

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

Date of Admission : _____

Room / Bed No : _____

IP5-00175946
BAH-00523589
Baby VARSHINI G
02-09-2018 7 Y 10 M 1 D (F)
Dr. UJJWALA DESAI

Attendant : _____ Dept : _____

Time of Discharge : _____ Time : _____

Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
4/2/26	12:30am	ER	143 118	Ⓟ

Cross Consultation Visit

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

[illegible]

Date _____

Investigations

Order No.

Signature

9/7/

CBP, CRP, Bloods. s/s,
PT/APTT

66735

} sample

५४

CSE, staff all

66736

Samohy

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
4/7	IV placement	①	86705	Samy
5/7	NHA	①	9689116	SL

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : 6/7/26

Time : 2:00pm

Prepared By : Anika

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Anika	UWJ		

ADMISSION SHEET


Registration Details :

Admission No : IP5-00175946 Admit Date : 03-Jul-2026 Admit Time : 11:47 PM UHID : BAH-00523589

Patient Details :

Patient Name	: Baby VARSHINI G	Age	: 7 Y 10 M 1 D
Guardian	: Mr G PARAMESHWAR	DOB	: 02-09-2018
Gender	: Female	Religion	: Hindu
Occupation	:	Martial Status	: Single
Address (H)	: 2-46,UPPER PALLY SC COLONY Musapet Mahabubnagar Telangana INDIA 509380	Phone No	: 9989451338/ 9010050442
		E-mail	: nomailid@gmail.com

Admission Details :

Admission Type : GENERAL WARD Bed No : GW 143 Ward Name : 1F-GENERAL WARD II
Room No : GW 143 Admission Type : First Visit

Contact Details :

Name	: Mr G PARAMESHWAR	Relationship	: Father
Contact Address	: 2-46,UPPER PALLY SC COLONY Musapet Mahabubnagar Telangana INDIA 509380	Phone No	: 9989451338 / 9010050442

Referral Doct - Sudheer Babu

S. Krishna
Signature

Doctor Details :

Doctor Name	: Dr. UJJWALA DESAI	Specialisation	: GENERAL PEDIATRICS
Referral Doctor	: Self	Phone No	:
Co-Consultant	: Dr. FAISAL B NAHDI		

Payment Details :

Payment Mode	: Cash	Deposit Amount	: 0.00
		Payor Name	: SELFPAY



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Varshini

UHID ID:

Department:

Consultant:

BAH-00523589

IP5-00175946

Baby VARSHINI G

02-09-2018

7 Y 10 M 1 D

(F)

Dr. UJJWALA DESAI



BAH-00523569
Baby VARSHINI G
02-09-2018
Dr. UJJWALA DESAI

IP5-00175946

7 Y 10 M 1 D (F)



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Sepsis

Desired goals of the treatment: Sho H. stability

Planned Labs:

CSP

CRP

Sho d cl

S/E

Stool US

M/INR - CSE

Planned Management

Ceftriaxone

Paracetamol

IV fluid

Vit K sht

VB around

Signature of the Doctor: Ashankha

Name of the Doctor: Ashankha

Date & Time: 24/7/2018

Signature of the Consultant: On

Name of the Consultant: Dr. Ujjwal

Date & Time: 4/7/18

DR. UJJWALA DESAI
Registration No: 90550



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>SIB</u> <u>Recurrent</u>	
4/7/26 8:30 AM	Di: Enterocolitis	<u>Plan</u> ① cont. med ⁿ as per chart ② send CSE, stools ③ trace blood cr ④ w/f fever/loose stools.
	No loose stools - since 5 days	
	Intake 1/7 → loose stools - 6-7 episodes/day 2/7 → taken bfm → x3 doses From 3/7 → blood mixed with stools.	
	<u>1/7</u> - Child alert vital stable	
	As normal w/s P/A - soft	
	admitted in 3/7/26 taken monocyte microbiol.	
	5/7 → stools (Dense w/ blood & mucus)	
	Enterocolitis: 2 shigellae.	Send CSE / culture Gastro diet
	DR. UJJWALA DESAI Registration No: 90550	

BAH-00523589
Baby VARSHINI G
02-09-2018
Dr. UJJWALA DESAI
IP5-00175946
7 Y 10 M 2 D
(F)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/26 8:30 Am	SIB <u>Recurrent</u> d: Enterocolitis no fever episodes loose stools. non bloody. Pr - fair OE - Well alert vitals stable RS - <u>Normal</u> ⊕ CS <u>Normal</u>. PIA <u>Normal</u>.	plan. ① cont. w ceftriaxone ② medication as per chart ③ trace stool 4s Blood 4s ④ monitor vitals ⑤ Lofran 60s ⑥ (RTU) CBP → 4m. CBP
(Mental) Blood 4s Sofar sterile	Enterocolitis. Recovery	✓ CBP } Comosaw CBP } 6Am <u>Madhus'</u> Likely for discharge tomorrow if loose stools better, to stop IV Rhidex <u>Don</u> Drug ju 9.
		DR. UJJWALA DESAI Registration No: 90550

