

ACTIVITY RECORD FOR BILLING

Name : BAH-00643509 IP5-00176534
Master MIRZA SAAD BAIG
 UHID No. : 23-10-2026 0 Y 8 M 24 D (M)
Dr. DR.V.V.R.SATYA PRASAD
 Date of Adm. : _____ Date of Discharge : _____ Time : _____
 Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
17/7/26	8:30pm	FR	117	Acu

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr:- Nabeel Sir	22/7/26	9716881	(Ry)
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

Signature

T. snare

Farid



Sushma

Sushma

Sources



Sushma

Appu

Chitra

[illegible]

Date _____

Name of Equipment

Connecting Time

Disconnecting Time

Order No.

Signature

17/7

Infusion pump.

10pm

9730548



PROCEDURE

[illegible]**ANY OTHER INFORMATION**

- ① US G-Abdomen
- ② Chest X-ray
- ③ VBG

Date : 23/7

Time : 11:30 Am

Prepared By :

: Chendur

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor

Chandani

C-w-L

ADMISSION SHEET


Registration Details :

Admission No : IP5-00176534 Admit Date : 17-Jul-2026 Admit Time : 06:02 PM UHID : BAH-00643509

Patient Details :

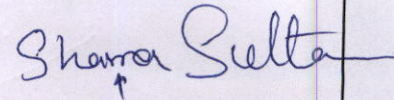
Patient Name	: Master MIRZA SAAD BAIG	Age	: 0 Y 8 M 24 D
Guardian	: Mr MIRZA OSMAN BAIG	DOB	: 23-10-2025 06:35 PM
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H NO 20-3-511/2 HOOL KHANA JALAL KUNCHA SHAH GUNJ, Bahadurpura Hyderabad Telangana INDIA 500064	Phone No	: 7702453877/ 9908506819
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type : GENERAL WARD Bed No : GW 117 Ward Name : 1F-GENERAL WARD I
 Room No : GW 117 Admission Type : First Visit

Contact Details :

Name : Mr MIRZA OSMAN BAIG Relationship : Father
 Contact Address : H NO 20-3-511/2 HOOL KHANA JALAL Phone No : 7702453877 / 9908506819
 KUNCHA SHAH GUNJ, Bahadurpura Hyderabad
 Telangana INDIA 500064



Signature

Doctor Details :

Doctor Name : Dr. DR.V.V.R.SATYA PRASAD Specialisation : PEDIATRIC NEPHROLOGY
 Referral Doctor : Self Phone No :
 Co-Consultant : Dr. SRUTHI BALLA

Payment Details :

Deposit Amount : 0.00
 Payment Mode : Cash Payor Name : SELFPAY



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Mirza Saad Baig

UHID ID:

BAH-00643509 IP5-00176534
Master MIRZA SAAD BAIG
23-10-2025 0 Y 8 M 24 D (M)
Dr. DR.V.V.R.SATYA PRASAD

Department:



Consultant:

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Sepsis

Desired goals of the treatment: _____

Hemodynamic stability

Planned Labs:

CBP
CRP
RP-2, Blood cfs
CUE, Urine cfs
Ultrasound abdomen
including scrotum

NIB Subm
17/07/2026
at 6pm

Planned Management

- DNS 3/4th maintenance
- Ceftriaxone
- Esomeprazole
- Strict I/O charting
- SYP, NODOSIS
- Tab. Tropan
- DROF. VET-D3

Signature of the Doctor: _____

Signature of the Consultant: _____

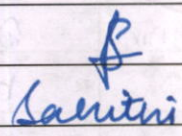
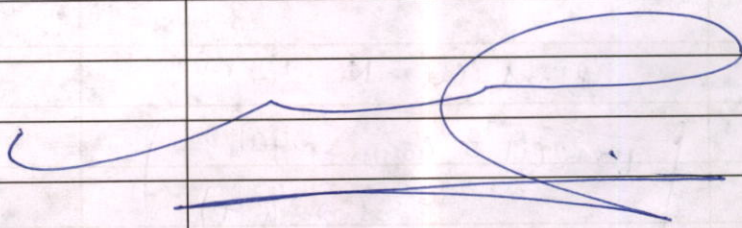
Name of the Doctor: Dr. Nandan

Name of the Consultant: _____

Date & Time: 17/07/2026, 6:25 PM

Date & Time: _____

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7/25 9 AM	Seen by Resident Acute febrile illness. u/o PUV S/P Cystoscopy.	Plan
	ongoing fever spikes- 4 AM - 101.7°F.	1. Continue CEFTRIAXONE NODOSIS TROPAN.
	feeding - reduced activity - decreased. O/E 40 cough.	2. USG abdomen & scrotum
	child asleep, afebrile hemodynamically stable perfusion good, Afat level. chest clear	3. Strict I/O charting
	abdomen soft.	4. monitor vitals & inform SAS
	u/o - 300ml @ 12 hrs.	5. Trace blood c/s & urine c/s
		 Senthil B
18/7/25	Seen by Dr Satya Prasad / Dr Senthil B	1. Send 5 vital panel 2. Nodosis - 5ml TID.
		

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7/26 4:30 PM	Seen by Resident ASis - AFI.	
	last fever - 5 AM 101.7°F	Plan
	oral intake fair	1. Continue medications as charted
	No fresh issues	2. Trace Adeno. - not detected
	hemodynamically stable	3. trace blood c/s,
	chest clear	urine c/s.
	abdomen soft.	4. monitor vitals q inform SOS
		\$ Sahithi
19/7 9 AM	Seen by Resident	
	ASis AFI	Plan
	Kidney PUV 8p Cystoscopy	- 1g Ceftriaxone (D ₂)
	Pain - 10/10 @ 8:15 AM	Trace urine c/s
	Nose block	- other medication as per ch
	OR	- Temp charting
	1-10/10 (H), clear	- monitor vitals
	PIA (H) BP-	- Diet - No chills
	In wt - 9kg (8.85kg)	
	U.O - 531 ml over 24hrs	
	Blood - cl - NG H'll now	
	Unrecl - Green - negative Cultures (H)	

BAH-00643509
Master MIRZA SAAD BAIG
23-10-2025
Dr. DR.V.V.R.SATYA PRASAD
0 Y 8 M 24 D
IP5-00176534
(M)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/17/26 11:40 AM	S/O B sugar	Calcium URP CRP VBCs Xray chest.

DR. V. V. R. SATYA PRASAD



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date & Time	Progress Notes	Doctor's Order
20/7/26 2:30 AM	Seen by Resident. ASis - AF1. Ongoing low grade fever spikes. last - 7 PM 100° 3 F passed 570 ml urine in 24 hrs. Nose block.	Plan 1. Continue Ceftriaxone Dy 2. Trace urine 4S 3. Monitor vitals Infuse SOS.
	O/E child alert, afebrile hemodynamically stable Chest clear, abdomen soft hydration fair	 Satya Prasad
20/7/26 11 AM	Seen by Dr. Satya Prasad, Dr. Bruthi B	CBP } CRP } Tm @ 6 AM. RP2 }



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/25 1:15pm	S/B Do - Butli	
	No fever since morning Hemodynamically stable.	<u>Adv</u>
	Child comfortable at rest	- Continue same Rx - Trace urine c/s & report
	U/O - good.	- 1/M CBP CRP RPz } 6Am
		- Vitals 4 Hly.
20/7/25 5pm	Seen by Resident Asis - Culture the UTI (E. coli) last fever 7Am	<u>Plan</u>
	hemodynamically stable feeding well.	1. more Continue medication as charted
	Urine c/s - E. coli growth (Verbal report).	2. Trace sensitivity report
		3. CBP CRP RPz } Tm @ 6Am.
		4. monitor vitals & inform SDS.
		<u>Saini</u>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/2026 10 AM	AS: UTI Dengue fever.	S/B Dr. Sullin
	No fevers	Plan
	Last fever - 19/7/26	ct some medication
	Adm	- Peds Surgery consults / Nabel
	Orally accepting	- monitor vitals 4 hrs
	Temp - 9.34 kg	- vitals
	Wt - 100/20 (80)	- T/M (CBP) (RP2) OT/PT (LFT) 6 AM
	U-O - 443ml over 24hrs.	Sullin
22/7/26 4 PM	Seen by Resident. ASin - UTI ; Dengue fever.	
	No fevers.	Plan
	oral intake fair	1. Continue medication as charged
	O/E	2. CBP RP2 LFT
	child asleep, afebrile	T/M @ 6 AM.
	hemodynamically stable.	
	Chest clear	3. monitor vitals q inform SOS
	abd soft.	
	passing adequate urine	S. Sullin

Dr. DR.V.V.R.SATYA PRASAD

[illegible]

BAH-00643509 IP5-00176534
Master MIRZA SAAD BAIG
23-10-2025 0 Y 8 M 24 D (M)
Dr. DR.V.V.R.SATYA PRASAD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RESULT SHEET

Date	17/7/26	19/7/26	21/7/26	23/7/26		
Time						
Hb	12.3	12	10.9	11.4		
PCV	36.1	38.4	35	35		
RBC	5.47	5.6	5.17	5.20		
WBC	10660	12,280	13,190	11,510		
N/L	58.3/38.5	16/80.9	12/82	14.5/72		
Platelets	2.88	152,000	1,23,000	2.97 wkn		
CRP	6	5	5			
ESR						
PCT						
RBS						
Na	133		136	138		
K	4.9		4.7	5.5 f		
Cl	104		111	110		
Ca/Mg		8.91				
Phosphate						
Urea	24		6	8		
Creatinine	0.4		0.3	0.2		
ALP				200		
SGPT			148	48		
SGOT			148	21		
T.Bill/Conj						
T.Protein			4.8			
S.Albumin			2.8			
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L Bicarbonate	15		16	20		



CROSS CONSULTATION FORM

Doctor Name : Dr. Nabeel. Date : 22/7/26 Time : 5pm

Diagnosis :

Hospital : RLH Bangalore

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

Signature: radhu.

Findings and Recommendations :

cls/B Dr. Nabeel.

40 Lt UDT (+) Culture (+) Adv
UTI.

K/c/o PUV fulguration
in Dec 25
(Circumcision done)

1) Plan to open Orchidopexy
after resolution of
UTI & ? Dengue.

O/E

H/o recurrent UTI → on
uroprophylaxis.

→ Lt testis felt at
superficial inguinal
ring

+
Cystoscopy to check for
remnant
valves.

→ Rt testis felt in
scrotum.

