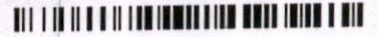


ADMISSION SHEET



Registration Details :

Admission No : IP5-00176232

Admit Date : 10-Jul-2026

Admit Time : 07:10 PM UHID : BAH-00424850

Patient Details :

Patient Name : Master SHIVCHARAN

Age : 7 Y 0 M 25 D

Guardian : Mr DHANRAJ

DOB : 15-06-2019

Gender : Male

Religion :

Occupation :

Marital Status : Single

Address (H) : H NO 1/3/2 , JONNEKENI , SANTHPUR , AURAD
(TQ) Santpur Bidar Karnataka INDIA 585421

Phone No : 9901618488/ 7026165898

E-mail : dhanrajadvocate@gmail.com

Admission Details :

Bed Type : SEMI PRIVATE

Bed No : SPVT 203

Ward Name : 2F-SECOND FLOOR

Room No : SPVT 203

Admission Type : First Visit

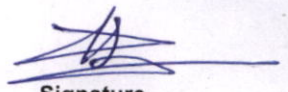
Contact Details :

Name : Mr DHANRAJ

Relationship : Father

Contact Address : H NO 1/3/2 , JONNEKENI , SANTHPUR ,
AURAD (TQ) Santpur Bidar Karnataka INDIA
585421

Phone No : 9901618488


Signature

Doctor Details :

Doctor Name : Dr. DINESH KUMAR CHIRLA

Specialisation : GENERAL PEDIATRICS

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : NIVA BUPA HEALTH INSURANCE
COMPANY LTD

BAH-00424850 IP5-00176232
 Master SHIVCHARAN
 15-06-2019 7 Y 0 M 25 D (M)
 Dr. DINESH KUMAR CHIRLA



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


BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

ACTIVITY RECORD FOR BILLING

Name : _____

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
10/2/26	8:15pm	er	203	

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

[illegible]

Date _____

Name of Equipment

Connecting Time

Disconnecting Time

Order No.

Signature

16/2

Inkision paper

10pm

9696954

10

[illegible][illegible]

Prepared By :

Billing Supervisor



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00424850
Master SHIVCHARAN
15-06-2019
Dr. DINESH KUMAR CHIRLA
7 Y 0 M 26 D
IP5-00176232
(M)

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Pain abdomen. since 4 days

Fever
Rash } since 3 days

Puffiness of face, edema of lower limbs since 2 days

History of present illness :

Child is apparently well 4 days ago. child developed above mentioned complaints.

Pain abdomen since 4 days ago.

→ on & off

Fever - max 100°F

- 1-2 spikes/day.

- since 3 days

- Decreases E on medication.

Rash - since 3 days

- started as maculopapular rash → later on 2nd day.

Ulcerated rash

Admitted in outside hospital, given IV antibiotics,

Inj Methylpred ↓

Rash faded & fever faded later

Puffiness of face, Edema developed yesterday

→

↓

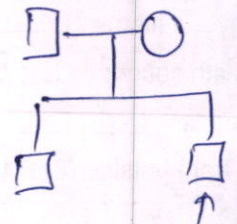
Hence shifted to our hospital for further management.



Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

(N) development

Immunization History :

Vaccination till date given



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 22.06kg (Centile _____)

On Examination :

Temperature : 97.3°F Pulse Rate : 118/min B.P. 105/57 (62) SpO2 97% on RA

Resp. rate and type of breathing : RR ~ 22/min

Rash → over face, body (petechial rash ⊕)

Lymphadenopathy _____

Oedema : → Puffiness of face below eyelids ⊕, Edema of

Allergies (if any): lower limbs upto legs ⊕.

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/LAE ⊕

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S1S2 ⊕, murmur ⊕

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Soft, NT, No organomegaly.

Auscultation : _____

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Plantars _____

Superficials:

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Sepsis ? HSP. (Henoch Schalein purpura)



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

CBP, CRP, RFT, LFT,

ESR, Urine protein, Creatinine, uric acid, Calcium.

Blood C_s

Dengue NS1.

USG Abdomen. T/m

Planned Management

• Ij Ceftriaxone

• Ij Esomeprazole

• Celoxyl lotion

• Syp. Atarax.