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/18 8 AM	Seen by resident	
	Asis - Enterocolitis	
	No fever	
	loose stools - 4, semi solid.	Plan
	pain abdomen - better	1. Continue medication
	oral intake fair.	as charted.
	U/O adequate	2. R/V plan discharge
	O/G	today
	child alert, afebrile	
	hemodynamically stable.	Salithi
	Perfusion good	
	chest clear	
	abdomen soft.	
		Cefbraxone IV.
		1. 59m at 12 noon
		before discharge
		continue IV antibiotic
		<u>2 more days.</u>
		Flb cefixime x 3 day
		Wednesday.
		Review. Friday/Saturday
		Salithi - report
		Do
		Dr. Ujjwala
		90 -
		DR. UJJWALA DESAI
		Registration No. 905504



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

	<u>outside</u>					
Date	3/7/26					
Time						
CUE - Alb						
CUE - Sugar	1 n/c					
CUE - Ketones						
CUE - PUS Cells	2-4					
CUE - RBC Cells						
CUE	1-2 E-C					
	<u>up to</u>					
Stool Pus Cell	35-40					
OVA / Cyst	n/c					
Occult Blood	✓					
	25-30 RBC					
	much, blood ⊕					

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

BAH-00523589 IP5-00175946
 Baby VARSHINI G 7 Y 10 M 1 D (F)
 02-09-2018
 Dr. UJJWALA DESAI

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

BirthRight™
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 Your Right to a Safe Delivery

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: *Dr. Ujjwala Desai*

Date & Time: 7/7/26 12:00 PM

Nurse Name & Signature: *Ujjwala Desai*

Date & Time: 04/7/26 12:00 PM

Ward

DRUG : <u>Syrup - Paracetamol</u>				Date <u>17/11/20</u> Time <u>10:30</u>
Dose	Route	Frequency	Start Dt.	
<u>5ml</u>	<u>PO</u>	<u>OD</u>	<u>17/11/20</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Madhusu</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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

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

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

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

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

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

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

Signature
VERIFIED BY : Name

35. Hey

REGULAR PRESCRIPTIONS

Weight. 25 kg Ward.

VERIFIED

DRUG <u>ly CEFTRIAXONE</u>				Date Time	<u>5/7</u> <u>4/7</u> <u>5/7</u>
Dose	Route	Frequency	Start Date		
<u>1.7g</u>	<u>iv</u>	<u>BD</u>	<u>5/7</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Shankar</u>				<u>10pm</u> <u>5/7</u> <u>4/7</u> <u>5/7</u>	
Additional Instructions:				<u>12hr starting</u> <u>5/7</u> <u>4/7</u> <u>5/7</u>	
Daily Doctor's Endorsement by a Sign					
DRUG <u>ly ES MODRADO LE</u>				Date Time	<u>5/7</u> <u>5/7</u> <u>6/7</u>
Dose	Route	Frequency	Start Date		
<u>30mg</u>	<u>iv</u>	<u>OD</u>	<u>5/7</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Shankar</u>				<u>10pm</u> <u>5/7</u> <u>5/7</u> <u>6/7</u>	
Additional Instructions:				<u>12hr starting</u> <u>5/7</u> <u>5/7</u> <u>6/7</u>	
Daily Doctor's Endorsement by a Sign					
DRUG <u>SYP. AZITHROMYCIN</u>				Date Time	<u>3/7</u>
Dose	Route	Frequency	Start Date		
<u>8.5ml</u>	<u>PO</u>	<u>OD</u>	<u>4/7</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Shankar</u>				<u>10pm</u> <u>4/7</u> <u>4/7</u> <u>5/7</u>	
Additional Instructions: <u>5ml / 200mg</u>				<u>10pm</u> <u>4/7</u> <u>4/7</u> <u>5/7</u>	
Daily Doctor's Endorsement by a Sign					
DRUG <u>ECONORM SALTET</u>				Date Time	<u>5/7</u>
Dose	Route	Frequency	Start Date		
<u>15ml</u>	<u>ORAL</u>	<u>BD</u>	<u>5/7</u>		
Name & Signature of the Doctor Starting the Drugs: <u>madhu</u>				<u>10pm</u> <u>5/7</u> <u>5/7</u> <u>6/7</u>	
Additional Instructions:				<u>10pm</u> <u>5/7</u> <u>5/7</u> <u>6/7</u>	
Daily Doctor's Endorsement by a Sign					

VERIFIED



		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	12:26 am	Inj BUSUPRAN	20mg	IV	Ah	(Masid Raticul)
4/7	2:PM	Vitamin K	10mg in 20ml NS over 1hr	IV	Ah	for
6/7/18		Inj CEFTRIAXONE	2g	IV	Ah	

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 02/09/2018 Time: 2PM 6PM	
Doctor / Nurse / Family Concern?	
Temperature (°F)	104
	103
	102
	101
	100
	99
	98
	97
	96
	95
94	
Heart Rate (bpm) and Blood Pressure (mmHg) *	190
	180
	170
	160
	150
	140
	130
	120
	110
	100
Note: BP does not score in early warning scoring	90
	80
	70
	60
	50
	Heart Rate (Number)
	70
	60
	50
	40
30	
20	
10	
Resp. Rate (bpm) (Over 1 Minute) *	
Resp Rate (Number)	
Resp Mod/ Severe Distress None / Mild	
Receiving O ₂ (l/min) O ₂ Saturations (%)	
Conscious Level Normal Altered	
GCS *	
TOTAL SCORE	
Number of shaded boxes	
Pain Score	
Observer's Initials	