(L open orchidopexy
+/- orchidectomy +
cystoscopy)

Consultant :

Name : Dr. Nabeel. Signature : [Signature] Date & Time : 22/7/26.

urza

MEDICATION RECONCILIATION FORM

Drug Allergies: ☒ Not known any Drug Allergies

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

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

Shifting From: ICU Shifted to: Ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Tab. THOPAN	1/2 tab	PO	BD	17/11/26 6:45 AM	☒ C ☐ DC
2		diuretic 10ml & give 5ml				☐ C ☐ DC
3	Syr. NODOSIS	6.5ml	PO	BD	17/11/26 9AM	☒ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: nandan

Date & Time: 17/11 @ 8p

Nurse Name & Signature: Subarna

Date & Time: 17/11/26 at 7:30pm



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Weight Ward

RCHBH / FRM / CLINICAL / 108

VERIFIER
VERIFIED BY : Name



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : Econorm Sachet				Date Time	20/10	21/10	22/10	23/10												
Dose	Route	Frequency	Start Dt.																	
1/2 sachet	P/O	TID	20/10 6AM	X	10PM	10PM	10PM	10PM	10PM	10PM	10PM	10PM	10PM	10PM	10PM	10PM	10PM	10PM	10PM	10PM
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				



DRUG CHART

Date of Admission: 17/07/2026 Drug Allergies: Nil ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG : <u>DROP. PARACETAMOL</u>				Date Time	<u>17/07/2026</u>															
Dose <u>1.3ml</u>	Route <u>PO</u>	Frequency <u>SOS</u>	Start Date <u>17/07/2026</u>																	
Doctor's Signature <u>Dr. Nandan</u>		Valid Period	Pharm.																	
Additional Instructions: <u>100mg/ml</u> <u>If temp > 100°F, minimum 6 hrs gap between 2 doses</u>																				

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

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



REGULAR PRESCRIPTIONS

Weight. 8.95kg. Ward.

VERIFIED

DRUG : <u>INJ. CEFTRIAXONE</u>				Date Time	17/7	18/7	19/7	20/7	21/7	22/7	23/7
Dose	Route	Frequency	Start Date								
450mg	IV	BD	17/7/26								
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandan</u>											
Additional Instructions:											
Daily Doctor's Endorsement by a Sign											

VERIFIED

DRUG : <u>INJ. ESOMEPRAZOLE</u>				Date Time	17/7	18/7	19/7	20/7	21/7	22/7	23/7
Dose	Route	Frequency	Start Date								
9mg	IV	OD	17/7/26								
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandan</u>											
Additional Instructions:											
Daily Doctor's Endorsement by a Sign											

DRUG : <u>SYN. NODOSIS</u>				Date Time	17/7						
Dose	Route	Frequency	Start Date								
6.5ml	PO	BD	17/7/26								
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandan</u>											
Additional Instructions:											
Daily Doctor's Endorsement by a Sign											

DRUG : <u>TAB. TROPAN</u>				Date Time	17/7	18/7	19/7	20/7	21/7	22/7	23/7
Dose	Route	Frequency	Start Date								
	PO	BD	17/7/26								
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandan</u>											
Additional Instructions: 1 tab = 2.5mg Dilute 1/2 tab in 10ml & give 5ml											
Daily Doctor's Endorsement by a Sign											

VERIFIED



Weight. Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses



I.V. FLUIDS CHART

Weight. 8.95kg Ward.

[illegible]

INFANT (<1 year)
Children's Observation &
Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 23/11 Time:

Doctor/Nurse/Family Concern? bam

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94

Heart Rate
(bpm)

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

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

Resp. Rate (bpm)
Over 1 Minute *

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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

Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: <u>22/10/2025</u> Time: <u>23/1</u>	
Doctor/Nurse/Family Concern? <u>6am</u> <u>10am</u> <u>1pm</u> <u>4pm</u> <u>7pm</u> <u>10pm</u> <u>2am</u>	
Today wt - 9.341 Temperature (F)	104 103 102 101 100 99 98 97 96 95 94
Heart Rate (bpm) and Blood Pressure (mmHg) * Note: BP does not score in early warning scoring	190 180 170 160 150 140 130 120 110 100 90 80 70 60 50
Heart Rate (Number)	<u>102b/m</u> <u>120b/m</u> <u>104b/m</u> <u>126b/m</u>
Resp. Rate (bpm) (Over 1 Minute) *	<u>26b/m</u> <u>29b/m</u> <u>26b/m</u> <u>26b/m</u>
Resp Distress	<u>Mod/ Severe</u> <u>None / Mild</u>
Receiving O ₂ (l/min)	<u>0.2l/min</u> <u>1.0l/min</u> <u>0.2l/min</u> <u>0.2l/min</u>
O ₂ Saturations (%)	<u>99%</u> <u>100%</u> <u>98%</u> <u>99%</u>
Conscious Level	<u>Normal</u> <u>Altered</u>
GCS *	<u>15/15</u> <u>15/15</u> <u>15/15</u> <u>15/15</u>
TOTAL SCORE	<u>1</u> <u>1</u> <u>1</u> <u>1</u>
Number of shaded boxes	<u>1</u> <u>1</u> <u>1</u> <u>1</u>
Pain Score	<u>2</u> <u>2</u> <u>2</u> <u>2</u>
Observer's Initials	<u>2</u> <u>2</u> <u>2</u> <u>2</u>

ACTIONS

NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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BAH-00643509 IP5-00176534

Master MIRZA SAAD BAIG

23-10-2025 0 Y 8 M 26 D (M)

Dr. DR.V.V.R.SATYA PRASAD

Doc. No. : RCH / FRM / CLINICAL / 124

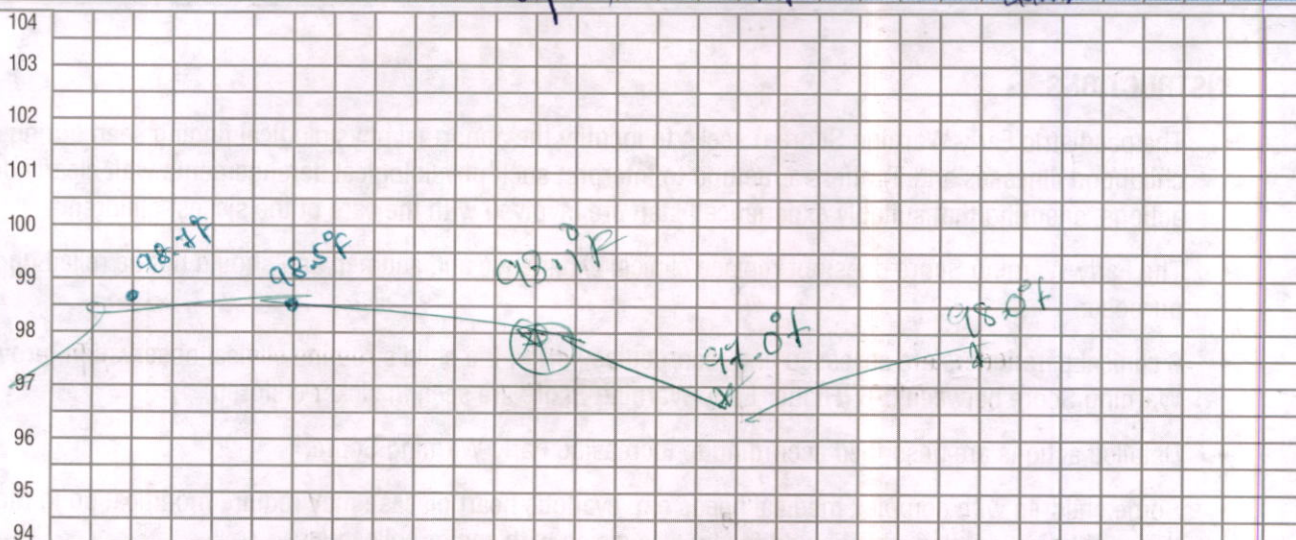
INFANT (<1 year)

Children's Observation &
Early Warning Scoring ChartPratiksha
Rainbow
Children's
Hospital
It takes a lot to treat the little.BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

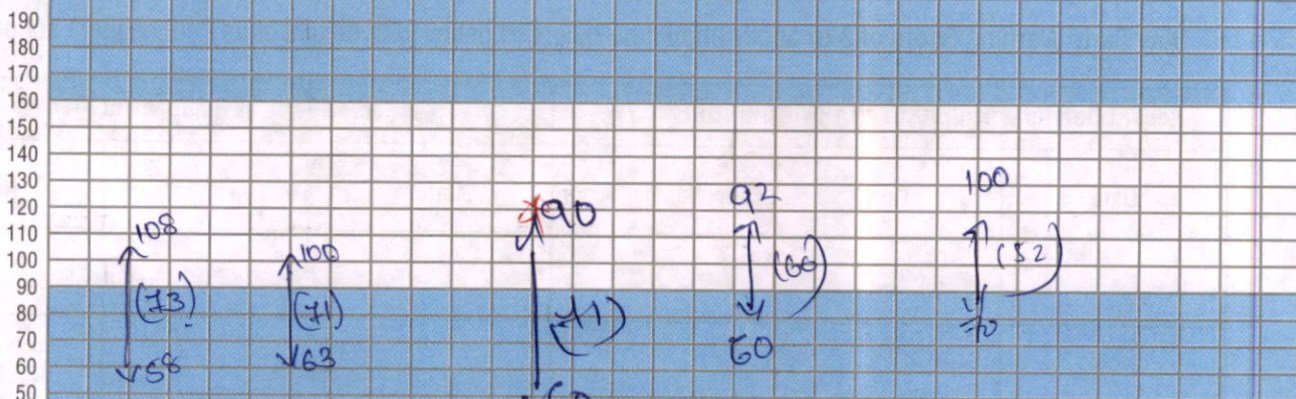
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 21/07/25 Time: 10:10 AM 10 PM 22/7

Doctor/Nurse/Family Concern?