Noted by
@muthi
10/7/26
@ 8:20pm

Signature of the Doctor: Dr. Ramya

Name of the Doctor: Dr. RAMYA

Date & Time: 10/7/26, 7:20pm

Signature of the Consultant: [Signature]

Name of the Consultant: Dr. Dinesh Kumar. C

Date & Time: 10/7/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		Pain abd → 4d
	Pain abdomen since 8/7/26	Fever } 3d
	(100-118) Fever 8/7/26	Resh } 3d
	Resh 8/7/26	Puffiness x 2d.
	↓	
	Resh uterine 8/7/26	
	↓ Puffiness of face (evening)	① RFT, ESR
	CBP (CRP) → Admitted.	② LFT.
	Hb 11.7	③ CBP, CRP.
	wbc 19900	④ Urine ptn Cret
	8/7/26	⑤ Blood Ue
	PLT. 2-512.	⑥ Daytime prophyl (NSL)
	✓ Gentamycin	⑦ Ceftriaxone
	✓ Amikacin	⑧ USA Abd.
	✓ MPS.	
	✓ Pan, Ren	
	✓ B. Borovide forte	
	↓	
	9/7/26 → hands & legs Edema (+)	⑨ Refusion → ① Atorvastatin
	↓	② Colasoft
	10/7/26 → CBC 11.8 12900	✓ good
	33-4 84/14 4-6 2-712	
	CRP = 82.63.	
	RFT → (N)	
	CE → pus cells - 9-6 cells.	
	Reb - (N)	
	8/7/26 USA Ab → (N)	

DR. DINESH KUMAR CHIRLA
Registration No: 66227



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/20 8:45AM	<u>CL/B</u> <u>Stident</u>	
	Tense Non-blanchable purpura } ∴ 4 days. 9 fous. - took Inj. methyl prednisolone 80mg. x 2 days.	PLAN: - IVF - to continue. - R/V. Azithromycin <u>HOLD</u> Steroids ✓ Use abdomen → <u>HOLD</u>.
	O/E Active Facial edema (+). blanchable rash (+) B.P = 98/60 mmHg. HR = 102/min WS = 82-1 RS = R/LVRS-1 P/A = mild distention	- PCT in existing sample. S.IgE. - IgE allergy profile. - Allegra - Add Syp. Omnacortil. 2mg/kg/day <u>Label</u> <u>Return</u>
	Imp: ?HSP Vertical rash	- PCT in existing sample Allergy profile. / S. IgE. - Add Omnacortil.
11/8/20 4:00PM	<u>CL/B</u> <u>Stident</u>	
	- Rash ↓. - vitals - stable O/E Active vitals - stable S/E - NAD	PLAN: - Deng as per chart. - Trace Allergy profile <u>Label</u> <u>Return</u>

DR. DINESH KUMAR CHIRLA
Registration No: 66227



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

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/7/26 8:30 AM	4/5/16 Dr. D-R	PLAN
	Assess: Urthelial rash	- Discharge today
		• Omeprazole forte
		Fml PO/ODX 3 days
		f/u Wednesdays
		- Allergy profile report.
		- Furosemide
		- Glycine



Outside Investigation

RESULT SHEET

Date	8/7/26	10/7/26	10/7/26	11/7/26		
Time			4 PM	10:41 PM		
Hb	11.7	11.8	11.2			
PCV	32.9	33.4%	34.2			
RBC	4.51	4.61	4.44			
WBC	19900	12900	13,32			
N/L	80/18	84/14	74/20			
Platelets	2.51L	2.71L	3.18			
CRP	53.94	82.63	190.1			
ESR			92			
PCT			0.8	0.882		
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea		21	12			
Creatinine		0.8	0.4			
ALP						
SGPT			17			
SGOT			18			
T.Bill/Conj			0.2 → 0.1 0.1 → 0.1			
T.Protein		6.7	6.1			
S.Albumin		3.3	2.8 ↓			
S.Globulin		3.2	3.3			
A/G Ratio			0.8			
Uric Acid		3.8				
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						



MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From: ICU

Shifted to: ward

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Ranga A

Date & Time : 10/7/26 @ 6:30pm

Nurse Name & Signature: Devi K

Date & Time : 10/7/26 @ 6:30pm

BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Your Right to a Safe Delivery

Sheet No:

REGULAR PRESCRIPTIONS

Dept. Ward.

DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

Docu. No. : RCHBH /FRM / CLINICAL / 108



DRUG CHART

Date of Admission: 10/7/20 Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name Signature

Weight. 22.06 kg Ward.

