

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

Date of Admission : _____

Room / Bed No : _____

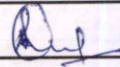
IP5-00176739
BAH-00633637
Master T JASHWANTH RUDRA
26-02-2025
Dr. UJJWALA DEBBI
1 Y 4 M 26 D (M)

Consultant: _____ Dept : _____

Date of Discharge : _____ Time: _____

Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
21/2/26	12am	ER	144B	

Cross Consultation Visit

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

[illegible]

Q117126

CBP, CRP, Blood clots

5 viruses panel

73350

Yusuf

22/7

X-ray test

026505

Tennant

OK

[illegible][illegible]

DIC

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
2/7/16	IV Placement	1	15381	<u>[Signature]</u>

ANY OTHER INFORMATION

oe-ray - 1

Date : 22/7/16

Time : 6:30 pm

Prepared By : [Signature]

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
[Signature]	1st floor		

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176739 Admit Date : 21-Jul-2026 Admit Time : 11:19 PM UHID : BAH-00633637

Patient Details :

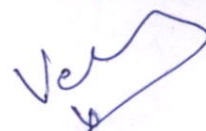
Patient Name	: Master T JASHWANTH RUDRA	Age	: 1 Y 4 M 25 D
Guardian	: Mr T VENKATAESH	DOB	: 26-02-2025 06:30 AM
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: FLAT NO F2 SWARAJ APTS , BESIDE RAJA HOSPITAL Madhura Nagar Hyderabad Telangana INDIA 500038	Phone No	: 9030279661 / 9059867408
		E-mail	: VENKAT24693@GMAIL.COM

Admission Details :

Bed Type : GENERAL WARD Bed No : GW 144 B Ward Name : 1F-GENERAL WARD II
 Room No : GW 144 B Admission Type : First Visit

Contact Details :

Name : Mr T VENKATAESH Relationship : Father
 Contact Address : FLAT NO F2 SWARAJ APTS , BESIDE RAJA Phone No : 9030279661 / 9059867408
 HOSPITAL Madhura Nagar Hyderabad
 Telangana INDIA 500038


 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 : SELF PAY



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

To Postmaster Ruden
BANK 00683637
144B

4
2a

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00633637 IP5-00176739
Master T JASHWANTH RUDRA
26-02-2026 1 Y 4 M 25 D (M)
Dr. UJJWALA DESAI

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

No cough, cold since 1 day
fast breathing since 3 hours.

History of present illness :

No cough, cold since 1 day.
no post-tussive vomiting.

Fast breathing (+) since 3 hours.
taken nebulisation at home - 2 times

No fever / vomitings / loose stools.

Oil - fair.
not taken Antibiotics.

No swimming in H^{ts}



Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Normal transition

Birth & Socio Economic History:

About Father : _____
About Mother : _____ middle
Any additional Information : _____

Developmental History :

appropriate for age

Immunization History :

_____ vaccinated till date



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 12.54kgs (Centile _____)

On Examination :

Temperature : 98.8°F Pulse Rate : 154/min B.P. _____ SP02 96% ↓ Room air

Resp.rate and type of breathing : 58/min

Rash _____ subcutal reactions ⊕

Lymphadenopathy nc

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BLAC ⊕, wheeze ⊕ expiratory

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S1S2 ⊕

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : soft

Ausculation : _____

Spine : _____ External Genitalia : _____

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

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Master T JASHWANTH RUDRA
26-02-2026 1 Y 4 M 26 D (M)
Dr. UJJWALA DESAI



Neurological History & Physical Examination

Central Nervous System :

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

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____

Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

_____ WALK _____



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Respiration
complications.

Desired goals of the treatment: Resolution of symptoms

Planned Labs:

CBP, CRP
Blood Cts
Urine
Serum panel
✓ vented 21/7/26

Planned Management

(1) ceftriaxone
(2) Paracetamol orally
(3) Hydrocortisone 2mg/kg
(4) Budecort RD
(4) Mistafree
Glomeproazole
1vf- 1/2 maintenance

Signature of the Doctor: Madhu

Name of the Doctor: Madhu

Date & Time: 21/7/26

Signature of the Consultant: Dr. Ujjwala Desai

Name of the Consultant: Dr. Ujjwala Desai

Date & Time: 21/7/26

IP5-00176739

Master 1 of
26-02-2025

1 Y 4 M 26 D

(M)

