

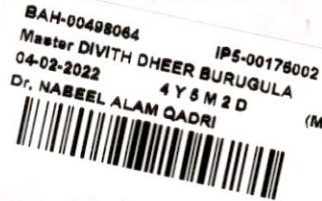
ACTIVITY RECORD FOR BILLING

Name : _____

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

Date of Admission: _____ 7 _____ Charge : _____ Time: _____

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



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/2/26	3:20Am	EL	229	Lachel.

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Faisal B. Nahdi	7/7/26	9691519	
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

Investigations

Order No.

Signature

Gf2

CRP, CRP

A 378

Refiam

Blood Cls

CISE done in of basis

6/2

me, using culture

260 67501

hanke

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
6/7	lv placement	1	89538	W. Khan
6/7	NHA	(1)	9690019	Hesla

ANY OTHER INFORMATION

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.....

.....

Date : 8/07/16 Time : e-ban Prepared By : Duth

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Duth	-	-	-

ADMISSION SHEET
Registration Details :

Admission No : IP5-00176002

Admit Date : 06-Jul-2026

Admit Time : 02:32 AM **UHID** : BAH-00498064

Patient Details :
Patient Name : Master DIVITH DHEER BURUGULA

Age : 4 Y 5 M 2 D

Guardian : Mr RANJITH KUMAR BURUGULA

DOB : 04-02-2022

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : FLAT NO 302 RK SUVARNA SHIVA RESIDENCY
 ROAD NO -6 SAMATHAPURI COLONY , New
 Nagole Hyderabad Telangana INDIA 500035

Phone No : 9010966005/ 9121310018

E-mail : na123@rainbowhospitals.in

Admission Details :
Bed Type : PRIVATE ROOM

Bed No : PVT 239

Ward Name : 2F-SECOND FLOOR

Room No : PVT 239

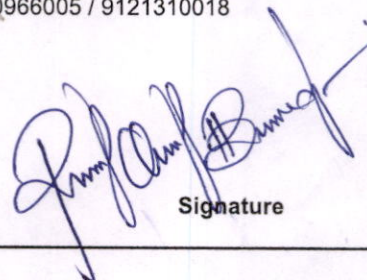
Admission Type : First Visit

Contact Details :
Name : Mr RANJITH KUMAR BURUGULA

Relationship : Father

Contact Address : FLAT NO 302 RK SUVARNA SHIVA
 RESIDENCY ROAD NO -6 SAMATHAPURI
 COLONY , New Nagole Hyderabad Telangana
 INDIA 500035

Phone No : 9010966005 / 9121310018


Signature
Doctor Details :
Doctor Name : Dr. NABEEL ALAM QADRI

Specialisation : PEDIATRIC SURGERY

Referral Doctor : SELF

Phone No :

Co-Consultant :

Payment Details :
Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : NIVA BUPA HEALTH INSURANCE
 COMPANY LTD



PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00498064 IP5-00176002
Master DIVITH DHEER BURUGULA
04-02-2022 4 Y 5 M 2 D (M)
Dr. NABEEL ALAM QADRI



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

Pediatric Multiorgan History & Physical Examination

Name : Divith Age/Sex 4y/M

Information given by: _____ Relationship Father

Chief Presenting Complaints & Duration (Chronologically)

C/O Swelling & pain in scrotum x 1 day

History of present illness :

Pre morbidly well child

Pain & swelling of scrotal
sac from 2pm on 05/07/26

sudden¹ in onset, progressive.

No H/o fever/ vomiting

Pediatric Multiorgan History & Physical Examination

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

Not significant

Birth & Neonatal History:

Not significant

Birth & Socio Economic History:

About Father : }
About Mother : } upper middle class.
Any additional Information : }

Developmental History :

Achieved as per age

Immunization History :

As per schedule

(P.T.O.)

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Acute Epididymo orchitis with funiculitis

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 18.6 kg (Centile _____)

On Examination :

Temperature : 98.6° Pulse Rate : 102 bpm B.P. 98/62 mmHg SP02 100% LA

Resp. rate and type of breathing : 25 br/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Sepsis

Desired goals of the treatment : _____

Resolution.

Planned Labs:

CBP

CRP

Blood c/s

USG scrotum -> Done

Noted by
Rachel

Planned Management

- INS. AUGMENTIN

- INS. PARACETAMOL

- INS. ESOMEPRAZOLE

Noted by
Rachel.