Page: 2/4



Weight. Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Weight. 22 kg Ward.



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
10/8	6:40pm	7	Infection control measures	M	1	0	1	1	-	Bhavan
10/8/20	8am	9	Normal diet	M	1	0	1	1	-	Nikethi

Part - III: CODES

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

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Sepsis	H stability	Iv fluids & Antibiotic		☐ Nursing ☐ Others:
10/12/26 6:40pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Sepsis	Hemodynamic stability	Iv fluids	Bhevar	☐ Medical ☒ Others:
11/12/26 8am	☐ Medical ☐ Nursing ☒ Others: dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Sepsis	Normal diet	RDA E - 1500 kcal/d P - 26g/d	Nitika	☐ 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:



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 8:20 PM Mode of Arrival: walking Admitting From: ☒ ER ☐ OPD ☐ Direct

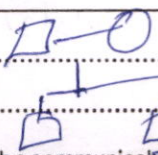
Allergy / Adverse Reaction NA

Body Weight: 22 Kg

Height: 106 cm

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

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

Family History: 

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

If yes please list,

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

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

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

Observations: Weight: 22 Length: 122.5 Head Circumference (< 2 years): 106

Temp.: 98.6 HR: 122 RR: 22 BP: 106/64

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

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

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

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

Character of Pain NA Location leg Frequency NA Duration NA

FUNCTIONAL SCREENING:

☒ No Abnormalities Detected

☐ Mobility Problem

☐ Walking Problem

☐ Developmental Delay

☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

☒ No Abnormalities Detected

☐ Underweight

☐ Overweight

☐ Special Feeding Method

☐ Feeding Problem

☐ Special diet

☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

If Yes Consultant Notified: (Date/Time): 10/7/26 8:30pm

Social History: Lives With family

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

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

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☒ Yes ☐ No

Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump : ☒ Yes ☐ No

Hand hygiene Explained: ☒ Yes ☐ No

☐ Others

Patient Rights & Responsibilities: ☒ Yes ☐ No

Information given to father

Nurse's Name: K. Sakuma Date: 10/7/26 Time: 8:40pm

Signature 

BAH-00424850
Master SHIVCHARAN
15-06-2019 7 Y 0 M 26 D (M)
Dr. DINESH KUMAR CHIRLA



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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EMERGENCY ROOM TRIAGE FORM

Patient's Name: Master Shivcharan Age: 8y
Date: 10/07/2020 Time of Arrival: 6:04pm
Gender: ☒ Male ☐ Female
Triage Completion Time: 6:06pm
☐ Not known any drug Allergies

Allergies: ☐ No ☐ Food ☐ Medications ☐ Other (Specify):
Source of Referral: ☒ Parents ☐ Others (Specify):
Mode of Arrival: ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance: ☒ Normal ☐ Sick Looking
Circulation / Colour: ☒ Normal ☐ Abnormal ☐ Bleeding
Work of Breathing: ☒ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

☒ Stable
☐ Unstable:
☐ Not - Life - Threatening
☐ Life - Threatening

Initial Vital Signs: Temp: 97.3°F PR: 118b/m BP: 105/50/60 RR: 22b/m SpO₂: 97% RA

Chief Complaints: Fever & Body rashes x 3 days; Cold x today morning
Swelling over the face, Hands and legs x 3 days
poor oral intake x 3 days

Triage Classification

- ☐ Level 1: Resuscitation
- ☐ Level 2: EMERGENCY: Life or limb threatening
- ☐ Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening
- ☐ Level 4: LESS URGENT: Significant illness but not life threatening
- ☐ Level 5: NON - URGENT: May receive care when convenient

NOTE: All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

CTAS

- ☐ Immediate
- ☐ < 15 min
- ☐ 30 min
- ☒ 60 min
- ☐ 120 min

Signature of Parent / Guardian

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

- Have you had fever (elevated temperature) in the past 2 weeks? ☒ Yes ☐ No
- Have you had cough or a rash in the past 2 weeks? ☐ Yes ☒ No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks? ☐ Yes ☒ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☒ Not applicable

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☒ No
If yes, State Location:
- Are your parents / close contacts at home healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☒ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from aid Cough
- ☐ Any patient with fever and respiratory symptoms who are "YES" to any of the questions on epidemiologic risk factors "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ Staff should use PPE (as appropriate).