Dr. UJJWALA DESAI



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/10/2020 4 AM	S/S Relieved	
	Δ S/S LRI = mild RD	Plan
	RR = 45/min	→ Continue IV medications
	SPO ₂ = 97%	→ Continue Neb
	HR = 147/min	
	Temp = 98.6°F	→ O ₂ (Low Flow) @ 1L
	CRP < 5	→ gradually ↓ se by morning based on work of breathing
		✓ X-ray chest.
		✓ T. Praveen

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/11/20	CLIN Resident	
8:30 AM	DS: LRTI.	
		Plan
	No fresh complaints.	- ct Plan O ₂ @ 1L/min.
	Accepts orally,	- 4 ly' ceftriaxone D _{1/2}
	feeding, stool and urine.	- nct - levofloxacin 4th day
		- Indecor RP
	OR	
	< RI - BAGE (H), clear ^{clear} no retractions	- Trace reports Admo
	+ clearing. No retractions	- monitor vital signs
	- RA @. RR - 36/min.	- w/ Resp distress
	Temp - 98.2°F	
	SpO ₂ - 99% @ 1L/min.	By
	Buccal panel - Neg	
	adeno - awaited	
		Stop Oxygen
	LRI	
	KIC Hyperactive	DOB
	airway,	DVUJWA
	presented E respiratory	9c
	distress.	22/11/20
		DR. UJJWALA DESAI
		Registration No: 90550

BAH-00633637 IP5-00176739
Master T JASHWANTH RUDRA
26-02-2025 1 Y 4 M 26 D (M)
Dr. UJJWALA DESAI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/3/24	Child Resident	
4pm	01: LRTI	
	Klebsiella hyperaerobicity disease.	Plan
	No fresh complaints	- 2 nd Ceftriaxone D2
	O/E	- At nebulization c/levolin 4 th time Budecort
	Sleeping comfortably	
	RR - 36/min	- Trace Adeno sept
	No retractions.	- monitor vitals
	SpO ₂ - 97.5%	- w/f Resp distress.
	CRT - 2 sec,	
	SpO ₂ - 99% on RA	
		Penf
		1000
		Dm/june 5m
	Discharge	Omnacon H1.
		20mg 1da x 2da
		Levolin 4bm
		Budecort 2bm
		Ceftriaxone at 5pm
		Flc cefixime 4d. Review - Saturday
		DR. UJJWALA DESAI Registration No: 90559

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00633637 IP5-00176739
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Dr. UJJWALA DESAI



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RESULT SHEET

Date	21/07/22				
Time					
Hb	11.1				
PCV	34.3				
RBC	4.64				
WBC	17,810				
N/L	38/48				
Platelets	3,75,000				
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 : dival panel - Neg
Adeno - awaited

Radiology : USG : _____
 X-Ray : _____
 ECHO : _____
 CT : _____
 MRI _____
 Others (ECG, Contrast Studies etc.,) : _____



DRUG CHART

Date of Admission: 21/7/25 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG :				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:				



REGULAR PRESCRIPTIONS

Weight. 12.54 kg Ward.

VERIFIED

DRUG : INT- CEFTRIAXONE				Date Time
Dose 600mg	Route IV	Frequency BD	Start Date 21/2/26	21/2 22/2
Name & Signature of the Doctor Starting the Drugs: <u>Madhu</u>				10 AM 12:30 PM 6 PM
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

VERIFIED

DRUG : INT- CLOMIPRAZOLE				Date Time
Dose 12mg	Route IV	Frequency OD	Start Date 21/2/26	21/2 22/2
Name & Signature of the Doctor Starting the Drugs: <u>Madhu</u>				6 AM EF 6:30 PM
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

VERIFIED

DRUG : NEB i CECIDIN				Date Time
Dose 0.63mg	Route NEB	Frequency Q4Hx4	Start Date 21/2/26	10 AM ER 4 AM 8 AM 12 PM 4 PM 8 PM
Name & Signature of the Doctor Starting the Drugs: <u>Madhu</u>				4 AM 8 AM 12 PM 4 PM 8 PM
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

VERIFIED

DRUG : NEB i RUDACT				Date Time
Dose 1 resp	Route NEB	Frequency BD	Start Date 21/2/26	3 AM 9 AM
Name & Signature of the Doctor Starting the Drugs: <u>Madhu</u>				3 AM 9 AM
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				