Dr. NABEEL ALAM QADRI
Reg. No: 7524

Signature of the Doctor: N. Nandan

Name of the Doctor: Dr. Nandan

Date & Time: 06/07/2026, 3 AM

Signature of the Consultant: Nabeel

Name of the Consultant: Nabeel

Date & Time: 6/7/26 09:10 am

Date & Time	Progress Notes	Doctor's Order
6/7/26 4:15pm	c/s/B Dr. Malika/Dr. Nikhita Asis - Epididymo orchitis No episode of fever since O/E - Afebrile Vitals - stable	<u>Asis</u> ① Full feeds as tolerated ② Pediatric consultation if/cough
7/7/26 8:15 am	c/s/B Dr. Shreeja Asis: Epididymo orchitis No fresh complaints. passed stools. O/E - afebrile Vitals stable.	<u>Advice:</u> - Full feeds. - → Rest as per Dr. Faisal <u>Advice</u>
Dr. Nabeel Alam Qadri Reg. No: 75241 9:30		Dr. Shreeja 7/7/26 8:15 am

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26 3:10pm	C/S/B Dr. Shreefa Ass: Epididymo orchitis - No fresh clo. D/E - afebrile vitals stable.	Advice - full feeds - Continue Dr. Faisal advice. D/C tomorrow
		Dr. NABEEL ALAM QADRI Reg. No. 75241
		Dr. Faisal
		7/2
		6:20pm
8/7/26 8:45 AM	C/S/B Dr. Malika POD: No fever spikes P/A - ASgt L/E - swelling reduced completely no redness	Adv 1) Full feeds 2) Plan discharge tomorrow 3) Pediatrician review today
	Dr. NABEEL ALAM QADRI Reg. No. 75241	Malika Dr. Malika 8/7/26 10:30 AM



CROSS CONSULTATION FORM

Doctor Name : Dr Faisal Nahdi Date : 7/7 Time : 9am

Diagnosis :

Hospital : RCH - B

Type of Referral :

☐ Emergency

☐ Urgent

☒ Non Urgent

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

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

Signature: _____

Findings and Recommendations :

could be epididymo orchitis

could be orchitis

Now c/o. Good Ceph

could be orchitis

Adv:

1) Flomist F nasal
 spray 1 puff twice
 x 15d. (2)

✓ 2) Nasoclen (1)

✓ 3) Tab Montan 2cnd
 1 x 30d.

✓ 4) Budecort BD x 7d.

Consultant :

DR. FAISAL B NAHDI
 Registration No: 66228

Name : M. Faisal Signature : [Signature] Date & Time : 7/7

BAH-00498064 IP5-00176002
Master DIVITH DHEER BURUGULA
04-02-2022 4 Y 5 M 2 D (M)
Dr. NABEEL ALAM QADRI



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RESULT SHEET

Date	6/7/26				
Time	8:07 AM				
Hb	12.7				
PCV	38				
RBC	380				
WBC	11.02				
N/L	497/29				
Platelets	371				
CRP	5				
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI

 Others (ECG, Contrast Studies etc.,) :



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 : Nabeel Dr. Nandan

Date & Time : 06/07/2026, 2:50 AM

Nurse Name & Signature : Lachel @

Date & Time : 6/7/26 @ 3 AM

Date of Admission: 6/2/20 Drug Allergies: ☐ Not known any Drug Allergies

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

SOS / PRN (As Required Medication)

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

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

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

Weight. 18.6 Kg Ward.

Page: 2/4

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.	

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.	

VERIFIED BY Signature

[illegible]

Weight. Ward.

[illegible]

Signature: _____

Sheet No:

nasal **REGULAR PRESCRIPTIONS**

Dept. Ward.

DRUG : Flomist F spray				Date/Time	7/7	8/7														
Dose	Route	Frequency	Start Dt.																	
1 puff	each	BID	7/7																	
Name & Signature of the Doctor Starting the Drugs:																				
<i>Akhile</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : Tab MONTAIR LC				Date/Time	7/7	KID														
Dose	Route	Frequency	Start Dt.																	
1 tab	PO	HIS	7/7																	
Name & Signature of the Doctor Starting the Drugs:																				
<i>Akhile</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : BUPESAL neb				Date/Time	7/7															
Dose	Route	Frequency	Start Dt.																	
Resp Neb		BID	7/7																	
Name & Signature of the Doctor Starting the Drugs:																				
<i>Akhile</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : SYP. MONTAIR-LC KID				Date/Time	7/7															
Dose	Route	Frequency	Start Dt.																	
5ml	PO	O.D/HIS	7/7																	
Name & Signature of the Doctor Starting the Drugs:																				
<i>Akhile</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

VERIFIED BY : Name Signature

Patient Sticker

Dept. Ward.

