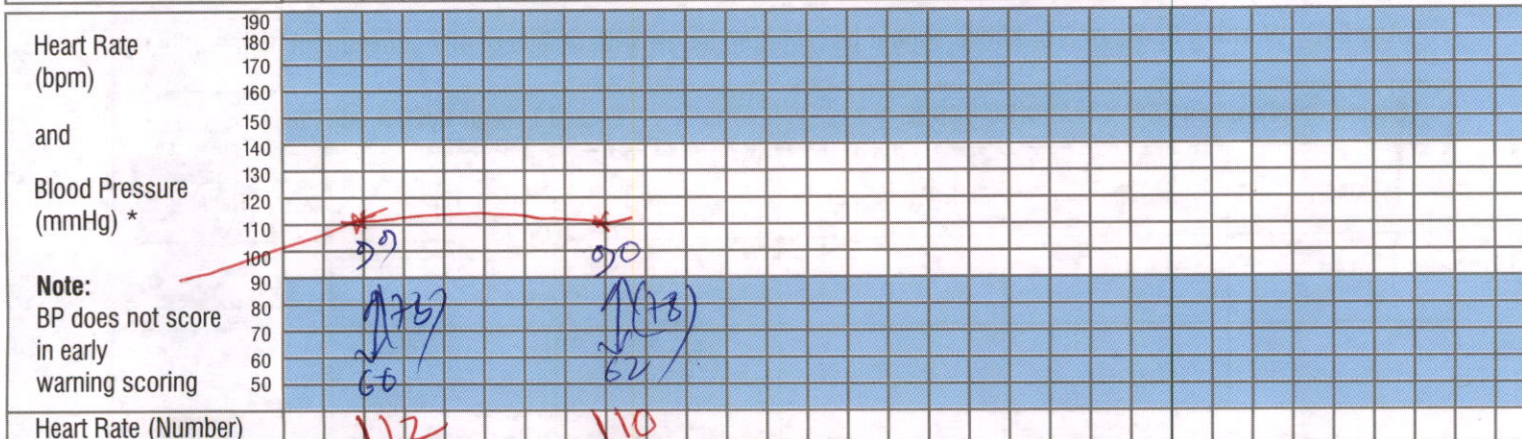
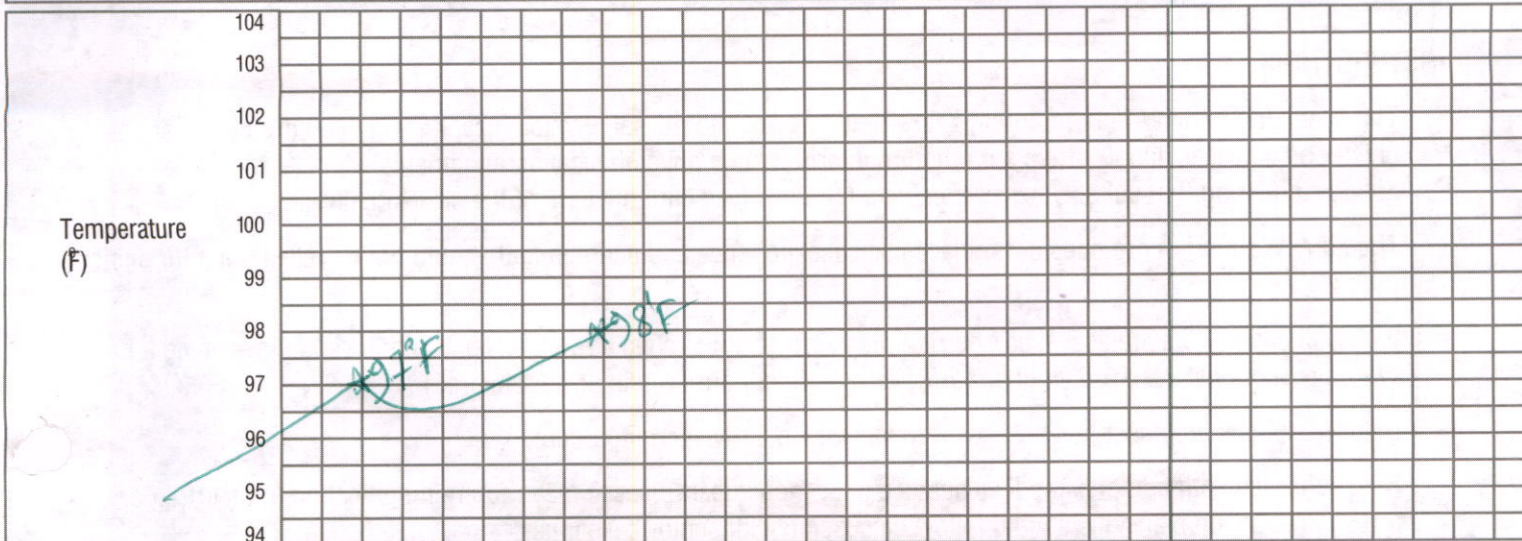
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 3 AM 6 AM