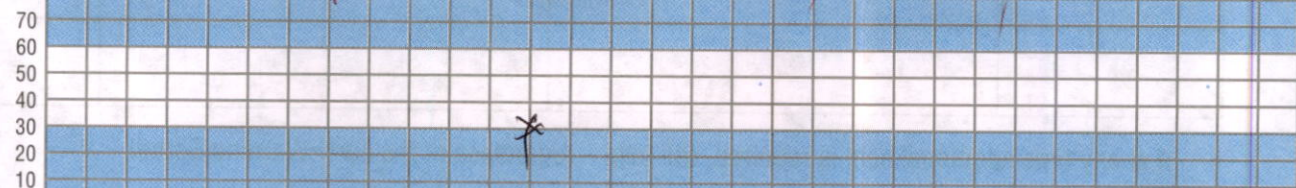
91.73kg
Temperature
(°F)104
103
102
101
100
99
98
97
96
95
94Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *Note:
BP does not score
in early
warning scoring190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

Heart Rate (Number)

108bpm 106bpm 101bpm 115bpm 102bpm

Resp. Rate (bpm)
(over 1 Minute) *70
60
50
40
30
20
10

Resp Rate (Number)

26bpm 27bpm 26bpm 26bpm 26bpm

Resp Mod/ Severe
Distress None / MildReceiving O₂ (l/min)
O₂ Saturations (%)

100% 100% 99% 96% 98%

Conscious Normal
Level Altered

GCS *

15/15 15/15 15/15 15/15 15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

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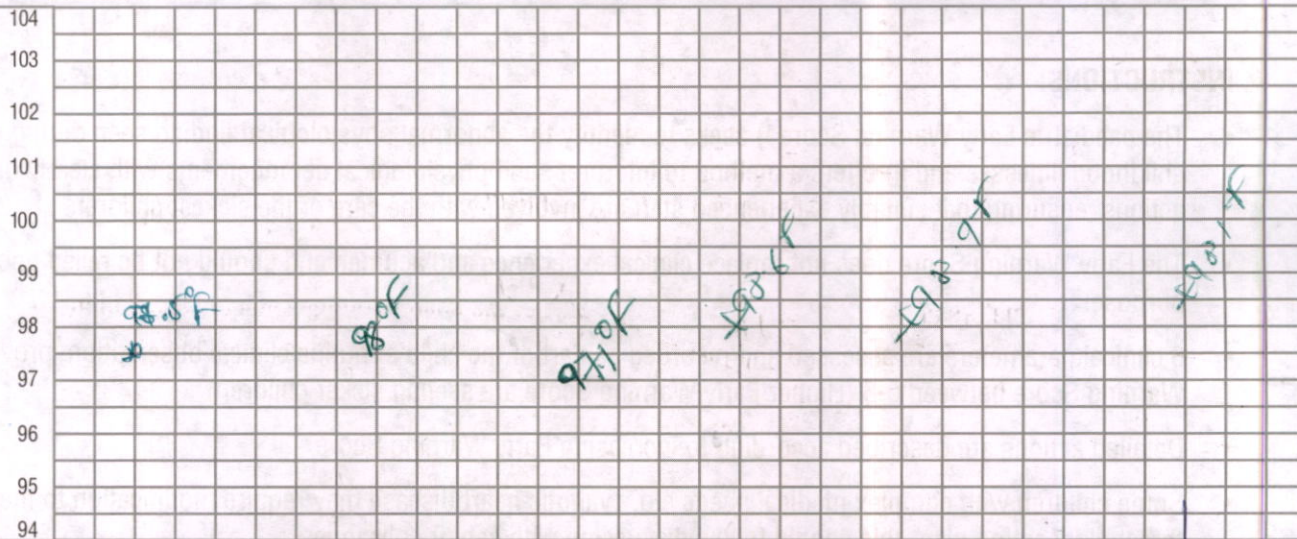
INFANT (<1 year) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 20/12/25 Time: 10am 1pm 6pm 10pm 2Am 6Am
Doctor/Nurse/Family Concern?

9.327
legs

Temperature
(F)

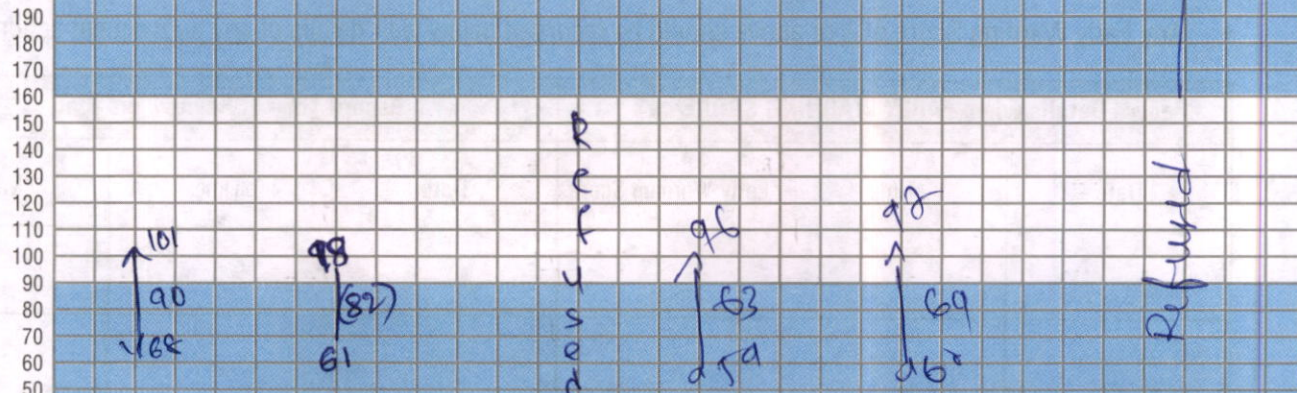


Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring



Heart Rate (Number)

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



Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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



Conscious Level
Normal / Altered

GCS *

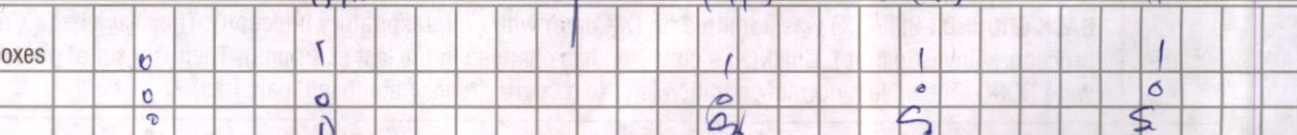


TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials



ACTIONS

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INFANT (<1 year)
Children's Observation &
Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

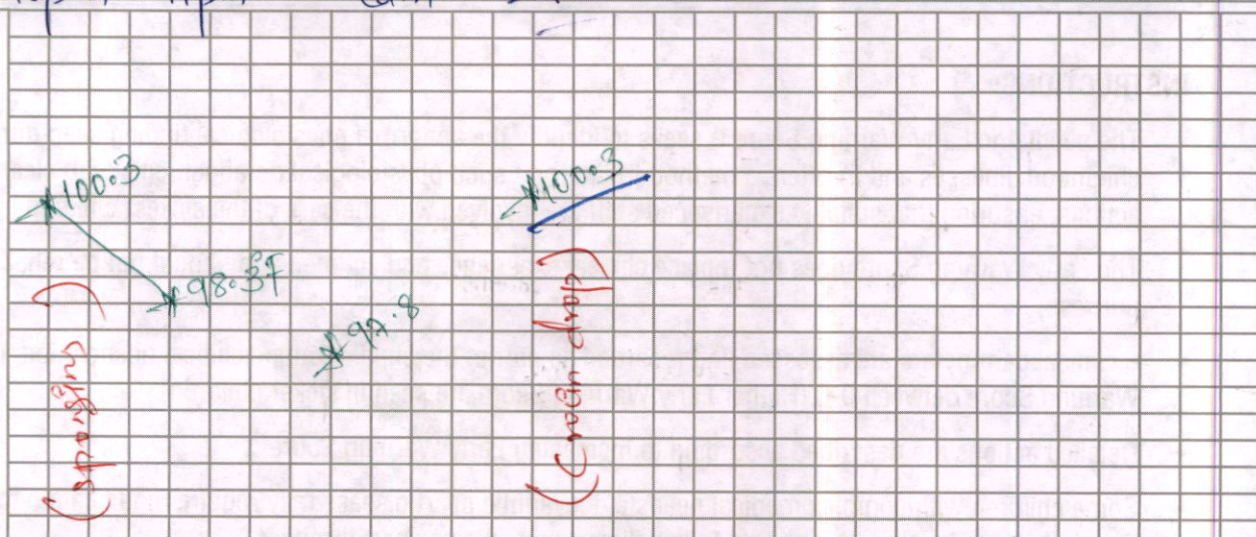
Date: 19/10/2025 Time: 20:37

Doctor/Nurse/Family Concern?

10pm 11pm 2am 7am

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94



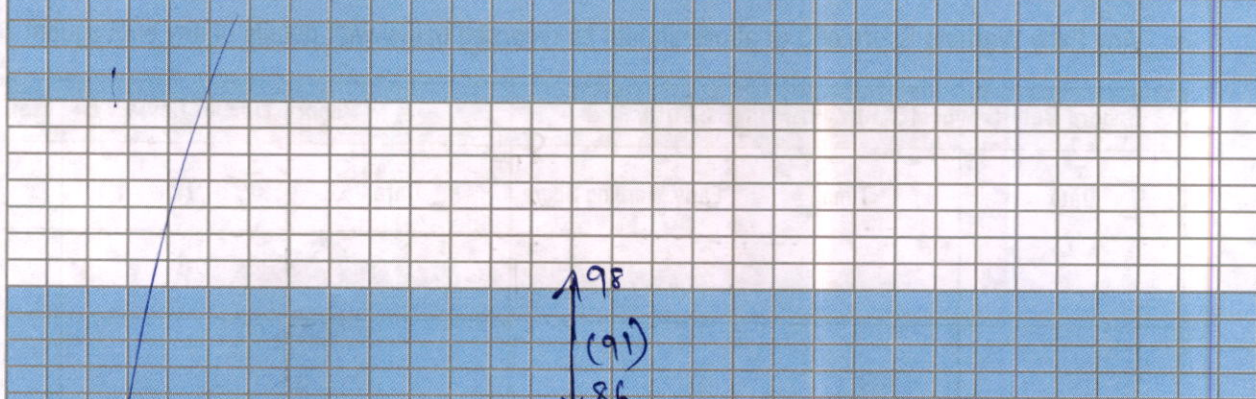
Heart Rate
(bpm)

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

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring



Heart Rate (Number)

sp. Rate (bpm)
over 1 Minute) *

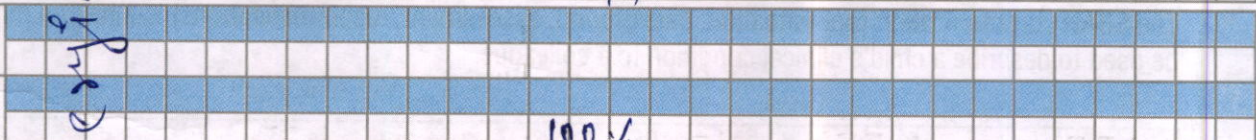
70
60
50
40
30
20
10



Resp Rate (Number)