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

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

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

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

VERIFIED BY : Name Signature



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
6/7/26 3AM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	epididymo orchitis	pain relief & hemodynamic stability.	iv antibiotics & analgesia	Sahithi	☐ Nursing ☐ Others:
6/7/26 3AM	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Pain and swelling over @ scrotum	Hemodynamic stability	iv medications	@	☒ Medical ☐ Others:
6/7/26 8AM	☐ Medical ☐ Nursing ☒ Others: Dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Ac. Epididymo orchitis	Soft diet	RDA E - 1350 Kcal/d P - 25g/d	Mounica	☐ 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:



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.
Patient's / Learner Language: Relugy 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		
6/7/26	3pm	10	fall risk education	M	1	0	1	1	NA	Q.
6/7/26	8am	9	soft diet	M	1	0	1	1	-	Moukice

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 2. Physical Impairment 3. Emotional Barriers 4. Language Barrier 5. Educational Level 6. Desire / Motivate to Learn 7. Impaired Thought Process/Cognitive limitations 8. Responsibilities at Home 9. Cultural Differences 10. Financial Difficulties 11. Beliefs and Values 12. Impaired Vision/ or Hearing 13. Cultural/Religion Practice 14. Others (Specify)									
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed									
Mechanism/s to overcome barrier/s: 1. None 2. Obtain translator 3. Reassurance & Support 4. Teach Family / Others 5. Respect values & beliefs 6. Respect Cultural / Religion Preference 7. Other, Specify									
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review									



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Divith Dheer Burugula Age : 4y/6m Gender : ☒ Male ☐ Female
Date : 6/7/26 Time of Arrival : 12:50AM Triage Completion Time : 12:52AM
Allergies : ☐ No ☒ Yes ☐ Food ☐ Medications ☐ Other (Specify) : milk and milk products ☐ Not known any drug Allergies
Source of Information : ☒ Parents ☐ Others (Specify) :
Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS	
Appearance	Work of Breathing	☒ Stable	
☒ Normal	☒ Normal	☐ Unstable :	
☐ Sick Looking	☐ Increased	☐ Not - Life - Threatening	
Circulation / Colour	☐ Decreased	☐ Life -Threatening	
☐ Normal ☐ Abnormal ☐ Bleeding	☐ Gasping / Apnea		

Initial Vital Signs: Temp: 98.3°F PR: 120bpm BP: 92/52 RR: 20bpm SpO₂: 100% RA
Chief Complaints: Swelling and pain in left side scabum since yesterday afternoon

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

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.
* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian: [Signature]

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Ramadevi

Signature of Triage Nurse : Ramadevi

Date & Time : 6/7/26 12:52AM



Patient Sticker

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

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

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 6/2/26 Time of arrival : 12:55AM
Chief Complaints: Ab pain and swelling over @ side cushion RBS: NA
Height : NA Weight : 18.60kg BMI : NA Head Circumference (<2 years) : NA
Allergies: ☒ Yes ☐ No ☐ Medications ☐ Blood Transfusion ☒ Food ☐ Other: NA
If yes, identify : MILK AND MILK PRODUCTS
Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker
☐ Character : NA ☐ Location : NA ☐ Frequency : NA ☐ Duration : NA

RISK FOR FALL:

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

- ☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

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

Social History: Lives With Family

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

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

Time of Initial assessment completed by ER Nurse : 12:55AM

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

Time	Nursing Notes
	16mg proten - 6ml - 8:30 pm.
	*Assessed the child condition
	*Iv placement done
	*sample sent
	*shifted to ward.

Samples collected by:

Mr. ramadevi

Time:

@ 3pm

Samples sent by :

Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
06/08/20	SYP. CROICIN-DS	PO	5-5ml	Mr. K. S.	[Signature]

Condition of patient at time of shift - out :	Details of Shift - out
HR: 108bpm BP: 105/65(70) CFT: 2 sec RR: 24bpm SPO ₂ : 100% RA GCS: 15/15 Temperature: 98.8 F Pain Score: 0/10 Repeat RBS (if applicable): NA	Shift - out from ER to: 289 Time of Shift - out: 3:15 AM Handover given to: Mr. K. S. (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

Iv placement.