Doctor / Nurse / Family Concern?



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

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

ACTIONS	Score 1 : Continue normal observation by staff nurse
	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)

10/7/25

No. : RCH/ FRM / CLINICAL / 125

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	8:30 am	9:30 am	11 am	1:30 pm	2:30 pm	4:40 pm	7:20 pm	8:50 pm	10:14 pm	11:00 pm
Doctor / Nurse / Family Concern?											
Temperature (F)	104										
	103										
	102										
	101										
	100										
Heart Rate (bpm)	190										
	180										
	170										
	160										
	150										
Blood Pressure (mmHg) *	140										
	130										
	120										
	110										
	100										
Note: BP does not score in early warning scoring											
Heart Rate (Number)											
Resp. Rate (bpm) (Over 1 Minute) *	70										
Resp Rate (Number)											
Resp Distress	Mod/ Severe										
Receiving O ₂ (l/min)	None / Mild										
O ₂ Saturations (%)											
Conscious Level	Normal										
GCS *	Altered										
TOTAL SCORE											
Number of shaded boxes											
Pain Score											
Observer's Initials											

ACTIONS

NB: Scores 3 should be recorded overleaf

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

UV-00165141 IP5-00176178
Nester PURANJEET ABRAM
5-08-2025 1 Y 1 M 5 D (M)
r. ANNAPOORNA TADAVARTHY



11/7
RCH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)

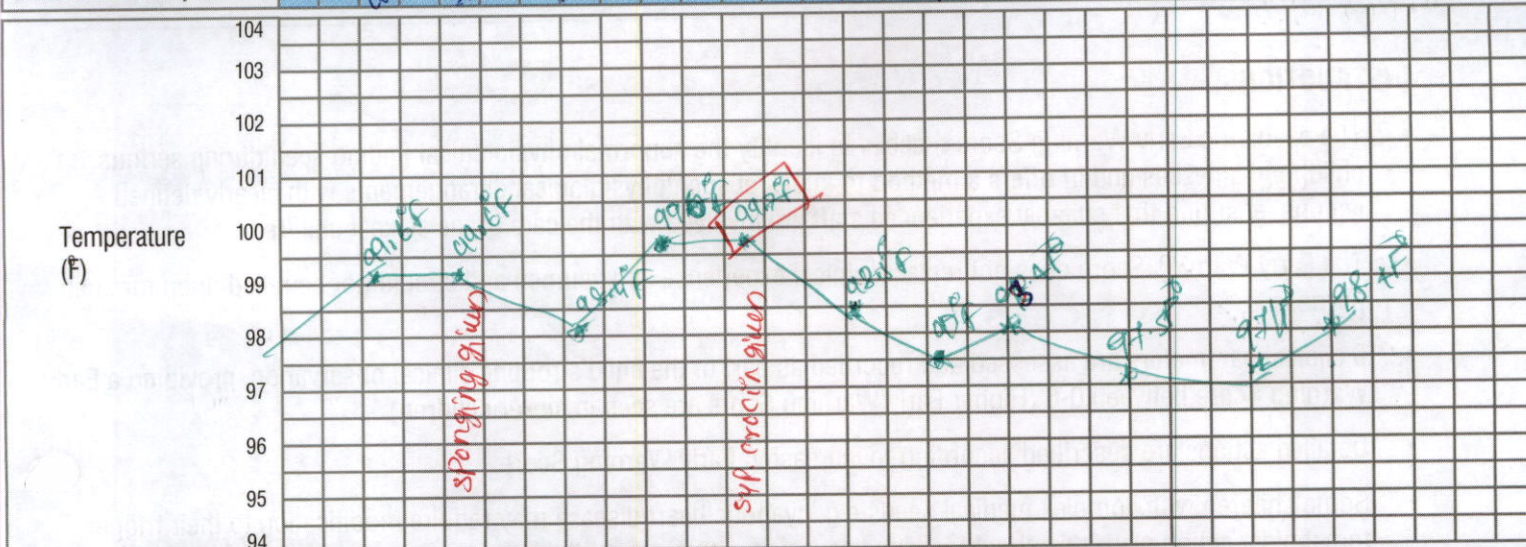
Children's Observation &
Early Warning Scoring Chart