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00523589 IP5-00175946
 Baby VARSHINI G
 02-09-2018 7 Y 10 M 2 D (F)
 Dr. UJJWALA DESAI



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

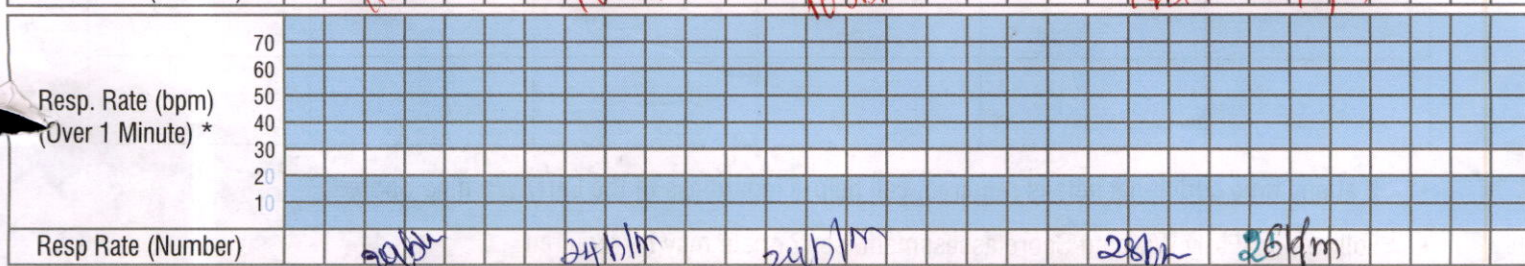
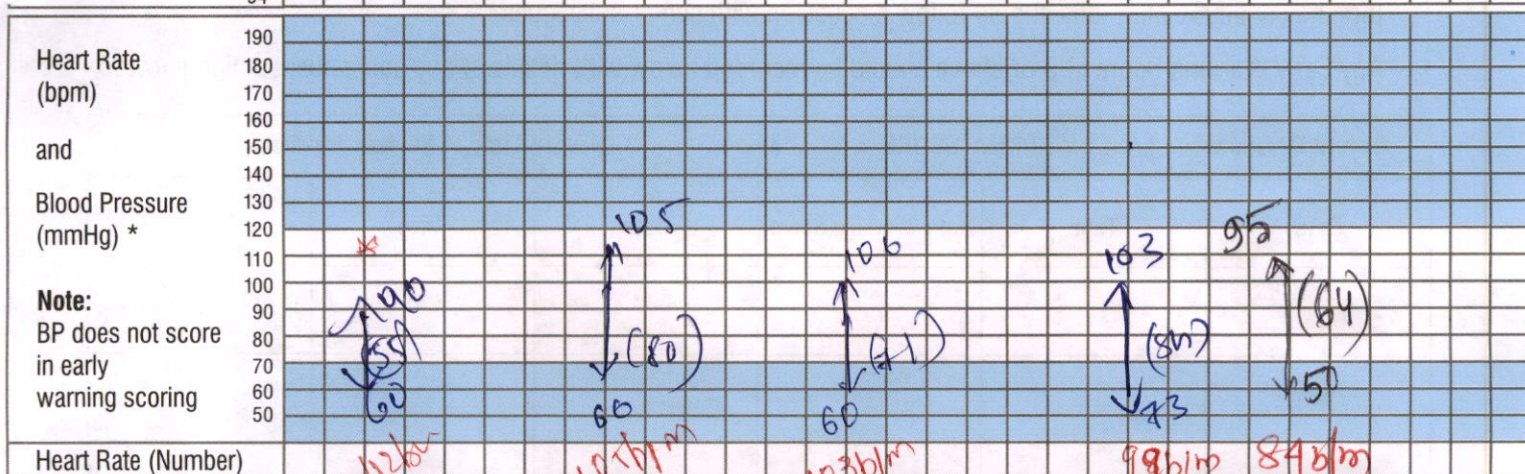
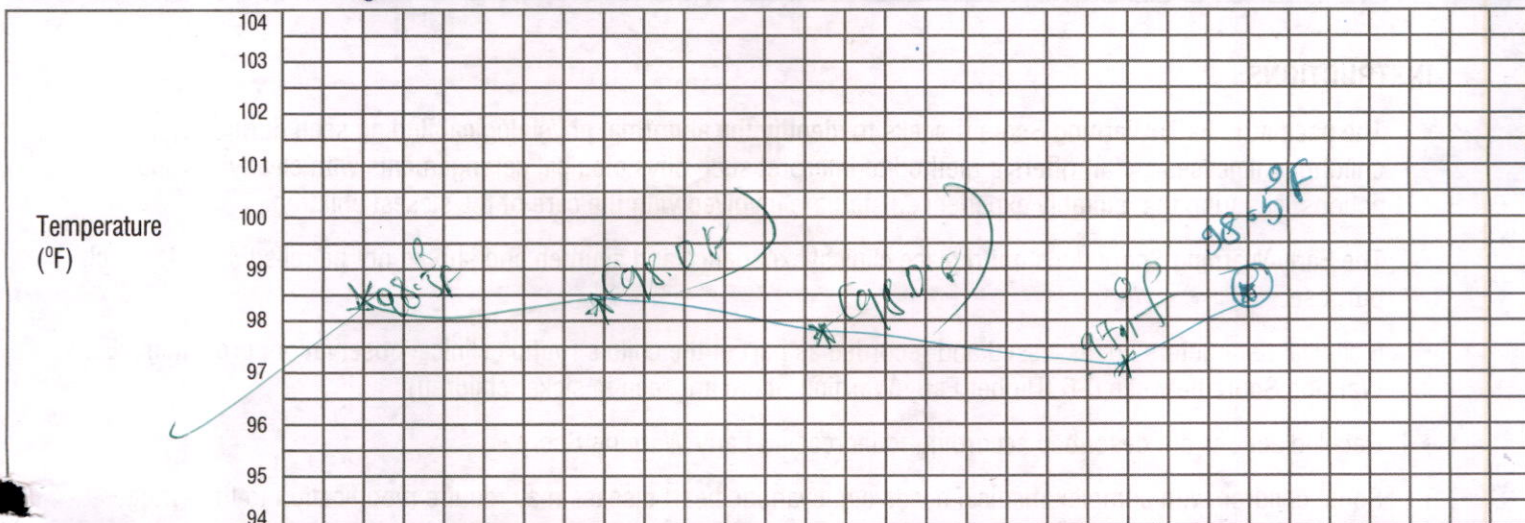
SCHOOL AGE (5-12 years) Children's Observation & Early Warning Scoring Chart