Name of the Nurse : Mr. Rachel

Signature of the Nurse : [Signature]

Date & Time : 6/7/20 @ 3:15 AM

Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 3:30 PM Mode of Arrival: By vehicle Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: milk and milk product Body Weight: 18.6 Kg

Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
NP	PA	NP

Family History: Healthy Family

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: 18.6 Length: Head Circumference (< 2 years):

Temp.: 98.7 HR: 120 RR: 20 BP: 100/60

Pain Score: 1/10 Specify Site: (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☐ Yes ☐ No Score: 11 (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: 1/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker

Character of Pain: 1/10 Location: left arm Frequency: Intermittent Duration: Intermittent

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):

Social History: Lives With Family

Siblings 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 Mother

Nurse's Name: Smith Date: 8 Time: 6/7/26

CB'WARR
Signature

3AH-00498064 IP5-00176002
Master DIMITH DHEER BURUGULA (M)
14-02-2022 4 Y 5 M 2 D
Dr. NABEEL ALAM QADRI

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

PRESCHOOL (1-5 years)

Children's Observation &
Early Warning Scoring Chart

Pratiksha
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 :	Time: 10AM	2PM	6PM	10PM	2AM	6AM	
Doctor / Nurse / Family Concern?							
Temperature (F)	104						
	103						
	102						
	101						
	100						
	99	98.2	97.2	98.2	98.4	98.2	
	98						
	97						
	96						
	95						
	94						
Heart Rate (bpm)	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
	90						
80							
70							
60							
50							
Note: BP does not score in early warning scoring							
Blood Pressure (mmHg) *	100/60	102/65	104/60	110/60	110/60	110/60	
Heart Rate (Number)	126b/m	123b/m	126b/m	124b/m	124b/m	108b/m	
Resp. Rate (bpm) (Over 1 Minute) *	70						
	60						
	50						
	40						
	30						
	20						
	10						
	Resp Rate (Number)						
		23b/m	26b/m	23b/m	24b/m	23b/m	22b/m
	Resp Distress	Mod/ Severe					
	None / Mild						
Receiving O ₂ (l/min)							
O ₂ Saturations (%)	100%	99%	100%	99%	99%	99%	
Conscious Level	Normal						
Altered							
GCS *	15/15	15/15	15/15	15/15	15/15	15/15	
TOTAL SCORE							
Number of shaded boxes	0	0	0	0	0	0	
Pain Score	0	0	0	0	0	0	
Observer's Initials	GA	BD	GA	GA	GA	GA	

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)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time: 10am	2pm	6pm	10pm	2AM	6AM
Doctor / Nurse / Family Concern?						
Temperature (F)	98.6F	98.5F	98.0F	98.8F	97.4F	98.4F
Heart Rate (bpm)	108	106	104	110	110	108
Blood Pressure (mmHg) *	66/44	53/31	57/33	60/40	60/40	58/32
Resp Rate (Number)	193b/m	115b/m	117b/m	118b/m	112b/m	108b/m
Resp Rate (bpm)	24b/m	25b/m	24b/m	23b/m	20b/m	20b/m
Resp Mod/ Severe Distress	None	None	None	None	None	None
Receiving O ₂ (l/min)	RIA	RIA	RIA	RIA	RIA	RIA
O ₂ Saturations (%)	100%	100%	99%	98%	98%	98%
Conscious Level	C	C	C	C	C	C
GCS *	15/15	15/15	15/15	15/16	15/16	15/16
TOTAL SCORE	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	HA	HA	HA	HA	HA	HA
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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EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time :	4 AM	6 AM	
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			
Blood Pressure (mmHg) *	90			
	80			
	70			
	60			
	50			
	40			
	30			
	20			
	10			
	0			
Note: BP does not score in early warning scoring	190			
	180			
	170			
	160			
	150			
	140			
	130			
	120			
	110			
	100			
Heart Rate (Number)	190			
	180			
	170			
	160			
	150			
	140			
	130			
	120			
	110			
	100			
Resp. Rate (bpm) (Over 1 Minute) *	70			
	60			
	50			
	40			
	30			
	20			
	10			
	0			
	Resp Rate (Number)	70		
		60		
50				
40				
30				
20				
10				
0				
Resp Distress		None / Mild		
		Severe		
	None / Mild			
	Severe			
	None / Mild			
	Severe			
	None / Mild			
	Severe			
	None / Mild			
	Severe			
Receiving O ₂ (l/min) O ₂ Saturations (%)	100			
	99			
	98			
	97			
	96			
	95			
	94			
	93			
	92			
	91			
Conscious Level	Normal			
	Altered			
	Normal			
	Altered			
	Normal			
	Altered			
	Normal			
	Altered			
	Normal			
	Altered			
GCS *	15			
	14			
	13			
	12			
	11			
	10			
	9			
	8			
	7			
	6			
TOTAL SCORE	0			
	1			
	2			
	3			
	4			
	5			
	6			
	7			
	8			
	9			
Number of shaded boxes	0			
	1			
	2			
	3			
	4			
	5			
	6			
	7			
	8			
	9			
Pain Score	0			
	1			
	2			
	3			
	4			
	5			
	6			
	7			
	8			
	9			
Observer's Initials				

