

ACTIVITY RECORD FOR BILLING

Name : _____

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

Date of Admission: _____ Ti _____ arge : _____ Time: _____

Room / Bed No : _____ Wa _____ illable bed type : _____

KUH-00080559 IP5-00176564
Baby BIJJULA TAPASSYA REDDY
06-03-2018 8 Y 4 M 12 D (F)
Dr. ANUPAMA Y



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
18/7/26	1:20 pm	ER	105	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr- sruthi Borena	20/07/26	9713569	Pratyanka
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

Investigations

Signature

2. Chander

35836

Snow

They



f

uric acid

[illegible]

Date	Procedure	Quantity	Order No.	Signature
18/7/20	PV placement	(1)	9366	Aruna
18/07/20	NHD	(1)	971002	Sau

ANY OTHER INFORMATION

USG - (1)

x-ray - (1)

Date : 21/7/20Time : 10:30AMPrepared By : Aruna

Staff NurseShift / WardBilling AssistantBilling Supervisor

ArunaSPT.

Date : 21/7/26

Time : 10:30 AM

Prepared By : Aruna

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor

Aruno

QNT.

ADMISSION SHEET
Registration Details :

Admission No : IP5-00176564

Admit Date : 18-Jul-2026

Admit Time : 12:41 PM **UHID** : KUH-00080559

Patient Details :
Patient Name : Baby BIJJULA TAPASSYA REDDY

Age : 8 Y 4 M 12 D

Guardian : Mr B UDAY KIRAN REDDY

DOB : 06-03-2018

Gender : Female

Religion :

Occupation :

Martial Status : Single

Address (H) : H NO 1-127, NEAR SHIVAALAYAM TMPLE,
 Brahmana Kotkur Kurnool Andhra Pradesh
 INDIA 518432

Phone No : 9908228737/ 7981834110

E-mail : UDHAYREDDY55@GMAIL.COM

Admission Details :
Bed Type : SEMI PRIVATE

Bed No : SPVT 105

Ward Name : 1F-VIBGYOR

Room No : SPVT 105

Admission Type : First Visit

Contact Details :
Name : Mr B UDAY KIRAN REDDY

Relationship : Father

Contact Address : H NO 1-127, NEAR SHIVAALAYAM TMPLE,
 Brahmana Kotkur Kurnool Andhra Pradesh INDIA
 518432

Phone No : 9908228737

R. Uday
 Signature

Doctor Details :
Doctor Name : Dr. ANUPAMA Y

Specialisation : GENERAL PEDIATRICS

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :
Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : CARE HEALTH INSURANCE LIMITED



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Tapasya Reddy

UHID ID:

KUH-00080559

IP5-00176564

Baby BIJJULA TAPASSYA REDDY

06-03-2018

8 Y 4 M 12 D

(F)

Dr. ANUPAMA Y



Department:

Consultant:

Pediatric Multiorgan History & Physical Examination

Name : Tapasya Age/Sex 8y 4m / F
 Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Fever x 3 days
 Abdominal pain x 3 days
 Vomiting x 3 days

History of present illness :

Child was apparently normal 3 days back. Later
 she developed fever & abdominal pain in onset, high grade. Subsequently
 with fever & again days
 she had abdominal pain which is diffuse & tender

↓
 vomiting - non bilious, non projectile & non
 bilious

she has no stool since 3 days in July

No Constipation

↓
 Abdominal signs due to distension

CRP - 22.5 mg/L

WBC - per cell count = 20,000

PLT - 11.4

TLC - 12,600

Platelet count

20,000

on Bactrim - 2 months

App. normal



Pediatric Multiorgan History & Physical Examination

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

4/0 Similar complaints in the past
Since 1 year - 3/4 times in last year

↓
MCCr - low - weight for age

CSH skin ⇒ Cytology

Birth & Neonatal History:

Term / LSCA / CLAB / BW - 3.5 kgs
(NNT)
Ald. Nicot. adn

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

exposed to smoke

Developmental History :

Reached at appropriate age in all 6 domains

Immunization History :

Vaccinated as per SOP



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) 130 cm (Centile _____) Height (cms): _____ (Centile) _____)

Weight (kgs) 22.4 kg (Centile _____)

On Examination :

Temperature : 99.2 Pulse Rate : 120/4 B.P. 101/77 (60) SPO2 94

Resp. rate and type of breathing : _____

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : RAS (+) (clear)

Air entry & breath sounds : _____

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : SLS (+)

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen :

Inspection Soft, Tenderness - diffuse, Dist in hepatogastric region

Palpation : _____

Auscultation : _____

Spine : _____ External Genitalia : ju

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Fever UTI

Bowel bladder dysfunction



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Sepsis, secondary infection

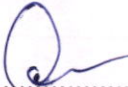
Desired goals of the treatment: Relief of symptoms

Planned Labs:

CUE
Cerebro culture
R₁ (Cerebro spinal fluid)
RP₂
VISA Abdomen
NIB
Sagan
18/7/26
12:20 pm

