

**Rainbow Children's Hospital - Banjara Hills**

8-2-120/103/1,2,3,4 and 5, Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad  
,Telangana, India ,500034.  
TEL NO :+91-40-4466 5555  
WEB : <https://rainbowhospitals.in>

**ADMISSION SHEET****Registration Details :**

Admission No : IP5-00176057

Admit Date : 07-Jul-2026

Admit Time : 12:57 AM UHID : BAH-00660882

**Patient Details :**

Patient Name : Master RYAN VIVIAN

Age : 6 Y 3 M 26 D

Guardian : Mr RATAN DANIEL

DOB : 11-03-2020

Gender : Male

Religion :

Occupation :

Marital Status : Single

Address (H) : FLAT NO- 105 APRNA CYBER Lingam Palli  
Hyderabad Telangana INDIA 500133

Phone No : 8978294529/ 6358635635

E-mail : NO@GMAIL.COM

**Admission Details :**

Bed Type : PRIVATE ROOM

Bed No : PVT 340

Ward Name : 3F-ZONE B

Room No : PVT 340

Admission Type : First Visit

**Contact Details :**

Name : Mr RATAN DANIEL

Relationship : Father

Contact Address : FLAT NO- 105 APRNA CYBER Lingam Palli  
Hyderabad Telangana INDIA 500133

Phone No : 8978294529 / 6358635635

  
Signature**Doctor Details :**

Doctor Name : Dr. KOKKULA PRANEETH

Specialisation : PEDIATRIC NEURO SURGERY

Referral Doctor : SELF

Phone No :

Co-Consultant :

**Payment Details :**

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELF PAY



## ACTIVITY RECORD FOR BILLING

Name : \_\_\_\_\_

UHID No. : \_\_\_\_\_ IP N **BAH-00660882** **IP5-00176057** it: \_\_\_\_\_ Dept : \_\_\_\_\_

Date of Admission: \_\_\_\_\_ **Master RYAN VIVIAN** **11-03-2020** **6 Y 3 M 28 D** (M) **Dr. KOKKULA PRANEETH** ischarge : \_\_\_\_\_ Time: \_\_\_\_\_



Room / Bed No : \_\_\_\_\_ Suggested Billable bed type : \_\_\_\_\_

## WARD TRANSFERS

| Date     | Time     | From | To  | Signature of Nurse |
|----------|----------|------|-----|--------------------|
| 07/04/20 | 2:05 am. | ER.  | BAC | Resonid.           |
|          |          |      |     |                    |
|          |          |      |     |                    |
|          |          |      |     |                    |
|          |          |      |     |                    |

## Cross Consultation Visit

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

## INVESTIGATIONS

[illegible]



### MEDICAL EQUIPMENT (WARD & ICU)

[illegible]



**PROCEDURE**

| Date   | Procedure    | Quantity | Order No. | Signature |
|--------|--------------|----------|-----------|-----------|
| 7/2/20 | IV placement | (1)      | 1178      | Chapman   |
|        |              |          |           |           |
|        |              |          |           |           |
|        |              |          |           |           |
|        |              |          |           |           |
|        |              |          |           |           |
|        |              |          |           |           |
|        |              |          |           |           |
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|        |              |          |           |           |
|        |              |          |           |           |
|        |              |          |           |           |
|        |              |          |           |           |

**ANY OTHER INFORMATION**

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Date :

Time :

Prepared By :

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





It takes a lot to treat the little.

## PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Ryaan Vivian

UHID ID:

BAH-00660882 IP5-00176057

Master RYAN VIVIAN

11-03-2020

6 Y 3 M 26 D

(M)

Dr. KOKKULA PRANEETH

Department:



Consultant:





## Pediatric Multiorgan History & Physical Examination

Name : \_\_\_\_\_ Age/Sex \_\_\_\_\_

Information given by: \_\_\_\_\_ Relationship \_\_\_\_\_

### Chief Presenting Complaints & Duration (Chronologically)

Accidentally fell on stone (8-9 feet), while playing yesterday  
at 7:15pm on 6/7/26

Phys. headache for sometimes, decreased spontaneously.

NO H/O Nausea, vomiting, LOC, seizure activity, & blurred vision

### History of present illness :

NO H/O fever, cold, cough, or burning micturition.

Outside CT Scan head done S/O → mild subarachnoid hemorrhage  
in Rt temporal cortical sulci

2 small 3-4mm sized hemorrhagic contusions without perifocal  
edema in left temporal lobe. Undisplaced fracture of left  
temporal bone

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Master RYAN VIVIAN  
11-03-2020 6 Y 3 M 26 D (M)  
Dr. KOKKULA PRANEETH



## Pediatric History, & Physical Examination

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

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### Birth & Neonatal History:

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ITO

### Birth & Socio Economic History:

About Father : \_\_\_\_\_

About Mother : \_\_\_\_\_

Any additional Information : \_\_\_\_\_

} upper middle class

### Developmental History :

② development

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### Immunization History :

vaccination upto dlt (IAP)

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## Pediatric Multiorgan History & Physical Examination

### Anthropometry :

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_) Height (cms): \_\_\_\_\_ (Centile) \_\_\_\_\_  
Weight (kgs) ) 20.1 kg (Centile \_\_\_\_\_)

### On Examination :

Temperature : 92.9°F Pulse Rate : 105/min B.P. 100/80 (R) SP02 100% on RA

Resp. rate and type of breathing : RR = 24/min

Rash \_\_\_\_\_

Lymphadenopathy \_\_\_\_\_

Oedema : Nil

Allergies (if any): \_\_\_\_\_

### Respiratory System :

Inspection (any s/o distress) : \_\_\_\_\_

Air entry & breath sounds : B/L AEF

Any addles sounds : \_\_\_\_\_

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

### Cardiovascular System :

Inspection of procordium : \_\_\_\_\_

Heart Sounds : S1S2 A

Any murmur : \_\_\_\_\_

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

### Per Abdomen :

Inspection \_\_\_\_\_

Palpation : Soft, NT

Ausculation : \_\_\_\_\_

Spine : \_\_\_\_\_ External Genitalia : \_\_\_\_\_

Relevant data from outside (CT, USG etc.,) \_\_\_\_\_



## Pediatric Multiorgan History & Physical Examination

### Central Nervous System :

Level of Consciousness : AVPU/GCS score : 2

Cranial Nerves : 2

### Motor System:

Nutriton : \_\_\_\_\_

Tone: \_\_\_\_\_ Power \_\_\_\_\_

Co-ordinator : \_\_\_\_\_

Posture : \_\_\_\_\_

Involuntary Movements : \_\_\_\_\_

### Reflexes :

DTR

Superficials:

Plantars \_\_\_\_\_

### Sensory System :

Bladder / Bowel : \_\_\_\_\_

### Clinical Summary & Diagnostic:

Traumatic brain injury.



## Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: \_\_\_\_\_

Desired goals of the treatment : \_\_\_\_\_

### Planned Labs:

CBP

Plain, Rt-? Extra sample } collected.

USG Abd → Sos.

### Planned Management

• Ij Ampil.

• Ij PCM stat, Sos: <sup>later</sup>

• Ij Pan

• SOS - shift to PLEW if symptoms worsen.

observed.