Resp Distress Mod/ Severe
None / Mild

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



Conscious Level Normal
Altered

GCS *

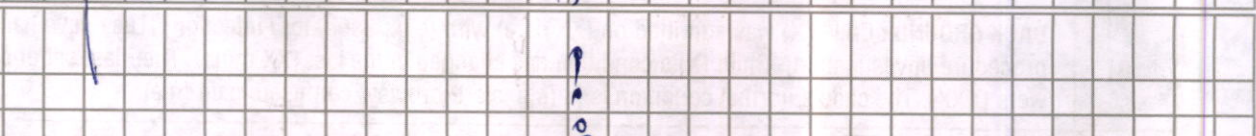


TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials



ACTIONS

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Date	Time	Early Warning Score	Date	Time	Name
		3P			
		(18)			
		28			

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BAH-00643509
Master MIRZA SAAD BAIG
23-10-2025 0 Y 8 M 25 D
Dr. DR.V.V.R.SATYA PRASAD (M)



(M)

No. : RCH / FRM / CLINICAL / 124

INFANT (<1 year)

Children's Observation &
Early Warning Scoring Chart

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

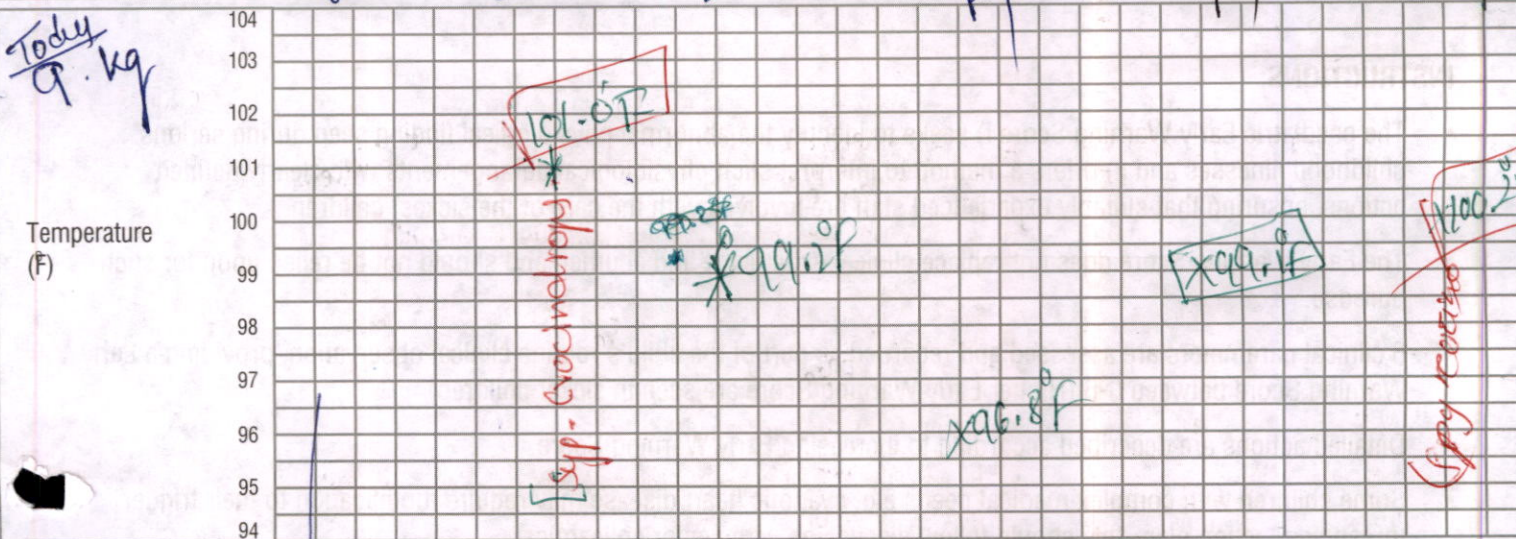
BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 19/11 Time:

Doctor/Nurse/Family Concern?

for 8:15 AM 9 AM 1 PM 6 PM 7:45 PM



Heart Rate (bpm)	190
and	180
Blood Pressure (mmHg) *	170
Note: BP does not score in early warning scoring	160
Heart Rate (Number)	150
	140
	130
	120
	110
	100
	90
	80
	70
	60
	50

Resp. Rate (bpm) (Over 1 Minute) *	70
Resp Rate (Number)	60
	50
	40
	30
	20
	10

Resp Distress	Mod/ Severe
Receiving O ₂ (l/min)	None / Mild
O ₂ Saturations (%)	
Conscious Level	Normal
GCS *	Altered
TOTAL SCORE	
Number of shaded boxes	
Pain Score	
Observer's Initials	

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INFANT (<1 year)
Children's Observation &
Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 18/12 Time:

Doctor/Nurse/Family Concern?

wt
9kg

Temperature
(F)

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

Heart Rate (Number)

Resp. Rate (bpm)
over 1 Minute) *

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

Conscious Normal
Level Altered

GCS *

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FLUID CHART

Sheet No. : 1

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

		Intake				Output					IV Site	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis 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										0	
	09:00 pm	25ml								103ml	0	Swal
	10:00 pm	25ml									0	Swal
	11:00 pm	25ml									0	Swal
	12:00 am										0	Swal
	01:00 am										0	Swal
Total Intake :						Total Output :						
	02:00 am	25ml									0	
	03:00 am	25ml								203	0	Swal
	04:00 am	25ml									0	Swal
	05:00 am	25ml									0	Swal
	06:00 am										0	Swal
	07:00 am										0	Swal
Total Intake :						Total Output : 303						
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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
18/12	08:00 am			28ml	/					2ml	0	
	09:00 am		milk	28ml	/		✓			307ml	0	
	10:00 am			28ml	/						0	Susha
	11:00 am	DNS			/						0	
	12:00 pm			28ml	/					500ml	0	
	01:00 pm			28ml	/					2ml	0	Susha
Total Intake :						Total Output :						
18/12	02:00 pm		milk	28ml	/						0	Susha
	03:00 pm			28ml	/						0	
	04:00 pm			28ml	/						0	
	05:00 pm	DNS		28ml	/					2ml	0	Susha
	06:00 pm				/		✓			22ml	0	
	07:00 pm				/						0	
Total Intake :						Total Output :						
18/12	08:00 pm			28ml	/						0	
	09:00 pm			28ml	/						0	
	10:00 pm			28ml	/						0	
	11:00 pm	DNS		28ml	/		✓			2ml	0	
	12:00 am			28ml	/					motion	0	
	01:00 am			28ml	/						0	
Total Intake :						Total Output :						
19/12	02:00 am			28ml	/						0	
	03:00 am			28ml	/						0	
	04:00 am			28ml	/						0	
	05:00 am	DNS		28ml	/						0	
	06:00 am			28ml	/						0	
	07:00 am			28ml	/						0	
Total Intake :						Total Output : 531						

Total 24 hrs. Intake	
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Total 24 hrs. Output	2.4cc/kg
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FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
19/12	08:00 am			28ml		/				169ml	0	
	09:00 am			28ml		/					0	Succi
	10:00 am	Oral milk		28ml		/					0	
	11:00 am	Oral milk		—		/					0	Succi
	12:00 pm	Oral milk		—		/					0	
	01:00 pm			—		/					0	Succi
Total Intake :						Total Output :						
19/12	02:00 pm			28ml		/					0	
	03:00 pm			28ml		/					0	Succi
	04:00 pm	Oral milk		28ml		/				2188 ml	0	
	05:00 pm	Oral milk		28ml		/					0	
	06:00 pm	Oral milk		28ml		/					0	Succi
	07:00 pm			28ml		/					0	
Total Intake :						Total Output :						
19/12	08:00 pm			28ml		/					0	
	09:00 pm		Oral	28ml		/					0	Chand
	10:00 pm	Oral		—		/				Emotion 188ml	0	
	11:00 pm	Oral		—		/					0	Chand
	12:00 am	Oral		28ml		/					0	
	01:00 am	Oral		28ml		/					0	Chand
Total Intake :						Total Output :						
20/12	02:00 am			28ml		/					0	
	03:00 am			28ml		/					0	Chand
	04:00 am	Oral		28ml		/					0	
	05:00 am	Oral		28ml		/				221ml	0	Chand
	06:00 am	Oral		28ml		/					0	
	07:00 am	Oral		28ml		/					0	Chand
Total Intake :						Total Output : 578						

Total 24 hrs. Intake

Total 24 hrs. Output

2.582 lcc / kg / hr

BAH-00643509 IP5-00176534
Master MIRZA SAAD BAIG
23-10-2025 0 Y 8 M 26 D (M)
Dr. DR.V.V.R.SATYA PRASAD



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
20/7	08:00 am			-						motion 139ml	0	Aruna
	09:00 am			28ml							0	
	10:00 am	DNS + NAHCO3		-							0	Aruna
	11:00 am			-							0	
	12:00 pm			28ml							0	Aruna
	01:00 pm			28ml							0	
Total Intake :						Total Output :						
20/7	02:00 pm			-						motion	0	Aruna
	03:00 pm	DNS		28ml							0	
	04:00 pm	+ NAHCO3		28ml						motion & stines	0	Aruna
	05:00 pm			-								
	06:00 pm			-								
	07:00 pm											
Total Intake :						Total Output :						
20/7	08:00 pm			28ml						131ml	0	
	09:00 pm			28ml							0	Susha
	10:00 pm	DNS + NAHCO3		28ml							0	
	11:00 pm			28ml							0	
	12:00 am										0	Susha
	01:00 am									200ml	0	
Total Intake :						Total Output :						
20/7	02:00 am			28ml							0	
	03:00 am			28ml							0	Susha
	04:00 am	DNS + NAHCO3		28ml							0	
	05:00 am			28ml							0	
	06:00 am										0	Susha
	07:00 am									217ml	0	
Total Intake : 364ml						Total Output : 687ml						
Total 24 hrs. Intake			Total 24 hrs. Output									
			3.120cc/kg									

BAH-00643509 IP5-00176534
Master MIRZA SAAD BAIG
23-10-2025 0 Y 8 M 26 D (M)
Dr. DR.V.V.R.SATYA PRASAD



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am		melk	28 ml								
	09:00 am			28 ml						not		Scanes
	10:00 am	DNS		28 ml						ues		
	11:00 am	10ml H ₂ O	melk							Suru		Crues
	12:00 pm									Pamper		
	01:00 pm									no chn		Crues