Planned Management

2lo chest
2af - PIPITAZ
2af - DNS @ walk
Sup Oxycine de sup
NIB
Sagan
18/7/26
12:20 pm

Signature of the Doctor: 

Name of the Doctor: Dr. Anupama Y

Date & Time: 18/7/26 / 12:20 pm

Signature of the Consultant: 

Name of the Consultant: Dr. Anupama Y

Date & Time: 18/7/26 / 2pm

DR. ANUPAMA Y
Registration No: 50853



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/09/2026	cl/clb p/w fellow	
8:30am	ΔUTI (Culture-awaited)	
	O/E	Plan:
	Afebrile	1) Continue wj. pinto 3
	Hemodynamically stable	2) wj for Inform soc
	No pain abdomen rhodes	3) Trace urine cl.
	K/clo Constipation (not on any med)	4) Plan to add
	Not passed stool since 2 days.	Sp. Smooth after round
		Seuf.
19/9/26	SIB Dr. Anupama	
12pm		
	UPE	
	Voiding Dyfnc	
	for <u>uric acid</u>	Plan
	fewer spikes but	- Trace urine cl
	chest clear.	- Nephrology consult.
		- add Smooth + Movt
		- CRP / → 6pm

DR. ANUPAMA Y
 Registration No. 50853



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/07/2026 5:40pm	<u>Clelb p/w fellow</u>	
	<u>ΔUTI</u>	<u>Plan</u>
	Bowel Bladder dysfunction	1) Cbp, csp @ 6pm
	o/e	2) Come c/s to trace
	Hemodynamically stable	3) Nephrology Consultation T/m
	Afebrile	4) W/F Full Speed
	accepting orally	<u>over</u>
		<u>AA</u> <u>DM</u>
20/07/2026 8:00 AM	<u>Clelb p/w fellow</u>	
	<u>ΔUTI</u>	<u>Plan</u>
	Bowel dysfunction	1) Trace come c/s
	o/e	2) Nephrology Consultation
	Hemodynamically stable	3) Prepare discharge Summary
	Afebrile	4) Stop IV fluids.
	accepting orally well	<u>over</u>
	<u>On</u>	
	mipiptaz	
	WBC ↓	
	CRP ↓	
	come c/s - Growth ⊕ (verbal)	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/20 9:57 AM	SIB Dr. Anupama	
	U+1	
	Recurrent U+1	
	voiding Dysfnc	Pla
	for constipation	
		- Trace urine up
	CRP hvd.	
		- Nephro consult
		DR. ANUPAMA Y Registration No: 50853
		<i>[Signature]</i>
20/7/20 10:30 AM	SIB Pw team	
	As urinary tract infection	Adv
	functional constipation -	- Get X-Ray abdomen
	voiding dysfunction /	erect and
	Recurrent UTI	urine studies Urinalysis
	E-coli in Urine	- Calcium and creatinine
	$>10^5$ CFU/ml	plan for prophylaxis
		enema buster Abdomen
	On exam ab	K-Ray
	Hemodynamically stable	- continue PIPID2
	appt. chest clear	- continue mow & Smith
	pln soft B&D	<i>[Signature]</i>

DR. ANUPAMA Y
Registration No. 50953



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

[illegible]



CROSS CONSULTATION FORM

Doctor Name : Dr. Sruthi Salla Date : 20/7/26 Time : 4PM

Diagnosis : UTI

Hospital : RCH-BH

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

Type of Referral :

☐ Emergency

☒ Urgent

☐ Non Urgent

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

Urinary Tract Infection

Signature: _____

Findings and Recommendations :

- 8y/o Female, 40 fever : 3d ; abd. pain : 3d, vomitings : 3d
- high grade, intermittent, no chills, subsiding = antipyretics.
- suprapubic squeezing type of pain.
- non bilious non projectile vomiting.

Past History - UTI - 1st Ep. June 2025 → inadequately treated
recurred @ Oct 2025 → received antibiotics

mcUG - ⊕
used ~~of~~ Bactrim till march 2026.

Now, UTI again.

CuE - 80-100 pus cells, nitrate ⊕ve.
urine 4S sent, report awaited.

Adv - Xray abdomen erect
- Spot urine for Calcium, Creatinine, Uric acid

Consultant :

Name : DR. SRUTHI (502393) Signature : [Signature] Date & Time : 20/7/2026
2pm

Temp: BBD

- 9 X-ray fecal loading +¹
Live Paedology's evening
3 start observations
- Plan uroprophylaxis based on cfs
report.
- DMST after 6 weeks from now
- Regular toilet training
 - Timed voiding
 - Double voiding
- Avoid Salty Snacks.
- Plenty of oral liquids

Dr. [Signature]

KUH-00080559 IP5-00176564
 Baby BIJJULA TAPASSYA REDDY
 06-03-2018 8 Y 4 M 12 D (F)
 Dr. ANUPAMA Y



Mo 3/4
Rainbow Children's Hospital
 It takes a lot to treat the little.