ACTIONS

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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)

Patient S

BAH-00498064 IP5-00176002
 Master DIVITH DHEER BURUGULA
 04-02-2022 4 Y 6 M 2 D (M)
 Dr. NABEEL ALAM QADRI



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

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 Your Right to a Safe Delivery

FLUID CHART

Sheet No. :

8/7

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

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

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
06/7											0	Hanika	
	08:00 am	↓	Jelly	-						✓	0	Hanika	
	09:00 am	↓	water	-							0	Hanika	
	10:00 am	NO		-			✓				0	Hanika	
	11:00 am	IVF		-							0	Hanika	
	12:00 pm	↑		-							0	Hanika	
	01:00 pm	↑		-					✓				
Total Intake : Good						Total Output : m-1 u-2							
06/7	02:00 pm	↓	Rice	-							0	Hanika	
	03:00 pm	↓	chapatti	-						✓	0	Hanika	
	04:00 pm	NO		-			✓				0	Hanika	
	05:00 pm	IVF		-							0	Hanika	
	06:00 pm	↑		-							0	Hanika	
	07:00 pm	↑		-					✓		0	Hanika	
	Total Intake : Good						Total Output : m-1 u-2						
06/7	08:00 pm	↓	Rice	-							0	Suab	
	09:00 pm	↓	chapatti	-						✓	0	Suab	
	10:00 pm	NO		-							0	Suab	
	11:00 pm	IVF		-			sp				0	Suab	
	12:00 am	↑		-					✓		0	Suab	
	01:00 am	↑		-							0	Suab	
	Total Intake :						Total Output : m-0 u-2						
7/7	02:00 am	↓		-							0	Suab	
	03:00 am	↓		-						✓	0	Suab	
	04:00 am	NO		-			sp				0	Suab	
	05:00 am	IVF		-					✓		0	Suab	
	06:00 am	↓		-							0	Suab	
	07:00 am	↑	water	-							0	Suab	
	Total Intake : Good						Total Output : m-0 u-2						
Total 24 hrs. Intake						Total 24 hrs. Output			m-2 u-8				



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							
7/7	08:00 am	No T/F		—							0	Mam
	09:00 am		Idgt	—						✓	0	
	10:00 am		too	—							0	
	11:00 am			—							0	
	12:00 pm			—			✓		✓	0		
	01:00 pm			—						0		
Total Intake :						Total Output : 0-2 M-1						
7/7	02:00 pm	No T/F		—							0	Mam
	03:00 pm		Rich	—						0		
	04:00 pm		H2O	—					✓	0		
	05:00 pm			—						0		
	06:00 pm			—					0			
	07:00 pm			—					✓	0		
Total Intake :						Total Output : 0-2 M-1						
7/7	08:00 pm	No T/F	Rich	—							0	Sach
	09:00 pm		water	—					✓	0		
	10:00 pm			—			pp			0		
	11:00 pm			—				✓	0			
	12:00 am			—					0			
	01:00 am			—					0			
Total Intake :						Total Output : M-0 0-2						
7/7	02:00 am	No T/F		—						✓	0	Sach
	03:00 am			—						0		
	04:00 am			—						0		
	05:00 am			—				✓	0			
	06:00 am			—			pp	✓	0			
	07:00 am		Rich	—				✓	0			
Total Intake :						Total Output : 0-3 M-0						
Total 24 hrs. Intake		Good.										
Total 24 hrs. Output		M-1 0-9.										

3AH-00498064 IP5-00176002
 Master: DIVITH DHEER BURUGULA
 14-02-2022 4 Y 5 M 3 D (M)
 Dr. NABEEL ALAM QADRI



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											
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												



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6/7/26

Assessment: Patient having weakness

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
2:00 AM	* Assess The baby	6:10 AM	* Assessed The baby	Patient is comfortable
↓	General condition	↓	General condition.	
6:00 AM	* Monitor the vital signs	6:10 AM	* Monitoring vital signs	
↓	* Ensure safety	↓	* provided side rails	
8:00 AM	* Administer medication as per doctor order	8:10 AM	* Administer medication as per doctor order	

Re-Assessment: Re-assessment was done

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Sanku

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

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 06/1/26

Assessment: patient having 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
2am ↓ 10am ↓ 2pm ↓ 8pm	Assess the patient condition. Monitor the vital signs. Maintain Ilo chart. Administer the medication as per doctor order. Maintain skin integrity. Maintain good nutritional status. provided comfortable position.	8:10am ↓ 10:30am ↓ 2:10pm ↓ 8:20pm	Assessed the patient condition. Monitored the vital signs. Maintained Ilo chart. Administered the medication as per doctor order. Maintained skin integrity. Maintained good nutritional status. provided comfortable position.	All plans are Implemented as per doctor order.