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 02/09/18 Time: 6 AM 10 AM 4 PM 5:30 PM 10 PM
 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		

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



SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 04/07/20 Time: 8am

Doctor / Nurse / Family Concern?

Temperature
 (°F)

Heart Rate
 (bpm)

and

Blood Pressure
 (mmHg) *

Note:

BP does not score
 in early
 warning scoring

Rate (Number)

Resp. Rate (bpm)
 over 1 Minute) *

Resp Rate (Number)

Resp Mod/ Severe
 Distress None / Mild

Receiving O₂ (l/min)
 Saturations (%)

conscious Normal
 Altered

SCORE

shaded boxes

initials

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

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

Score 5 & 6 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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BAH-00523569 IP5-00175946
 Patient Baby VARSHINI G 7 Y 10 M 1 D (F)
 02-09-2018 Dr. UJJWALA DESAI



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.

		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		H ₂ O	50 ml							0	Graves	
Total Intake :						Total Output :							
	02:00 am		50ml	50ml						✓	0	Graves	
	03:00 am	Vit-K	50ml	50ml				✓			0		
	04:00 am		50ml	50ml						✓	0		
	05:00 am		50ml	50ml				✓			0		
	06:00 am		50ml	50ml						✓	0		
	07:00 am		50ml	50ml				✓			0		
Total Intake :						Total Output :							
						Total 24 hrs. Output							

BAH-00523589 IP5-00175946
 Baby VARSHINI G
 02-09-2018 7 Y 10 M 2 D (F)
 Dr. UJJWALA DESAI



FLUID CHART

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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								
4/1	08:00 am	1		50ml		/			/		0	Sub	
	09:00 am		Oral	50ml			✓			✓	0		
	10:00 am	DNS	Oral	75ml							0		
	11:00 am			95ml							0		
	12:00 pm	1		75ml							0		
	01:00 pm			75ml			✓				0		
Total Intake :						Total Output :							
4/2	02:00 pm	1		75ml		/			/		0	Chand	
	03:00 pm			75ml			✓			✓	0		
	04:00 pm	DNS		75ml							0		
	05:00 pm	1		75ml						✓	0		
	06:00 pm			75ml			✓				0		
	07:00 pm	1					✓			✓	0		
Total Intake :						Total Output :							
4/3	08:00 pm	1							/		0	Ch	
	09:00 pm			45ml					/		0		
	10:00 pm			45ml					/	✓	0		
	11:00 pm	DNS		45ml					/		0		
	12:00 am	1		45ml					/		0		
	01:00 am			45ml					/		0		
Total Intake :						Total Output :							
5/1	02:00 am	1		45ml					/		0	Ch	
	03:00 am			45ml					/		0		
	04:00 am			45ml					/		0		
	05:00 am	DNS		45ml					/		0		
	06:00 am	1		45ml					/		0		
	07:00 am			45ml					/		0		
Total Intake :						Total Output :							

Total 24 hrs. Intake	
-----------------------------	--

Total 24 hrs. Output	
-----------------------------	--

BAH-00523589 IP5-00175946
 Baby VARSHINI G
 02-09-2018 7 Y 10 M 2 D (F)
 Dr. UJJWALA DESAI



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.