POSTOP MBG 5/1/20 10/20
BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

RESULT SHEET

Date	<i>Outside</i> 18/7/26	18/7/26	19/7/26				
Time		5 PM	6 PM				
Hb	11.4		12.5				
PCV	34.5		39.2				
RBC	4.2		4.61				
WBC	17,600		9720				
N/L	20/21		45.2/43.2				
Platelets	2.84		4.10				
CRP	225.46		66				
ESR							
PCT							
RBS							
Na		138					
K		4.4					
Cl		103					
Ca/Mg							
Phosphate							
Urea		21					
Creatinine		0.5					
ALP							
SGPT							
SGOT							
T.Bill/Conj							
T.Protein							
S.Albumin							
S.Globulin							
A/G Ratio							
Uric Acid							
S.Amylase							
Sr.Lipase							
Blood Lactate							
S.Cholesterol							
PT/INR							
APTT							
CSF Protein / Sugar							
Cells							
N/L	Bicarbonate = 20						

[illegible]

Culture and Sensitivities : Outbreak
USG: Cystic changes

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: ICU

Shifted to: Ward

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Debelaji

Date & Time: 18/7/26 @ 12:25 pm

Nurse Name & Signature: Sagar

Date & Time: 18/7/26 @ 12:20 pm

KUH-00080559 IP5-00176564
 Baby BIJJULA TAPASSYA REDDY
 06-03-2018 8 Y 4 M 12 D (F)
 Dr. ANUPAMA Y

DRUG CHART

Date of Admission: 12/21/18 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG : <u>Sup. CROCIN DS</u>				Date Time															
Dose <u>6ml</u>	Route <u>PO</u>	Frequency <u>SOS</u>	Start Date																
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm.																
Additional Instructions: <u>(5ml/20mg)</u> <u>Take 6th - strictly gap between 2doses</u>																			

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

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

REGULAR PRESCRIPTIONS

Weight. 22.03 kgs Ward.

DRUG : 20g PIPERACILLIN TAZOBACTAM

Date Time 18/7 19/7 20/7 21/7

Dose 22gms Route IV Frequency TID Start Date 18/7/18

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : 20g ESMOPRAZOLE

Date Time 18/7 19/7 20/7 21/7

Dose 20mg Route IV Frequency OD Start Date 18/7/18

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : Symp. SMUTH

Date Time 19/7 20/7

Dose 10ml Route PO Frequency H/S Start Date 19/07

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : MUOUT POWDER

Date Time 19/7 20/7

Dose PO Frequency H/S Start Date 19/07

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

2 Spoon + 200ml water

Daily Doctor's Endorsement by a Sign

VERIFIED

VERIFIED

VERIFIED

VERIFIED



		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]



I.V. FLUIDS CHART

Weight. 22036..... Ward.

[illegible]



SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 20/7	Time: 6:00 AM	10 AM	2 PM	6 PM	10 PM	2 AM	6 AM
Doctor / Nurse / Family Concern?							
Temperature (F)	97.4°F	98.0°F	98.1°F	97.7°F	98.3°F	98.0°F	97.5°F
Heart Rate (bpm)	156/m	110/m	101/m	102/m	104/m	90/m	87/m
Blood Pressure (mmHg) *	99/73	100/60	100/60	100/60	98/61	101/63	103/65
Resp. Rate (bpm)	28/m	28/m	28/m	28/m	26/m	27/m	28/m
Receiving O ₂ (l/min)	100%	99%	100%	99%	100%	100%	99%
Conscious Level	15/15	15/15	15/15	15/15	15/15	15/15	15/15
GCS *	15/15	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE	1	1	1	1	1	1	1
Number of shaded boxes	1	1	1	1	1	1	1
Pain Score	0	0	0	0	0	0	0
Observer's Initials	a	a	a	a	a	a	a

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)



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/3/26	Time: 10AM	1PM	6PM	10PM	2AM	
Doctor / Nurse / Family Concern?						
Temperature (F)	104					
	103					
	102					
	101					
	100					
	99					
	98	97.4°F	97.0°F	96.7°F	97.8°F	98.0°F
	97					
	96					
	95					
94						
Heart Rate (bpm)	190					
	180					
	170					
	160					
	150					
	140					
	130					
	120					
	110					
	100					
Blood Pressure (mmHg) *	130					
	120					
	110					
	100					
	90					
	80					
	70					
	60					
	50					
	40					
Note: BP does not score in early warning scoring	105					
	100					
	95					
	90					
	85					
	80					
	75					
	70					
	65					
	60					
50						
Heart Rate (Number)	105					
	100					
	95					
	90					
	85					
	80					
	75					
	70					
	65					
	60					
Resp Rate (Number)	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	Resp Mod/ Severe Distress None / Mild					
Receiving O ₂ (l/min) O ₂ Saturations (%)						
	Conscious Level Normal Altered					
GCS *						
	TOTAL SCORE					
Pain Score						
	Observer's Initials					