Total Intake :

Total Output :

	02:00 pm											
	03:00 pm	not	not							Pamper		
	04:00 pm	10ml H ₂ O								not		
	05:00 pm									Change		
	06:00 pm									215 ml		
	07:00 pm											

Total Intake :

Total Output :

	08:00 pm											
	09:00 pm			28 ml								
	10:00 pm			28 ml						12 ml		
	11:00 pm			28 ml								
	12:00 am			28 ml								
	01:00 am											

Total Intake :

Total Output :

	02:00 am											
	03:00 am			28 ml						108 ml		
	04:00 am			28 ml								
	05:00 am			28 ml								
	06:00 am											
	07:00 am											

Total Intake :

Total Output :

Total 24 hrs. Intake	
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Total 24 hrs. Output	1.976055 cc/kg/day
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FLUID CHART

Sheet No. :

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

		Intake			Output					IV Site	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		Thrombo-phlebitis Score
			Mouth	I.V	N.G							
22/7	08:00 am	1	Milk	28ml		/					0	Shah
	09:00 am	1		28ml		/	✓			168ml	0	
	10:00 am	Dnst	Milk	-		/					0	
	11:00 am	10ml		28ml		/					0	
	12:00 pm	HCO3		28ml		/					0	
	01:00 pm	1		28ml		/					0	
Total Intake :			(150ml)			Total Output :						
22/7	02:00 pm	1		28 ml		/					0	R
	03:00 pm	Dnst	Milk	28 ml		/				100ml	0	
	04:00 pm			-		/	✓				0	
	05:00 pm	10ml		28ml		/	✓			100ml	0	
	06:00 pm	HCO3		28ml		/					0	
	07:00 pm	1		28 ml		/					0	
Total Intake :			I- 140ml			Total Output : 200ml m-2						
22/7	08:00 pm	↑		28ml		/					0	Shah
	09:00 pm			28ml		/					0	
	10:00 pm	Dnst		28ml		/				168ml	0	
	11:00 pm	but HCO3		-		/					0	
	12:00 am	✓				/					0	
	01:00 am	✓				/					0	
Total Intake :			Total Output :						Emotion			
23/7	02:00 am	↑				/	✓			73ml	0	Shah
	03:00 am					/					0	
	04:00 am	Dnst				/					0	
	05:00 am	but HCO3				/					0	
	06:00 am	↓				/					0	
	07:00 am					/					0	
Total Intake :			Total Output :						609ml			

Total 24 hrs. Intake

Total 24 hrs. Output 271 cc/Kg



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 17/7/26

Assessment: Baby having Edema / UTI

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
9pm	→ Assess the general condition of the baby	9:15 pm	→ Assessed the general condition of the baby.	By done all the procedure baby condition is Improved
10pm	→ Monitor the vitals signs	10:15 pm	→ Monitored the vitals signs.	
12pm	→ plan send urine	11:15 pm	→ CUE, urine cbs.	
12pm	→ provide comfortable position → provide said rails	12	→ provided comfortable position → provided said rails	
6am	→ Maintain I/O chart	6:30	→ maintained I/O chart	
7:30	→ Administer medication as per doctor order	8am	→ Administered medication as per doctor order	

Re-Assessment: By done vitals

Special Notes: USG Abdomen / Monitor urine output

Nurse Signature: [Signature] Nurse Name: Swarna Date & Time: 18/7/26 @ 8am

BAH-00643509 IP5-00176534
Master MIRZA SAAD BAIG
23-10-2025 0 Y 8 M 24 D (M)
Dr. DR.V.V.R.SATYA PRASAD



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: 18/7/26

Assessment: Baby having edema related to disease condition

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8Am	Assess the pt general Condition	9Am	Assessed the pt general Condition	By doing all implementation as per order
10Am	monitor vital sign	11Am	monitor vital sign	
	maintain DO chart		maintain DO chart	
12pm	provide comfortable position	1P.m	provide comfortable position	
2pm	provide nebulization	3pm	provided nebulization	
6pm	Administered medication	7pm	Administered medication	

Re-Assessment:

Special Notes: monitor vitals monitor

Nurse Signature: Sm

Nurse Name: Sushma 0177121

Date & Time: 18/7/26 8PM

SAH-00643509 IP5-00176534
Master MIRZA SAAD BAIG
23-10-2025 0 Y 8 M 25 D
Dr. DR.V.V.R.SATYA PRASAD (M)

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 18/11/26

Assessment: Baby having pyrexia

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the general condition of the patient.	8pm	* Assessed the general condition of the patient	By doing all the procedure the patient can be stable.
10p	* maintain personal hygiene.	10p	* maintained personal hygiene.	
2am	* monitor urine out put.	2am	* monitored urine out put.	
6am	* monitor vitals.	6am	* monitored	

Re-Assessment: Monitor vitals.

Special Notes:

Nurse Signature: [Signature] Nurse Name: Dmya Date & Time: 19/11/26, 8am

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☒ Night

Date: 19/7/26

Assessment: Baby having poor oral Intake

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	→ Assess the general condition of the baby	8:5 AM	→ Assessed the general condition of the baby.	By done all the procedure baby condition is Improved.
9am	→ Monitor the vitals signs	10:5 am	→ Monitored the vitals signs	
11am	→ plan for IV fluids.	12PM	→ DNL 84 10 ml HCO ₃ 28ml/hr.	
2p	→ no for come for round	3pm	→ plan for to send CRP, CRP,	
6pm	→ provide comfortable position	6:30 pm	→ provided comfortable position.	
7:30 PM	→ Administer medication as per doctor order	8pm	→ Administered medication as per doctor order	

Re-Assessment:

Special Notes:

Monitor urine output

Nurse Signature: 

Nurse Name: Swarna

Date & Time: 19/7/26 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 19/12/20

Assessment: pt having Fever

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the pt General Condition	8:10pm	→ Assessed the pt General Condition	pt is stable
10pm	→ Check the Vital signs	10:10pm	→ Checked the Vital signs	
12am	→ Plan for Administration medication	12:10am	→ Providing Medication As per doctor Order	
2am	→ Plan for S/O Chart	2:10am	→ Maintaining S/O Chart	
8am	→ Plan for Comfortable Position	8:10am	→ Providing Comfortable Position	

Re-Assessment: Re-Assessment Every 4th hrly

Special Notes:

Nurse Signature: @y

Nurse Name: Chandona

Date & Time: 20/12/20 2:30am

BAH-00643509
Master MIRZA SAAD BAIG
23-10-2025 0 Y & M 26 D (M)
Dr. DR.V.V.R.SATYA PRASAD

NURSING CARE RECORD

Shift: ☐ Afternoon ☐ Night

Date: 20/7/26

Assessment: Baby has poor intake

- 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 general condition of the baby. 9:30am Dr. satya sir advis CBP, CRP, RP₂ tlm. 2pm monitor vital sings and recored. IVF DNS + NAHCO₃ 28ml/hr ongoing. 6pm Administred medication as per doctor orders.		8am Assessed the general condition of the baby 9:30am Dr. satya sir advised CBP, CRP RP₂ tlm 2pm monitored vital sings & recored IVF DNS + NAHCO₃ 28ml/hr ongoing 6pm Administred medication as per doctor orders.	by done all these to improve baby condition.

Re-Assessment:

Special Notes:

CBP, CRP, RP₂

Nurse Signature: Nurse Name:

Date & Time: 20/7/26 @ 5pm

BAH-00643509 IP5-00176534
 Master MIRZA SAAD BAIG
 23-10-2025 0 Y 8 M 26 D
 Dr. DR.V.V.R.SATYA PRASAD (M)

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: 20/12/26

Assessment: Baby having poor intake

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the pt general condition	8pm	Assess the pt general condition	By done all implementation as per order
9pm	Monitor vital sign	10pm	Monitor vital sign	
10pm	Monitor I/O Chart	11pm	Monitor I/O Chart	
11pm	Provide Comfortable position	12Am	provided Comfortable position	
12Am	Administer medication	6Am	administered medication	

Re-Assessment:

Special Notes:

Nurse Signature: Sushma

Nurse Name: Sushma

Date & Time: 21/12/26 @ 8Am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 21/07/26

Assessment: Baby having edema pre

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the baby general Condition and monitor the vitals and record.	8:10am	Assessed the baby general Condition and monitored the vitals and recorded.	By doing all above procedure baby Condition improving well.
9am	After rounds doctor advice to do LFT, dengue nls, Igm. in sample.	9:30am	After rounds doctor advised to do LFT in same sample. It is done.	
10am	Dr. Nabeel sir Consultation.	10:30am	To do Dengue (nls, Igm)	
11am	Measure Urine Output daily.	11:10am	Dr. Paediatric Surgeon Consultation.	
12pm	Continue medication as per chart & nebulization - 3% nls 3ml BD.	11:30am	measure urine output daily.	
1pm	Continue ONS + HCO ₃ 10ml 25ml/hr.	12:30pm	Continued medication as per chart 4 neb. 3% nls 3ml BD.	
2pm	Ensure the safety needs	1:30pm	Continued ONS + HCO ₃ 10ml/hr.	
		2:10pm	Ensured the safety needs	

Re-Assessment: Re assessment done

Special Notes: Dengue (nls, Igm), Paediatric Surgeon's Consultation.