Sheet No:

REGULAR PRESCRIPTIONS

Weight 12kg

Ward

DRUG : <u>Syrup HISTAFREE</u>				Date Time															
Dose <u>2.5ml</u>	Route <u>PO</u>	Frequency <u>TID</u>	Start Dt. <u>21/2/26</u>																
Name & Signature of the Doctor Starting the Drugs: <u>Madhul</u>																			
Additional Instructions: <u>6pm</u>																			
Daily Doctor's Endorsement by a Sign																			
DRUG : <u>Syr HYDROCORTISONE</u>				Date Time															
Dose <u>25mg</u>	Route <u>IV</u>	Frequency <u>OD</u>	Start Dt. <u>22/7</u>																
Name & Signature of the Doctor Starting the Drugs: <u>Salithi</u>																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG : <u>Syr HYDROCORTISONE</u>				Date Time															
Dose <u>35mg</u>	Route <u>IV</u>	Frequency <u>TID</u>	Start Dt. <u>22/7</u>																
Name & Signature of the Doctor Starting the Drugs: <u>Salithi</u>																			
Additional Instructions: <u>2PM Red Power</u>																			
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																			

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				
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

VARIABLE DOSE		Date Time								
				Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :			Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Start Date		Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor			Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:			Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

STAT / ONCE ONLY DRUGS[illegible]



I.V. FLUIDS CHART

Weight. 12.54 kg Ward.

[illegible]

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Master T JASHWANTH RUDRA
26-02-2025
Dr. UJJWALA DESAI
IP5-00176739
1 Y 4 M 26 D
(M)

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

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

Pratiksha
Rainbow
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 22/4 Time:

Doctor / Nurse / Family Concern?

10Am 2pm

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94

98.3
97.7

Heart Rate
(bpm)

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

190
100
60
116/m
100
60
116/m

Heart Rate (Number)

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

70
60
50
40
30
20
10

Resp Rate (Number)

26/m 26/m

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

100% 99%

Conscious Level
Normal Altered

15/15 15/15

GCS *

TOTAL SCORE

Number of shaded boxes

0

Pain Score

0

Observer's Initials

0

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 Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

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BAH-00633637 IPS-00176739
Master T JASHWANTH RUDRA
26-02-2026 1 Y 4 M 26 D (M)
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	DNS		20ml							0	
Total Intake :					Total Output :							
	02:00 am			20ml							0	
	03:00 am	DNS		20ml							0	
	04:00 am			20ml							0	
	05:00 am			20ml							0	
	06:00 am	DNS		20ml							0	
	07:00 am										0	
Total Intake :					Total Output :							
Total 24 hrs. Intake					Total 24 hrs. Output							

Patient Sticker

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 26-02-2025 1 Y 4 M 26 D (M)
 Dr. UJJWALA DESAI



FLUID CHART

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

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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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
22/4	08:00 am	Dry		20ml	/	/	/	/	/	/	0	Chen
	09:00 am		20ml	0								
	10:00 am		—	0								
	11:00 am		—	0								
	12:00 pm		20ml	0								
	01:00 pm		20ml	0								
	Total Intake :			Total Output :								
22/4	02:00 pm	Dry		20ml	/	/	/	/	/	/	0	Srinik
	03:00 pm		20ml	0								
	04:00 pm		20ml	0								
	05:00 pm			0								
	06:00 pm			0								
	07:00 pm			0								
	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: 21/6/20

Assessment: Pt on O2 1lit

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
3pm	→ assess the pt general condition	8:30pm	→ assessed the pt general condition	
11pm	→ provide comfortable position	11:30pm	→ provided comfortable position	
2Am	→ monitor vital signs	2:30pm	→ monitor vitals signs	
4Am	→ maintained I/O chart	4:30pm	→ maintained I/O chart	
6Am	→ Administer all medication as per doctors order	6:30pm	→ Administer all medication as per order	baby stable

Re-Assessment:

Special Notes: been noted if so

Nurse Signature: Jamuna

Nurse Name: Jamuna

Date & Time: 22/7/26 8am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 22/7

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
8am	→ Assess the pt General Condition	8:10am	→ Assessed the pt General Condition	pt is stable
10am	→ Check the Vital Signs	10:10am	→ Checked the Vital Signs	
12pm	→ plan for administration medication	12:10pm	→ maintain I/O Chart	
2pm	→ Strict I/O Chart	2:10pm	→ providing Comfortable position	
	→ plan for Comfortable position			