ACTIONS

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- Score 1 : Continue normal observation by staff nurse
 Score 2 : Shift in charge nurse to be informed and continue hourly observations
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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)



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 15/03/26	Time: 5pm	10pm	2am	6am
Doctor / Nurse / Family Concern?				
Temperature (F)	99.0F	97.0F	98.0F	97.5F
Heart Rate (bpm)	126bpm	105bpm	112bpm	106bpm
Blood Pressure (mmHg) *	98/62	90/53	99/60	109/59
Resp Rate (Number)	26bpm	26bpm	22bpm	22bpm
Receiving O ₂ (l/min)	100%	97%	98%	100%
GCS *	15/15	15/15	15/15	15/15
TOTAL SCORE	0	1	1	1
Number of shaded boxes	0	1	1	1
Pain Score	0	0	0	0
Observer's Initials				

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

KUH-00080559 IP5-00176564
 Baby BIJJULA TAPASSYA REDDY
 06-03-2018 8 Y 4 M 12 D (F)
 Dr. ANUPAMA Y



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FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site 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									✓	0	
Total Intake :						Total Output :						
18/07	02:00 pm			40ml							0	Sraw
	03:00 pm									✓	0	
	04:00 pm	ONLY		40ml						0		
	05:00 pm			40ml						✓	0	
	06:00 pm									0		
	07:00 pm			40ml						0		
Total Intake :						Total Output :						
19/7	08:00 pm										0	Anish
	09:00 pm			40ml						✓	0	
	10:00 pm			40ml						0		
	11:00 pm	ONLY		40ml						✓	0	
	12:00 am									0		
	01:00 am									0		
Total Intake :						Total Output :						
19/7	02:00 am										0	Anish
	03:00 am			40ml							0	
	04:00 am	ONLY		40ml						✓	0	
	05:00 am									0		
	06:00 am									0		
	07:00 am									✓	0	
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						



FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
19/12	08:00 am	↑		40ml		/	/	/			0	Shaily
	09:00 am	↑	Gdy	40ml		/	/	/			0	Shaily
	10:00 am	DNS	Hw	-		/	/	/		✓	0	Shaily
	11:00 am			-		/	/	/		✓	0	Shaily
	12:00 pm	↓		40ml		/	/	/		✓	0	Shaily
	01:00 pm	↓		40ml		/	/	/			0	Shaily
Total Intake :						Total Output :						
19/12	02:00 pm	↑	RPe	40ml		/	/	/		✓	0	Shaily
	03:00 pm	↑	Hw	40ml		/	/	/		✓	0	Shaily
	04:00 pm	DNS		40ml		/	/	/		✓	0	Shaily
	05:00 pm			40ml		/	/	/			0	Shaily
	06:00 pm	↓		-		/	/	/		✓	0	Shaily
	07:00 pm	↓		-		/	/	/		✓	0	Shaily
Total Intake :						Total Output :						
19/12	08:00 pm		RPe	40ml		/	/	/			0	Shaily
	09:00 pm		RPe	40ml		/	/	/			0	Shaily
	10:00 pm	DNS		40ml		/	/	/		✓	0	Shaily
	11:00 pm			40ml		/	/	/			0	Shaily
	12:00 am			40ml		/	/	/			0	Shaily
	01:00 am			40ml		/	/	/			0	Shaily
Total Intake :						Total Output :						
20/12	02:00 am		RPe	40ml		/	/	/			0	Shaily
	03:00 am		RPe	40ml		/	/	/			0	Shaily
	04:00 am	DNS		40ml		/	/	/		✓	0	Shaily
	05:00 am			40ml		/	/	/			0	Shaily
	06:00 am			40ml		/	/	/			0	Shaily
	07:00 am			40ml		/	/	/			0	Shaily
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse											
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine													
20/03/18			Mouth	I.V	N.G																		
	08:00 am	1	0.1/14			/																	
	09:00 am					/																	
	10:00 am	NO WF				/																	
	11:00 am					/																	
	12:00 pm					/																	
	01:00 pm	1				/																	
Total Intake :						Total Output :																	
20/03/18	02:00 pm	1	0.1/14			/																	
	03:00 pm					/																	
	04:00 pm	NO WF				/																	
	05:00 pm					/																	
	06:00 pm					/																	
	07:00 pm	1				/																	
Total Intake :						Total Output :																	
20/03/18	08:00 pm	↑				/	✓																
	09:00 pm	NO WF				/	✓																
	10:00 pm					/																	
	11:00 pm					/																	
	12:00 am					/																	
	01:00 am	↓				/																	
Total Intake :						Total Output :																	
21/3	02:00 am	↑				/																	
	03:00 am					/																	
	04:00 am	NO WF				/																	
	05:00 am					/																	
	06:00 am					/																	
	07:00 am	↓				/																	
Total Intake :						Total Output :																	
Total 24 hrs. Intake												Total 24 hrs. Output											

KUH-00080559 IP5-00176564
 Baby BIJJULA TAPASSYA REDDY (F)
 06-03-2018 8 Y 4 M 13 D
 Dr. ANUPAMA Y

FLUID CHART

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Sheet No. :

1. All measurements in ml.
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3. 24 hrs. total to be entered in the kardex in RED.