Signature of the Doctor: Ramya

Name of the Doctor: Dr. Ramya A

Date & Time: 7/2/2020 12:30pm

Signature of the Consultant: [Signature]

Name of the Consultant: Dr. Praneeth

Date & Time: 7/2/2020

Dr. KOKKULA PRANEETH  
Reg. No: APMC/FMR/92741







## 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



## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time        | Progress Notes                                                                                                                                                                                                                                                                                                                       | Doctor's Order                                                                                               |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| 07/04/26<br>8:30am | C/S/B Neuroteam                                                                                                                                                                                                                                                                                                                      |                                                                                                              |
|                    | <p>→ Alleged H/o accidental fall from slide @ 07:15pm on 6/7/26 at playground.</p> <p>→ No H/o LOC / seizures / ENT bleed / vomitings</p> <p>→ No head ache over (R) temporal &amp; parietal region</p> <p>→ No difficulty in opening mouth (+)</p> <p>→ pain while</p> <p>→ transient amnesia</p> <p>Δ: mild TBI (Blunt Injury)</p> |                                                                                                              |
|                    | <p>O/E: vitals - Stable</p> <p>Child conscious, Oriented</p> <p>GCS: 15/15</p> <p>EDM - full</p> <p>B/L pupils normal size R/L</p> <p>No CN involvement</p> <p>Tone - (N)</p> <p>power - (N)</p> <p>DTR: +2 / +2</p> <p>+2 / +2</p> <p>plantar ↓ ↓</p> <p>No Cerebellar signs</p>                                                    | <p>Issues: HeadAche ↓ ; No CSF leak</p> <p>Adv</p> <p>① GCS &amp; vital monitoring</p> <p>② Stop LEVIPIL</p> |
|                    | <p>Outside CT: mild SAH in (R) temporal cortical sulci</p> <p>2 small (3-4mm) H/GIC Contusions Cent parietal edema in (L) temporal lobe</p>                                                                                                                                                                                          |                                                                                                              |



## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time                  | Progress Notes                                  | Doctor's Order                      |
|------------------------------|-------------------------------------------------|-------------------------------------|
| 2/7/2020                     | cls/B Dr. Praneeth                              |                                     |
|                              | Mild head injury                                |                                     |
| Fall - yesterday<br>7:45 pm  | cls Head ache<br>Dizziness                      |                                     |
|                              | O/E Conscious, alert<br>no focal deficit        | Adv                                 |
| NCOT head<br>9:15 pm         |                                                 | (1) Observe                         |
| (R) Temporal<br>sylvian SA D |                                                 | (2) Serial x/mult                   |
|                              |                                                 | (3) PRN for pain                    |
|                              |                                                 | (4) Discharge tomorrow<br>if stable |
|                              | Dr. KOKKULA PRANEETH<br>Reg. No. APMC/FMR/92741 | Dr. Praneeth                        |
|                              |                                                 | al/By Sywan                         |













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BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

| Date & Time        | Progress Notes                                                                                                                                                                                          | Doctor's Order                 |
|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|
| 08/04/26<br>8:30am | <u>C/S/B Neuroteam</u><br><br>Issues: No fresh complaints<br>No pain over (R) temporal region (+) →<br><br><u>O/F:</u><br>Child oriented<br>E4V5M6<br>Vitals - stable<br>No focal neurological deficits | <u>Adx</u><br>① plan discharge |



#### Patient Sticker

### PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



BAH-00660882 IP5-00176057  
 Master RYAN VIVIAN  
 11-03-2020 8 Y 3 M 26 D (M)  
 Dr. KOKKULA PRANEETH



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## RESULT SHEET

|                     |         |  |  |  |  |  |
|---------------------|---------|--|--|--|--|--|
| Date                | 07/7/26 |  |  |  |  |  |
| Time                | 7:30 AM |  |  |  |  |  |
| Hb                  | 12.2    |  |  |  |  |  |
| PCV                 | 36.4    |  |  |  |  |  |
| RBC                 | 4.63    |  |  |  |  |  |
| WBC                 | 13370   |  |  |  |  |  |
| N/L                 |         |  |  |  |  |  |
| Platelets           | 3.89    |  |  |  |  |  |
| CRP                 |         |  |  |  |  |  |
| ESR                 |         |  |  |  |  |  |
| PCT                 |         |  |  |  |  |  |
| RBS                 |         |  |  |  |  |  |
| Na                  |         |  |  |  |  |  |
| K                   |         |  |  |  |  |  |
| Cl                  |         |  |  |  |  |  |
| Ca/Mg               |         |  |  |  |  |  |
| Phosphate           |         |  |  |  |  |  |
| Urea                |         |  |  |  |  |  |
| Creatinine          |         |  |  |  |  |  |
| ALP                 |         |  |  |  |  |  |
| SGPT                |         |  |  |  |  |  |
| SGOT                |         |  |  |  |  |  |
| T.Bill/Conj         |         |  |  |  |  |  |
| T.Protein           |         |  |  |  |  |  |
| S.Albumin           |         |  |  |  |  |  |
| S.Globulin          |         |  |  |  |  |  |
| A/G Ratio           |         |  |  |  |  |  |
| Uric Acid           |         |  |  |  |  |  |
| S.Amylase           |         |  |  |  |  |  |
| Sr.Lipase           |         |  |  |  |  |  |
| Blood Lactate       |         |  |  |  |  |  |
| S.Cholesterol       |         |  |  |  |  |  |
| PT/INR              |         |  |  |  |  |  |
| APTT                |         |  |  |  |  |  |
| CSF Protein / Sugar |         |  |  |  |  |  |
| Cells               |         |  |  |  |  |  |
| N/L                 |         |  |  |  |  |  |







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11-03-2020 6 Y 3 M 26 D (M)  
Dr. KOKKULA PRANEETH

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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: ER

Shifted to: Ward (3rd)

| S.No | MEDICATION NAME<br>(GENERIC NAME CAPITAL LETTERS) | DOSE<br>(mg, mcg) | ROUTE<br>(PO, NG, SC, IV) | FREQUENCY | LAST DOSE<br>Date / Time | ON<br>ADMISSION<br>/ SHIFTING                          |
|------|---------------------------------------------------|-------------------|---------------------------|-----------|--------------------------|--------------------------------------------------------|
| 1    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 2    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 3    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 4    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 5    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 6    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 7    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 8    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 9    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 10   |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |

\* C- Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Remy

Date & Time : 7/7/26 ; 1:26 pm

Nurse Name & Signature : Alexis

Date & Time : 07/07/26 @ 2am





## DRUG CHART

Date of Admission: ..... 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)

|                                       |                    |                         |                              |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---------------------------------------|--------------------|-------------------------|------------------------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b> <i>Ig PARACETOMOL</i>   |                    |                         |                              | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose<br><i>20mg</i>                   | Route<br><i>IV</i> | Frequency<br><i>SOS</i> | Start Date<br><i>27/2/20</i> |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature<br><i>Praneeth</i> |                    | Valid Period            | Pharm.                       |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:              |                    |                         |                              |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|                          |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------|-------|--------------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b>            |       |              |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|                          |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------|-------|--------------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b>            |       |              |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |



Weight. 20.1 kg Ward. ....

Page: 2/4





Date  
Time

|                                |            | Date<br>Time | Nurse Sig. | Nurse Sig. | Nurse Sig. | Nurse Sig. |
|--------------------------------|------------|--------------|------------|------------|------------|------------|
| <b>DRUG :</b>                  |            | 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

|                                |            | Date<br>Time | Nurse Sig. | Nurse Sig. | Nurse Sig. | Nurse Sig. |
|--------------------------------|------------|--------------|------------|------------|------------|------------|
| <b>DRUG :</b>                  |            | 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 |
|------|------|------------|-----------------------------|-------|-----------|--------|
|      |      |            |                             |       |           |        |
|      |      |            |                             |       |           |        |
|      |      |            |                             |       |           |        |
|      |      |            |                             |       |           |        |
|      |      |            |                             |       |           |        |
|      |      |            |                             |       |           |        |
|      |      |            |                             |       |           |        |
|      |      |            |                             |       |           |        |
|      |      |            |                             |       |           |        |
|      |      |            |                             |       |           |        |

Signature  
VERIFIED BY : Name





## I.V. FLUIDS CHART

Weight. .... Ward. ....