Re-Assessment: Re-Assessment was done,

Special Notes: continue same treatment.

Nurse Signature:

Nurse Name: Hanks

Date & Time: 06/1/26 @ 8pm

3AH-00498064 IPS-00176002
 Master DIVITH DHEER BURUGULA
 14-02-2022 4 Y 5 M 2 D (M)
 Dr. NABEEL ALAM QADRI



NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6/7/26

Assessment: patient having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess The pt General condition	8:10pm	Assessed The pt general condition	All plan are Implemented
12AM	Monitor vital signs	12:10AM	Monitoring vital signs	
2AM	ensure safety	4:10AM	provided side rail	
6AM	Maintain personal Hygiene	6:10AM	Maintained personal Hygiene	
8AM	Administer medications per doctor orders	8:10AM	Administered medications per doctor orders.	

Re-Assessment: Re-Assessment was done

Special Notes: Today Pediatric consultant review.

Nurse Signature: [Signature]

Nurse Name: Soallo

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



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 7/7/26

Assessment: BABY having IS pain

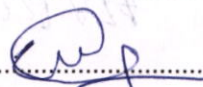
Goals

- | | | | | | |
|---|---|--|---|---|---|
| ☐ 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
8 AM	→ Assess the BABY General condition	8 AM	→ Assessed the BABY General condition	→ BABY VITALS Stable
10 AM	→ Monitor the BABY VITALS	10 AM	→ Monitored the BABY VITALS	
12 PM	→ maintain I/O chart	12 PM	→ maintained I/O chart	
2 PM	→ Administer the medication given by doctor order	2 PM	→ Administer the medication given by doctor order	
8 PM	→ provide comfortable position	8 PM	→ provided comfortable position	

Re-Assessment: Reduce the Pain

Special Notes: at same medication

Nurse Signature:  Nurse Name: Mounika Date & Time: 7/7/26 2 PM



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 7/2/26

Assessment: Patient having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess The pt General condition	8:10pm	* Assers The pt General condition	all plan as Implemented pt is comfortable
12AM	* Monitor the vital signs	12:10AM	* monitoring the vital signs	
2AM	* ensure safety	2:10AM	* provided side rails	
6AM	* provide comfortable position	6:10AM	* provided comfortable position	
8AM	* Administer medication as per doctor orders	8:10AM	* administered medication as per doctor orders	

Re-Assessment: Re-Assessment was done pt is comfortable.

Special Notes: NA

Nurse Signature: [Signature]

Nurse Name: Swathi

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

Patient Sticker

NURSING CARE RECORD


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


BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

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. Nabeel Alam Department: Date of Admission: 6/12/26

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area	CP 3:15AM	HD unit 3:30AM-8AM	HD unit 8AM-2PM	HD unit 2PM-8PM	HD unit 8PM-8PM	HD unit 8PM-8AM	
	Shift Time	NA	NA	NA	NA	NA	NA	
ASSESSMENT	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	NA	NA	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
RECOMMENDATIONS	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	98.6 F	98.4 F	98.6 F	98.6 F	98.6 F	98.4 F
		Res:	20b/m	20b/m	20b/m	20b/m	20b/m	20b/m
		SpO ₂ :	99%	98%	100%	98%	100%	99%
		Pulse:	105b/m	105b/m	105b/m	105b/m	105b/m	105b/m
		BP:	103/68	102/66	106/66	102/68	102/60	104/69
	Fall Risk Score:	0	0	0	0	0	0	
Pain Score:	0	0	0	0	0	0		
Other Special Orders / Medications:	Safety Needs:	side rails	side rails	side rails	side rails	side rails	side rails	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Post Operative Procedure Special Orders:	NA	NA	NA	NA	NA	NA		
Handed Over By Name :	Lachel	Swathi	Hanika	Swathi	Mounika	Swathi		
Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]		
Date:	6/12/26	6/12/26	6/12/26	7/12/26	7/12/26	8/12/26		
Time:	3AM	8AM	3PM	8PM	8PM	8PM		
Taken Over By Name :	Swathi	Hanika	Swathi	Mounika	Swathi	Rosmarie		
Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]		
Date:	6/12/26	6/12/26	6/12/26	7/12/26	7/12/26	8/12/26		
Time:	3PM	8AM	8PM	8AM	8PM	8:15AM		



BRADEN 'Q' SCALE

					Date :	6/2/20	7/2	8/2	
					Time :	3 AM	6 AM	6 PM	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e. extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4		
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4		
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4		
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		
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE		28	28	28
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name		Dr. Nabeel Alam Qadri	Dr. Nabeel Alam Qadri	Dr. Nabeel Alam Qadri

