

ADMISSION SHEET

Registration Details :


Admission No : IP5-00175941 Admit Date : 03-Jul-2026 Admit Time : 08:49 PM UHID : LBH-00031091

Patient Details :

Patient Name	: Baby KANTAMANENI PARINITHI CHOWDARY	Age	: 8 Y 4 M 0 D
Guardian	: Mr KANTAMANENI SATYANVESH	DOB	: 03-03-2018
Gender	: Female	Religion	: Hindu
Occupation	:	Martial Status	: Single
Address (H)	: H NO 54/32,R G K P COLONY Kachivani Singaram Hyderabad Telangana INDIA 500088	Phone No	: 9550596022/ 9676846033
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type : BASINET Bed No : CRDL-DLX308-1 Ward Name : 3F-ZONE A
 Room No : CRDL-DLX308-1 Admission Type : First Visit

Contact Details :

Name : Mr KANTAMANENI SATYANVESH Relationship : Father
 Contact Address : H NO 54/32,R G K P COLONY Kachivani Phone No : 9550596022 / 9676846033
 Singaram Hyderabad Telangana INDIA 500088


 Signature

Doctor Details :

Doctor Name : Dr. ANUPAMA Y Specialisation : GENERAL PEDIATRICS
 Referral Doctor : Self Phone No :
 Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
 Payor Name : STAR HEALTH AND ALLIED
 INSURANCE CO LTD

LBH-00031091 IP5-00175941
 Baby KANTAMANENI PARINITHI
 03-03-2018 8 Y 4 M 0 D (F)
 Dr. ANUPAMA Y

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ACTIVITY RECORD FOR BILLING

Name : _____

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

Date of Admission: _____ Time : _____ Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/7/26	9:20 pm	ER	ward	[Signature]

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
03/07	IV Placement	①	6385	Samuel

ANY OTHER INFORMATION

.....

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.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



PEDIATRIC IN-PATIENT MEDICAL RECORD

LBH-00031091 IP5-00175941
Baby KANTAMANENI PARINITHI
03-03-2018 8 Y 4 M 0 D (F)
Dr. ANUPAMA Y

Patient Name:

PARINITHI .

UHID ID:

Department:

Consultant:



Pediatric Multiorgan History & Physical Examination

Name : Parinithi Chowdary Age/Sex 8y / Female

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Vomitings $\therefore$ 7 days

Pain abdomen $\therefore$ 7 days

History of present illness :

Apparently symptomatic 7 days ago

- Vomiting 5-7 c/day

Non-bilious

not associated with

food particles or vomitus.

Pain abdomen umbilical

colicky

not aggravated by feeding



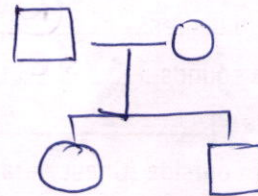
Pediatric Multiorgan History & Physical Examination

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

H/o similar complaints $\therefore$ 3 months
subsiding $\pm$ symptomatic medications
 $\&$

Birth & Neonatal History:

T.G / AYA / CABS / No H/o
NICU stay.



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____
Upper middle

Developmental History :

②

Immunization History :

till date as per NIS.



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 27.18 (Centile _____)

On Examination :

Temperature : 98.2 F Pulse Rate : 96 B.P. 109/67 SPO2 99.1

Resp. rate and type of breathing : _____
22/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : (N)

Air entry & breath sounds : RL VRSP

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : (N)

Heart Sounds : S1 S2

Any murmur : _____

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

Per Abdomen :

Inspection (N)

Palpation : Non Tender NO Htn

Auscultation : _____

Spine : (N) External Genitalia : N/E

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Aw

Cranial Nerves : 1

Motor System:

Nutriton : 1

Tone: 1

Power 4/5

Co-ordinator : 1

Posture : 1

Involuntary Movements : 1

Reflexes :

DTR

Superficials:

Plantars 1

Sensory System :

Bladder / Bowel : Regular

Clinical Summary & Diagnostic:

UTI
Ac. cholecystitis



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Complications.

Desired goals of the treatment : _____

Febrile.