Name of Triage Nurse: NR Subnuri

Date & Time: 10/07/2020 at 6:06pm

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

Signature of Triage Nurse: [Signature]

(P.T.O.)

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

Time	Nursing Notes
6:10 pm	- Assessed the pt condition
	- monitor the vitals
	- Iv placement done
	- sample collected
	- shifted to ward

Samples collected by: / NR. Rotikal

Samples sent by:

Time: / 2:53pm

Medication given in ER:

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

Condition of patient at time of shift - out :

HR: 142 b/m BP: 103/78 CFT: 22 sec
 RR: 24 b/m SPO₂: 100%
 GCS: 15/15 Temperature: 98.2° F
 Pain Score: 0/10
 Repeat RBS (if applicable): nil

Details of Shift - out

Shift - out from ER to: 103
 Time of Shift - out: 8:15pm
 Handover given to: Karalakey
 (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

Iv placement

Name of the Nurse :

Blavay?

Signature of the Nurse :

[Signature]

Date & Time : 10.12.21 @ 2:10pm



No. : RCH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)
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 : Time:

Doctor / Nurse / Family Concern?

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)

Resp Rate (bpm)
(0-1 Minute) *

70
60
50
40
30
20
10

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

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 Observation to continue.
Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



10/7/28
Doc. No. : RCH/ FRM / CLINICAL / 125

PRESCHOOL (0-5 years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date :		Time:		
Doctor / Nurse / Family Concern?				
Temperature (F)	104			
	103			
	102			
	101			
	100			
	99	98.6		
	98	98.6		
	97			
	96			
	95			
94				
Heart Rate (bpm)	190			
	180			
	170			
	160			
	150			
	140			
	130			
	120			
	110			
	100			
Blood Pressure (mmHg) *	130			
	120			
	110			
	100			
	90			
	80			
	70			
	60			
	50			
	Note: BP does not score in early warning scoring			
Heart Rate (Number)		122b/m 118b/m 108b/m		
Resp. Rate (bpm) (Over 1 Minute) *	70			
	60			
	50			
	40			
	30			
	20			
	10			
	Resp Rate (Number)		22b/m 20b/m 24b/m	
	Resp Distress	Mod/ Severe		
		None / Mild		
Receiving O ₂ (l/min)		RA	RA	
O ₂ Saturations (%)		100%	99%	
Conscious Level				
Normal / Altered				
GCS *		15/15	15/15	
TOTAL SCORE				
Number of shaded boxes		0	0	
Pain Score		0	0	
Observer's Initials				

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

FLUID CHART

Sheet No. :

10/8/14

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

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :					Total Output :							
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :					Total Output :							
	08:00 pm			30ml						0	10ml	
	09:00 pm			30ml						0	10ml	
	10:00 pm			30ml						0	10ml	
	11:00 pm			30ml						0	10ml	
	12:00 am			30ml						0	10ml	
	01:00 am									0	10ml	
Total Intake :					Total Output :							
	02:00 am			30ml						0	10ml	
	03:00 am			30ml						0	10ml	
	04:00 am			30ml						0	10ml	
	05:00 am			30ml						0	10ml	
	06:00 am									0	10ml	
	07:00 am									0	10ml	
Total Intake :					Total Output :							
Total 24 hrs. Intake					Total 24 hrs. Output							

FLUID CHART

Sheet No. :

11/7/24

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 Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
11/7	08:00 am	I		32ml							0	Jana Jana Jana Jana Jana Jana
	09:00 am	I		32ml							0	
	10:00 am	DNS		32ml					200ml		0	
	11:00 am	I									0	
	12:00 pm	I									0	
	01:00 pm								100ml		0	
Total Intake :				96ml		Total Output :					0-300ml	
11/7	02:00 pm	I		32ml							0	Jana Jana Jana Jana Jana Jana
	03:00 pm	I		32ml					250ml		0	
	04:00 pm	DNS		32ml							0	
	05:00 pm	I							100ml		0	
	06:00 pm	I									0	
	07:00 pm	I		32ml					200ml		0	
Total Intake :				128ml		Total Output :					0-550ml	
11/7	08:00 pm	I									0	Jana Jana Jana Jana Jana Jana
	09:00 pm	I									0	
	10:00 pm	DNS		32ml					250ml		0	
	11:00 pm	I		32ml							0	
	12:00 am	I		32ml							0	
	01:00 am										0	
Total Intake :				128ml		Total Output :					0-0	
12/7	02:00 am	I		32ml							0	Jana Jana Jana Jana Jana Jana
	03:00 am	I		32ml							0	
	04:00 am	DNS		32ml							0	
	05:00 am	I		32ml					300ml		0	
	06:00 am	I									0	
	07:00 am	I									0	
Total Intake :				128ml		Total Output :					0-300ml	
Total 24 hrs. Intake				480ml		Total 24 hrs. Output						1.400ml