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

Total 24 hrs. Intake

Total 24 hrs. Output

KUH-00080559 IP5-00176564
 Baby BIJJULA TAPASSYA REDDY
 06-03-2018 8 Y 4 M 13 D (F)
 Dr. ANUPAMA Y



NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 18/07/22

Assessment: Baby having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2PM	→ Assess the baby general condition and monitor the vitals and record.	2PM	→ Assessed the baby general condition and monitored the vitals and recorded.	By doing all above procedure baby condition improving well.
4PM	→ Continue medication as per chart	4PM	→ Continued medication as per chart	
8PM	→ Continue ONS @ 10ml/hr.	8PM	→ Continued ONS @ 10ml/hr.	
6PM	→ Trace	6PM	→ Tracing reports	
8PM	→ Ensure the safety needs.	8PM	→ Ensured the safety needs	

Re-Assessment: Re assessment done

Special Notes: Nil

Nurse Signature: Srawan K.

Nurse Name: K. Srawanthi ID: 607682

Date & Time: 18/07/22 @ 8pm

KUH-00080559 IP5-00176564
 Baby BIJJULA TAPASSYA REDDY
 06-03-2018 8 Y 4 M 13 D (F)
 Dr. ANUPAMA Y



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 18/8/26

Assessment: baby having mild infection according their condition

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	8pm	⇒ Assessed Pt General condition	pt condition is normal
10pm	⇒ monitor vital signs	10pm	⇒ monitored vital signs	
2am	⇒ maintain I/O chart	2am	⇒ maintained I/O chart	
8am	⇒ Administer the medications as per doctors order	8am	⇒ Administered the medications as per doctors order.	

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name: Anika

Date & Time: 19/8/26 2am

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 Baby BIJJULA TAPASSYA REDDY
 06-03-2018 8 Y 4 M 13 D (F)
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NURSING CARE RECORD

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Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 19/04/26

Assessment: Baby having pain in abdomen

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the baby general condition	8am	→ Assessed the baby general condition	By done the all procedures the baby condition is improved slowly.
10am	→ provide comfort position	10am	→ provided comfortable position	
12pm	→ monitor the vitals & Recorded it	12pm	→ monitored the vitals & Recorded it	
2pm	→ administer the all drugs as per doctor orders	2pm	→ administered the all drugs as per doctor orders	
4pm		4pm		
6pm		6pm		
8pm	→ Ensure the safety	8pm	→ Ensured the safety side rails	

Re-Assessment:

Special Notes:

Done by giving pain medication's
 Baby having CBP CRP today 6pm and Nephrology Review 7pm

Nurse Signature:

[Signature]

Nurse Name:

Shailaja (605567)

Date & Time:

19/04/26 (8pm)

KUH-00080559 IP5-00176564
 Baby BIJJULA TAPASSYA REDDY
 06-03-2018 8 Y 4 M 13 D (F)
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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 14/7/26

Assessment: pt having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	→ Assess the pt General condition	8PM	→ Assessed Pt General condition	Pt condition
10AM	→ monitor vital signs	10PM	→ monitored vital signs	
2PM	→ maintained I/O chart	2PM	→ maintained I/O chart	
8PM	→ Administered the medications as per doctors order.	8PM	→ Administered the medications as per doctors order.	

Re-Assessment: well

Special Notes:

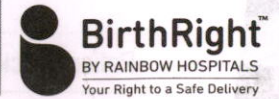
Nurse Signature: [Signature]

Nurse Name: Saurav

Date & Time: 20/7/26 8PM

KUH-00080559 IP5-00176564
 Baby BIJJULA TAPASSYA REDDY
 06-03-2018 8 Y 4 M 13 D (F)
 Dr. ANUPAMA Y

NURSING CARE RECORD



Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 20/07/26

Assessment: pt having pure 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	*Assessed The pt General condition	9am	*Assessed The pt General condition	pt is stable
10am	*checked The pt all vitay	11am	*checked The pt all vitay	
12pm	*maintain Ileo chart	1PM	*maintained Ileo chart	
3pm	*provide comfortable position	4PM	*provided comfortable position	
6pm	*administer all medication given as per doctor order	8PM	*administered all medication given as per doctor order	

Re-Assessment:

Special Notes: Southi nam consultation done

Nurse Signature: [Signature] Nurse Name: Shanti Date & Time: 20/07/26 8PM

KUH-00080559
 Baby BIJJULA TAPASSYA REDDY
 06-03-2018 8 Y 4 M 13 D (F)
 Dr. ANUPAMA Y

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/7/26

Assessment: Stomach pain & Discomfort

- 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
8 PM	Assess general condition of the patient.	8 to 10 PM	Assessed general condition of the patient.	By done as implementation as per doctor's order.
10 AM	Monitor vital signs.	10 AM	Monitored vital signs.	
11 AM	Maintain to chart.	11 to 30 AM	Maintained to chart.	
5 AM	Provide comfortable position to the patient.	5 to 50 AM	Provided comfortable position to the patient.	
6 PM	Administer medication as per doctor's order.	6.5 PM	Administered medication as per doctor's order.	