[illegible]



## INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

### Identified Education Needs:

- |                            |                                                                      |                                                                |                                                             |
|----------------------------|----------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------|
| 1. Diagnosis               | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet                                            | 13. Risk / Safety                                           |
| 2. Treatment and Care Plan | 6. Discharge Medication                                              | 10. Fall Risk Education                                        | 14. Activity / Exercise                                     |
| 3. Pain Management         | 7. Infection Control Measures                                        | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs                           |
| 4. Informed Consent        | 8. Diagnostic Test / Procedures                                      | 12. Patient's / Family Rights                                  | 16. Special Discharge / Follow-up Education / Coping Skills |
|                            |                                                                      |                                                                | 17. Others .....                                            |

### Part - II

| Date   | Time | Need Identified | Information Taught       | Use codes from the list in part III |                   |                |                                   |               | Comments | Designation / Signature |
|--------|------|-----------------|--------------------------|-------------------------------------|-------------------|----------------|-----------------------------------|---------------|----------|-------------------------|
|        |      |                 |                          | Person Taught                       | Learning Barriers | Teaching Tools | Mechanism/s to overcome barrier/s | Understanding |          |                         |
| 04/07  | 2am  | 2               | Treatment and Care plan. | F                                   | 1                 | 0              | 1                                 | 1             | Nic      | (Signature)             |
|        |      |                 |                          |                                     |                   |                |                                   |               |          |                         |
| 7/7/20 | 9am  | 9               | Left side                | flm                                 | 1                 | 0              | 1                                 | 1             | -        | (Signature)             |
|        |      |                 |                          |                                     |                   |                |                                   |               |          |                         |

### Part - III: CODES

|                                                                                                                     |                               |                                                   |                                 |                                |  |  |  |  |  |
|---------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------|---------------------------------|--------------------------------|--|--|--|--|--|
| Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify) ..... |                               |                                                   |                                 |                                |  |  |  |  |  |
| Learning Barriers:                                                                                                  |                               |                                                   |                                 |                                |  |  |  |  |  |
| 1. No Learning Barriers                                                                                             | 4. Language Barrier           | 7. Impaired Thought Process/Cognitive limitations | 10. Financial Difficulties      | 13. Cultural/Religion Practice |  |  |  |  |  |
| 2. Physical Impairment                                                                                              | 5. Educational Level          | 8. Responsibilities at Home                       | 11. Beliefs and Values          | 14. Others (Specify) .....     |  |  |  |  |  |
| 3. Emotional Barriers                                                                                               | 6. Desire / Motivate to Learn | 9. Cultural Differences                           | 12. Impaired Vision/ or Hearing |                                |  |  |  |  |  |
| Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed                                          |                               |                                                   |                                 |                                |  |  |  |  |  |
| Mechanism/s to overcome barrier/s:                                                                                  |                               |                                                   |                                 |                                |  |  |  |  |  |
| 1. None                                                                                                             | 3. Reassurance & Support      | 5. Respect values & beliefs                       | 7. Other, Specify .....         |                                |  |  |  |  |  |
| 2. Obtain translator                                                                                                | 4. Teach Family / Others      | 6. Respect Cultural / Religion Preference         |                                 |                                |  |  |  |  |  |
| Understanding:                                                                                                      |                               |                                                   |                                 |                                |  |  |  |  |  |
| 1. Verbalizes Understanding                                                                                         | 2. Demonstrates Understanding | 3. Needs Review                                   |                                 |                                |  |  |  |  |  |



# MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

*traumatic Brain Injury*

| Date Time             | Discipline                                                                                                                        | Type                                                                                                                                                    | Patient Needs / Problem List  | Goal             | Plan / Intervention                                       | Signature          | Team Verification                                                                                                   |
|-----------------------|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|------------------|-----------------------------------------------------------|--------------------|---------------------------------------------------------------------------------------------------------------------|
| <i>07/07</i>          | <input checked="" type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:               | <input type="checkbox"/> Initial<br><input checked="" type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op | <i>TBI</i>                    | <i>H Study</i>   | <i>- IV med</i><br><i>- observation</i>                   | <i>[Signature]</i> | <input checked="" type="checkbox"/> Nursing<br><input type="checkbox"/> Others:                                     |
| <i>07/07<br/>2a</i>   | <input type="checkbox"/> Medical<br><input checked="" type="checkbox"/> Nursing<br><input type="checkbox"/> Others:               | <input type="checkbox"/> Initial<br><input checked="" type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op | <i>traumatic Brain Injury</i> | <i>H Study</i>   | <i>- IV pleur</i><br><i>- IV medull</i>                   | <i>[Signature]</i> | <input type="checkbox"/> Medical<br><input checked="" type="checkbox"/> Others:                                     |
| <i>7/7/26<br/>8am</i> | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input checked="" type="checkbox"/> Others: <i>trauma</i> | <input checked="" type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op | <i>mild TBI</i>               | <i>soft diet</i> | <i>RDA</i><br><i>E - 1500 kcal/d</i><br><i>P - 25 g/d</i> | <i>[Signature]</i> | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input checked="" type="checkbox"/> Others: |
|                       | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:                          | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op            |                               |                  |                                                           |                    | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:            |
|                       | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:                          | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op            |                               |                  |                                                           |                    | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:            |





## EMERGENCY ROOM TRIAGE FORM

Patient's Name : Ryan Vivian Age : 6 yr. Gender: ☒ Male ☐ Female

Date : 07/07/26 Time of Arrival : 12:26 AM Triage Completion Time : 10:28 AM

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<br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Sick Looking                                      | Work of Breathing<br><input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased<br><input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea | <input checked="" type="checkbox"/> Stable<br><input type="checkbox"/> Unstable :<br><input type="checkbox"/> Not - Life - Threatening<br><input type="checkbox"/> Life - Threatening |
| Circulation / Colour<br><input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding |                                                                                                                                                                                   |                                                                                                                                                                                       |

Initial Vital Signs: Temp: 97.9 F PR: 105 bpm BP: 100/80 (87) RR: 25 bpm SpO<sub>2</sub>: 100% RA

Chief Complaints: Accidental fall on slide while playing yesterday @ 7:15 PM (6/27/26) and back after complaining of pain.

| Triage Classification                                                                                                      | CTAS                                       |
|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Level 1 : Resuscitation                                                                           | <input type="checkbox"/> Immediate         |
| <input type="checkbox"/> Level 2 : EMERGENT : Life or limb threatening                                                     | <input type="checkbox"/> < 15 min          |
| <input type="checkbox"/> Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening | <input type="checkbox"/> 30 min            |
| <input type="checkbox"/> Level 4 : LESS URGENT : Significant illness but not life threatening                              | <input checked="" type="checkbox"/> 60 min |
| <input type="checkbox"/> Level 5 : NON - URGENT : May receive care when convenient                                         | <input type="checkbox"/> 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 : Javaya

Date & Time : 07/07/26 @ 10:28 AM

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

Signature of Triage Nurse : Javaya





## NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 07/07/26 Time of arrival : 12:29 a.  
Chief Complaints: 40 Fall while playing yesterday, now Headache. RBS: -

Height : - Weight : 20.1kg BMI : - Head Circumference (<2 years) : -

Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: -

If yes, identify : -

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

☐ Character: Acute ☐ Location: Head ☐ 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 ☒ Yes ☐ No  
• Uses furniture for support ☐ Yes ☒ No

### Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☒ No

### IF YES FOR ANY CATEGORY = RISK FOR FALLING

### Fall Risk Intervention:

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

### Functional Screening: ☒ No Abnormalities Detected

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

### Inform consultant for positive criteria

### Nutritional Screening: ☒ No Abnormalities Detected

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

### Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

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

Social History: Lives With Family

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 : 12:31 a.



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

| Time | Nursing Notes                |
|------|------------------------------|
|      | Dr Ranya assessed the child. |
|      | - IV placed done.            |
|      | - Samples sent.              |
|      | - shifted to room.           |
|      |                              |
|      |                              |
|      |                              |
|      |                              |

Samples collected by:

Time:

Samples sent by:

Time:

**Medication given in ER:**

| Date / Time | Medication   | Route | Dosage & Instructions | Doctor Sign | Nurse Sign 1 |
|-------------|--------------|-------|-----------------------|-------------|--------------|
| 7/7/24      | Inj Cefepime | IV    | 400mg                 | [Signature] | [Signature]  |
| 7/7/24      | Inj PAN      | IV    | 20mg                  | [Signature] | [Signature]  |
|             |              |       |                       |             |              |
|             |              |       |                       |             |              |
|             |              |       |                       |             |              |
|             |              |       |                       |             |              |

**Condition of patient at time of shift - out :**

**Details of Shift - out**

HR: 120 bpm BP: 102/63 CFT: 233  
RR: 26 bpm SPO<sub>2</sub>: 99% RA  
GCS: VUS Temperature: 98°F  
Pain Score: 0/10  
Repeat RBS (if applicable):

Shift - out from ER to: 2:40  
Time of Shift - out: 2:05 am  
Handover given to: \_\_\_\_\_  
(Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV placed

Name of the Nurse: [Signature]

Signature of the Nurse: [Signature]

Date & Time: 07/07/24 2:05 am



BAH-00660882  
Master RYAN VIVIAN  
11-03-2020 6 Y 3 M 26 D (M)  
Dr. KOKKULA PRANEETH

IP5-00176057

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

BirthRight™  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## Nursing General Admission Assessment Form For Pediatrics

### Diagnosis:

Arrival Time: ..... Mode of Arrival: 2:30 AM Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction ..... Body Weight: ..... Kg

..... Height: ..... cm

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

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

Family History: .....