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	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 : [Signature] Name : Bipanjita

Signature of Ward In Charge :

Signature : [Signature] Name : Anita

3AH-00498064 IP5-00176002
 Master DMITH DHEER BURUGULA (M)
 4 Y 5 M 3 D
 14-02-2022
 Dr. NABEEL ALAM QADRI

CHECKLIST FOR THROMBOPHLEBITIS

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

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									
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				Rosary									

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

Signature of Shift In Charge :

Signature : Barnali Name : Barnali

Signature of Ward In Charge :

Signature : Anisha Name : Anisha



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/7/26	8AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
6/7/26	5AM	1/10	Left Scrotum	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inj. Paracetamol given	Swath
6/7/26	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA No	Swath
6/7/26	2pm	1/10	Left Scrotum	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inj. PCM given	Hanky
6/7/26	3pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Hanky
6/7/26	10pm	1/10	Left Scrotum	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inj. PCM give	Swath
6/7/26	4pm	0/10	NA	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Swath
6/7/26	6AM	0/10	Left Scrotum	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inj. PCM given	Swath
7/7/26	7AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Reduce the pain	Swath
7/7/26	2pm	1/10	Left Scrotum	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inj. PCM given	Swath

Re-assessment Frequency:

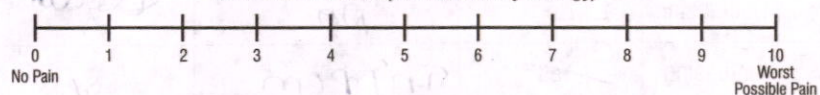
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

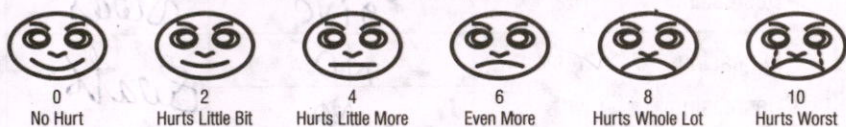
Numerical Pain Scale (Obstetric and Gynecology)



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
7/7	3AM	0/10	RD	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Re Assessment done at 3 AM	Swab
7/7	4PM	1/10	left scrotum	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Fig - PCM given.	Swab
7/7	1PM	0/10	RD	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Re Assessment done at 1 PM	Swab
8/7	6AM	1/10	left scrotum	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Fig - PCM given	Swab
8/7	7AM	0/10	RD	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Re Assessment done	Swab
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

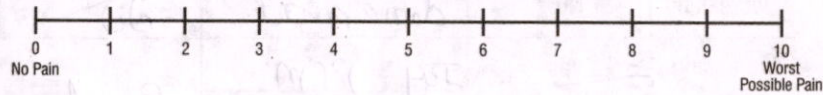
- Every eight hours for all hospitalized patients.
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 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

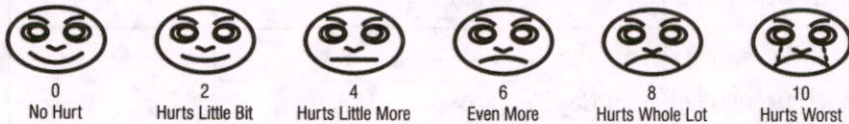
Numerical Pain Scale (Obstetric and Gynecology)



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



Patient Stickr

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	3		
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2		
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1		
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2	2	2	2		
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2		
	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			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		
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 :	Lachar	SO	Swat		
Signature :	[Signature]	[Signature]	[Signature]		
Date :	6/7/24	24	8/7		
Time :	3 AM	6 AM	6 PM		