Pratiksha
Rainbow
Children's
Hospital
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	10:20	11:20	12:30	2pm	3pm	4pm	5pm	7pm	12Am	3Am	6Am
Doctor / Nurse / Family Concern?		am	am	pm								



Heart Rate (bpm)	190											
and	180											
Blood Pressure (mmHg) *	170											
	160											
	150											
	140											
	130											
	120											
	110											
	100											
	90											
	80											
	70											
	60											
	50											
Note: BP does not score in early warning scoring												
Heart Rate (Number)		106bpm					106bpm	126bpm	126bpm	132bpm	132bpm	

resp. Rate (bpm) (Over 1 Minute) *	70											
	60											
	50											
	40											
	30											
	20											
	10											
Resp Rate (Number)		32bpm					32bpm	36bpm	32bpm	38bpm	40bpm	

Resp Distress	Mod/ Severe											
	None / Mild											
Receiving O ₂ (l/min)												
O ₂ Saturations (%)		95%					99%	99%	98%	99%	98%	
Conscious Level	Normal											
	Altered											
GCS *												

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

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.

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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Date	Time	Early Warning Score	Date	Time	Name

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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)

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :		Time:	
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		
and Blood Pressure (mmHg) *	80		
	70		
	60		
	50		
	40		
	30		
	20		
	10		
	0		
	0		
	Note: BP does not score in early warning scoring		
Heart Rate (Number)			
resp. Rate (bpm) (Over 1 Minute) *	70		
	60		
	50		
	40		
	30		
	20		
	10		
	0		
	0		
	0		
	Resp Rate (Number)		
Resp Distress	Mod/ Severe None / Mild		
Receiving O ₂ (l/min)			
O ₂ Saturations (%)			
Conscious Level	Normal Altered		
GCS *			
TOTAL SCORE			
Number of shaded boxes			
Pain Score			
Observer's Initials			
ACTIONS 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.	

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CUV-00165141 IP5-00176178
 Master PURANJEET ABRAM
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FLUID CHART

Sheet No. :

10/7/26

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.

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	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		ml								0	sum	
	04:00 am			30ml			20				0	sum	
	05:00 am			30ml							0	sum	
	06:00 am		ml	30ml							0	sum	
	07:00 am			30ml							0	sum	
Total Intake :						Total Output :						0-1	ml
Total 24 hrs. Intake		Total 24 hrs. Output											

FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am	1		30ml							0	Swagone	
	09:00 am	1	30ml								0	Swagone	
	10:00 am	1	30ml								0	Swagone	
	11:00 am	1									0	Swagone	
	12:00 pm	1									0	Swagone	
	01:00 pm	1									0	Swagone	
Total Intake : 90ml						Total Output : V-2 M-1							
	02:00 pm	1									0	Swagone	
	03:00 pm	1									0	Swagone	
	04:00 pm	1									0	Swagone	
	05:00 pm	1									0	Swagone	
	06:00 pm	1									0	Swagone	
	07:00 pm	1									0	Swagone	
Total Intake :						Total Output : V-3 M-1							
	08:00 pm	1									0	Yam	
	09:00 pm	1									0	Yam	
	10:00 pm	1									0	Yam	
	11:00 pm	1									0	Yam	
	12:00 am	1									0	Yam	
	01:00 am	1									0	Yam	
Total Intake :						Total Output : V-1 M-0							
	02:00 am	1									0	Yam	
	03:00 am	1									0	Yam	
	04:00 am	1									0	Yam	
	05:00 am	1									0	Yam	
	06:00 am	1									0	Yam	
	07:00 am	1									0	Yam	
Total Intake :						Total Output : V-0 M-0							
Total 24 hrs. Intake		Dals 90ml 40											
Total 24 hrs. Output		V-6 M-3											