		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							
5/9	08:00 am	↑		45ml	/	/		/	/	0	J. Shetty	
	09:00 am	↑	only H2O	45ml						0		
	10:00 am	↓								0		
	11:00 am									0		
	12:00 pm	↓	45ml	0								
	01:00 pm		45ml	0								
Total Intake :					Total Output :							
5/9	02:00 pm	↑		45ml	/	/		/	/	0	J. Shetty	
	03:00 pm	↑	Rice water	45ml						0		
	04:00 pm	↓		45ml						0		
	05:00 pm		45ml	0								
	06:00 pm	↓		0								
	07:00 pm			0								
Total Intake :					Total Output :							
5/9	08:00 pm	↑			/	/		/	/	0	Prinipale	
	09:00 pm									0		
	10:00 pm	↓								0		
	11:00 pm	NO IV								0		
	12:00 am									0		
	01:00 am	↓								0		
Total Intake :					Total Output :							
6/9	02:00 am	↑			/	/		/	/	0	Prinipale	
	03:00 am									0		
	04:00 am	NO IV								0		
	05:00 am									0		
	06:00 am									0		
	07:00 am	↓								0		
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								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

BAH-00523589 IP5-00175946

Baby VARSHINI G

02-09-2018 7 Y 10 M 1 D (F)

Dr. UJJWALA DESAI



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 03/07/2026

Assessment: Baby having abdominal pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
1:30 am	Assess the baby general condition and monitor the vitals and record.	1:40 am	Assessed the baby general condition and monitored the vitals and recorded.	By doing all above procedure baby condition improving well.
2:20 am	After the doctor review, advice Inj- Buscopan 20mg.	2:40 am	After the doctor review advised Inj- Buscopan 20mg	
3:10 am	Inj- Ceftriaxone 1.7g, Inj- vet-k 10mg & 10ml NS over 1hr. Sy. Azee 8.5ml.	3:30 am	Inj- ceftriaxone 1.7gram, Inj- vet-k 10mg & 20ml over all 1hr, Sy. Azee 8.5ml	
4:10 am	Continue ORS 2/3rd maintenance @ 50ml/hr.	4:20 am	Continue ORS (2/3rd) maintenance @ 50ml/hr	
6 am	Trace reports stool cl, cse.	6:30 am	Trace reports stool cl, cse.	
7 am	Provided comfortable position	7:30 am	Provided comfortable position.	
8 am	Ensure the safety needs.	8:10 am	Ensured the safety needs.	

Re-Assessment: Re assessment done

Special Notes: Nil

Nurse Signature: Craws kNurse Name: K. Sravanthi [607682]

Date & Time: 04/07/26 @ 8am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 4/7/26

Assessment: Baby 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
8am	* Assess the baby general condition. monitor vital signs.	8am	* Assessed the baby general condition. monitored vital signs	Baby condition is improving slowly
10am	* provide comfortable position	10am	* provided comfortable position	
11am	* maintain ILO charting	11am	* maintained ILO charting	
12pm	* Administer medication as per doctor order	12pm	* Administered medication as per doctor order	
2pm	* ensure Safety side rails.	2pm	* Ensured safety side rails	

Re-Assessment:

Special Notes: watch for fever, loose stool.

Nurse Signature: [Signature]

Nurse Name: Sneelcha (221086)

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

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Baby VARSHINI G
02-09-2018 7 Y 10 M 2 D (F)
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NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 4/7/26

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
2pm	→ Assess the pt General Condition	2:10pm	→ Assessed the pt General Condition	
4pm	→ Check the Vital signs	4:10pm	→ Checked the Vital Signs	
6pm	→ Plan for Administration medication	6:10pm	→ providing Medication as per doctor Order	
8pm	→ plan for strict I/O Chart	8:10pm	→ strictly I/O Chart	
	→ plan for Comfortable Position		→ providing Comfortable Position	pt is stable

Re-Assessment: Re-Assessment Every 4th hrly

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Chandana

Date & Time: 4/7/26 28pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 05/07/16

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
8pm	*Assess the pt General Condition	9pm	*Assessed the pt General Condition	pt is stable
10pm	*check the pt vitals	11pm	*checked the pt vitals	
11pm	*maintain iso chart	12am	*maintained iso chart	
12am	*provide comfortable position	1am	*provided comfortable position	
3am	*administer all medication given as per doctor order	3am	*administered all medication given as per doctor order	

Re-Assessment:

Special Notes:

Nurse Signature: *

Nurse Name: shanthi

Date & Time: 05/07/16 8am

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 Baby VARSHINI G
 02-09-2018 7 Y 10 M 2 D (F)
 Dr. UJJWALA DESAI



NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/7/26

Assessment: Baby having loose stool.

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 baby.	8am	Assessed the general condition of the baby.	Off improves after giving medicine.
9am	Administer medication as per doctor order.	9am	Administered medication as per doctor order.	
10am	Monitor vital signs.	10am	Monitored vital signs.	
11am	Continue w fluids.	11am	Continued w fluids.	
12pm	Trace stool cl & blood cl.	12pm	Traced stool cl & blood cl.	
1pm	plan for CBP, CRP tomorrow	1pm	Planned for CBP, CRP tomorrow	
2pm		2pm		

Re-Assessment:

Special Notes: watch for loose stool, CBP, CRP tomorrow

Nurse Signature: Shailaja. Nurse Name: Shailaja. (605562) Date & Time: 5/7/26 @ 2pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/7/26

Assessment: Baby 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
2pm	* Assess dr. baby general condition. monitor vital signs.	2pm	* Assessed dr baby general condition. monitored vital signs	Baby condition is Improving & slowly
3pm	* provide comfortable position.	3pm	* provided comfortable position	
4pm	* Encourage take orally well	4pm	* Encouraged take orally well	
6pm	* Administer medication as per doctor order	6pm	* Administered medication as per doctor order	
7pm	* Ensure safety side rails	7pm	* Ensured safety side rails.	