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 6/7/26 Time: 8:30 am

Weight: 18.6 kg Centile: 75th

Height: 106 cm Centile: 75th

Inference: Well Child

RDA: - Calories: 1350 kcal/d Protein: 23 g/d

Diet Recommendations: Soft diet

Re-Assessment: Avoid spicy, outside, chilled foods

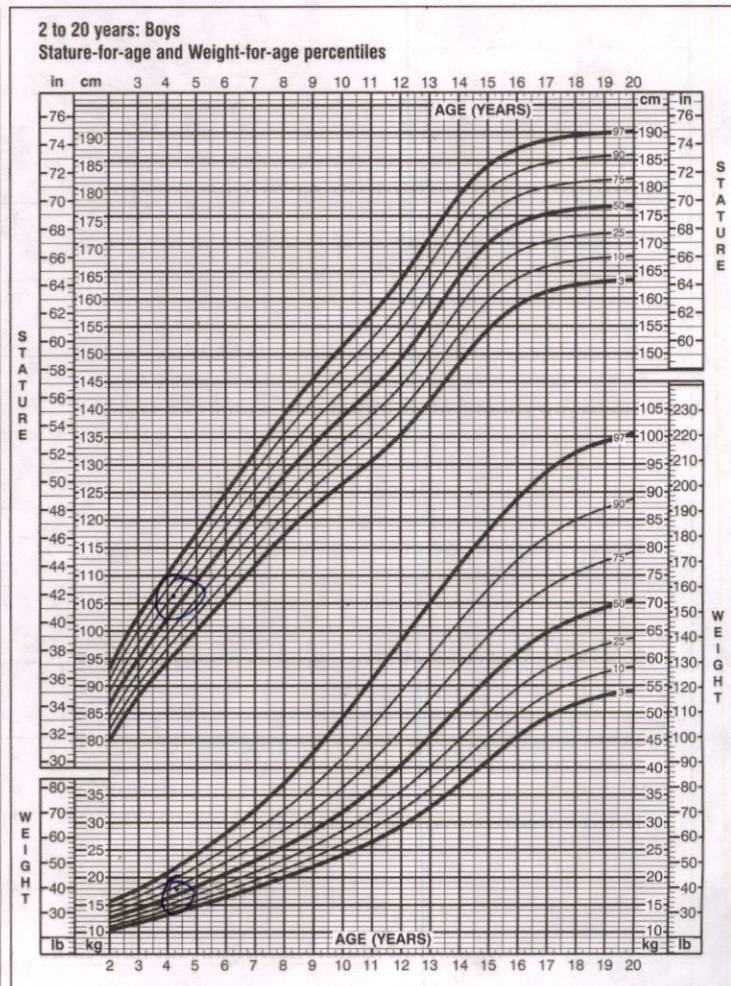
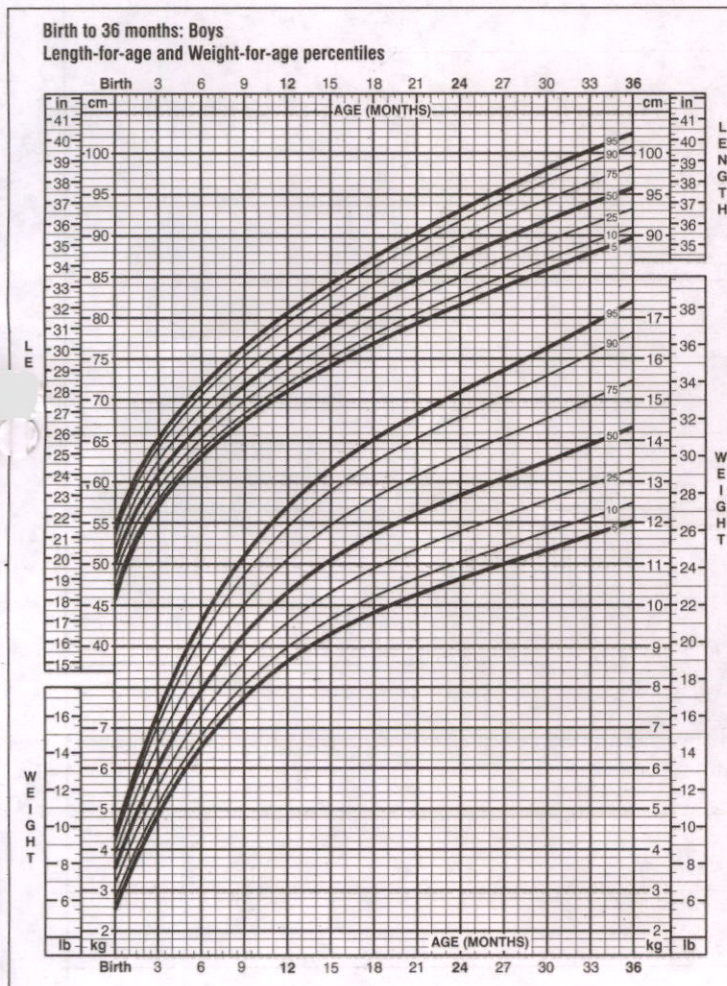
Food Allergies: Dairy Veg/Non-veg Veg

Diagnosis: Acute Epididymo Orchitis

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: vaishnavi

GROWTH CHART (BOYS)



Dietician's Name: Monica

Dietician's Signature: Monica

Daily Notes:

8/9/26
9 am

child is stable. Intake is better

continue on soft diet

Nilla

8/9/26
9 am

Child is stable. Intake is good.

Continue soft diet

Nanna