FLUID CHART

Sheet No. : 3

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

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											0	Tulli
	09:00 am	↓ milk					1					0	Tulli
	10:00 am	↓ milk					NA					0	Tulli
	11:00 am	↑ milk										0	Tulli
	12:00 pm	↑					✓					0	Tulli
	01:00 pm											0	Tulli
Total Intake :						Total Output :						U-2 M-2	
	02:00 pm	↓ milk										0	Tulli
	03:00 pm	↓ milk					✓					0	Tulli
	04:00 pm	↓ milk					✓					0	Tulli
	05:00 pm	↑ milk					✓					0	Tulli
	06:00 pm	↑					✓					0	Tulli
	07:00 pm											0	Tulli
Total Intake :						Total Output :						U-3 M-2	
	08:00 pm	↓ milk					1					0	Sush
	09:00 pm	↓ milk					1					0	Sush
	10:00 pm	↓ milk					NA					0	Sush
	11:00 pm	↓ milk					1					0	Sush
	12:00 am	↓ milk					1					0	Sush
	01:00 am	↓ milk										0	Sush
Total Intake :						Total Output :						U-2 M-0	
	02:00 am	↓ milk					1					0	Sush
	03:00 am	↓ milk					1					0	Sush
	04:00 am	↓ milk					NA					0	Sush
	05:00 am	↓ milk					1					0	Sush
	06:00 am	↓ milk					1					0	Sush
	07:00 am	↓ milk										0	Sush
Total Intake :						Total Output :						U-1 M-0	
Total 24 hrs. Intake						Total 24 hrs. Output			U-8 M-4				

12/7/20

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											0	sum
	09:00 am	milk										0	sum
	10:00 am											0	sum
	11:00 am	milk										0	sum
	12:00 pm											0	sum
	01:00 pm	pu										0	su
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							

CUV-00165141 IP5-00176176

Master PURANJEET ABRAM

05-06-2025 1 Y 1 M 5 D (M)

Dr. ANNAPOORNA TADAVARTHY



NURSING CARE RECORD

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

Date: 10/7/26

Assessment: PT having

Goals

- ☒ Maintain Airway and Oxygenation
- ☒ Maintain Personal Hygiene
- ☐ Identify Potential Complications

- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ Any Others. Specify.....

- ☒ Maintain Fluid Balance
- ☐ Meet Elimination Needs

- ☐ Improve Activity Tolerance
- ☒ Ensure Safety

- ☒ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety

- ☒ Maintain Skin Integrity
- ☐ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
3AM	→ Assess the PT condition.	3AM	→ Assessed the PT condition.	PT is stable
4AM	→ vital chart maintain	4AM	→ vital chart maintain	
6AM	→ Ensure safety	6AM	→ continue IV antibiotic	
8AM	→ continue IV flush	8AM		

Re-Assessment:

Special Notes: MT

Nurse Signature: S

Nurse Name: sumana

Date & Time: 10/7/26 @ 8AM

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 10/7/26

Assessment: Patient is having fever spikes

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the general condition of the patient	9am	Assessed the general condition of the patient	patient is stable
10am	Administer medication as per doctor's order	11am	Administered medication as per doctor's order	
12pm	Maintain good nutritional status	1pm	Maintained good nutritional status	
2pm	Continue IV fluids	4pm	Continued IV fluids	
5pm	watch for fever spikes	6pm	fever medicine given	
7pm	ensure safety	8pm	provide side rally	

Re-Assessment: Re-assessment done every 2nd hourly

Special Notes: Trace cue, chest x ray done

Nurse Signature: Swarna Nurse Name: Swarna 1015692 Date & Time: 10/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/17/26

Assessment: Baby is having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the Baby's General Condition	8:30pm	Assessed the Baby's General Condition	Now Baby is stable
10pm	Administer medications as per chart	10:30pm	Administered medication as per chart	
12am	Maintain fluid balance	12:00am	monitored fluid balance	
3am	Monitor vital signs	3:30am	monitored vital signs	
7am	Ensure safety	7:00am	Ensure safety	

Re-Assessment: Re-assessment done every 3rd hourly

Special Notes: continue obs.