Nurse Signature: Smruti

Nurse Name: K. Sravanthi ID: 607662

Date & Time: 21/07/26 @ 2pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 21/11/25

Assessment: Baby Having Edema

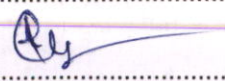
Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the Baby General Condition, monitor vitals & Record	2:30pm	→ Assessed the Baby General, monitored vitals & Recorded	By 4u this doc pt condition improved
3pm	→ maintain no clear	4pm	→ maintained no clear	
5pm	→ plan to do send LFIL Dengue NS 1gm	6pm	→ planned to do send LFIL Dengue NS 1gm	
8pm	→ Administer medication as per doctor order	8pm	→ Administered medication as per doctor order	

Re-Assessment:

Special Notes:

Nurse Signature: 

Nurse Name: Apurva Kulkarni (081268)

Date & Time: 21/11/25 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 21/07/26

Assessment:

baby having hemodynamically stable (no fever spikes)

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the pt general condition.	8/10am	Assessed pt general condition.	by done above care the care pt condition now
10pm	provide comfortable position.	10/10am	provided comfortable position.	
12am	monitor vital signs.	12/10am	monitored vitals & recorded.	
	maintain i/o chart		maintained i/o chart	
	Ensure safety.	2/110a	Ensured safety.	
2am	Administer medications as per chart	6/10a	Administered medications	
6am		8/10a	as per chart	
8am				

Re-Assessment:

monitored vitals & maintained i/o chart

Special Notes:

strictly i/o chart (D/W + 10ml H₂O) meals were not pt

Nurse Signature:

[Signature]

Nurse Name:

[Signature]

Date & Time:

22/7/26 @ 8am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 22/11/26

Assessment: Baby Having Edema

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
9am	→ Assess the Baby General Condition, monitor vitals Record	9:10am	→ Assessed the Baby General Condition, monitored vitals Recorded	By An this done pt condition is improved
10am	→ provide comfortable position	10:20am	→ provided comfortable position	
11am	→ maintain I/O Check	11:30am	→ maintained I/O Check	
12pm	→ Continue IV fluids Dns + 10ml H ₂ O (28ml/hr)	12:30am	→ Continued IV fluids Dns + 10ml H ₂ O (28ml/hr)	
1pm	→ Administer medication as per doctor order	2pm	→ Administered medication as per doctor order	

Re-Assessment:

Special Notes: plan to do CBP, Rf, OI/PT, T/m, Gm

Nurse Signature:

Nurse Name: Shailaja

Date & Time: 22/11/26 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 22/7/26

Assessment: Baby having Edema

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the baby general condition & monitor the vital sign.	2:30 pm	→ Assessed the baby general condition & monitored the vital sign.	By doing all the procedure Baby condition is improved slowly.
4pm	→ Maintain the Ilo chest	4:30 pm	→ Maintained the Ilo chest	
5pm	→ Administer the medication as per doctor order	5:30 pm	→ Administered the medication as per doctor order	
6pm	→ provide the comfortable position.	7:30 pm	→ provided the comfortable position.	

Re-Assessment:

Special Notes:

CBP/ RP₂/ OT/ PT LFT T/M @ 6am

Nurse Signature: V. Ravina

Nurse Name: V. Ravina (607729)

Date & Time: 22/7/26 @ 8pm

BAH-00643509
Master MIRZA SAAD BAIG
23-10-2025 0 Y 8 M 29 D
Dr. DR.V.V.R.SATYA PRASAD (M)

NURSING CARE RECORD

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Children's
Hospital
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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 22/07/26

Assessment: baby having UTI

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the baby general condition	8:10 pm	Assessed pt general condition,	by doing above all the care pt condition normal
10pm	provide comfortable position.	10:10 pm	provided comfortable position,	
12am	monitor vital signs	12:10 am	monitored vitals & recorded	
12am	maintain i/o chart		maintained i/o chart	
2am	doctor advised to do CBP	2:10 am	Ongoing i/o fluid Dns + 10ml HCO ₃	
2am	CRP ₂ , Lft H/m	6:10 am	Ensured safety,	
6am	Ensure safety,		Administered medications (Antibiotics)	
8am	Administer medication as per Chd	8:10 am	as doctor Prescribed	

Re-Assessment: monitored vitals strictly maintain i/o chart

Special Notes: CBP, CRP₂, Lft H/m

Nurse Signature: [Signature] Nurse Name: Anuradha Date & Time: 23/07/26 2pm

BAH-00643509 IP5-00176534
 Master MIRZA SAAD BAIG
 23-10-2025 0 Y 8 M 29 D (M)
 Dr. DR.V.V.R.SATYA PRASAD

NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ 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

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sulye prasad Department: Nephro Date of Admission: 17/11/25

SITUATION		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:						
BACKGROUND	Area	Shift Time						
	Medical Condition (Any special condition to be noted):	ER 8:30 AM - 12:00 PM	1st floor 12:00 PM - 2:00 PM	1st floor 2:00 PM - 4:00 PM	1st floor 4:00 PM - 6:00 PM	1st floor 6:00 PM - 8:00 PM	1st floor 8:00 PM - 10:00 PM	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	98.1°C	96.1°F	97.1°F	98.2°C	96.3°F	98.1°F
		Res:	26b/m	24	28	28b/m	28	28b/m
		SpO ₂ :	98%	100%	100%	99%	99	100%
		Pulse:	128b/m	120	120	118b/m	107	111b/m
		BP:	89/51	90/64	96/60	99/62	96/70	98/60
		Fall Risk Score:	03	03	03	12	12	12
	Pain Score:	0/0	0/10	0/10	0/10	0/10	0/10	
	Recommendations	Safety Needs:	Yes	Yes	Yes	Yes	Yes	Yes
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Others Specify:		NO	NO	NA	NA	NA	NA	
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:		NO	NA	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NO	NA	NA	NA	NA	NA	
Handed Over By Name :		Annab	Swarna	Lushma	Ding	Swarna	Chandana	
Signature :								
Date:		17/11/25	18/11/25	18/11/25	19/11/25	19/11/25	20/11/25	
Time:		8:30pm	8am	8pm	6am	8pm	8am	
Taken Over By Name :		Swarna	Lushma	Ding	Swarna	Chandana	Aranya	
Signature :								
Date:		18/11/25	18/11/25	18/11/25	19/11/25	19/11/25	20/11/25	
Time:		8:30pm	8am	8pm	8am	8pm	8pm	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Satya Prasad Department: Nephrology Date of Admission: 17/07/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known					
	<u>Acute AFI</u>		If Yes Specify:					
BACKGROUND	Area	Shift Time	<u>1st floor</u> <u>8-8pm</u>	<u>1st floor</u> <u>8am-2pm</u>	<u>1st floor</u> <u>8am-2pm</u>	<u>1st floor</u> <u>2pm-8pm</u>	<u>2nd floor</u> <u>8pm-8am</u>	<u>1st floor</u> <u>8am-2pm</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>98°F</u>	<u>98.1°F</u>	<u>98.5</u>	<u>97.9°F</u>	<u>98.0</u>	<u>98.2°F</u>
		Res:	<u>26b/m</u>	<u>26</u>	<u>26br</u>	<u>28b/m</u>	<u>26</u>	<u>30b/m</u>
		SpO ₂ :	<u>99%</u>	<u>99%</u>	<u>99.1</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>
		Pulse:	<u>112b/m</u>	<u>112</u>	<u>111</u>	<u>120b/m</u>	<u>112b/m</u>	<u>110b/m</u>
		BP:	<u>112/6</u>	<u>100/6</u>	<u>100/60</u>	<u>90/60</u>	<u>98/60</u>	<u>90/59</u>
		Fall Risk Score:	<u>13</u>	<u>13</u>	<u>13</u>	<u>13</u>	<u>13</u>	<u>13</u>
Pain Score:		<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	
Recommendations	Safety Needs:		<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:			<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :			<u>Aruna</u>	<u>Sushma</u>	<u>K. Sravanthi</u>	<u>Aparanjitha</u>	<u>Shailaja</u>	
Signature :			<u>Aruna</u>	<u>Sushma</u>	<u>K. Sravanthi</u>	<u>Aparanjitha</u>	<u>Shailaja</u>	
Date:			<u>20/7</u>	<u>21/7</u>	<u>21/07/26</u>	<u>21/7</u>	<u>22/7</u>	
Time:			<u>5pm</u>	<u>8am</u>	<u>@ 2pm</u>	<u>@ 8pm</u>	<u>@ 2pm</u>	
Taken Over By Name :			<u>Sushma</u>	<u>K. Sravanthi</u>	<u>Aparanjitha</u>	<u>Shailaja</u>	<u>Ranjana</u>	
Signature :			<u>Sushma</u>	<u>K. Sravanthi</u>	<u>Aparanjitha</u>	<u>Shailaja</u>	<u>Ranjana</u>	
Date:			<u>20/7</u>	<u>21/07/26</u>	<u>21/7</u>	<u>21/7</u>	<u>22/7</u>	
Time:			<u>8pm</u>	<u>@ 8am</u>	<u>@ 2pm</u>	<u>@ 8am</u>	<u>@ 2pm</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. S. Satya Prasad Department: Nephrology Date of Admission: 12/7/24

SITUATION	Diagnosis: <u>ASIS: AFI</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	Area	Shift Time	<u>1st floor</u> <u>2nd floor</u>	<u>after</u> <u>shift</u>				
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>				
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:	<u>97.8°F</u>	<u>98.0°F</u>				
		Res:	<u>26b/m</u>	<u>26</u>				
		SpO ₂ :	<u>100%</u>	<u>99%</u>				
		Pulse:	<u>126b/m</u>	<u>12</u>				
		BP:	<u>99/68</u>	<u>98/70</u>				
		Fall Risk Score:	<u>13</u>	<u>13</u>				
Pain Score:	<u>0/10</u>	<u>0/10</u>						
Recommendations	Safety Needs:		<u>Yes</u>	<u>Yes</u>				
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:		<u>NA</u>	<u>NA</u>				
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>				
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>					
Handed Over By Name :		<u>Ravina</u>	<u>Ankita</u>					
Signature :		<u>[Signature]</u>	<u>[Signature]</u>					
Date:		<u>22/7</u>	<u>23/7</u>					
Time:		<u>@ 8pm</u>	<u>@ 8am</u>					
Taken Over By Name :		<u>Ankita</u>	<u>Chand</u>					
Signature :		<u>[Signature]</u>	<u>[Signature]</u>					
Date:		<u>23/7</u>	<u>23/7</u>					
Time:		<u>@ 8pm</u>	<u>@ 8am</u>					



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

BAH-00643509 IP5-00176534
Master MIRZA SAAD BAIG
23-10-2025 0 Y 8 M 26 D (M)
Dr. DR.V.V.R.SATYA PRASAD



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THE HUMPTY DUMPTY SCALE

22/7 23/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4			
	3 to less than 7 years old	3	2	4			
	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	2	2			
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2			
	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			3	13			

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		44	44			
Call device within reach		44	40			
Wheels Locked		44	40			
Room free of clutter		44	44			
Adequate Lighting		44	44			
Wheel Chair Support		no	no			
Other Intervention(s) Specify		no	no			
Nurse's Name :		Abhis	Abhis			
Signature :		Abhis	Abhis			
Date :		22/7	23/7			
Time :		06:00	06:00			