Re-Assessment:

Special Notes: CBP, CRP tomorrow

Nurse Signature: Sixisha

Nurse Name: Sixisha

Date & Time: 5/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

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
8pm	Assess general condition of the patient.	8:10 pm	Assessed general condition of the patient.	By done as implementation, as per doctor's order.
10pm	Monitor vital signs.	10:5 pm	Monitored vital signs.	
11pm	Maintain I/O chart.	11pm	Maintained I/O chart.	
6 AM	Administer medication as per doctor's order.	6:5 AM	Administered medication as per doctor's order.	
7 AM	Encourage for nutritional diet.	7:30 AM	Given nutritional diet.	

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

Special Notes: w/r loose stools.

Nurse Signature: PB

Nurse Name: Pratyanka

Date & Time: 6/7/26 8 AM

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Baby VARSHINI G
02-09-2018 7 Y 10 M 2 D (F)
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NURSING CARE RECORD


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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:

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Ujjwala Desai Department: Paed Date of Admission: 09/7/20

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	<u>Dysentery</u>						
BACKGROUND	Area	<u>5/2</u>	<u>1st floor</u>	<u>1st floor</u>	<u>1st floor</u>	<u>1st floor</u>	<u>1st floor</u>
	Shift Time	<u>12:30 am</u>	<u>12:30 am - 8am</u>	<u>8am - 2pm</u>	<u>2pm - 8pm</u>	<u>8pm - 12am</u>	<u>12am - 2pm</u>
	Medical Condition (Any special condition to be noted):	<u>nil</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>98.6°F</u>	<u>98.1°F</u>	<u>98.2°F</u>	<u>98.3°F</u>	<u>98.1°F</u>	<u>98.6°F</u>
	Res:	<u>22b/m</u>	<u>26b/m</u>	<u>22m</u>	<u>26b/m</u>	<u>18b/m</u>	<u>26b/m</u>
	SpO ₂ :	<u>98%</u>	<u>98%</u>	<u>98%</u>	<u>99%</u>	<u>100%</u>	<u>99%</u>
	Pulse:	<u>110b/m</u>	<u>110b/m</u>	<u>100b/m</u>	<u>116b/m</u>	<u>120b/m</u>	<u>120b/m</u>
	BP:	<u>112/63</u>	<u>113/61</u>	<u>100/62</u>	<u>98/60</u>	<u>100/60</u>	<u>98/60</u>
	Fall Risk Score:	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>
	Pain Score:	<u>0</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>Yes</u>
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Others Specify:		<u>nil</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>nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Post Operative Procedure Special Orders:		<u>nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Handed Over By Name :		<u>Rushi</u>	<u>X. Brauvarathi</u>	<u>Sneha</u>	<u>Chandana</u>	<u>Shanthi</u>	<u>Shailaja</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>09/07</u>	<u>09/07</u>	<u>09/07</u>	<u>09/07</u>	<u>09/07</u>	<u>09/07</u>
Time:		<u>12:30am</u>	<u>@ 8am</u>	<u>2pm</u>	<u>@ 2pm</u>	<u>@ 8am</u>	<u>@ 2pm</u>
Taken Over By Name :		<u>X. Brauvarathi</u>	<u>Sneha</u>	<u>Chandana</u>	<u>Shanthi</u>	<u>Shailaja</u>	<u>Sivisha</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>09/07/20</u>	<u>09/07/20</u>	<u>09/07/20</u>	<u>09/07/20</u>	<u>09/07/20</u>	<u>09/07/20</u>
Time:		<u>@ 12:30am</u>	<u>8am</u>	<u>@ 2pm</u>	<u>@ 8pm</u>	<u>@ 8am</u>	<u>@ 2pm</u>

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. Ujjwala Desai Department: Pediatrics Date of Admission: 04/11/26

SITUATION	Diagnosis: <u>Dysentery</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
	Area						
BACKGROUND	Shift Time	<u>1st Hour 2pm-8pm</u>	<u>2nd Hour 8pm-8am</u>				
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>				
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	<u>97.9F</u>	<u>98.1F</u>			
		Res:	<u>24h</u>	<u>21bpm</u>			
		SpO ₂ :	<u>100%</u>	<u>100%</u>			
		Pulse:	<u>94b</u>	<u>83bpm</u>			
		BP:	<u>103/75</u>	<u>110/70</u>			
		Fall Risk Score:	<u>10</u>	<u>10</u>			
Pain Score:	<u>0/10</u>	<u>0/10</u>					
Recommendations	Safety Needs:	<u>yes</u>	<u>side rail</u>				
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	<u>NA</u>	<u>NA</u>				
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>				
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>				
Handed Over By Name :		<u>Srissha</u>	<u>Priyanka</u>				
Signature :		<u>Srissha</u>	<u>Priyanka</u>				
Date:		<u>5/11/26</u>	<u>6/11</u>				
Time:		<u>8pm</u>	<u>2 AM</u>				
Taken Over By Name :		<u>Priyanka</u>	<u>Srissha</u>				
Signature :		<u>Priyanka</u>	<u>Srissha</u>				
Date:		<u>5/11</u>	<u>6/11</u>				
Time:		<u>8pm</u>	<u>2 AM</u>				

Patient



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	3	3	2		
	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			10	10	10		