Nurse Signature: [Signature]

Nurse Name: Yamuna @606205

Date & Time: 11/17/26 @ 8am

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 11/7/26

Assessment: Patient is having Discomfort

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	* Assess the patient condition	9am	* Assessed the patient condition	Patient is stable
10am	* monitor vitals	11am	* monitored vitals.	
12pm	* maintain personal hygiene	1pm	* maintained personal hygiene.	
2pm	* ensure safety	3pm	* provided side rails.	
4pm	* Administer medication as per doctor order	5pm	* Administered medication given as per doctor order.	
6pm	* prevent infection	7pm	* prevented infection	

Re-Assessment: 1

Special Notes:

Nurse Signature: 

Nurse Name: Jyoti (Gautam)

Date & Time: 11/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/7/26

Assessment: patient is having dis

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the baby condition and vitals checked	8:30 pm	* Assessed the baby condition and vitals checked	* now baby condition is stable
10pm	* monitor the I/O chart	10:30 pm	* monitored the I/O chart	
12pm	* Check the Fever spikes	12:30 AM	* checked the Fever spikes	
3AM	* Administered medicine as per chart	3:30 AM	* Administered medicine as per chart	
6AM	* Stop IV fluids	6:30 AM	* Stopped IV fluids	
4AM	* Ensure Safety		* Ensured Safety	

Re-Assessment: Assess the baby condition now it is stable

Special Notes: Nil

Nurse Signature: Sush Nurse Name: Sush - 607635 Date & Time: 11/7/26 @ 8pm

CUV-00165141 IP5-00176178
 Master PURANJEET ABRAM
 05-06-2023 1 Y 1 M 6 D (M)
 Dr. ANNAPOORNA TADAVARTHY



NURSING CARE RECORD

**Rainbow®
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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 12/7/26

Assessment: PT having cough

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	→ Assess the PT condition.	8AM	→ Assessed the PT condition.	PT is stable
10AM	→ vital chart maintain	10AM	→ vital chart maintained	
11AM	→ Ensure safety → continue nebulization → stop IV fluid	11AM	→ Ensured safety → continue nebulization	

Re-Assessment:

Special Notes: neb. Hyper

Nurse Signature: S

Nurse Name: sumana

Date & Time: 12/7/26

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

CUV-00165141
Master PURANJEET ABRAM
05-06-2025 1 Y 1 M 3 D
Dr. ANNAPOORNA TADAVARTHY (M)

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HIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Annapoorna Department: _____ Date of Admission: 10/7/26

SITUATION	Diagnosis: <u>AFS</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known		If Yes Specify: _____	
BACKGROUND	Area	ER	3rd Fl	3rd Floor	3rd Floor	3rd Floor
	Shift Time	2:30 PM	3 AM - 8 AM	8 AM - 1 PM	1 PM - 5 PM	5 PM - 8 PM
ASSESSMENT	Medical Condition (Any special condition to be noted):	NO	NA	NA	NA	NA
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
RECOMMENDATIONS	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp: 101.7 F	98.4 F	98.8 F	98.9 F	98.2 F
	Res:	26 bpm	24 bpm	26 bpm	24 bpm	26 bpm
	SpO ₂ :	97%	98%	99%	100%	99%
	Pulse:	113 bpm	112 bpm	118 bpm	114 bpm	120 bpm
	BP:	109/56	100/70	101/68	101/71	102/62
	Fall Risk Score:	12	12	12	12	12
	Pain Score:	0/10	0/10	0/10	0/10	0/10
	Safety Needs:	NO	NO	side rails	side rails	side rails
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Others Specify:	NO	NA	NA	NA	NA	
Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:	NO	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NO	NA	NA	NA	NA
Handed Over By Name :		Anand	Swamy	Swamy	Swamy	Swamy
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		10/7	10/7	10/7	11/7	12/7
Time:		2:30 PM	8 AM	8 PM	8 AM	8 AM
Taken Over By Name :		Swamy	Swamy	Swamy	Swamy	Swamy
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		10/7	10/7	10/7	11/7	12/7
Time:		3 AM	8 AM	8 PM	8 AM	8 AM



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: 3rd Floor Date of Admission: 10/7/20

SITUATION	Diagnosis: <u>AFI</u>		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
	Area	Shift Time					
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>NA</u>					
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	<u>98°F</u>				
		Res:	<u>26/bm</u>				
		SpO ₂ :	<u>99%</u>				
		Pulse:	<u>118/bm</u>				
		BP:	<u>100/64</u>				
		Fall Risk Score:	<u>12</u>				
Pain Score:	<u>0/10</u>						
Recommendations	Safety Needs:	<u>yes</u>					
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	<u>NA</u>					
	Special Diet:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>NA</u>					
Post Operative Procedure Special Orders:		<u>NA</u>					
Handed Over By Name :		<u>Shane</u>					
Signature :		<u>[Signature]</u>					
Date:		<u>12/8/20</u>					
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