Planned Labs:

Urine c/s
Blood c/s
CRP.
AKS
Shanar
3/7/20

Planned Management

- Acute

Signature of the Doctor: _____

Name of the Doctor: *M. Rahul Kumar*

Date & Time: *3/7/26; 8:30pm*

Signature of the Consultant: _____

Name of the Consultant: *D. Anupama Y*

Date & Time: *3/2/26*

DR ANUPAMA Y
Registration No: 50853



DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	3			
7	Nursing plan of care and handover sheets	2			
8	Consultation sheet	1			
9	General consent for treatment				
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	2			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart	1			
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
Total No. of Pages		24			

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

Date & Time	Progress Notes	Doctor's Order
4/6/26 8AM	C/S/B	picu fellow -
	ASB! - UTI	
	on room Atr	plan.
	hemodynamically stable	1. w/ fever spikes
	NO fever spikes	2. Monitor vitals.
	NO vomiting	
	NO pain abdomen	3. encourage oral intake
	Inf Augmentin - D2	3. Trace urine & blood culture
	CRP - 5.0	Dr. Nathan
4/6/26 10AM	C/S/B Dr. Anupama	
	Acute gastroenteritis chertika symptomatic bacteremia.	plan.
	on room Atr	1. w/ fever spikes.
	hemodynamically stable.	2. Add sy smerty, mvaot
	NO fever spikes.	

DR. ANUPAMA Y
 Registration No: 50853

Date & Time	Progress Notes	Doctor's Order
4/7/24 6pm	<u>C/S/B PICU Resident</u> Δ: Acute GEI Symptoms: lethargic Afebrile Child hemodynamically stable on room air	Plan ① Cont antibiotics ② Stop IV fluids ③ Encourage oral intake ④ Monitor vitals ⑤ Trace cultures ⑥ Watch for fever <i>[Signature]</i>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/12/18 8:30am	<u>C/S/6 Resident</u> 4: Acute Gastroenteritis i Symptomatic Bacteremia. child afebrile hemodynamically stable o/e: resp P/A } @ CVS } Vitals - stable	<u>Plan</u> 1) Continue Inj Augmentin (D3) 2) Ondem - SOS 3) Encourage orally 4) Monitor vitals w/ f fever spiker 5) Inform SOS <u>noted by Jyothi</u> <u>Dr. Jayashree</u>
5/2 10:47am	<u>GRB Dr. Anupama</u> Gastritis Acute Gastroenteritis Symptomatic Bacteremia	<u>Plan</u> <u>Discharge</u> afebrile vomiting not - Lanzol / nit D - MOUTR - Growth - Augmentin x 3 days Plu thrushday video consult (5-6pm)

Registration No: 50853
 DR. ANUPAMA Y

[illegible]

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RESULT SHEET

Date	3/2/26				
Time					
Hb	13.9				
PCV					
RBC	5.42				
WBC	8900				
N/L	40/56				
Platelets	3.65 lakh				
CRP	5.0				
ESR					
PCT					
RBS					
Na	135				
K	4.9				
Cl	99				
Ca/Mg					
Phosphate					
Urea	25				
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					

Date	30/26					
Time						
CUE - Alb	Nil					
CUE - Sugar	Nil					
CUE - Ketones	Nil					
CUE - PUS Cells	15-20					
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

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MEDICATION RECONCILIATION FORM

Drug Allergies: ☒ Not known any Drug Allergies

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

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

Shifting From: 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
						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Rahul R

Date & Time : 5/2/26 @ 10:00 AM

Nurse Name & Signature : Bhavan B

Date & Time : 5/2/26 @ 9:20 PM



DRUG CHART

Date of Admission: 3/2/21 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>SYP. CROCIW-DS</u>				Date Time															
Dose	Route	Frequency	Start Date																
<u>8mg</u>	<u>PO</u>	<u>SOS</u>	<u>3/2</u>																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			
<u>> 99°F</u> <u>(240mg/5mg) max 4 times</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:																			

VERIFIED BY : Name Sign

Weight. 27kg Ward.