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

s 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: 20.1 Length: 0 Head Circumference (< 2 years): .....

Temp.: 97 HR: ..... RR: ..... BP: .....

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

Fall Risk Assessment: ☐ Yes ☐ No Score: 16 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 0) (Document in the Braden Q Assessment Sheet)

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

Character of Pain 0 Location 0 Frequency 0 Duration 0



**FUNCTIONAL SCREENING:**☒ No Abnormalities Detected☐ Mobility Problem☐ Walking Problem☐ Developmental Delay☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

**NUTRITIONAL SCREENING:**☒ No Abnormalities Detected☐ Underweight☐ Overweight☐ Special Feeding Method☐ Feeding Problem☐ Special diet☐ No Abnormality Detected

Inform consultant for positive criteria

**Psychological Screening:**☒ No Significant FindingsUnusual concerns about patient's Psychological Status: ☐ Yes ☐ No

If Yes Consultant Notified: ..... Dr. Kokula praneeth ..... (Date/Time): 7/7/26 @ 2:00pm

Cultural & Spiritual Needs: ☒ Yes ☐ No if Yes specify ..... Inform consultant for positive criteria.**Social History:** Lives With ..... NASiblings in household ☐ Yes ☒ No (if yes How Many?) .....All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach : ☒ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump : ☐ Yes ☒ NoHand hygiene Explained: ☒ Yes ☐ No ☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ No

Information given to ..... mother

Nurse Signature: ..... DeiyaNurse Name: ..... Deiya

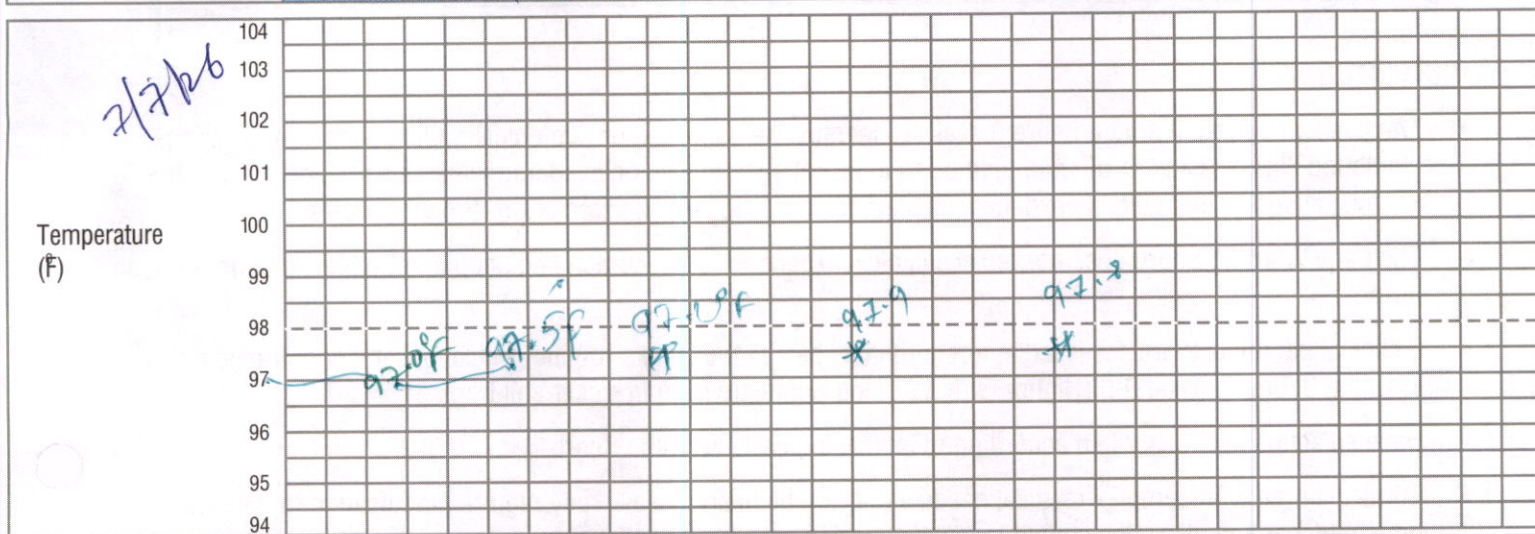
Date: ..... 7/7/26 @

Time: ..... 2:30 Am



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : ..... Time: 6 AM 12 PM 3 PM 6 PM 9 PM 6 AM  
Doctor / Nurse / Family Concern?



Heart Rate (bpm) and Blood Pressure (mmHg) \*

Note: BP does not score in early warning scoring

Heart Rate (Number)

| Time  | Heart Rate (bpm) | Blood Pressure (mmHg) |
|-------|------------------|-----------------------|
| 6 AM  | 100              |                       |
| 12 PM | 106              |                       |
| 3 PM  | 98               |                       |
| 6 PM  | 105              |                       |
| 9 PM  | 100              |                       |

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

Resp Rate (Number)

| Time  | Resp. Rate (bpm) |
|-------|------------------|
| 6 AM  | 23               |
| 12 PM | 22               |
| 3 PM  | 21               |
| 6 PM  | 22               |
| 9 PM  | 22               |

Resp Mod/ Severe Distress None / Mild

Receiving O<sub>2</sub> (l/min) O<sub>2</sub> Saturations (%)

Conscious Level Normal Altered

GCS \*

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

| Time  | Resp Mod/ Severe Distress | Receiving O <sub>2</sub> (l/min) | O <sub>2</sub> Saturations (%) | Conscious Level | GCS * | TOTAL SCORE | Number of shaded boxes | Pain Score | Observer's Initials |
|-------|---------------------------|----------------------------------|--------------------------------|-----------------|-------|-------------|------------------------|------------|---------------------|
| 6 AM  |                           | 100%                             | 100%                           | 15/15           | 15/15 | 0           | 0                      | 0          | P                   |
| 12 PM |                           | 100%                             | 100%                           | 15/15           | 15/15 | 0           | 0                      | 0          | N                   |
| 3 PM  |                           | 99%                              | 99%                            | 15/15           | 15/15 | 0           | 0                      | 0          |                     |
| 6 PM  |                           | 100%                             | 100%                           | 15/15           | 15/15 | 0           | 0                      | 0          |                     |
| 9 PM  |                           | 99%                              | 99%                            | 15/15           | 15/15 | 0           | 0                      | 0          |                     |

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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



# CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

## INSTRUCTIONS:

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

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

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

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

|          |                                                                                                                                                                                                                                                                                                                                     |
|----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>I</b> | <b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)                                                                                                                                                                                                                                                     |
| <b>S</b> | <b>SITUATION:</b> 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>B</b> | <b>BACK GROUND:</b> 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) |
| <b>A</b> | <b>ASSESSMENT:</b> 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.                                                                                         |
| <b>R</b> | <b>RECOMMENDATION:</b> 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)                                                                                                                                                |



## Sheet No. : .....

- |                      |          | Intake          |       |     |     | Output               |           |       |          |       | IV Site                | Sign. Nurse |
|----------------------|----------|-----------------|-------|-----|-----|----------------------|-----------|-------|----------|-------|------------------------|-------------|
| Date                 | Time     | Nature of Fluid | Route |     |     | NG                   | Diarrhoea | Vomit | Drainage | Urine | Thrombophlebitis Score |             |
|                      |          |                 | 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 :       |           |       |          |       |                        |             |
|                      | 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 |           |       |          |       |                        |             |