Re-Assessment: Re-Assessment every 4th hrly

Special Notes:

Nurse Signature: @

Nurse Name: Chandan

Date & Time: 22/7/25 2:20pm



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Ujjwala Desai Department: ER Date of Admission: 21/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
BACKGROUND	Area	<u>ER</u>	<u>ward</u>	<u>1st floor</u>	<u>1st floor</u>		
	Shift Time	<u>12am</u>	<u>8pm to 8pm</u>	<u>8am to 8pm</u>	<u>2pm to 8pm</u>		
	Medical Condition (Any special condition to be noted):	<u>nil</u>	<u>ascl</u>	<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>98.8°F</u>	<u>96.3°F</u>	<u>98.2°F</u>	<u>98°F</u>	
		Res:	<u>52b/m</u>	<u>52b/m</u>	<u>28b/m</u>	<u>23b/m</u>	
		SpO ₂ :	<u>97%</u>	<u>98%</u>	<u>99%</u>	<u>99%</u>	
		Pulse:	<u>154b/m</u>	<u>180b/m</u>	<u>131b/m</u>	<u>129b/m</u>	
		BP:			<u>98/60</u>		
	Fall Risk Score:	<u>12</u>	<u>12</u>	<u>0/10</u>	<u>0/10</u>		
Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>			
Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>		
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	
	Others Specify:	<u>nil</u>	<u>ascl</u>	<u>na</u>	<u>na</u>		
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>nil</u>	<u>ascl</u>	<u>na</u>	<u>na</u>		
	Post Operative Procedure Special Orders:	<u>nil</u>	<u>ascl</u>	<u>na</u>	<u>na</u>		
	Handed Over By Name :	<u>Susmita</u>	<u>Janeva</u>	<u>Chande</u>	<u>Nikita</u>		
	Signature :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
	Date:	<u>21/7/26</u>	<u>22/7/26</u>	<u>22/7</u>	<u>22/7</u>		
	Time:	<u>12am</u>	<u>8am</u>	<u>2pm</u>	<u>5pm</u>		
	Taken Over By Name :	<u>Janeva</u>	<u>Chande</u>	<u>Nikita</u>			
	Signature :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
	Date:	<u>21/7/26</u>	<u>22/7</u>	<u>22/7</u>			
	Time:	<u>12:30pm</u>	<u>8am</u>	<u>2pm</u>			

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Area							
BACKGROUND	Shift Time							
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:							
	Temp:							
	Res:							
	SpO ₂ :							
	Pulse:							
	BP:							
Fall Risk Score:								
Pain Score:								
Recommendations	Safety Needs:							
	Physiotherapy		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:							
	Special Diet:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:							
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature :								
Date:								
Time:								
Taken Over By Name :								
Signature :								
Date:								
Time:								

Pat

BAH-00633637 IP5-00176739
Master T JASHWANTH RUDRA
26-02-2025 1 Y 4 M 26 D (M)
Dr. UJJWALA DESAI



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BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

HUMPTY DUMPTY SCALE

21/7/26 9:27

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	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			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	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			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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			
TOTAL			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			
Call device within reach		yes	yes			
Wheels Locked		yes	yes			
Room free of clutter		yes	yes			
Adequate Lighting		yes	yes			
Wheel Chair Support		NO	NO			
Other Intervention(s) Specify		NO	NO			
Nurse's Name :		Sumita	Francis			
Signature :		[Signature]	[Signature]			
Date :		21/7/26	22/7			
Time :		11:20 PM	6 AM			

BAH-00633637

IP5-00176739

Master T JASHWANTH RUDRA

26-02-2025

1 Y 4 M 25 D

(M)

Dr. UJJWALA DESAI



BRADEN 'Q' SCALE

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					Date :	21/1/26	22/1/27		
					Time :	11:20 PM	6 AM		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	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			
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			
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			
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			
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			
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			
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			
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	ZE			

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

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
21/7/26	11:20 PM	0	nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
22/7	@6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	PRU	Jannu
22/7	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NO	Chandan
				☐ 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		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