Page: 2/4

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 Baby KANTAMANENI PARINITHI
 03-03-2018 8 Y 4 M 0 D (F)
 Dr. ANUPAMA Y



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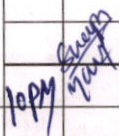
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Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : <u>NUCUT powder</u>				Date <u>14</u>															
Time <u>14</u>																			
Dose	Route	Frequency	Start Dt.																
	<u>PO</u>	<u>TIS</u>	<u>4/2</u>																
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Anupama</u>																			
Additional Instructions: <u>2 scoops + 300 ml water</u>																			
Daily Doctor's Endorsement by a Sign				<u>Dr. Anupama</u>															
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																			

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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																				

VERIFIED BY : Name Signature



Weight. Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

[illegible]



3/7/20

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time: 10 pm	2 Am	6 Am
Doctor / Nurse / Family Concern?			
Temperature (F)	98.10 F	98.0 F	
Heart Rate (bpm)	108 (170)	104 (170)	
Blood Pressure (mmHg) *	59	60	
Heart Rate (Number)	80b/m	116b/m	
Resp. Rate (bpm) (Over 1 Minute) *	24/m	28/m	
Resp Rate (Number)	24/m	28/m	
Resp Mod/ Severe Distress			
Receiving O ₂ (l/min)			
O ₂ Saturations (%)	100%	100%	
Conscious Level	Normal	Normal	
GCS *	15	15	
TOTAL SCORE	0	0	
Number of shaded boxes	0	0	
Pain Score	0	0	
Observer's Initials	DR	DR	

Patient is Refused

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)

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 Baby KANTAMANENI PARINITHI
 03-03-2018 8 Y 4 M 1 D (F)
 Dr. ANUPAMA Y



: RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation &
 Early Warning Scoring Chart

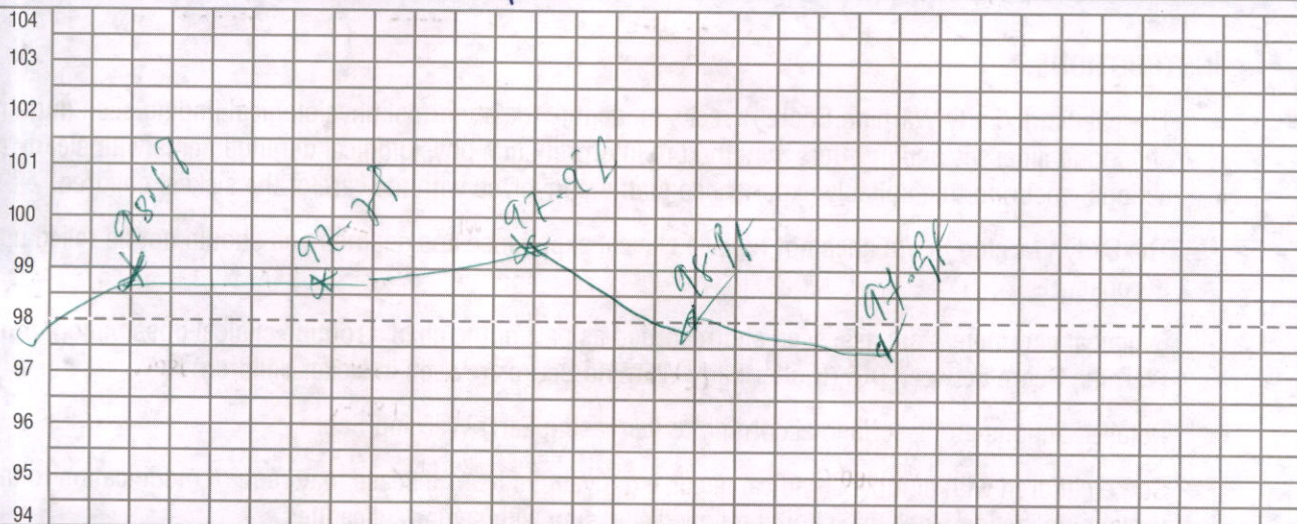
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 10 AM 2 PM 6 PM 10 PM 6 AM
 Doctor / Nurse / Family Concern?

Temperature
 (F)