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes	yes		
Call device within reach	yes	yes	yes		
Wheels Locked	yes	yes	yes		
Room free of clutter	yes	yes	yes		
Adequate Lighting	yes	yes	yes		
Wheel Chair Support	no	no	no		
Other Intervention(s) Specify	no	no	no		
Nurse's Name :	Rhane	Shirley	Angela		
Signature :	[Signature]	[Signature]	[Signature]		
Date :	4/07	5/07	6/7		
Time :	6am	6am	6am		

BAH-00523589
Baby VARSHINI G
02-09-2018 7 Y 10 M 1 D
Dr. UJJWALA DESAI (F)

BRADEN 'Q' SCALE

					Date :	4-7	8-10	11-13	
					Time :	12a	6a	6-11p	
Mobility	completely immobile: Cannot 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	1
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	5
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	5
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	3	1
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						28	28	27	
Evaluator's Name						Ujjwala	Ujjwala	Angela	

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



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			-	-	1	-	-	-	→ Cannula Change	
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		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						Shruti	Suchi Choudhary	Sunil	Meha	Manish			

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 : Saurav Name : Saurav

Signature of Ward In Charge :

Signature : Neeraja Dey Name : Neeraja Dey



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						
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				84			Sahar			ed			

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 : sonny

Signature of Ward In Charge :

Signature : Name : Neeraj

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
04/07	3:30 am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NP	Braves
4/7	11am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	subh
4/7	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chandana
5/07	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Ref
5/7	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Ref
5/7	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pargank
6/7	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pargank
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

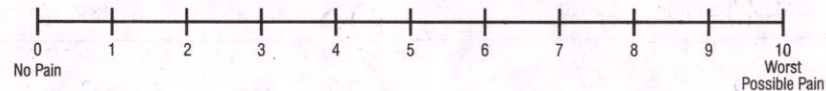
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Patient's / Learner Language: Telugu 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		
4/2	12am	5	medication	M	1	0	1	1	MC	Chasuri

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									

BAH-00523589

IPS-00175946

Baby VARSHINI G

02-09-2018

7 Y 10 M 1 D

(F)

Dr. UJJWALA DESAI



MULTI-DISCIPLINARY PLAN OF CARE FORM

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Diagnosis:

Dysentery

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
4/7/20 12:00	☒ Medical ☐ Nursing ☐ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	Dysentery	Pain mgt	+VP -wmls	<i>[Signature]</i>	☒ Nursing ☐ Others:
4/7/20 12:20 a	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	Blood in stool Abdomen pain	H Stools	- pain mgt - IV medula	<i>[Signature]</i>	☒ Medical ☐ Others:
4/7/20 8:30 Am	☐ Medical ☐ Nursing ☒ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Dysentery Fever 101.1 F w/leukocytes	Gastro diet	RDA E: 1500 kcal/d P: 26 g/d	<i>[Signature]</i>	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

BAH-00523589

IP5-00175946

Baby VARSHINI G

02-09-2018

7 Y 10 M 1 D

(F)

Dr. UJJWALA DESAI



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

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

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's 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

explain to mother & father

☐ Bathing ☒ Yes ☐ No

☐ Eating ☐ Yes ☒ No

☐ Walking ☐ Yes ☒ No

☐ Dressing ☐ Yes ☒ No

☐ Toileting ☐ Yes ☒ No

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: S. S. S. S.

Nurse Name: K. S. S. S.

Date and Time: 4/07/20 @ 4 am

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00523589 IP5-00175946 Baby VARSHINI G 02-09-2018 7 Y 10 M 1 D (F) Dr. UJJWALA DESAI 		Date & Time of Admission 09/7/26 @ 11:47pm	Date & Time of Transfer Order 4/7/26 @ 12:30 a
		Transfer Ordered by Dr. Akanksha	Reason for Transfer Admission
From Unit ER	To Unit 143.	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 21	Number of Imaging Films No	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ op file If yes, what? Gi. Ni'shala	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Sample	①	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Dr. Ujjwala Desai		Name of Person Ordered Transfer Dr. Akanksha	
Patient & Clinical Records Received by : K. Sravanthi			
& Time of Patient Received : 4/07/26 @ 1:25am			

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

☐ Bed

☐ Nurse not Available

☐ Available Bed not ready



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 12:30am Mode of Arrival: By walk Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Body Weight: 35 Kg

NA Height: 132 cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>NA</u>	<u>NA</u>	<u>NA</u>

Family History: NA

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: 35kg Length: Head Circumference (< 2 years):

Temp.: 98.5°F HR: 106bpm RR: 26bpm BP: 105/61

Pain Score: 0/10 Specify Site: NA (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☒ Yes ☐ No Score: 10 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☒ Wong Baker

Character of Pain NP Location NA Frequency NA Duration NA

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 FindingsUnusual 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 With parentsSiblings in household ☐ Yes ☐ No (if yes How Many?) one elder brotherAll Information Obtained From ☐ Patient ☒ Mother ☒ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach : ☐ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump : ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No ☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ NoInformation given to parentsNurse Signature: GrauskNurse Name: K. GrauanthiDate: 04/07/26Time: @ 11:10 am