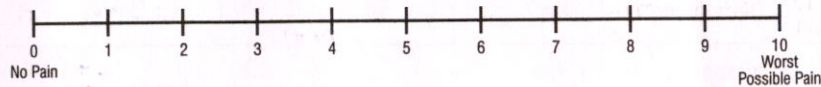
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, 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

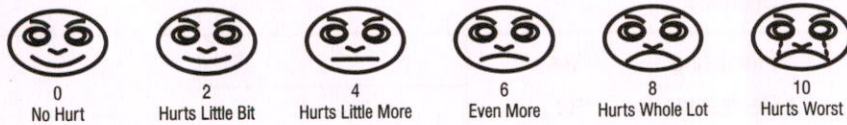
Numerical Pain Scale (Obstetric and Gynecology)



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



CHECKLIST FOR THROMBOPHLEBITIS

21/7

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					
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	1	1					
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			2	2	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	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			4	4	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			5	5	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 : Anishan Name : Anishan

Signature of Ward In Charge :

Signature : Neeraja Name : Neeraja

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

Identified Education Needs:

1. Diagnosis
2. Treatment and Care Plan
3. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights
13. Risk / Safety
14. Activity / Exercise
15. Social & Rehabilitation Needs
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		
21/7/26	11:20 PM	7	Infection control measures	M	4	0	1	1	-	<i>[Signature]</i>
22/7/26	9:30 AM	9	soft High protein diet	M	1	0	1	1	-	<i>[Signature]</i>

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

MULTI-DISCIPLINARY PLAN OF CARE FORM

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
21/7/26	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	cold, cough x yesterday	H. Stability	Pv fluids	be.	☐ Nursing ☐ Others:
21/7/26 @ 11:20 PM	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	cold, cough x yesterday.	H. Stable.	IV medication		☐ Medical ☐ Others:
22/7/26 9:30 AM Dr. Dheeksh	☐ Medical ☐ Nursing ☒ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	LRTI	Soft High Protein diet	<u>RDA</u> C:- 1200kcal/d P:- 20g/d	Moubr	☐ 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-00633637 IP5-00176739
Master T JASHWANTH RUDRA
26-02-2025 1 Y 4 M 3 D (M)
Dr. UJJWALA DESAI

Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 1 AM Mode of Arrival: wheel chair Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: NA Body Weight: 12.54 Kg

Height: cm

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

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

Family History:

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

If yes please list,

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

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

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

Observations: Weight: 12.54 kg Length: Head Circumference (< 2 years):

Temp.: 97.6 F HR: 110 bpm RR: BP:

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

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

Character of Pain N Location Frequency Duration

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 WithSiblings in household ☐ Yes ☒ No (if yes How Many?)All Information Obtained From ☐ Patient ☒ Mother ☒ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach : ☒ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump : ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ NoInformation given to *parents*Nurse Signature: *Cy*Nurse Name: *Chandana*Date: *22/11/24*Time: *2:00 PM*



DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: as per doctor order

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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

☒ Needs Assistance In:

Remarks

☒ Medication ☒ Yes ☐ No

☐ Bathing ☐ Yes ☒ No

☐ Eating ☐ Yes ☒ No

☐ Walking ☐ Yes ☒ No

☐ Dressing ☐ Yes ☒ No

☐ Toileting ☐ Yes ☒ No

explain to the parents

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: personal hygiene

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

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: Jamuna

Nurse Name: Jamuna

Date and Time: 22/1/26 @ 12am

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00633637 IP5-00176739 Master T JASHWANTH RUDRA 26-02-2026 1 Y 4 M 26 D (M) Dr. UJJWALA DESAI 		Date & Time of Admission 21/7/26 @ 11:19 PM	Date & Time of Transfer Order 22/7/26 @ 12am
		Transfer Ordered by Dr. Madhuri	Reason for Transfer Admission
From Unit ER	To Unit 144-B	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what? ... op file	Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films nil			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Nebulizer mask	1	
2.	nil		
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Dr. Sureshita		Name of Person Ordered Transfer Dr. Madhuri	
Patient & Clinical Records Received by : Jannara			
Date & Time of Patient Received : 22/7/26 @ 12am			

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

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



EMERGENCY ROOM TRIAGE FORM

Patient's Name : T. Jashwanth Rudra Age : 2y 15m Gender: ☒ Male ☐ Female
Date : 21/2/26 Time of Arrival : 10:00pm Triage Completion Time : 10:02pm
Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): ☐ 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 ☒ Normal ☐ Sick Looking	Circulation / Colour ☒ Normal ☐ Abnormal ☐ Bleeding	☐ Stable ☒ Unstable : ☒ Not - Life - Threatening ☐ Life -Threatening
Work of Breathing ☐ Normal ☒ Increased ☐ Decreased ☐ Gasping / Apnea		

Initial Vital Signs: Temp: 98.8F PR: 150bpm BP: 97/60 RR: 50bpm SpO₂: 97% CRA
Chief Complaints: Cold, cough x yesterday. Diarrhea x yesterday.