# 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<br>Thrombo-<br>phlebitis<br>Score | Sign.<br>Nurse |       |
|----------------|----------|--------------------|-------|-----|--------|-------------------------|-----------|-------|----------|-------------------------------------------|----------------|-------|
| Date           | Time     | Nature<br>of Fluid | Route |     |        | NG                      | Diarrhoea | Vomit | Drainage |                                           |                | Urine |
|                |          |                    | Mouth | I.V | N.G    |                         |           |       |          |                                           |                |       |
| 2/3/24         | 08:00 am |                    |       |     |        |                         |           |       |          |                                           | 0              |       |
|                | 09:00 am | H <sub>2</sub> O   |       |     |        |                         | ✓         |       |          | ✓                                         | 0              |       |
|                | 10:00 am |                    |       |     |        |                         |           |       |          |                                           | 0              |       |
|                | 11:00 am | food               |       |     |        |                         |           |       |          |                                           | 0              |       |
|                | 12:00 pm |                    |       |     |        |                         |           |       |          |                                           | 0              |       |
|                | 01:00 pm | Jhu                |       |     |        |                         |           |       |          |                                           | 0              |       |
| Total Intake : |          |                    |       |     |        | Total Output : M-1 U-   |           |       |          |                                           |                |       |
|                | 02:00 pm | H <sub>2</sub> O   |       |     |        |                         |           |       |          | ✓                                         | 0              |       |
|                | 03:00 pm | food               |       |     |        |                         |           |       |          |                                           | 0              |       |
|                | 04:00 pm |                    |       |     |        |                         | np        |       |          |                                           | 0              |       |
|                | 05:00 pm |                    |       |     |        |                         |           |       |          |                                           | 0              |       |
|                | 06:00 pm | soop               |       |     |        |                         |           |       |          |                                           | 0              |       |
|                | 07:00 pm |                    |       |     |        |                         |           |       |          | ✓                                         | 0              |       |
| Total Intake : |          |                    |       |     |        | Total Output : M-7 U-2  |           |       |          |                                           |                |       |
|                | 08:00 pm | food               |       |     |        |                         |           |       |          |                                           | 0              |       |
|                | 09:00 pm |                    |       |     |        |                         |           |       |          | ✓                                         | 0              |       |
|                | 10:00 pm | H <sub>2</sub> O   |       |     |        |                         |           |       |          |                                           | 0              |       |
|                | 11:00 pm |                    |       |     |        |                         | ✓         |       |          |                                           | 0              |       |
|                | 12:00 am | H <sub>2</sub> O   |       |     |        |                         |           |       |          | ✓                                         | 0              |       |
|                | 01:00 am |                    |       |     |        |                         |           |       |          |                                           | 0              |       |
| Total Intake : |          |                    |       |     |        | Total Output : M-10 U-2 |           |       |          |                                           |                |       |
|                | 02:00 am | H <sub>2</sub> O   |       |     |        |                         |           |       |          |                                           | 0              |       |
|                | 03:00 am |                    |       |     |        |                         |           |       |          |                                           | 0              |       |
|                | 04:00 am | H <sub>2</sub> O   |       |     |        |                         |           |       |          | ✓                                         | 0              |       |
|                | 05:00 am |                    |       |     |        |                         | np        |       |          |                                           | 0              |       |
|                | 06:00 am | H <sub>2</sub> O   |       |     |        |                         |           |       |          | ✓                                         | 0              |       |
|                | 07:00 am |                    |       |     |        |                         |           |       |          |                                           | 0              |       |
| Total Intake : |          |                    |       |     |        | Total Output : M-10 U-2 |           |       |          |                                           |                |       |

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

|                      |          |
|----------------------|----------|
| Total 24 hrs. Output | M-20 U-7 |
|----------------------|----------|



BAH-00660882 IP5-00176057  
Master RYAN VIVIAN  
11-03-2020 6 Y 3 M 26 D (M)  
Dr. KOKKULA PRANEETH



## 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: 07/7/26

Assessment: patient having pain & headache

Goals

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

| Time         | Plan of Care                           | Time         | Implementation                                      | Evaluation             |
|--------------|----------------------------------------|--------------|-----------------------------------------------------|------------------------|
| 2:10<br>→ AM | → Assess the patient General condition | 2:10<br>→ AM | → Assessed the patient General condition            | patient is comfortable |
| 4:10<br>→ AM | → Assess the patient vitals signs      | 4:20<br>→ AM | → Assessed the patient vitals signs                 |                        |
| 5:10<br>→ AM | → To maintain I/O chart                | 5:20<br>→ AM | → Maintained I/O chart                              |                        |
| 6:10<br>→ AM | → To encourage oral intake             | 6:10<br>→ AM | → Encourage oral intake                             |                        |
| 7:10<br>→ PM | → To provide comfortable position      | 8:10<br>→ AM | → provided comfortable position<br>→ ensure safety. |                        |

Re-Assessment: patient is Good

Special Notes: Extra sample

Nurse Signature: [Signature] Nurse Name: Deeya

Date & Time: 07/7/26 @ 8 AM



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S ☒ Morning ☒ Afternoon ☐ Night

Date: 7/7/26

Assessment: patient conscious / active

### 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 |
|------|----------------------------------------|--------|----------------------------------|------------|
| 8am  | → Assess the patient general condition | 8.10a  | → patient stable                 | pt stable  |
| 10am | → monitor vitals                       | 10.10a | → vitals stable                  |            |
| 1pm  | → monitor I/O chart                    | 12.00p | → monitored I/O chart documented |            |
| 4pm  | → to administer medication             | 2.00pm | → administered medication        |            |
| 6pm  | → to encourage orally                  | 6.30pm | → oral intake good               |            |
| 7pm  | → to encourage ambulatory              | 7.30pm | → well ambulatory                |            |

Re-Assessment: Re-assessed after 2 hr pt stable

Special Notes: observe the patient activity

Nurse Signature: Satya

Nurse Name: Satya

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



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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 2/7/20

Assessment:

pt having Acute pain at heart

Goals

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

| Time | Plan of Care                               | Time | Implementation                      | Evaluation    |
|------|--------------------------------------------|------|-------------------------------------|---------------|
| 8pm  | → Assess the pt general condition & vitals | 8pm  | → Assessed the pt general condition | Ensure Safety |
| 11pm | → Relieve pain & Discomfort                | 11pm | → Relieved pain & Discomfort        |               |
| 1Am  | → Maintain fluid balance                   | 1Am  | → Maintained fluid balance          |               |
| 3Am  | → Encourage orally                         | 3Am  | → Encouraged orally                 |               |
| 5Am  | → Administer Medication                    | 5Am  | → Administered medication           |               |
| 7am  | as per chart                               | 7Am  | as per chart                        |               |

Re-Assessment:

Reduce pain

Special Notes:

NA

Nurse Signature: Shisha

Nurse Name: Shisha

Date & Time: 8/7/20 @ 8pm



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11-03-2020 6 Y 3 M 26 D (M)

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# NURSING CARE RECORD

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BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: .....

Assessment: .....

Goals

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

| Time | Plan of Care | Time | Implementation | Evaluation |
|------|--------------|------|----------------|------------|
|      |              |      |                |            |

Re-Assessment: .....

Special Notes: .....

Nurse Signature: .....

Nurse Name: .....

Date &amp; Time: .....





## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: paed. Date of Admission: 07/07/20