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 4/7/26 Time: 8:30 AM

Weight: 35.3 kgs Centile: >90th

Height: 182 cms Centile: 77th

Inference: Overweight child

RDA: - Calories: 1500 kcal/d Protein: 26g/d

Diet Recommendations: Gastro & Normal diet

Re-Assessment: Avoid spicy, chilled and outside foods (Eggs, wheat, milk, fruits, Rgp)

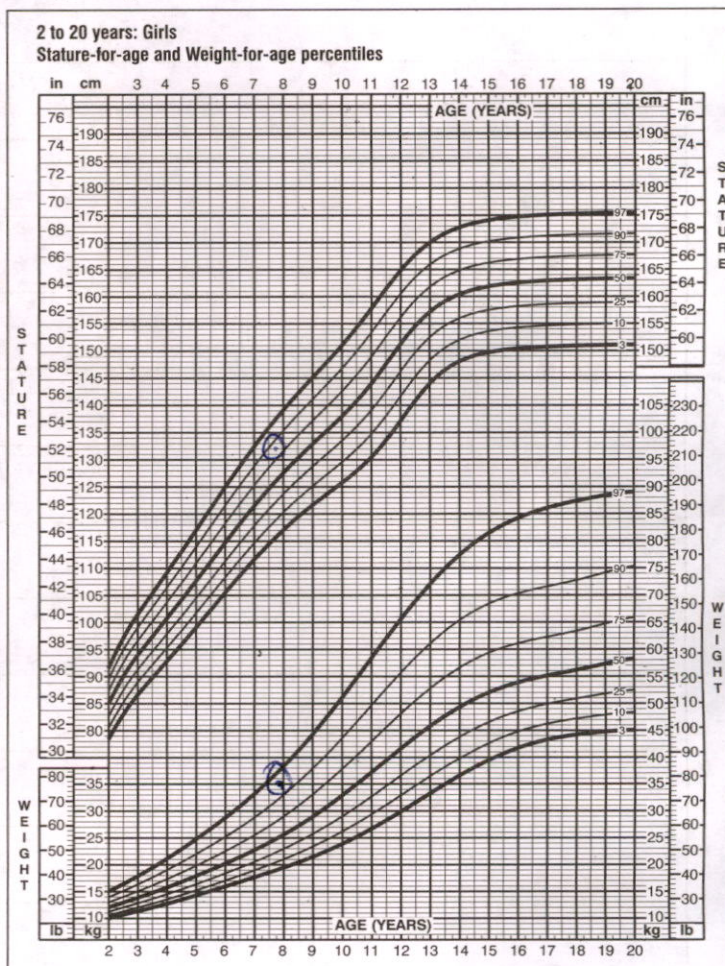
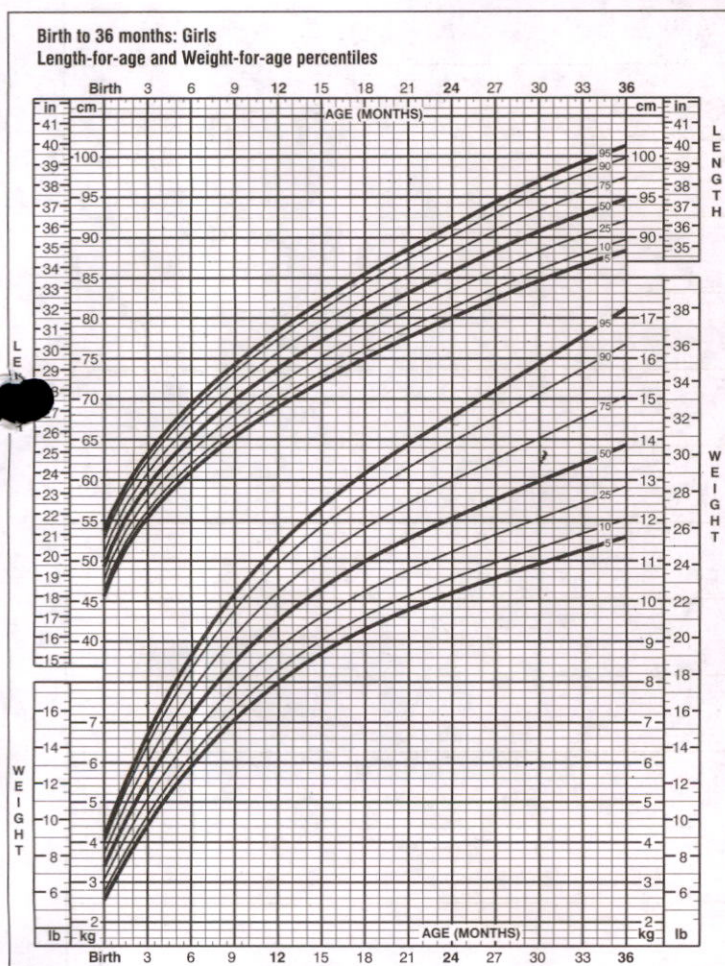
Food Allergies: NO Veg/Non-veg: non-veg

Diagnosis: Dysentery / Urinary & Enterocolitis

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: G. Nishada

GROWTH CHART (GIRLS)



Dietician's Name: Mouflea

Dietician's Signature: Mouflea

Daily Notes:

5/26/26
8am

Child is stable Intake is fair

continue on Gastro diet

NGT ~~OK~~

6/7/26
10am

Child is stable Oral Intake is fair

Continue on Gastro diet.

- NGT ~~OK~~