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dinesh Kumar Department: ER Date of Admission: 10/7/20

SITUATION		Diagnosis: <u>sepsis</u>				Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:		
BACKGROUND	Area	<u>ER</u> <u>8:15pm</u>	<u>ICU</u> <u>8:15pm</u>	<u>ICU</u> <u>8:15pm</u>	<u>ICU</u> <u>8:15pm</u>			
	Shift Time							
BACKGROUND	Medical Condition (Any special condition to be noted):	<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>98.2°F</u>	<u>98.6</u>	<u>98.7°F</u>	<u>98.6</u>		
		Res:	<u>24/min</u>	<u>22/min</u>	<u>23/min</u>	<u>24/min</u>		
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>		
		Pulse:	<u>142/min</u>	<u>126/min</u>	<u>132/min</u>	<u>122/min</u>		
		BP:	<u>98/78</u>	<u>100/65</u>	<u>104/60</u>	<u>101/62</u>		
		Fall Risk Score:	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>		
Pain Score:	<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>			
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>yes</u>	<u>no</u>	<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>	<u>NA</u>	<u>NA</u>			
Post Operative Procedure Special Orders:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>				
Handed Over By Name :	<u>Shavai</u>	<u>Kabani</u>	<u>manish</u>	<u>Kabani</u>				
Signature :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>				
Date:	<u>10/7</u>	<u>11/7/20</u>	<u>11/7/20</u>	<u>12/7/20</u>				
Time:	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>				
Taken Over By Name :	<u>Kabani</u>	<u>manish</u>	<u>Kabani</u>	<u>manish</u>				
Signature :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>				
Date:	<u>10/7/20</u>	<u>11/7/20</u>	<u>11/7/20</u>	<u>12/7/20</u>				
Time:	<u>8:20pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>				

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Area						
BACKGROUND	Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:					
	Res:						
	SpO ₂ :						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
	Recommendations	Safety Needs:					
Physiotherapy		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Others Specify:							
Special Diet:		☐ 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-00424850
Master SHIVCHARAN
15-08-2019 7 Y 0 M 26 D (M)
Dr. DINESH KUMAR CHIRLA
IP5-00176232

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: 10/7/24

Assessment: Baby having legs - swelling

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 baby General condition	9pm	Assessed the baby General condition	Baby vital Stable
11pm	⇒ monitor vital & signs	11pm	⇒ monitored vital & signs	
2am	⇒ maintain 20 chart	2am	⇒ monitored 20 chart	
4am	⇒ Ensure safety	4am	⇒ placed comfortable position	
8am	⇒ provide comfortable position	4am	⇒ provided side rails	
8am	⇒ Administer medication as per doctor order	8am	⇒ Administered medication as per doctor order	

Re-Assessment:

Special Notes: will review & plan in AM & 11.55

Nurse Signature: Kala

Nurse Name: Kalavathi

Date & Time: 11/7/24 @ 8am

BAH-00424850 IP5-00176232
 Master SHIVCHARAN
 15-06-2019 7 Y 0 M 25 D (M)
 Dr. DINESH KUMAR CHIRLA



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: 11/7/26

Assessment: Baby having i/s pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	→ Assess The BABY General Condition.	8AM	→ Assessed The BABY General Condition.	→ BABY vital stable
10AM	→ monitor the BABY vitals.	10AM	→ monitored The BABY vitals	
12PM	→ maintain I/O Chart	12PM	→ maintained I/O Chart	
4PM	→ Administer the medication given by doctor order	4PM	→ Administer the medication given by doctor order	
8PM	→ provide comfortable position.	8PM	→ provided comfortable position.	