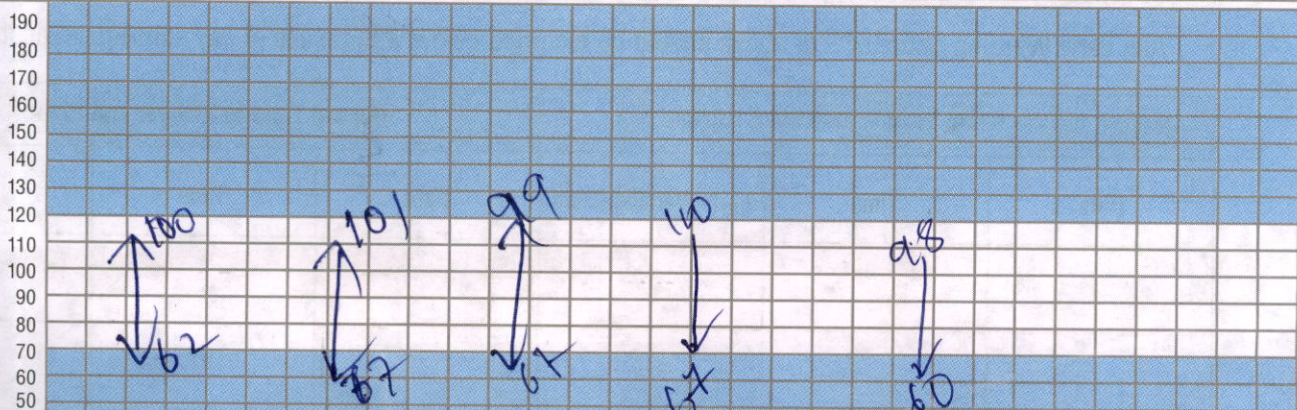


Heart Rate
 (bpm)

and

Blood Pressure
 (mmHg) *

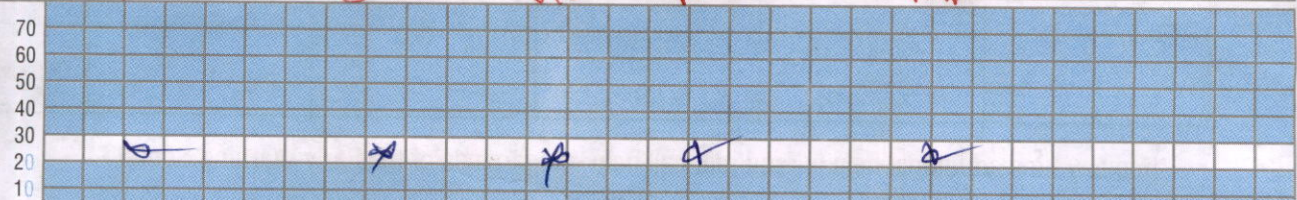
Note:
 BP does not score
 in early
 warning scoring



Heart Rate (Number)

92 bpm 82 bpm 99 bpm 108 bpm 119 bpm

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



Resp Rate (Number)

20 bpm 20 bpm 20 bpm 20 bpm 20 bpm

Resp Mod/ Severe
 Distress None / Mild

Receiving O₂ (l/min)
 O₂ Saturations (%)

99-1 98-1 99-1 100-7 100-7

Conscious Level
 Normal Altered

GCS *

(M) (M) (M) (M) (M)

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

(M) (M) (M) (M) (M)
 (C) (C) (C) (C) (C)
 (W) (W) (W) (W) (W)

ACTIONS

NB: Scores 3 should be
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- Score 1 : Continue normal observation by staff nurse
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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)



FLUID CHART

Sheet No. : ①

3/7/26

- All measurements in ml.
- 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			NG	Diarrhoea	Vomit	Output			IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G				Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm	1	H2O	30ml			1		1	0	0	Rim	
	09:00 pm	1	H2O	30ml			1		1	0	0	Rim	
	10:00 pm	1		30ml			1		NP	0	0	Rim	
	11:00 pm	DNS		30ml			1		NP	0	0	Rim	
	12:00 am	1	H2O	30ml			1		1	0	0	Rim	
	01:00 am	1		30ml			1		1	0	0	Rim	
Total Intake :			T-150ml			Total Output :			U-0 M-0				
	02:00 am	1		30ml			1		✓	0	0	Rim	
	03:00 am	1	H2O	30ml			1			0	0	Rim	
	04:00 am	1		30ml			1			0	0	Rim	
	05:00 am	DNS		30ml			NP			0	0	Rim	
	06:00 am	1	H2O	30ml			1			0	0	Rim	
	07:00 am	1		30ml			1			0	0	Rim	
Total Intake :			T-180			Total Output :			U-1 M-0				
Total 24 hrs. Intake			T-330ml			Total 24 hrs. Output			U-1 M-0				