|                                          |                                                        |                                                                     |                                                                                                                       |                                                                     |                                                          |                                                          |                                                          |
|------------------------------------------|--------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| SITUATION                                | Diagnosis:                                             |                                                                     | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known |                                                                     |                                                          |                                                          |                                                          |
|                                          | TBI                                                    |                                                                     | If Yes Specify: .....                                                                                                 |                                                                     |                                                          |                                                          |                                                          |
| BACKGROUND                               | Area                                                   | Shift Time                                                          | 2:05 am - 3:00 pm                                                                                                     | 3:00 pm - 8:00 pm                                                   | 8:00 pm - 11:00 pm                                       |                                                          |                                                          |
|                                          | Medical Condition (Any special condition to be noted): |                                                                     | u/c                                                                                                                   | NA                                                                  |                                                          |                                                          |                                                          |
| ASSESSMENT                               | Allergy:                                               | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                          | Tubes/Drains/Catheter:                                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                          | Vital Signs:                                           | Temp:                                                               | 98.0 F                                                                                                                | 97.9 F                                                              | 98.0                                                     |                                                          |                                                          |
|                                          | Res:                                                   | 26 bpm                                                              | 26 bpm                                                                                                                | 28                                                                  |                                                          |                                                          |                                                          |
|                                          | SpO <sub>2</sub> :                                     | 97%                                                                 | 98%                                                                                                                   | 99                                                                  |                                                          |                                                          |                                                          |
|                                          | Pulse:                                                 | 108 bpm                                                             | 107                                                                                                                   | 100                                                                 |                                                          |                                                          |                                                          |
|                                          | BP:                                                    | 112/72                                                              |                                                                                                                       | 100/60                                                              |                                                          |                                                          |                                                          |
|                                          | Fall Risk Score:                                       | 11                                                                  | 4/10                                                                                                                  | 4/10                                                                |                                                          |                                                          |                                                          |
| Pain Score:                              | 0/10                                                   | 0/10                                                                | 0/10                                                                                                                  |                                                                     |                                                          |                                                          |                                                          |
| Recommendations                          | Safety Needs:                                          | Yes                                                                 | Yes                                                                                                                   | Yes                                                                 |                                                          |                                                          |                                                          |
|                                          | Physiotherapy                                          | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                          |
|                                          | Others Specify:                                        | u/c                                                                 | NA                                                                                                                    | NA                                                                  |                                                          |                                                          |                                                          |
|                                          | Special Diet:                                          | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                              | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                          |
|                                          | Other Special Orders / Medications:                    | u/c                                                                 | NA                                                                                                                    | NA                                                                  |                                                          |                                                          |                                                          |
| Post Operative Procedure Special Orders: |                                                        | u/c                                                                 | NA                                                                                                                    | NA                                                                  |                                                          |                                                          |                                                          |
| Handed Over By Name :                    |                                                        | Praneeth                                                            | Satya                                                                                                                 | Shritha                                                             |                                                          |                                                          |                                                          |
| Signature :                              |                                                        | [Signature]                                                         | [Signature]                                                                                                           | [Signature]                                                         |                                                          |                                                          |                                                          |
| Date:                                    |                                                        | 07/07/20                                                            | 07/07/20                                                                                                              | 07/07/20                                                            |                                                          |                                                          |                                                          |
| Time:                                    |                                                        | 8:10 am                                                             | 8 pm                                                                                                                  | 8 am                                                                |                                                          |                                                          |                                                          |
| Taken Over By Name :                     |                                                        | Praneeth                                                            | Shritha                                                                                                               |                                                                     |                                                          |                                                          |                                                          |
| Signature :                              |                                                        | [Signature]                                                         | [Signature]                                                                                                           |                                                                     |                                                          |                                                          |                                                          |
| Date:                                    |                                                        | 7/7/20                                                              | 07/07/20                                                                                                              |                                                                     |                                                          |                                                          |                                                          |
| Time:                                    |                                                        | 8 am                                                                | 8 pm                                                                                                                  |                                                                     |                                                          |                                                          |                                                          |



## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

|                        |                                                                              |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| <b>SITUATION</b>       | Diagnosis: .....                                                             | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |                                                          |                                                          |                                                          |                                                          |                                                          |
| <b>BACKGROUND</b>      | Area<br><div style="text-align: right; margin-right: 50px;">Shift Time</div> |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                        | Medical Condition<br>(Any special condition to be noted):                    |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
| <b>ASSESSMENT</b>      | Allergy:                                                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                        | Tubes/Drains/Catheter:                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                        | Vital Signs:                                                                 |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                        | Temp:                                                                        |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                        | Res:                                                                         |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                        | SpO <sub>2</sub> :                                                           |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                        | Pulse:                                                                       |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                        | BP:                                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                        | Fall Risk Score:                                                             |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                        | Pain Score:                                                                  |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
| <b>Recommendations</b> | Safety Needs:                                                                |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                        | Physiotherapy                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                        | Others Specify:                                                              |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                        | Special Diet:                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                        | Other Special Orders / Medications:                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                        | Post Operative Procedure Special Orders:                                     |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                        | Handed Over By Name :                                                        |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                        | Signature :                                                                  |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                        | Date:                                                                        |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                        | Time:                                                                        |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                        | Taken Over By Name :                                                         |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                        | Signature :                                                                  |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                        | Date:                                                                        |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|                        | Time:                                                                        |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |



BAH-00660882 IP5-00176057  
Master RYAN VIVIAN  
11-03-2020 6 Y 3 M 26 D (M)  
Dr. KOKKULA PRANEETH



## PAIN ASSESSMENT FORM

**Rainbow Children's Hospital**  
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**BirthRight™**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

|          |      |   | Location             | Duration                                                                     | Acuity                                                             | Character                                                         |                                                                   | Modifying Factors                                                          | Patient / Family Educated                                   | Intervention         | Sign   |
|----------|------|---|----------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------|----------------------|--------|
| 04/04/20 | 2am  | 0 | ulc                  | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp<br><input type="checkbox"/> Aching | <input type="checkbox"/> Dull<br><input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | self<br>med          | (Numb) |
| 7/7/20   | 6am  | 0 | NA                   | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp<br><input type="checkbox"/> Aching | <input type="checkbox"/> Dull<br><input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | under<br>Observation | Deep   |
| 7/7/20   | 12pm | 0 | under<br>Observation | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp<br><input type="checkbox"/> Aching | <input type="checkbox"/> Dull<br><input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | under<br>Observation | Satya  |
| 7/7/20   | 8pm  | 0 | NA                   | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp<br><input type="checkbox"/> Aching | <input type="checkbox"/> Dull<br><input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | under<br>Observation | Shreya |
| 8/7/20   | 1am  | 0 | NA                   | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp<br><input type="checkbox"/> Aching | <input type="checkbox"/> Dull<br><input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | under<br>Observation | Shreya |
|          |      |   |                      | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp<br><input type="checkbox"/> Aching | <input type="checkbox"/> Dull<br><input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                      |        |
|          |      |   |                      | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp<br><input type="checkbox"/> Aching | <input type="checkbox"/> Dull<br><input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                      |        |
|          |      |   |                      | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp<br><input type="checkbox"/> Aching | <input type="checkbox"/> Dull<br><input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                      |        |
|          |      |   |                      | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp<br><input type="checkbox"/> Aching | <input type="checkbox"/> Dull<br><input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                      |        |
|          |      |   |                      | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp<br><input type="checkbox"/> Aching | <input type="checkbox"/> Dull<br><input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                      |        |

### Re-assessment Frequency:

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

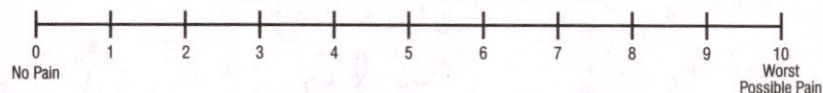


# PAIN ASSESSMENT TOOLS

**FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)**

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

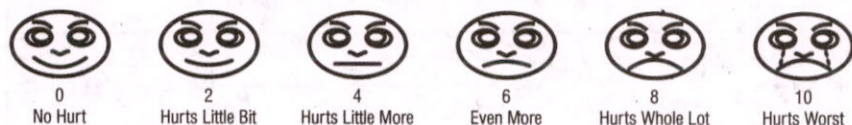
**Numerical Pain Scale (Obstetric and Gynecology)**



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

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

**Wong - Baker (Pediatrics) Above 7 Years**





BAH-00660862

IP5-00176057

Master RYAN VIVIAN

11-03-2020

6 Y 3 M 26 D

(M)