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

Special Notes: trace blood culture Reports.

Nurse Signature: PB

Nurse Name: Pragyanka

Date & Time: 21/7/26 8 AM



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Anupama Y Department: ER Date of Admission: 18/7/26

SITUATION	Diagnosis: <u>Fever 24 day</u> <u>Stomach pain 24 day</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
	Area	Shift Time	ER 1:20 pm	1st floor 7pm to 8am	5th floor 8:30 am to 1pm	1st floor 8am to 8pm	1st floor 8pm to 8am
BACKGROUND	Medical Condition (Any special condition to be noted):		Nil	NA	NA	NA	NA
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>99.1</u>	<u>97.3</u>	<u>98.0 F</u>	<u>98.3 F</u>	<u>98.4 F</u>
	Res:		<u>22 blm</u>	<u>26</u>	<u>24 blm</u>	<u>28 blm</u>	<u>26 blm</u>
	SpO ₂ :		<u>100%</u>	<u>99%</u>	<u>99%</u>	<u>100%</u>	<u>100%</u>
	Pulse:		<u>104 blm</u>	<u>112</u>	<u>115 bpm</u>	<u>112 blm</u>	<u>81 blm</u>
	BP:		<u>95/61</u>	<u>98/70</u>	<u>100/60</u>	<u>95/73</u>	<u>110/81</u>
	Fall Risk Score:		<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>
Recommendations	Pain Score:		<u>0</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>
	Safety Needs:		<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Side rails</u>
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		Nil	NA	NA	NA	NA
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		Nil	NA	NA	NA	NA
Post Operative Procedure Special Orders:		Nil	NA	NA	NA	NA	
Handed Over By Name :		<u>Sagan</u>	<u>Ankita</u>	<u>Shailaja</u>	<u>Saurabh</u>	<u>Chub</u>	<u>Priyanka</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>18/7/26</u>	<u>19/7/26</u>	<u>19/7</u>	<u>20/7</u>	<u>20/7</u>	<u>21/7</u>
Time:		<u>1:20 pm</u>	<u>2am</u>	<u>(8pm)</u>	<u>8am</u>	<u>8pm</u>	<u>8AM</u>
Taken Over By Name :		<u>Ankita</u>	<u>Shailaja</u>	<u>Saurabh</u>	<u>Chub</u>	<u>Priyanka</u>	<u>Sweet</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>18/7</u>	<u>19/7</u>	<u>19/7</u>	<u>20/7</u>	<u>20/7</u>	<u>21/7/26</u>
Time:		<u>3pm</u>	<u>2am</u>	<u>8pm</u>	<u>8am</u>	<u>8pm</u>	<u>8am</u>



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area						
	Shift Time						
BACKGROUND	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:							

KUM-00080559 IP5-00176564
 Baby BIJJULA TAPASSYA REDDY
 06-03-2018 8 Y 4 M 12 D (F)
 Dr. ANUPAMA Y



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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE 18/7 19/7 20/7 21/7

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	3	
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1	1	
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	
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	1	
TOTAL			10	10	10	10	

Intervention : -Fall Risk : Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

Bed in low position	YES	YES	YES	YES
Call device within reach	YES	YES	YES	YES
Wheels Locked	YES	YES	YES	YES
Room free of clutter	YES	YES	YES	YES
Adequate Lighting	YES	YES	YES	YES
Wheel Chair Support	NO	NO	NO	NO
Other Intervention(s) Specify	NO	NO	NO	NO
Nurse's Name :	Sagan	Smith	Smith	Prigat
Signature :	[Signature]	[Signature]	[Signature]	[Signature]
Date :	18/7	19/7	20/7	21/7
Time :	12:15 pm	8:25	9:25	8 AM

KUH-00080559 IP5-00176564
 Baby BIJJULA TAPASSYA REDDY
 06-03-2018 8 Y 4 M 12 D (F)
 Dr. ANUPAMA Y



BRADEN 'Q' SCALE

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					Date : 18/7/26	12:15am	12:45pm	2:15pm	2:45pm
					Time : 12:15am	12:45pm	2:15pm	2:45pm	3:15pm
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	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	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	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	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	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	4	3
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	4
TOTAL SCORE					28	28	28	27	27
Evaluator's Name					Dr. Anupama Y	Dr. Anupama Y	Dr. Anupama Y	Dr. Anupama Y	Dr. Anupama Y