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

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 : 21/2/26 10:02pm

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

BAH-00633637 IP5-00176739
Master T JASHWANTH RUDRA
26-02-2026 1 Y 4 M 26 D (M)
Dr. UJJWALA DESAI



**Rainbow[®]
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It takes a lot to treat the little.


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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 21/7/25 Time of arrival : 10:03 PM
Chief Complaints : Cold, cough x yesterday. RBS : NA
Height : Weight : 12.5 kg BMI : Head Circumference (<2 years)
Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:
If yes, identify
Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker
☐ Character ☐ Location ☐ Frequency ☐ Duration

RISK FOR FALL:

- ☒ If patient is < 6 years
tick below fall risk intervention directly
☐ If Patient is > 6 years
Assess the below parameters
- History of Falling: within past 3 months ☐ Yes ☐ No
- Ambulatory Aids:**
- Wheelchair ☐ Yes ☐ No
 - Uses furniture for support ☐ Yes ☐ No
- Gait/Transferring:**
- Bedrest / immobile ☐ Yes ☐ No
 - Weak ☐ Yes ☐ No
 - Impaired ☐ Yes ☐ No
- Mental Status:** Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

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

Social History: Lives With Parents

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

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

Time of Initial assessment completed by ER Nurse : 21/7/26 @ 11:52 PM

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

Time	Nursing Notes
7:30 PM	Buckart given at home levorin 0.63mg given at home.

Samples collected by: John

Time: 11:30 PM

Samples sent by :

Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
2/17/16 11:18 PM	NEB E	LEVORIN	0.63mg	NEB - (2)	LAJAY

Condition of patient at time of shift - out :	Details of Shift - out
HR: 154b/min BP: CFT: 42 sec RR: 52b/min SPO ₂ : 97% GCS: 15/15 Temperature: 98.8°F Pain Score: 0 Repeat RBS (if applicable): Nil	Shift - out from ER to: 144B Time of Shift - out: 12am Handover given to: Jannina (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

Tr placement done

Name of the Nurse : Seesmita

Signature of the Nurse : [Signature]