Dr. KOKKULA PRANEETH



## BRADEN 'Q' SCALE

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

BirthRight  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Date :                  | 07/07/2022 |       |    |    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------|-------|----|----|
|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Time :                  | 2am        |       | 8A |    |
| Mobility                                                                                                                                                                     | <b>1. Completely immobile:</b><br>Does not make even slight changes in body or extremity position without assistance.                                                                                                                                                                                                                    | <b>2. Very limited:</b><br>Makes occasional slight changes in body or extremity position but unable to completely turn self independently.                                                                                                                                                                                                                   | <b>3. Slightly limited:</b><br>Makes frequent through slight changes in body or e:xtremity position independently.                                                                                                                                                                              | <b>4. No limitations:</b><br>Makes major and frequent changes in position without assistance.                                                                                                                                                                                          | 4                       | 4          |       |    |    |
| "Activity The degree of physical activity"                                                                                                                                   | <b>1. Bedfast :</b><br>Confined to bed                                                                                                                                                                                                                                                                                                   | <b>2. Chairfast :</b><br>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."                                                                                                                                                                                                         | <b>3. Walks occasionally:</b><br>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.                                                                                                                        | <b>4. All patients too young to ambulate; OR walks frequently:</b><br>Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.                                                                                                    | 4                       | 4          |       |    |    |
| Sensory Perception                                                                                                                                                           | <b>1. Completely limited:</b><br>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.                                                                                                                  | <b>2. Very limited:</b><br>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.                                                                                                                               | <b>3. Slightly limited:</b><br>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.                                                           | <b>4. No impairment:</b><br>Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.                                                                                                                                    | 4                       | 4          |       |    |    |
| Moisture Degree to which skin is exposed to moisture                                                                                                                         | <b>1. Constantly moist:</b><br>Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.                                                                                                                                                                   | <b>2. Very moist:</b><br>Skin is often, but not always, moist. Linen must be changed at least every 8 hours.                                                                                                                                                                                                                                                 | <b>3. Occasionally moist:</b><br>Skin is occasionally moist, requiring linen change every 12 hours.                                                                                                                                                                                             | <b>4. Rarely moist:</b><br>Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.                                                                                                                                                                   | 4                       | 4          |       |    |    |
| <b>FRICTION-SHEAR</b><br><b>Friction</b> Occurs when Skin moves against support surfaces<br><b>Shear</b> Occurs when skin and adjacent bony surface slide across one another | <b>1. Significant problem:</b><br>Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.                                                                                                                                                                                                        | <b>2. Problem:</b><br>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.                                                                                                                    | <b>3. Potential problem:</b><br>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.            | <b>4. No apparent problem:</b><br>Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."                         | 4                       | 4          |       |    |    |
| Nutritional Usual food intake pattern                                                                                                                                        | <b>1. Very Poor:</b><br>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. | <b>2. Inadequate:</b><br>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. | <b>3. Adequate:</b><br>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. | <b>4. Excellent:</b><br>Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. | 4                       | 4          |       |    |    |
| Tissue Perfusion & Oxygenation                                                                                                                                               | <b>1. Extremely compromised:</b><br>Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.                                                                                                                                                                                   | <b>2. Compromised:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.                                                                                                                                                                                                | <b>3. Adequate:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.                                                                                                                                        | <b>4. Excellent:</b><br>Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.                                                                                                                                                                               | 4                       | 4          |       |    |    |
| <b>Severe Risk : less than 9   High Risk : 10-12   Moderate Risk : 13-14   Mild Risk : 15-18   Not at Risk: 19-23</b>                                                        |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | <b>TOTAL SCORE</b>      |            | 28    |    | 28 |
| Docu. No. : RCHBH /FRM / CLINICAL / 119                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | <b>Evaluator's Name</b> |            | Nutan |    | Ch |



| Risk Score  | Category      | Action                                                                                                                                                                                                                                                                                                                                       | <b>Support Surfaces</b><br>(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       | <ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul> | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 13-14       | Moderate Risk | <ul style="list-style-type: none"> <li>• Use the Same Protocol as for “<b>At Risk</b>” Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>                                                                                                                                                        | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 10-12       | High Risk     | <ul style="list-style-type: none"> <li>• Follow the same protocol as for “<b>Moderate Risk</b>” Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>                                                                                                             | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| Less than 9 | Severe Risk   | <ul style="list-style-type: none"> <li>• Use same protocol as for “<b>High Risk</b>” Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>                                                                                                                     | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |





## THE HUMPTY DUMPTY SCALE

0-10+ 8/8

| 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    |      |      |      |
|                                           | 7 to less than 13 years old                                                                                | 2     |      |      |      |      |      |
|                                           | 13 years old and above                                                                                     | 1     |      |      |      |      |      |
| Gender                                    | Male                                                                                                       | 2     | 2.   | 2    |      |      |      |
|                                           | Female                                                                                                     | 1     |      |      |      |      |      |
| Diagnosis                                 | Neurological Diagnosis                                                                                     | 4     |      |      |      |      |      |
|                                           | Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc. | 3     |      |      |      |      |      |
|                                           | Psych / Behavioral Disorders                                                                               | 2     |      |      |      |      |      |
|                                           | Other Diagnosis                                                                                            | 1     | 1    | 1    |      |      |      |
| Cognitive Impairments                     | Not Aware of Limitations                                                                                   | 3     |      |      |      |      |      |
|                                           | Forget Limitations                                                                                         | 2     |      |      |      |      |      |
|                                           | Oriented to own Ability                                                                                    | 1     | 1    | 1    |      |      |      |
|                                           | History of Falls or Infant - Toddler Placed in Bed                                                         | 4     |      |      |      |      |      |
| Environmental Factors                     | Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)            | 3     |      |      |      |      |      |
|                                           | Patient Placed in Bed                                                                                      | 2     | 2.   | 2    |      |      |      |
|                                           | Outpatient Area                                                                                            | 1     |      |      |      |      |      |
| Response to Surgery / Sedation Anesthesia | Within 24 hours                                                                                            | 3     |      |      |      |      |      |
|                                           | Within 48 hours                                                                                            | 2     |      |      |      |      |      |
|                                           | More than 48 hours / None                                                                                  | 1     | 1    | 1    |      |      |      |
| Medication Usage                          | Sedatives (excluding ICU patients sedated and paralyzed)                                                   | 3     |      |      |      |      |      |
|                                           | Hypnotics                                                                                                  | 3     |      |      |      |      |      |
|                                           | Barbiturates                                                                                               | 3     |      |      |      |      |      |
|                                           | Phenothiazines                                                                                             | 3     |      |      |      |      |      |
|                                           | Antidepressants                                                                                            | 3     |      |      |      |      |      |
|                                           | Laxatives / Diuretics                                                                                      | 3     |      |      |      |      |      |
|                                           | Narcotics                                                                                                  | 3     |      |      |      |      |      |
|                                           | One of the Meds listed above                                                                               | 2     |      |      |      |      |      |
|                                           | Other Medications / None                                                                                   | 1     | 1    | 1    |      |      |      |
| TOTAL                                     |                                                                                                            |       | 11   | 11   |      |      |      |

Intervention :

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

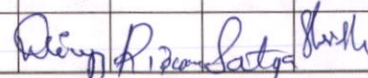
High Risk Humpty Dumpty Score = 12 or above

|                               |       |       |  |  |  |  |
|-------------------------------|-------|-------|--|--|--|--|
| Bed in low position           | yes   | yes   |  |  |  |  |
| Call device within reach      | yes   | yes   |  |  |  |  |
| Wheels Locked                 | yes   | yes   |  |  |  |  |
| Room free of clutter          | yes   | yes   |  |  |  |  |
| Adequate Lighting             | yes   | yes   |  |  |  |  |
| Wheel Chair Support           | no    | no    |  |  |  |  |
| Other Intervention(s) Specify | no    |       |  |  |  |  |
| Nurse's Name :                | Nurse | Staff |  |  |  |  |
| Signature :                   | all   | Don   |  |  |  |  |
| Date :                        | 4/4   | 8/8   |  |  |  |  |
| Time :                        | 1:20  | 2:00  |  |  |  |  |





## 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 /<br>Observe cannula                                                              | 0     |                                                                                       |   | 0 | 0     | 0 | 0 |       |   |   |         |
| 2                      | One of the following signs is evident :<br>* Slight pain near the IV Site /<br>* Slight redness near IV Site                                         | Possibly first signs of phlebitis /<br>Observe cannula                                                  | 1     |                                                                                       |   | - | -     | - | - |       |   |   |         |
| 3                      | Two of the following Signs are evident:<br>Pain at IV site Redness                                                                                   | Early stage of phlebitis /<br>Resite Cannula                                                            | 2     |                                                                                       |   | - | -     | - | - |       |   |   |         |
| 4                      | All of the following Signs are evident :<br>Pain along Path of cannula<br>Redness around Site Swelling                                               | Medium stage of phlebitis /<br>Resite Cannula Consider Treatment                                        | 3     |                                                                                       |   | - | -     | - | - |       |   |   |         |
| 5                      | All of the following Signs are evident and Extensive :<br>Pain along Path of cannula<br>Redness around Site<br>Swelling palpable Venous cord         | Advanced stage of phlebitis or<br>the start of thrombophlebitis /<br>Re site Cannula Consider Treatment | 4     |                                                                                       |   | - | -     | - | - |       |   |   |         |
| 6                      | All of the following Signs are evident and Extensive : Pain<br>along Path of cannula Redness<br>around Site Swelling palpable<br>Venous cord pyrexia | Advanced stage of<br>thrombophlebitis /<br>Initiate treatment Re site<br>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 : Sobharani Name : Sobharani

Signature of Ward In Charge :

Signature : Rizwana Name : Rizwana



BAH-00660882 IP5-00176057  
Master RYAN VIVIAN 6 Y 3 M 26 D (M)  
11-03-2020  
Dr. KOKKULA PRANEETH

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

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## DISCHARGE PLANNING FORM

Nationality : .....