FLUID CHART

Sheet No. : 2

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

		Intake			Output					IV Site	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	N.G						
	08:00 am								✓	0	ADK
	09:00 am	tho				✓				0	ADK
	10:00 am									0	ADK
	11:00 am	tho							✓	0	ADK
	12:00 pm									0	ADK
	01:00 pm	tho								0	ADK
Total Intake :			tho			Total Output :			m - v		
	02:00 pm									0	ADK
	03:00 pm	tho								0	ADK
	04:00 pm								✓	0	ADK
	05:00 pm									0	ADK
	06:00 pm	tho							✓	0	ADK
	07:00 pm									0	ADK
Total Intake :			tho			Total Output :			m - 0		
	08:00 pm									0	Yann
	09:00 pm	tho	tho							0	Yann
	10:00 pm	tho							✓	0	Yann
	11:00 pm	tho								0	Yann
	12:00 am								✓	0	Yann
	01:00 am	tho								0	Yann
Total Intake :			tho			Total Output :			6 2 m 0		
	02:00 am									0	Yann
	03:00 am	tho							✓	0	Yann
	04:00 am									0	Yann
	05:00 am	tho							✓	0	Yann
	06:00 am									0	Yann
	07:00 am	tho								0	Yann
Total Intake :			tho			Total Output :			6 2 m 0		
Total 24 hrs. Intake			tho			Total 24 hrs. Output			6 2 m 0		



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/26

Assessment: Patient is having Discomfort.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
9pm	Assess the general condition of the patient.	9:30pm	Assessed the general condition of the patient.	Now is the patient stable
10pm	Administer the medication as per Drug chart.	10:30pm	Administered the medication as per Drug chart.	
12Am	Maintain the I/O Chart.	12:30Am	Maintaining the I/O Chart.	
5Am	Maintain the Good Nutrition.	5:30Am	Maintaining the Good Nutritional Intake	
7Am	Ensure the Safety.	7:30Am	Provided the Side rails	

Re-Assessment: Re-Assessment Done with fully

Special Notes: NIL

Nurse Signature: (Signature)

Nurse Name: Dina

Date & Time: 3/7/26 @ 8Am



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 2/7/18

Assessment: patient having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	=> Assess the patient General condition.	10am	=> Assessed the patient General condition.	
11am	=> plan for monitor patient vitals.	12pm	=> monitoring patient vitals.	
2pm	=> plan for monitor patient I/O chart.	4pm	=> monitoring patient I/O chart.	
5pm	=> maintain personal hygiene	6pm	=> personal hand hygiene	
7pm	=> plan for Dr Fluid.	7:30pm	=> continue IV fluid	Patient now stable

Re-Assessment:

Special Notes:

Nurse Signature: Alexys

Nurse Name: Alexys / 606820

Date & Time: 2/7/18 8am

LBH-00031091 IP5-00175941
 Baby KANTAMANENI PARINITHI
 03-03-2018 8 Y 4 M 1 D (F)
 Dr. ANUPAMA Y



NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/26

Assessment: patient is having discomfort

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the patient General condition	8:50pm	Assess the patient General condition	Now patient is stable
10pm	Monitor vital signs	10:50pm	monitored vital signs	
12am	Maintain fluid Balance	12:50am	Maintained fluid Balance	
3am	Administer medication as per chart	3:50am	Administered medication as per chart	
7am	Ensure safety	7:50am	Ensured safety	

Re-Assessment: Re-Assessment done every 3 hours

Special Notes: Nil

Nurse Signature: [Signature]

Nurse Name: Yamuna @ 606255

Date & Time: 4/7/26 @ 8am

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Anupama Y Department: ER Date of Admission: 3/2/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known				
			If Yes Specify:				
BACKGROUND	Area	Shift Time	ER 9:00pm-12:00am	3rd Floor 8pm-8am	2nd Floor 8am-8pm	3rd Floor 8pm-8am	
	Medical Condition (Any special condition to be noted):		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:	98.2°	97.9°	97.2°	98.1°	
		Res:	24 b/m	24 b/m	24 b/m	28 b/m	
		SpO ₂ :	100%	100%	99%	100%	
		Pulse:	142 b/m	75 b/m	99 b/m	112 b/m	
		BP:	103/73	98/59	100/62	100/72	
	Fall Risk Score:	10	10	10	10		
Pain Score:	0/10	0/10	0/10	0/10			
Recommendations	Safety Needs:	yes	yes	yes	yes		
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	yes	yes	yes	yes		
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NA	NA	NA	NA		
Post Operative Procedure Special Orders:		NA	NA	NA	NA		
Handed Over By Name :		Blavani	Rino	Alexis	Zano		
Signature :		[Signature]	[Signature]	[Signature]	[Signature]		
Date:		3/2/26	4/2/26	4/2/26	5/2/26		
Time:		9:00pm	8AM	8pm	8am		
Taken Over By Name :		Rino	Alexis	Rino	Syothi		
Signature :		[Signature]	[Signature]	[Signature]	[Signature]		
Date:		3/2/26	4/2/26	4/2/26	5/2/26		
Time:		9:30pm	8am	8pm	8am		