Pa CUV-00165141 IP5-00176178
Master PURANJEET ABRAM
05-06-2026 1 Y 1 M 6 D (M)
Dr. ANNAPOORNA TADAVARTHY

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HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	9	9	9	9	9
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	9	2	2	2	2
Cognitive Impairments	Not Aware of Limitations	3	2	2			
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1	1	1
	History of Falls or Infant - Toddler Placed in Bed	4			1	1	1
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	1
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3			1		
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
TOTAL			12	12	12	12	12

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	Yes	Yes	✓	Yes	Yes
Call device within reach	Yes	Yes	✓	Yes	Yes
Wheels Locked	Yes	Yes	✓	Yes	Yes
Room free of clutter	Yes	Yes	✓	Yes	Yes
Adequate Lighting	Yes	Yes	✓	Yes	Yes
Wheel Chair Support	No	NA	✓	No	NA
Other Intervention(s) Specify	No	NA	✓	No	NA
Nurse's Name :	Amal	Shree	Yash	Juni	Sush
Signature :	Amal	Shree	Yash	Juni	Sush
Date :	10/7	10/7	11/7	11/7	12/7
Time :	1:40 pm	8 am	8 am	8 pm	8 am



308-b

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 10/7/26 Time: 9 am

Weight: 9.25 kg Centile: < 5th

Height: 56 cm Centile: < 5th

Inference: underweight child

RDA: — Calories: 1200 kcal/d Protein: 20 gm/d

Diet Recommendations: soft diet

Re-Assessment: Avoid spig, chilled & outside foods

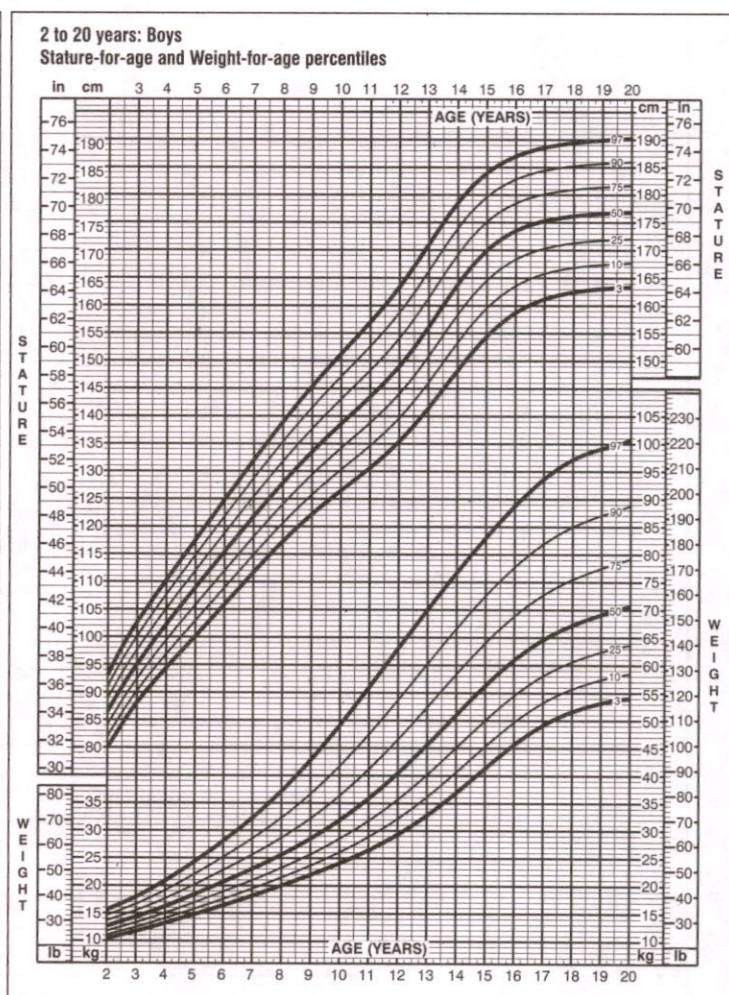
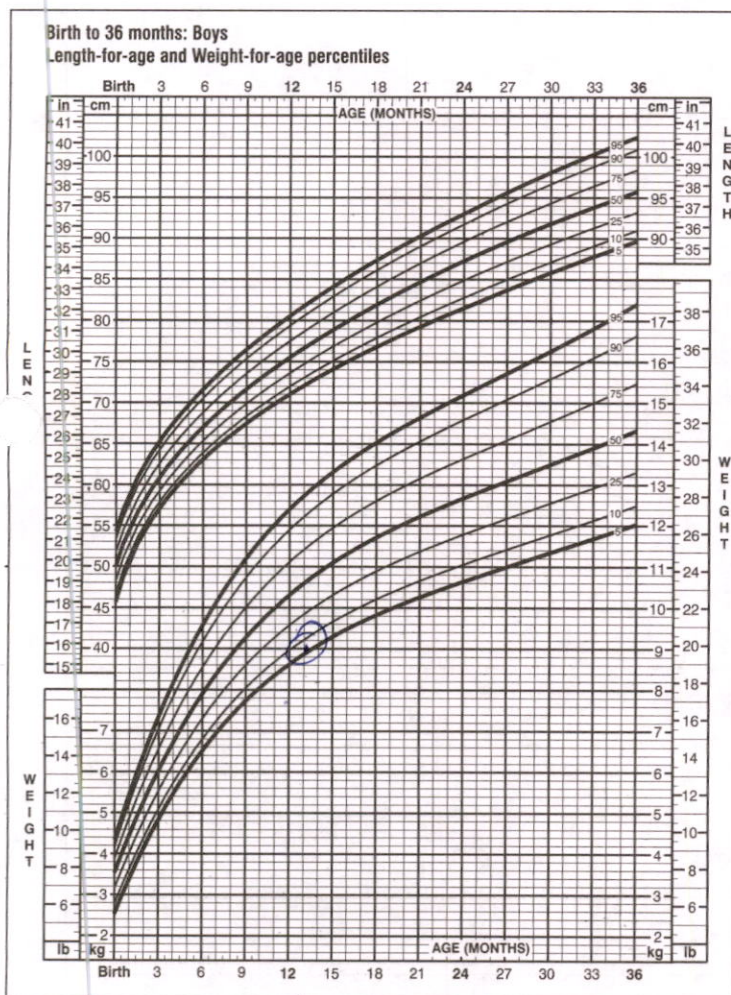
Food Allergies: No Veg/Non-veg: NON-veg