Re-Assessment: Reduce the pain

Special Notes: c + same medication

Nurse Signature:

Nurse Name: mounika

Date & Time: 11/7/26 8PM

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 17/7/20

Assessment: Baby having good activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the baby General condition	8pm	Assessed the baby oral condition	Baby comfortable & sleeping well
10pm	monitored vital & sign	10pm	monitored vital & sign	
12am	Monitored the chest	12am	Monitored the chest	
2am	Ensure safety	2am	provided side rally	
4am	Provide comfortable position	4am	provided comfortable position	
8am	Administer medication as per doctor order	8am	Administered medication as per doctor order	

Re-Assessment:

Special Notes: wlf fever & BP. volume out per

Nurse Signature: *Kala*

Nurse Name: kabesulu

Date & Time: 17/7/20 8am

BAH-00424850 IPS-00176232
 Master SHIVCHARAN
 15-06-2019 7 Y 0 M 26 D (M)
 Dr. DINESH KUMAR CHIRLA



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



CHECKLIST FOR THROMBOPHLEBITIS

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

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 :

Signature of Ward In Charge :

Signature : Name :



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
10/7	7:50 PM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Sharon
11/2/26	6am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	pebbles
11/2/26	2 PM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	mountain
12/7/26	10 PM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	labour
12/7/26	6am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Kidney
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

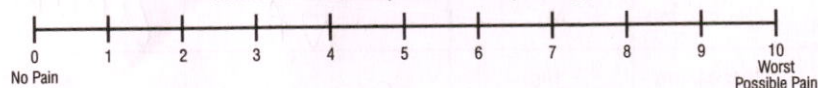
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





BRADEN 'Q' SCALE

					Date :	10/7	11/7	12/7	
					Time :	9:30 pm	10:30 pm	11:30 pm	
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. extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	
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	
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 of 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	
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									
					TOTAL SCORE	28	28	28	
					Evaluator's Name	K. K. K.	K. K. K.	K. K. K.	

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



DISCHARGE PLANNING FORM

Nationality : Indians

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

1. Anticipated Date of Discharge : 14/6/2019

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 :

☐ Medication	☒ Yes	☐ No
☐ Bathing	☒ Yes	☐ No
☐ Eating	☒ Yes	☐ No
☐ Walking	☒ Yes	☐ No
☐ Dressing	☒ Yes	☐ No
☐ Toileting	☒ Yes	☐ No

Remarks

4. Nutritional Plan :

☐ Dietary Instruction Discussed with the :
☐ Patient ☒ Family Member

☐ Others : no

5. Discharge Planning Discussed with the :

☐ Patient ☒ Family Member

☐ Others : no

6. Patient / Family Educational Plan :

☒ Educational Topics/s : Home hygiene

Patient's Educational Topic/s discussed with the :

☐ Patient ☒ Family Member

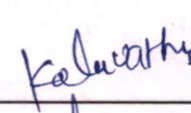
☐ Others : _____

Nurse Signature : Kalavathy

Nurse Name : Kalavathy

Date and Time : 12/6/2019 8:30pm

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00424850 IP5-00176232 Master SHIVCHARAN 15-06-2019 7 Y 0 M 25 D (M) Dr. DINESH KUMAR CHIRLA 		Date & Time of Admission 10/7/26 @ 7:10pm	Date & Time of Transfer Order 10/7/26 @ 8:15pm
		Transfer Ordered by Dr. Ranya	Reason for Transfer Admission
From Unit ER	To Unit 203	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 21	Number of Imaging Films No	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ op file If yes, what? 	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Dr. Bhavani		Name of Person Ordered Transfer Dr. Ranya	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received : 10/7/26 8:25pm			