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						
	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:						

LBH-00031091

IP5-00175941

Baby KANTAMANENI PARINITHI
03-03-2018 8 Y 4 M 0 D (F)

Dr. ANUPAMA Y



BRADEN 'Q' SCALE

					Date :	3/7/26	4/7/26	5/7/26	6/7/26
					Time :	8:50pm	8AM	8AM	8AM
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 extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	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	
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	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	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	
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	
TOTAL SCORE					28	28	28	28	
Evaluator's Name					Shanani	Ram	Algo	Ram	

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

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Baby KANTAMANENI PARINITHI
03-03-2018 8 Y 4 M 0 D (F)
Dr. ANUPAMA Y



Patient

**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

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3/7	4/7	4/7	4/7	
	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			1	1	
	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 :	Shanani	Rina	Rina	Rina
Signature :	[Signature]	[Signature]	[Signature]	[Signature]
Date :	3/7	4/7	4/7	4/7
Time :	8:50pm	8am	8am	8am



PAIN ASSESSMENT FORM

Date	Time	Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/7/26	8:50 pm	2/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Shavani
4/7/26	2 AM	6/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Rishu
4/7/26	6 pm	8/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Alexis
4/7	11 pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Yamen
5/7	7 am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Truu
				☐ 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:

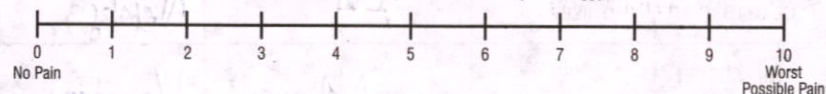
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

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

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 : Sugatha Name : Sugatha

Signature of Ward In Charge :

Signature : Anitha Name : Anitha

LBH-00031091 IP5-00175941
 Baby KANTAMANENI PARINITHI
 03-03-2018 8 Y 4 M 0 D (F)
 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



3/7/20

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		
3/7/26	8:30pm	7	Infection control measures	M	1	0	1	1	-	Bhavani
4/7/26	8am	9	NORMAL diet	M/f	1	0	1	1	-	Same

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:	<table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								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	
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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:	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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Understanding:	<table border="0"> <tr> <td>1. Verbalizes Understanding</td> <td>2. Demonstrates Understanding</td> <td>3. Needs Review</td> </tr> </table>								1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review												
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LBH-00031091 IPS-00175941
 Baby KANTAMANENI PARINITHI
 03-03-2018 8 Y 4 M 0 D (F)
 Dr. ANUPAMA Y

MULTI-DISCIPLINARY PLAN OF CARE FORM

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Diagnosis:



Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
3/7/26 8:00p	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Abdominal pain vomiting	stability	Dr fluids antibiotic	Rahul	☐ Nursing ☒ Others:
3/7/26 8:50pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Abdominal pain, vomiting	Hemodynamic stability	Dr fluids antibiotics	Shavani	☐ Medical ☒ Others:
4/7/26 6am	☐ Medical ☐ Nursing ☒ Others: <u>hickies</u>	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Abdominal UTI	normal diet	RPA E- <u>Isoskard</u> P- <u>27gm/d</u>	Saizre	☐ 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:

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 orders

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

Needed Assistance

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: about Hand Hygiene

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Rima

Date and Time: 3/7/20 10pm



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 9:30pm Mode of Arrival: wheel chair Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction

Body Weight: 27 Kg

Height: 129 cm

NIL

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

Past Medical History	Past Surgical History	Previous Hospital Admission
NIL	NIL	NIL

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: 27Kg Length: 129cm Head Circumference (< 2 years):