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Docu. No. : RCHBH/FRM / CLINICAL / 119

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
18/7/26	12:15 pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil Nil	
18/7	8pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Di
19/7	4AM	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	B
19/07	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shairaf
19/07	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shairaf
19/7	4AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shairaf
19/07	12PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shairaf
21/7	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shairaf
				☐ 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:

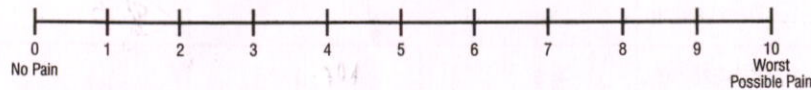
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain intervention.

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





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									
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				Swach									

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 : pulakesh Name : pulakesh

Signature of Ward In Charge :

Signature : Neeraja Name : Neeraja

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0										
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3										
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	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 personnel ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	19/7/26 DAY-1			DAY-2			20/7/26 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			-	-	-	-	-	-	-	Removed cannula
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													

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 : Sourav

Signature of Ward In Charge :

Signature : [Signature] Name : Nandu

KUH-00080559 IP5-00176564
Baby BIJJULA TAPASSYA REDDY (F)
06-03-2018 8 Y 4 M 12 D
Dr. ANUPAMA Y

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Part I
Patient's / Learner Language: Telegu 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		
18/7/26	12:15 pm	7.	infection control measures	M	1	0	1	1	-	
18/7/26	2:30 pm	9	normal diet & plenty of oral liquids	M	1	0	1	1	-	Nithila

Part - III: CODES

Who was taught:		PT: Patient	F: Father	<u>M: Mother</u>	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 <u>O: Oral</u> 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

Diagnosis: Fever 4 day, Stomach 4 day

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
18/7/26 12:20 pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fever Abd-pain, nausea Febrile UTI	Hemodynamic stability	As medication		☐ Nursing ☐ Others:
18/7/26 12:20 pm	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fever 4 days Stomach pain 4 days	H-Stability	Vitals monitoring		☒ Medical ☐ Others:
18/7/26 2:30 pm	☐ Medical ☐ Nursing ☐ Others: dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Febrile UTI, Bladder bradder dysfunction	Normal diet + plenty of oral liquids	RDA:- E:- 1550 kcal/day P:- 27 g/day	Nikites	☐ 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:

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 18/7/26 Time: 2:30pm

Weight: 22.4 kgs Centile: 70th

Height: 130 cms Centile: 50th

Inference: underweight child

RDA: — Calories: 1550 kcal/d Protein: 22 g/d

Diet Recommendations: Normal diet & plenty of oral liquids

Re-Assessment: Avoid spicy, chilled & outside foods

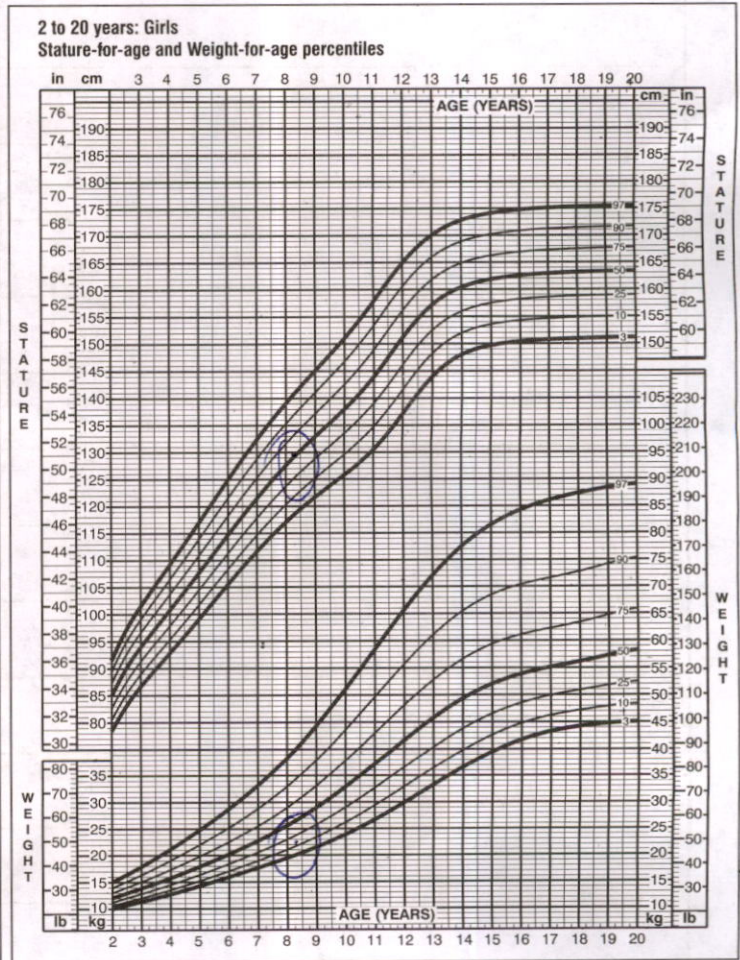
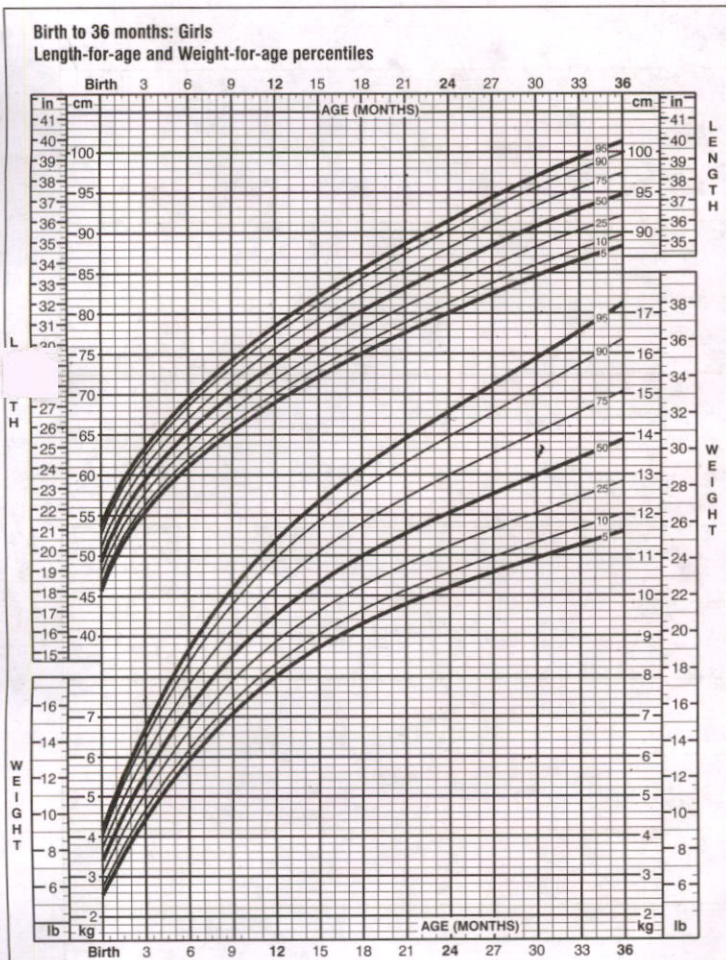
Food Allergies: NO Veg/Non-veg: Non-veg

Diagnosis: febrile UTI, Bowel bladder dysfunction.

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: J.D.

GROWTH CHART (GIRLS)



Dietician's Name: Niritha

Dietician's Signature: Niritha

Daily Notes:

19/7/16
NAM

Child is stable Intake is fair

Continue on Normal diet & plenty of liquids diet.

- Washburn

20/7/16
8:30am

Child is stable. Intake is well

continue on Normal diet & plenty of liquids - Nibite



DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: as per doctor's advice

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☒ Transfer

Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

☐ Medication ☐ Yes ☒ No

Explain to the mother & father

☒ Bathing ☒ Yes ☐ No

☒ Eating ☒ Yes ☐ No

☒ Walking ☒ Yes ☐ No

☒ Dressing ☒ Yes ☐ No

☒ Toileting ☒ Yes ☐ No

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient

☐ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient

☐ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Personal Hygiene

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

☐ Patient

☐ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: K. Srajanthi

Date and Time: 18/06/2026 1:40 PM

Docu. No. : RCHBH /FRM / CLINICAL / 191

KUM-00080559 IP5-00176564
Baby BIJJULA TAPASSYA REDDY
06-03-2018 8 Y 4 M 12 D (F)
Dr. ANUPAMA Y

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

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Your Right to a Safe Delivery

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Tapanya Reddy Age : 8 years Gender: ☐ Male ☒ Female
Date : 18/07/26 Time of Arrival : 12:05 pm Triage Completion Time : 12:07 pm
Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): nil ☐ Not known any drug Allergies
Source of Information : ☒ Parents ☐ Others (Specify) _____
Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance

☒ Normal

☐ Sick Looking

Circulation / Colour

☒ Normal

☐ Abnormal

☐ Bleeding

Work of Breathing

☒ Normal

☐ Decreased

☐ Increased

☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

☒ Stable

☐ Unstable :

☐ Not - Life - Threatening

☐ Life -Threatening

Initial Vital Signs: Temp: 99.7 OF PR: 120b/m BP: 101/55 (66) RR: 24b/m SpO₂: 100% RA

Chief Complaints: cl. Fever x 4 days. Stomach pain x 4 days.

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: B. Uday

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 : Arundhati

Date & Time : 18/07/26 @ 12:07 pm

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

Signature of Triage Nurse : [Signature]