Diagnosis: App. ↓ evaluation [? viral]

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Gausia Sultan

GROWTH CHART (BOYS)



Dietician's Name: Lalima

Dietician's Signature: Lalima

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PATIENT TRANSFER FORM

Patient Name & UHID No. CUV-00165141 IP5-00176178 Master PURANJEET ABRAM 05-06-2025 1 Y 1 M 5 D (M) Dr. ANNAPOORNA TADAVARTHY 		Date & Time of Admission 10/7/26 1:55 PM	Date & Time of Transfer Order 10/7/26 2:20 PM
		Transfer Ordered by Dr. Nandan	Reason for Transfer Admission
From Unit ER	To Unit 308 - 1	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 25	Number of Imaging Films 10	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If yes, what? (Opium)	
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 Annel		Name of Person Ordered Transfer Dr. Nandan	
Patient & Clinical Records Received by : Suman			
Date & Time of Patient Received : 10/7/26 @ 2:30 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

WAGGON

CUV-00165141 IP5-00176178
Master PURANJEET ABRAM
05-06-2025 1 Y 1 M 5 D (M)
Dr. ANNAPOORNA TADAVARTHY



DISCHARGE PLANNING FORM

Nationality: INDIAN

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

1. Anticipated Date of Discharge: 11/7/26

2. Destination Post Discharge: Home
Family Members Notified (Person Contacted)
Transfer
Hospital Facility Notified (Person Contacted)

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

ASSISTANCE needed

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:
Patient's Educational Topic/s discussed with the:
Patient Family Member Others:

Nurse Signature:

Nurse Name: sumand

Date and Time: 10/7/26 3:34

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 ☐ Special Feeding Method
- ☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening:

- ☐ No Significant Findings

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

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify Inform consultant for positive criteria.**Social History:** Lives WithSiblings in household ☐ Yes ☒ No (if yes How Many?)All Information Obtained From ☒ Patient ☒ Mother ☐ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**