Temp.: 97.1°F HR: 80b/m RR: 24b/m BP: 96/59

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

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

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

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

Character of Pain 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 Findings

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

If Yes Consultant Notified: Dr. Anupama (Date/Time): B/7/26

Social History: Lives With

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

All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☒ Yes ☐ No

Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump : ☒ Yes ☐ No

Hand hygiene Explained: ☒ Yes ☐ No ☐ Others

Patient Rights & Responsibilities: ☒ Yes ☐ No

Information given to Mother

Nurse's Name: Rinu Date: B/7/26 Time: 10 p.m Signature: Rinu



EMERGENCY ROOM TRIAGE FORM

Patient's Name: Parinithi Chowdary Age: 8 y 4 m Gender: ☐ Male ☒ Female
Date: 3/7/26 Time of Arrival: 8:11 pm Triage Completion Time: 8:13 pm
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	Work of Breathing ☒ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea	☒ Stable ☐ Unstable: ☐ Not - Life - Threatening ☐ Life -Threatening
Circulation / Colour ☒ Normal ☐ Abnormal ☐ Bleeding		

Initial Vital Signs: Temp: 98.2 F PR: 96 bpm BP: 109/67 RR: 22 bpm SpO₂: 99% RA
Chief Complaints: Abdominal pain x 1 week (on/off) vomit x 7

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: 3/7/26 at 8:13 pm



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 3/2/20 Time of arrival : 8:15 pm
Chief Complaints : c/o Abdominal pain x 1 week (on, off) RBS : 26.6 mg/dl
Height : 129 cm Weight : 27.18 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 : 2/10 Pain Tool Used : ☐ N Pass ☐ FLACC ☒ Wong Baker
☐ Character : Aching ☐ Location : Abdomen ☐ Frequency : Acute ☐ Duration : Intermittent

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
- Uses furniture for support

☐ Yes ☒ No
☐ Yes ☒ No

Gait/Transferring:

- Bedrest / immobile
- Weak
- Impaired

☐ Yes ☒ No
☐ Yes ☒ No
☐ 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 : (Date/Time):

Social History: Lives With : Parents

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

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

Time of Initial assessment completed by ER Nurse : 8:17 pm

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

Time	Nursing Notes
	- Assessed the pt condition
	- monitor the vitals
	- IV placement done
	- sample collected
	- shifted to ward

Samples collected by:

Samples sent by :

Dr. Rafique

Time:

Time:

8:46pm

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :	Details of Shift - out
HR: 142/min BP: 103/75 CFT: 2.5sec RR: 24/min SPO ₂ : 100% GCS: 15/15 Temperature: 98.2°K Pain Score: 0.1/10 Repeat RBS (if applicable):	Shift - out from ER to: 8.0 Time of Shift - out: 9:20pm Handover given to: Pima (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

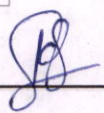
IV placement

Name of the Nurse : Bhavani

Signature of the Nurse :

Date & Time : 3/7/26 8:17pm

PATIENT TRANSFER FORM

Patient Name & UHID No. LBH-00031091 IP5-00175941 Baby KANTAMANENI PARINITHI 03-03-2018 8 Y 4 M 0 D (F) Dr. ANUPAMA Y 		Date & Time of Admission 3/7/26 @ 8:49 pm	Date & Time of Transfer Order 3/7/26 @ 9:10 pm
		Transfer Ordered by Dr. Razi	Reason for Transfer Admission
From Unit ER	To Unit Ward	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 21	Number of Imaging Films No	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ op file If yes, what? 	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Oral + Intratix	1	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Dr. Bhavani		Name of Person Ordered Transfer Dr. Razi	
Patient & Clinical Records Received by : Dr. Razi 3/7/26 @ 9:30 pm			
Date & Time of Patient Received :			