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

1. Anticipated Date of Discharge : .....
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 :

- |                                     |                                         |                             |
|-------------------------------------|-----------------------------------------|-----------------------------|
| <input type="checkbox"/> Medication | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Bathing    | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Eating     | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Walking    | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Dressing   | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Toileting  | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |

Remarks

yes 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 Topics/s : .....
- Patient's Educational Topic/s discussed with the :  
☐ Patient ☒ Family Member ☐ Others : .....

Nurse Signature : ..... *[Signature]*

Nurse Name : ..... *[Signature]*

Date and Time : 7/7/20 @ 2:30 PM

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







# PATIENT TRANSFER FORM

|                                                                                                                                                                                                                            |                                |                                                                                                                                                                            |                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| Patient Name & UHID No.<br><br>BAH-00860882 IP5-00176057<br>Master RYAN VIVIAN<br>11-03-2020 6 Y 3 M 26 D (M)<br>Dr. KOKKULA PRANEETH<br> |                                | Date & Time of Admission<br>07/07/26 @ 12:15 PM                                                                                                                            | Date & Time of Transfer Order<br>07/07/26 @ 2:05 PM |
|                                                                                                                                                                                                                            |                                | Transfer Ordered by<br>Dr. Ranga.                                                                                                                                          | Reason for Transfer<br>Admission.                   |
| From Unit<br>ER.                                                                                                                                                                                                           | To Unit<br>3A0.                | Information to Attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                            |                                                     |
| Number of Sheets in Clinical File<br>19                                                                                                                                                                                    | Number of Imaging Films<br>Nil | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/><br>If yes, what ? |                                                     |
| Medications / Consumables / Surgicals / Hand over                                                                                                                                                                          |                                |                                                                                                                                                                            |                                                     |
| Sl.No.                                                                                                                                                                                                                     | Item Name                      | Quantity                                                                                                                                                                   |                                                     |
| 1.                                                                                                                                                                                                                         |                                |                                                                                                                                                                            |                                                     |
| 2.                                                                                                                                                                                                                         |                                |                                                                                                                                                                            |                                                     |
| 3.                                                                                                                                                                                                                         |                                |                                                                                                                                                                            |                                                     |
| 4.                                                                                                                                                                                                                         |                                |                                                                                                                                                                            |                                                     |
| 5.                                                                                                                                                                                                                         |                                |                                                                                                                                                                            |                                                     |
| Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                                           |                                |                                                                                                                                                                            |                                                     |
| Name & Signature of Person who is Transferring<br>Mr. Praneeth.                                                                                                                                                            |                                | Name of Person Ordered Transfer<br>Dr. Ranga.                                                                                                                              |                                                     |
| Patient & Clinical Records Received by :<br>                                                                                            |                                |                                                                                                                                                                            |                                                     |
| Date & Time of Patient Received :<br>7/7/26 @ 2:15 PM                                                                                                                                                                      |                                |                                                                                                                                                                            |                                                     |

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





340

## NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 7/7/26 Time: 9:30m

Weight: 20.1kg Centile: 72<sup>nd</sup>

Height: 90cm Centile: 72<sup>nd</sup>

Inference: well child

RDA: — Calories: 1500kcal/d Protein: 25gm/d

Diet Recommendations: light diet

Re-Assessment: avoid spicy, chilled & outside foods

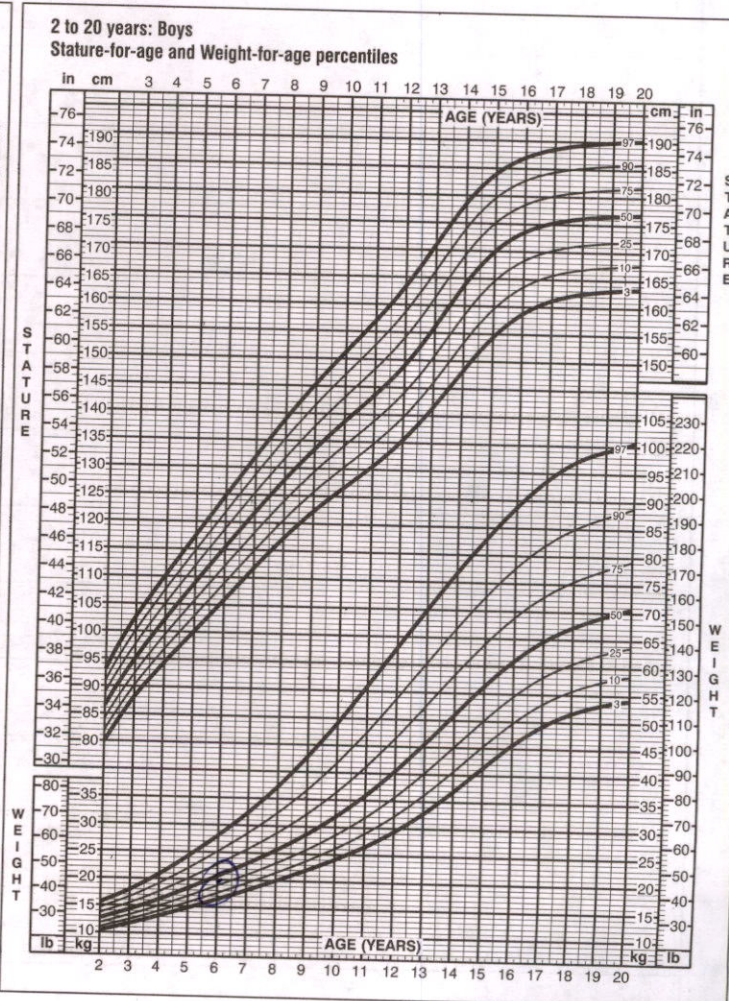
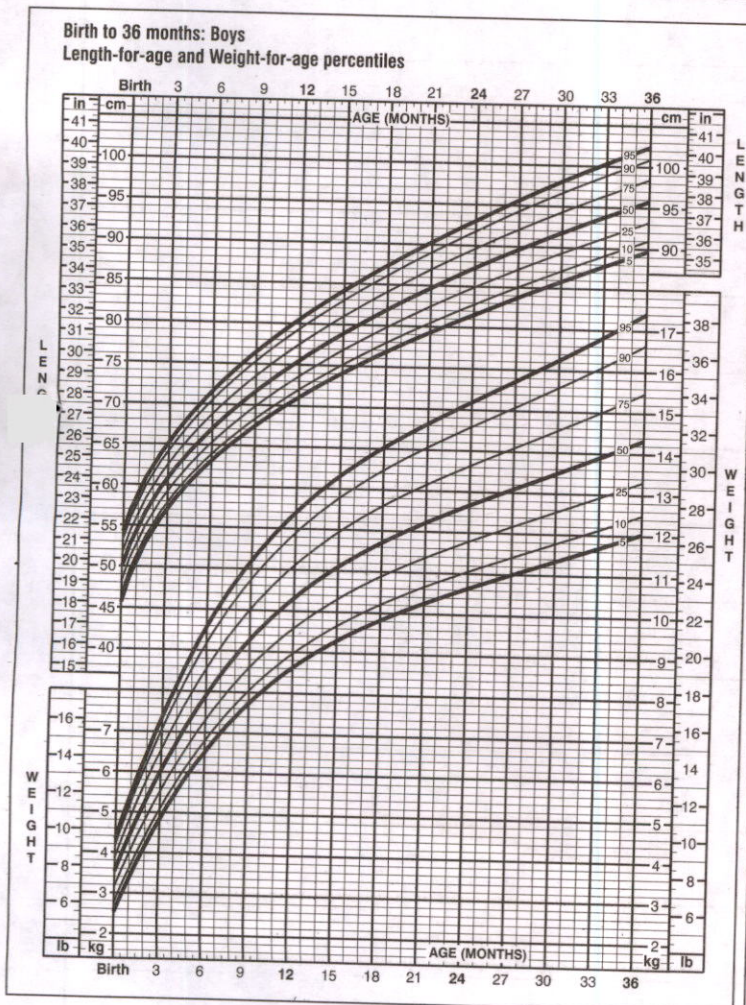
Food Allergies: No Veg/Non-veg: NON-veg

Diagnosis: mild TB1

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

### GROWTH CHART (BOYS)



Dietician's Name: Raina

Dietician's Signature: [Signature]



[illegible]