- Call Bell in Reach : ☒ Yes ☐ No Waste Disposal Explained: ☒ Yes ☐ No
- Infusion Pump : ☒ Yes ☐ No Hand hygiene Explained: ☒ Yes ☐ No ☐ Others
- Patient Rights & Responsibilities: ☒ Yes ☐ No

Information given to *parents*Nurse Signature: *[Signature]*Nurse Name: *sumand*Date: *10/7/26*Time: *3:41*

Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 3 AM Mode of Arrival: Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction - nil - Body Weight: Kg

Height: cm

Past Medical History: Obtained From ☒ Patient ☒ Family Member ☐ Medical Record ☐ Other (specify)

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>- nil -</u>	<u>- nil -</u>	<u>- nil -</u>

Family History:

Has the child or close family member had recent contact with a communicable disease? ☒ Yes ☐ No

If Yes, please list:

Was the child's birth normal? ☒ Yes ☐ No If No, please describe problems:

Are the child's immunization up to date? ☒ Yes ☐ No

Current Medication: ☐ None ☒ Yes, If Yes, fill reconciliation form

Observations: Weight: Length: Head Circumference (< 2 years):

Temp.: 98°F HR: 110 bpm RR: 26 bpm BP: 99/62

Pain Score: 13 Specify Site: 2 7 (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☐ Yes ☒ No Score: (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☐ Yes ☒ No If Yes, Pain Score: Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker

Character of Pain Location Frequency Duration

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
10/24	1:40 PM	10	few Risk Education	moth		owl	1	1	no	
10/26	9 AM	9	soft diet	m/f	1	0	1	1	-	

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)

Learning Barriers:

1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	

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

Mechanism/s to overcome barrier/s:

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

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

CUV-00165141 IP5-00176178
 Master PURANJEET ABRAM
 05-06-2025 1 Y 1 M 6 D (M)
 Dr. ANNAPOORNA TADAVARTHY

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MULTI-DISCIPLINARY PLAN OF CARE FORM

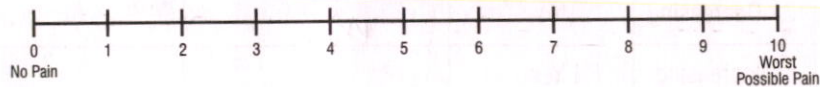
Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
10/7/25	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	AFT	A - Steady	ivf Antibiot	[Signature]	☐ Nursing ☐ Others:
10/7/25	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	AFT	A Steady	ivf med/abn	Auel	☐ Medical ☐ Others:
10/7/26 9 AM	☐ Medical ☐ Nursing ☒ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	gh	soft diet	RDA E - 1200 kcal/d P - 20g w/d	[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:

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
10/7/25	7:49 PM	0/10	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NO NO	Asus
10/7/25	8 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Yany
10/7	11 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Yany
10/7	5 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Yany
11/7	2 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Yany
11/7	8 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Yany
11/7	10 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suchu
12/7	12 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suchu
12/7	3 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suchu
12/7	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suchu

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.

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0										
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													

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 of Ward In Charge :

Signature : Name :

Signature : Name :



CHECKLIST FOR THROMBOPHLEBITIS

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

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : Name : Lovely

Signature of Ward In Charge :

Signature : Name : Anytho

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0	0	0		
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			-	-	-	-	-	-		
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			-	-	-	-	-	-		
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			-	-	-	-	-	-		
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			-	-	-	-	-	-		
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-	-	-	-	-		
Signature of the Nurse						5	Swap	200	200	200	200		

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : Name : Sudip

Signature of Ward In Charge :

Signature : Name : Anish

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



BRADEN 'Q' SCALE

					Date :				
					Time :				
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.					
"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.					
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.					
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.					
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."					
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.					
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.					
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE				
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name				

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
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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



BRADEN 'Q' SCALE

					Date :	10/7/2024	11/7/2024	12/7/2024
					Time :	15:10	8:00 PM	8:00 PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	9	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.	9	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.	9	4	4	4
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	9	4	4	4
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Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be < 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	9	4	4	4
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23								
Docu. No. : RCHBH /FRM / CLINICAL / 119								
					TOTAL SCORE			
					Evaluator's Name			
					Anil Kumar			



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	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					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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					
Total							

Intervention:

-Fall Risk: Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position						
Call device within reach						
Wheels Locked						
Room free of clutter						
Adequate lighting						
Wheel chair support						
Other Intervention(s) Specify						
Nurse's Name:						
Signature:						
Date:						
Time:						