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



308-A

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 4/7/26 Time: 8am

Weight: 27kg Centile: 72nd

Height: 100cm Centile: 25th

Inference: well child

RDA: - Calories: 1550 Kcal/D Protein: 27 gm/D

Diet Recommendations: Normal diet & plenty of oral liquids

Re-Assessment: avoid spig, chilled & outside foods

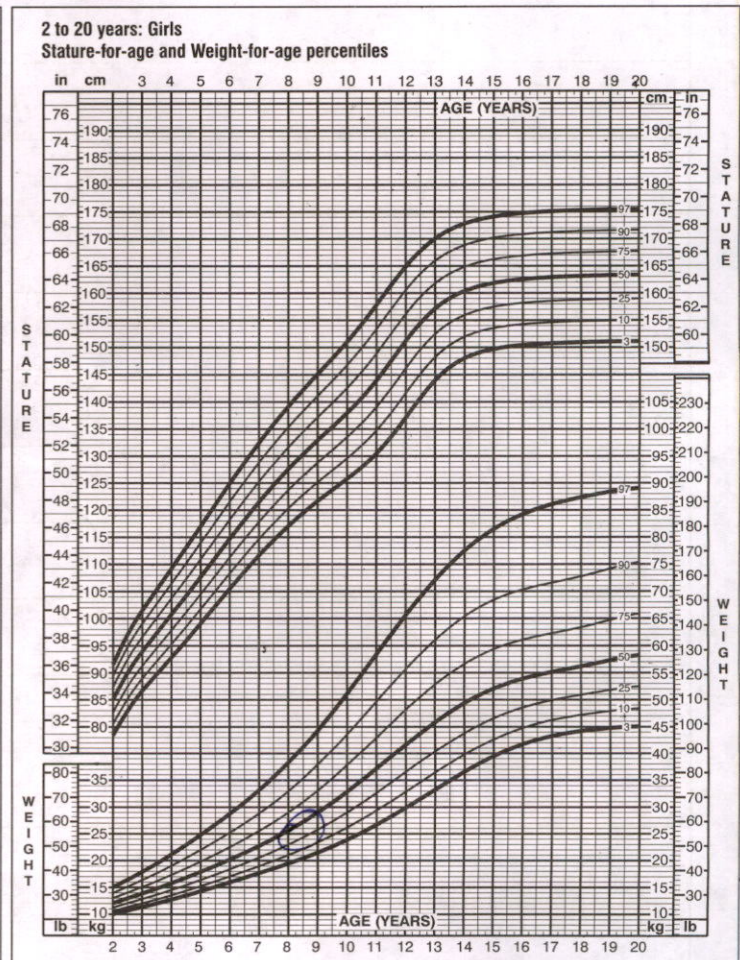
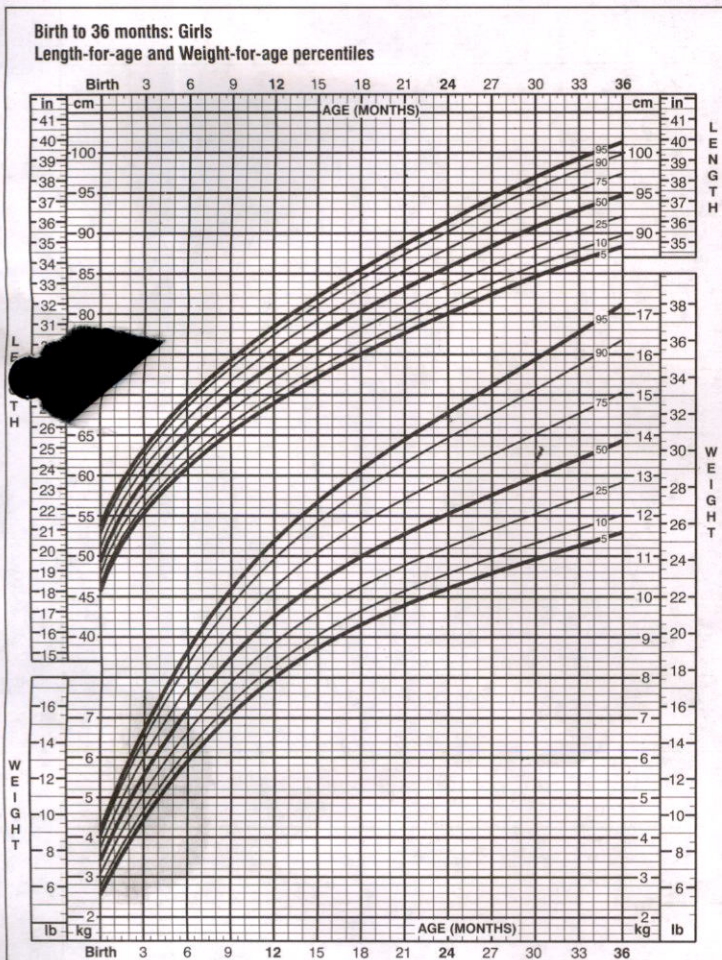
Food Allergies: No Veg/Non-veg: Non-veg

Diagnosis: UTI

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (GIRLS)



Dietician's Name: Laine

Dietician's Signature: Laine

[illegible]