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



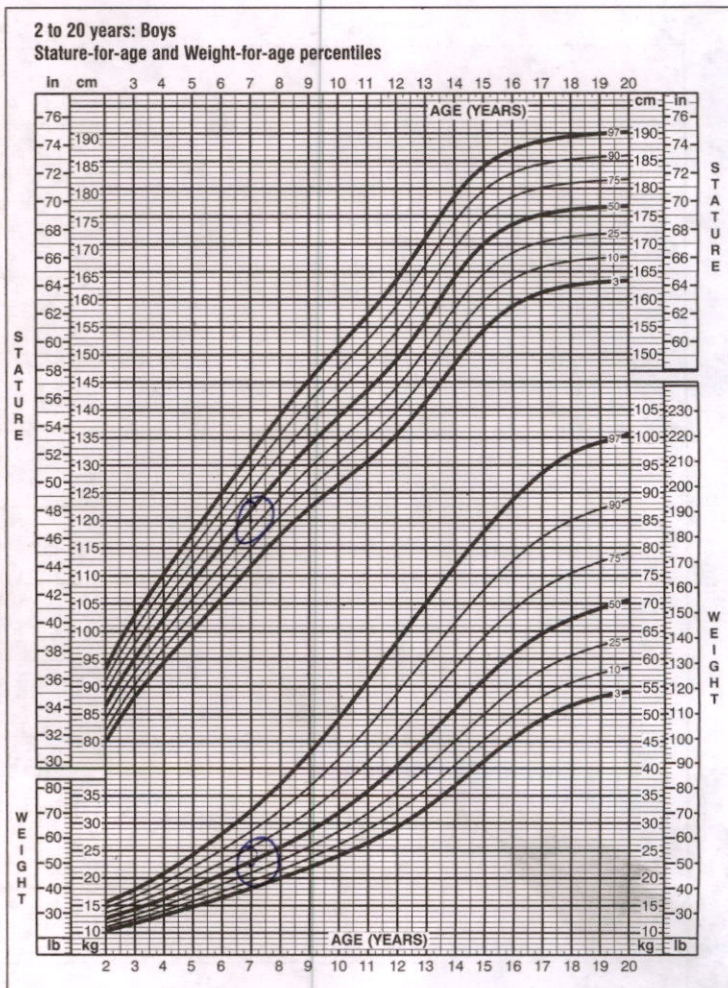
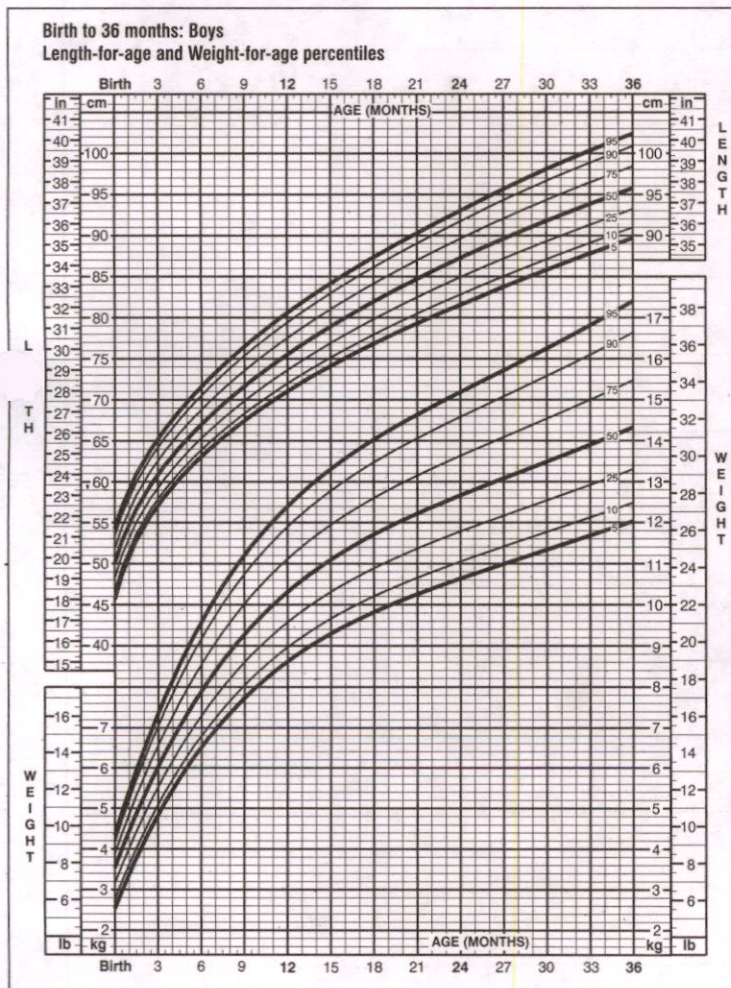
203

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 11/7/26 Time: 8am

Weight: 22.06 kgs Centile: >25th
Height: 120 cm Centile: >25th
Inference: Well child
RDA: — Calories: 1500 kcal/d Protein: 26g/d
Diet Recommendations: Normal diet
Re-Assessment: Avoid spicy, Chilled, Outside foods
Food Allergies: No Veg/Non-veg: Veg
Diagnosis: Sepsis 2 HSP
Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral
Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: Nikitha

Dietician's Signature: [Signature]

Daily Notes:

12/7/26
fam

child is stable. Intake is fair
continue to normal diet

K. Shultz