Date & Time : 2/17/16 @ 11:58 PM



144 B

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 12/7/26 Time: 8:30 AM

Weight: 12.54 Kg Centile: >75th

Height: 82 cm Centile: 75th

Inference: Overweight child

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

Diet Recommendations: Soft High Protein diet

Re-Assessment: Avoid spicy, chilled and outside foods

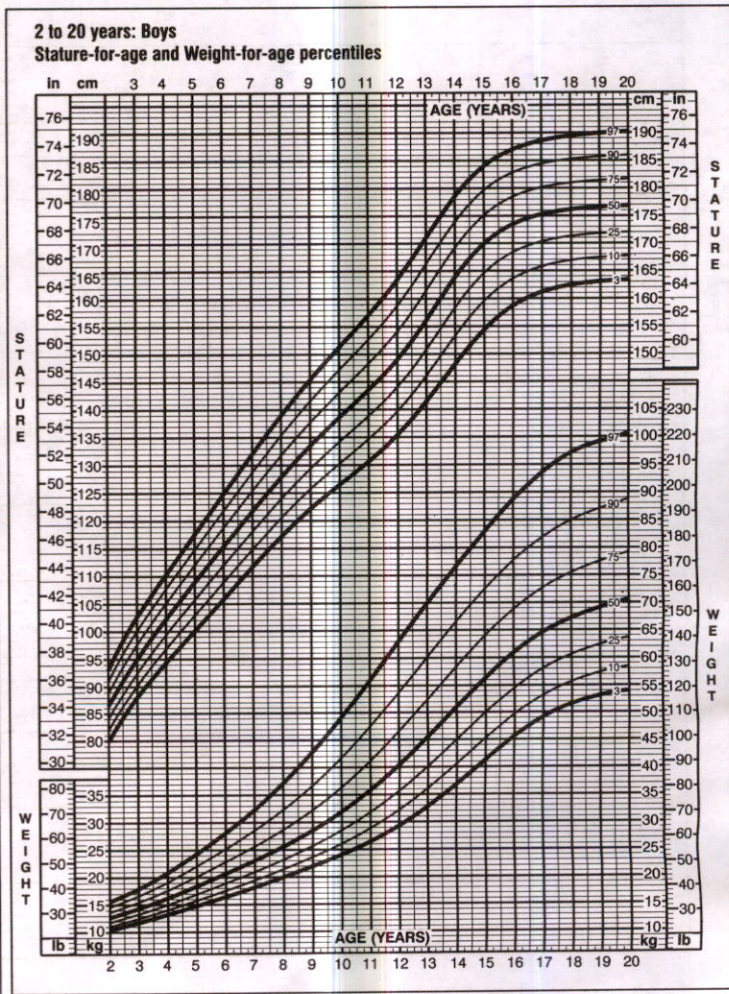
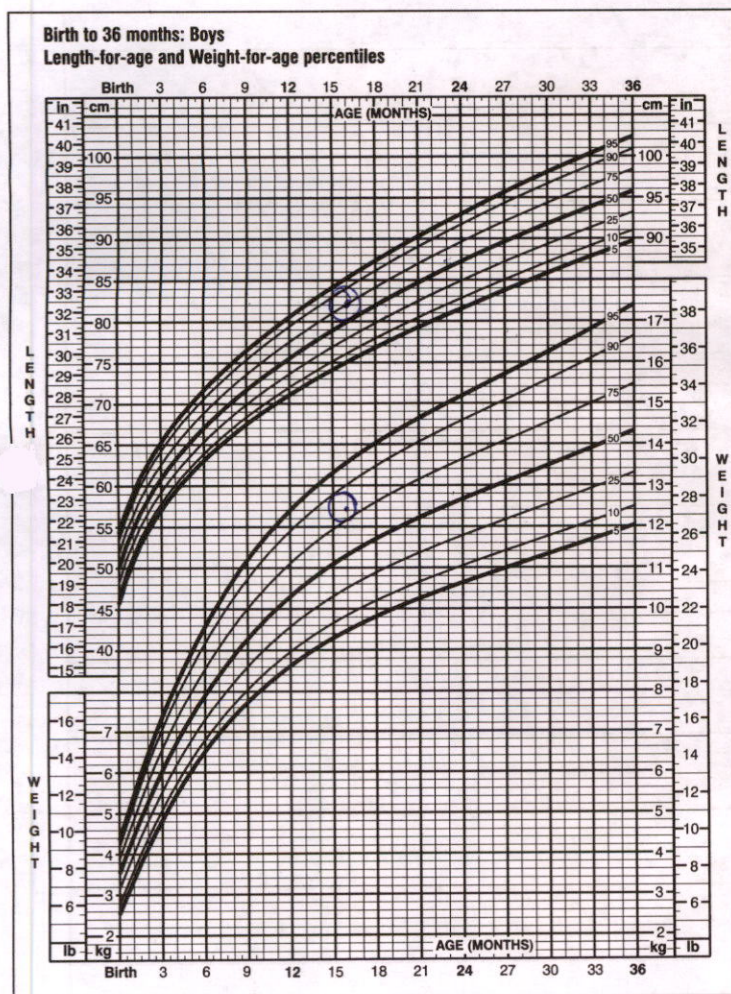
Food Allergies: NO Veg/Non-veg: veg

Diagnosis: LRTI

Nutritional Intervention - ☐ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Radika

GROWTH CHART (BOYS)



Dietician's Name: Mounica

Dietician's Signature: Mounica

Birthright

NUTRITIONAL HEALTH ASSESSMENT - 802	
Weight	100 lbs
Height	5' 10"
Age	35
Sex	Male
Occupation	Teacher
Marital Status	Married
Number of Children	2
Smoking Status	Non-smoker
Alcohol Consumption	Occasional
Medical History	None
Family History	None
Current Medications	None
Recent Illnesses	None
Stress Level	Low
Exercise Routine	Regular
Dietary Habits	Healthy
Sleep Patterns	Regular
Mental Health	Stable
Overall Health	Good