BAH-00643509 IP5-00176534
Master MIRZA SAAD BAIG
23-10-2025 0 Y 8 M 24 D (M)
Dr. DR.V.V.R.SATYA PRASAD



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THE HUMPTY DUMPTY SCALE

17/12 18/12 19/12 20/12 21/12

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

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	Yes	✓	Yes	Yes	Yes	Yes
Call device within reach	Yes	✓	Yes	Yes	Yes	Yes
Wheels Locked	Yes	✓	Yes	Yes	Yes	Yes
Room free of clutter	Yes	✓	Yes	Yes	Yes	Yes
Adequate Lighting	Yes	✓	Yes	Yes	Yes	Yes
Wheel Chair Support	No	X	NA	NA	NA	NA
Other Intervention(s) Specify	No	X	NA	NA	NA	NA
Nurse's Name :		Aashu	Shrey	Shrey	Shrey	Shrey
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :		17/12	18/12	19/12	20/12	21/12
Time :		6:30	6:30	6:30	6:30	6:30

BRADEN 'Q' SCALE

					Date :	21/2	22/2	23/2	
					Time :	5 AM	6 PM	6 AM	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	3	3	3		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	2	2	2		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	3	3	3		
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	3	3	3		
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4		
TOTAL SCORE					23	23	23		
Evaluator's Name					Pishy	Ankur	Chabe		

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

BAH-00643509
Master MIRZA SAAD BAIG
23-10-2025 0 Y 8 M 24 D (M)
Dr. DR.V.V.R.SATYA PRASAD

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 :	14/12	15/12	16/12	20/12
					Time :	6:30	6:45	6:55	6:55
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		3	3	3	3
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		2	2	2	2
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		3	3	3	3
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		3	3	3	3
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
					TOTAL SCORE	28	28	28	28
					Evaluator's Name	Aus	2	2	2

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

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

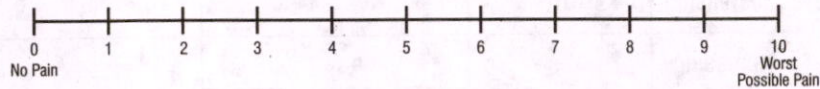
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

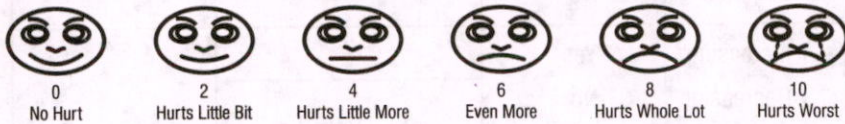
Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
21/2	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Susha
21/02	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shree
21/2	10p	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Anita
22/2	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Chitra
22/2	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shree
22/2	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Anita
23/2	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Anita
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

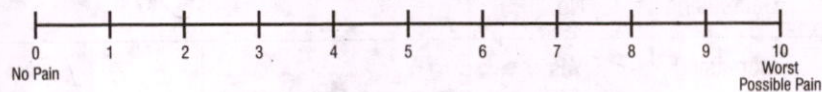
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs 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

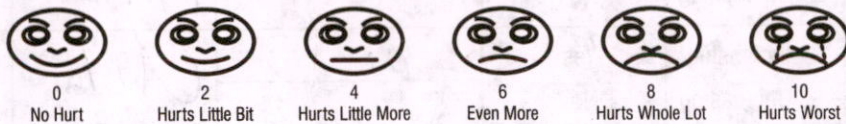
Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
17/7/22	6:30 PM	0/10	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NO NO	Amul
18/7	2:30 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Amul
18/7	11 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sushma
18/7	11 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Drugs
19/7	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Drugs
19/7	8 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	See
19/7	4 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chondane
20/7	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chondane
20/7	2 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Amul
20/7	11 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sushma

Re-assessment Frequency:

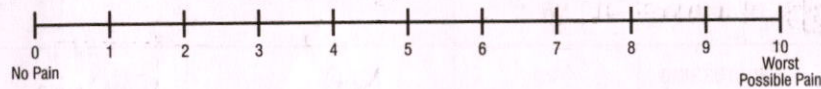
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

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)



Wong - Baker (Pediatrics) Above 7 Years



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
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Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0	0	0	0	0	Cannula removed on 20/7/25
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-	-	-	-	-	-	-	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-	-	-	-	-	-	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-	-	-	-	-	-	-	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-	-	-	-	-	-	-	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-	-	-	-	-	
Signature of the Nurse				Aruna Arundhathi	Arundhathi	Arundhathi	Arundhathi	Arundhathi	Arundhathi	Arundhathi	Arundhathi	Arundhathi	

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

Signature of Shift In Charge :

Signature : Pulakesh Name : Pulakesh

Signature of Ward In Charge :

Signature : Neeraja Devi Name : Neeraja Devi

CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

BAH-00643304 IPS-001/0534
Master MIRZA SAAD BAIG
23-10-2025 0 Y 8 M 25 D (M)
Dr. DR.V.V.R.SATYA PRASAD

CHECKLIST FOR THROMBOPHLEBITIS

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	17/17 DAY-1			18/12/26 DAY-2			19/12 DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	6	6	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			0	-	-	-	-	-	-	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			0	-	-	-	-	-	-	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	ER		0	-	-	-	-	-	-	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			0	-	-	-	-	-	-	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			0	-	-	-	-	-	-	
Signature of the Nurse							Sul Butiq Sush			Anusree Chandel			

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 : Name : Sourav

Signature of Ward In Charge :

Signature : Name : Noor

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part

Patient's / Learner Language: English 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		
17/7	6:30 m	10	Full Risk Education	met	1	CU	1	1	no	kal
18/7/26	9am	9	DBM feeds	m	1	0	1	1	-	Nirbhay

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

AFI

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
17/10/25 7pm	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fever X 2day	H-Stability	WFDNS		☐ Nursing ☐ Others:
17/10/25 7pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fever X 3days	H-Stability	IVF DNS		☐ Medical ☐ Others:
18/10/25 9am	☐ Medical ☐ Nursing ☒ Others: dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	AFI ? UTI	DBM feeds + stage II weaning foods + IEC advised	<u>RD 2</u> E: - 98 kcal/kg/d P: - 1.8 g/kg/d	Niritha	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

BAH-00643509 IP5-00176534
Master MIRZA SAAD BAIG
23-10-2025 0 Y 8 M 24 D (M)
Dr. DR.V.V.R.SATYA PRASAD



DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: 19/7/26

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

☐ Medication ☒ Yes ☐ No

☐ Bathing ☒ Yes ☐ No

☐ Eating ☒ Yes ☐ No

☐ Walking ☐ Yes ☒ No

☐ Dressing ☐ Yes ☒ No

☐ Toileting ☐ Yes ☒ No

Explained to mother

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: personal hygiene

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Swarna

Date and Time: 17/7/26 @ 8:30pm

PATIENT TRANSFER FORM

Patient Name & IHD No BAH-00643509 IP5-00176534 Master MIRZA SAAD BAIG 23-10-2025 0 Y 8 M 24 D (M) Dr. DR.V.V.R.SATYA PRASAD 		Date & Time of Admission 17/7/26 at 6:02 pm	Date & Time of Transfer Order 17/7/26 at 8:30 pm
		Transfer Ordered by Dr. Nandan	Reason for Transfer Admission
From Unit ER	To Unit 117	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 75	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what? op file		Patient shifted with ID band: Yes ☒ No ☐ If No:
Number of Imaging Films			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Plarn	4	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Anand/Kanthave		Name of Person Ordered Transfer Dr. Nandan	
Patient & Clinical Records Received by : Swarena			
Date & Time of Patient Received : 17/7/26 @ 8:40 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

Total
Total Intake
Total 24 hr.
Docu. No. : RCHF

117

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 18/12/26 Time: 9am

Weight: 8.95 kgs Centile: >25th

Height: 70 cms Centile: >25th

Inference: well child

RDA: — Calories: 98 kcal/kg/d Protein: 1.8 g/kg/d

Diet Recommendations: DBM feeds

Re-Assessment: Stage II weaning foods +ccr advised

Food Allergies: No Veg/Non-veg: Veg

Diagnosis: AFI ? urinary tract infection

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: R.

GROWTH CHART (BOYS)

Birth to 36 months: Boys
Length-for-age and Weight-for-age percentiles

2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles

BAH-00643509 IP5-00176534
Master MIRZA SAAD BAIG
23-10-2025 0 Y 8 M 24 D (M)
Dr. DR.V.V.R.SATYA PRASAD

Doc. No. : RCH / FRM / CLINICAL / 124

INFANT (<1 year)
Children's Observation &
Early Warning Scoring Chart

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

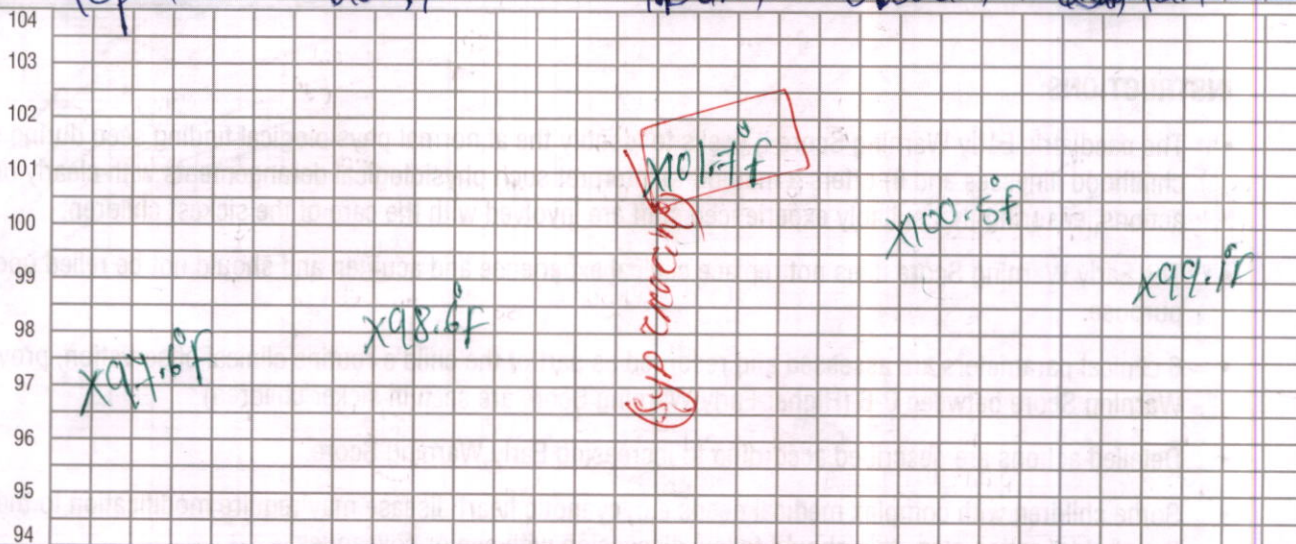
Bi
BY RAINBOW
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

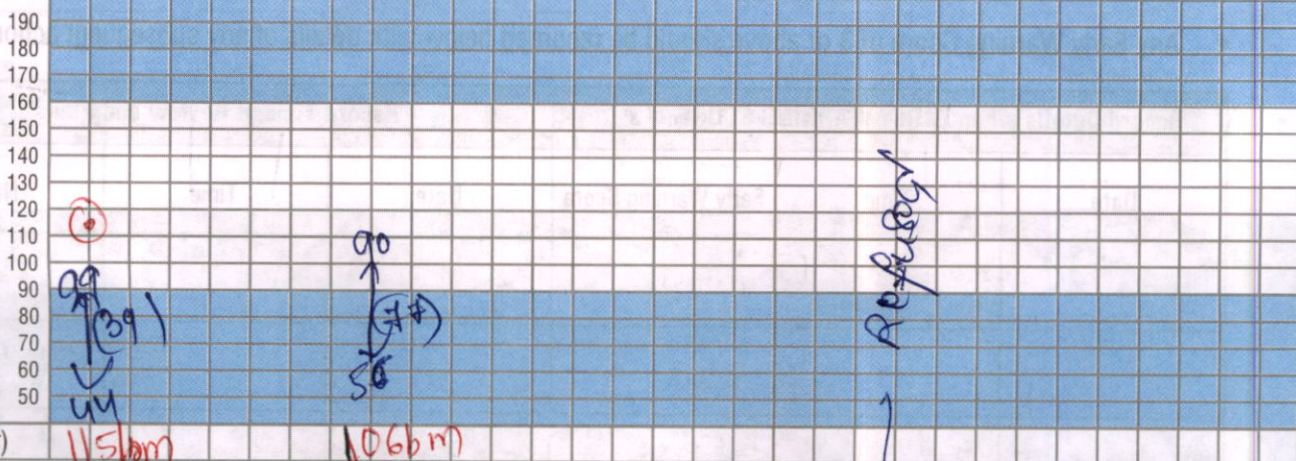
Date: 17/12/26 Time:

Doctor/Nurse/Family Concern? 10pm 2am 4.5am 5.30am 6.30am

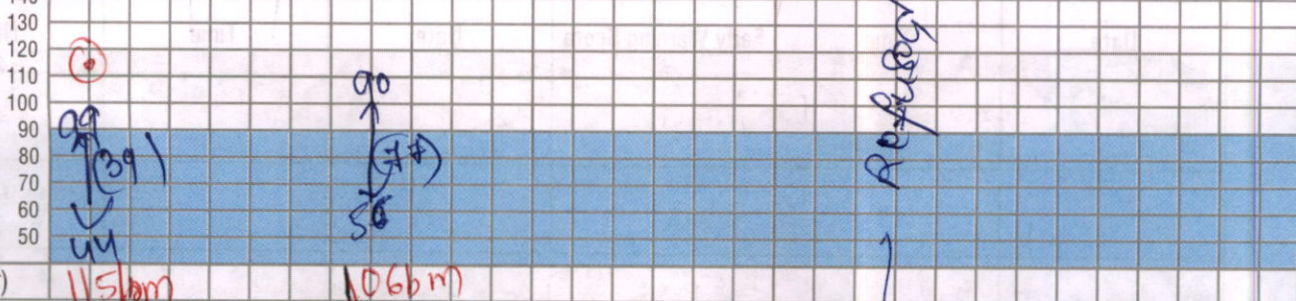
Temperature
(F)



Heart Rate
(bpm)



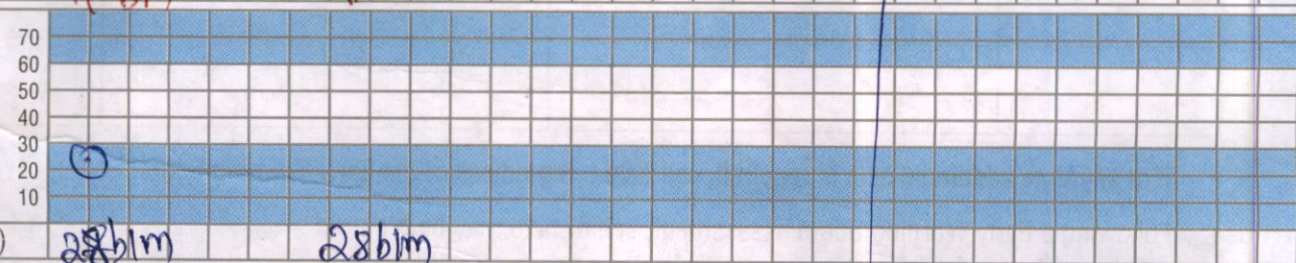
Blood Pressure
(mmHg) *



Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

Resp. Rate (bpm)
over 1 Minute *



Resp Distress Mod/ Severe
None / Mild

Receiving O₂ (l/min)

Daily Notes:

19/7/20
11 AM Chell is stable Intake is fair.

Continue τ DBM feeds τ stage II weaning foods

Nele

20/7/26
11 AM Child is stable Intake is optimal

Continue to DBM Feeds to Stage II weaning Foods.

Negative

23/2/22
gam Child is stable. Intake is fair

continue to stage II weaning foods

WHE

- 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.

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 18/12/26 Time: 9am

Weight: 8.95 kgs Centile: >25th

Height: 70 cms Centile: >25th

Inference: well child

RDA: — Calories: 98 kcal/kg/d Protein: 1.8 g/kg/d

Diet Recommendations: DBM feeds

Re-Assessment: Stage II weaning foods + see advised

Food Allergies: NO Veg/Non-veg: Veg

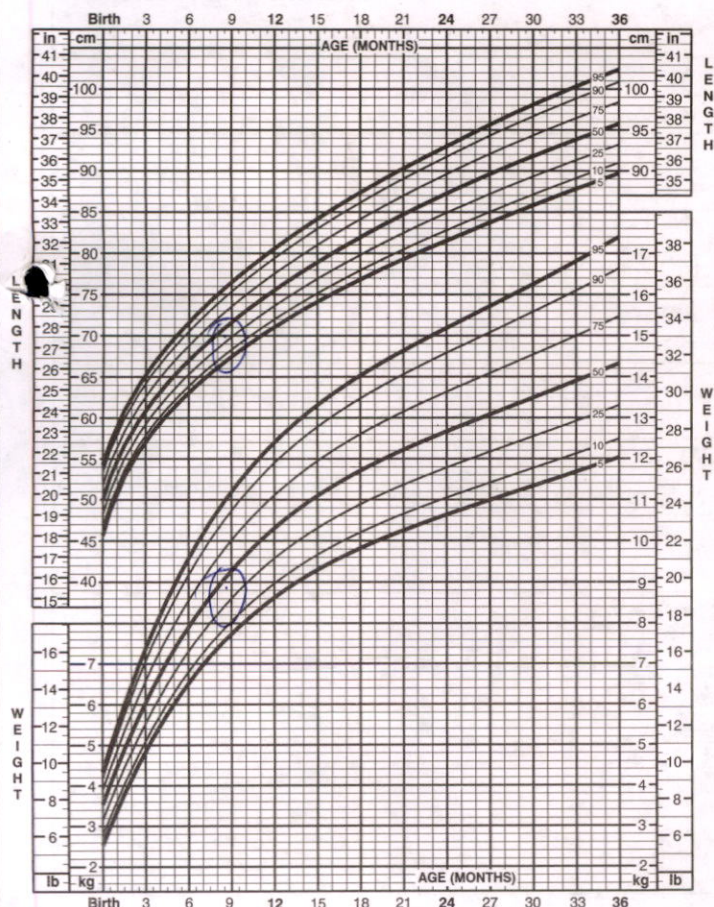
Diagnosis: AFI ? urinary tract infection

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

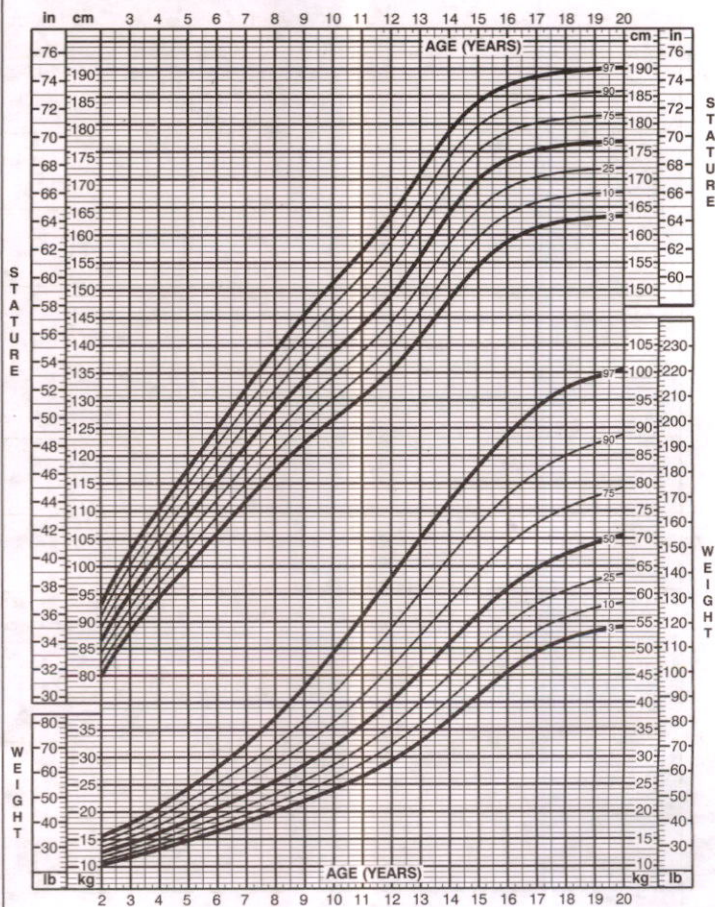
Patient's Signature: [Signature]

GROWTH CHART (BOYS)

Birth to 36 months: Boys
Length-for-age and Weight-for-age percentiles



2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles



Dietician's Name: Nikitha

Dietician's Signature: Nikitha

Daily Notes:

19/7/26
11AM

Child is stable Intake is fair.

Continue to DBM Feeds to stage II weaning foods

- Nelson

20/7/26
11AM

Child is stable Intake is Optimal

Continue to DBM Feeds to stage II weaning Foods.

- Nelson

23/7/26
8AM

Child is stable. Intake is fair

continue to stage II weaning foods

WHE