

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

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

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

BAH-00659186
Master SOMASEKHAR SHARMA (M)
21-02-2023 3 Y 4 M 10 D
Dr. SIRISHA RANI

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
01/07/26	12:20 PM	ER	C911 Oncology	By
1/7/26	'6 PM	1st floor	132	Meelin

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
10/12/20	RBS (161mg/dl)	036421	(Sm)
01/12/20	CBP, CRF, Strept	2606585	m
	creative		
1/12/20	USG Abdomen	0321173	Appa
1/12/20	USG Abdomen	0321	Meena
3/7/20	CBP, S.E, LFT, Fibrous, RB	2606647	Am
4/7	CBP, SG.	26067082	
6/7	CBP, Eloc, Creat, RBS	67398	
6/7	Urine c/s	26067549	Sany
6/7	CBP	26067583	Sany
7/7	CBP	67801	Appa
- 7/7	X-ray clut abdomen	038672	Meena
8/7	B-Glucose, Galactoman	26068381	Sany
9/7	CBP	26068465	Meena
10/7/20	CBP, S.E, LFT	26068977	Meena

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
2/7	Blood transfusion (PRBC)	①	9684390	Dr. J
3/7	Blood Transf (FFB)	①	9686198	Surf
6/7	Blood Transfusion (SPD)	①	9690484	J
9/7/26	chemotherapy	①	9605113.	Chif

ANY OTHER INFORMATION

Don't charge for NHA - nicithg

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Date: 10/7/26

Time: @ 1pm

Prepared By: veena

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
veena	Day oncology		

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175816 Admit Date : 01-Jul-2026 Admit Time : 11:35 AM UHID : BAH-00659186

Patient Details :

Patient Name : Master SOMASEKHAR SHARMA SOMARAJU Age : 3 Y 4 M 10 D
Guardian : Mr PURNACHANDRA RAO S DOB : 21-02-2023
Gender : Male Religion :
Occupation : Martial Status : Single
Address (H) : FLAT NO 401, PLOT NO 1, SHRIYA VRK Phone No : 8688844482/ 8904627696
ASHIWAD APARTMENTS, ROAD NO 1, INCOME E-mail : CHEMCHANDU@GMAIL.COM
TAX COLONY, NEAR PRATYANGIRA DEVI
TEMPLE KURTALA PEETAM KAMAL, Kothapet
Hyderabad Telangana INDIA 500035

Admission Details :

Bed Type : SEMI PRIVATE Bed No : SPVT 111 Ward Name : 1F-VIBGYOR
Room No : SPVT 111 Admission Type : First Visit

Contact Details :

Name : Mr PURNACHANDRA RAO S Relationship : Father
Contact Address : FLAT NO 401, PLOT NO 1, SHRIYA VRK Phone No : 8688844482 / 8904627696
ASHIWAD APARTMENTS, ROAD NO 1,
INCOME TAX COLONY, NEAR PRATYANGIRA
DEVI TEMPLE KURTALA PEETAM KAMAL,
Kothapet Hyderabad Telangana INDIA 500035

Signature

Doctor Details :

Doctor Name : Dr. SIRISHA RANI Specialisation : HEMATO ONCOLOGY
Referral Doctor : Self Phone No :
Co-Consultant : Dr. SANDHYA VADDADI

Payment Details :

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

Sauer

WBC - 0.26

Pt - 23000

Mandeele

WBC - 0.02

Pt - 88000



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PEDIATRIC IN-PATIENT MEDICAL RECORD



Patient Name:

Somasekhar ~~Sharma~~ Sharma

UHID ID:

Department:

Consultant:

BAH-00859186 IP5-00175816
Master SOMASEKHAR SHARMA (M)
21-02-2023 3 Y 4 M 10 D
Dr. SIRISHA RANI





Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

CBP, S-Electrolytes,
RBS.

N.B.
Charan
1/7/26.

Planned Management

• IV fluids.

• LP

• Chemotherapy.

Noted by
meelina

Signature of the Doctor: Ramya

Name of the Doctor: Dr. Ramya

Date & Time: 1/7/26, 11:30am

Signature of the Consultant: [Signature]

Name of the Consultant: Dr. Sirisha Rani

Date & Time: 1/7/26 @ 12:30pm

Dr. SANDHYA VADDADI
Reg. No: 71654

BAH-00659166
Master SOMASEKHAR SHARMA
21-02-2023
Dr. SIRISHA RANI
IPS-00175816
3 Y 4 M 10 D
(M)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/7/26 12:30pm	slb m sandhya V Δ B cell - A/I on induction ± A/I ± ? neutrophilic WBCs clo loose stools → multiple episodes no fever, no bleeding occ abd pain UOPV O/E pt I° us std RTS: BAF+ LIA distended RS (+) mid tenderness	Ⓟ send CB → Add Amikacin send CBP, SE, CRP creatinine, stool CB run → Z&D drops romosarole Medoprenne US abdomen and monitor urine output E - stool wt. Replace stool ± RL every 2 shifts room RS 10 pm report hitz bath 7 - bath out

Dr. SANDHYA VADDADI
Reg. No: 71664

Noted by Malin



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/26 9:40 AM	Morning rounds Well Afebrile. Induction/ E?N leukopenic counts. cl - 4 loose stools. 2 amussidol Intake / Adequate Urine / Adequate No fever / monitoring hydration good. SPE → RW F. CFTU CNS Hx P/A / (M)	Adv. 1) Take stool cl 2) wait drugs as per chart 3) RW Labs 4) encourage gas/bowel 5) monitor hydration 6) Inform SOC. T/M L&E chemo ORR today Dr. Sandhya RPT CBP TID JE, RBS, fibrinogen, LFT Sandhya V, SDP delay 2/7/26 @ 10 AM Dr. SANDHYA VADDEDI Reg. No: 71664 - Serial NO continued LA TID K/B Gayathri 2/7/26 1 PM



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/2023 9am	B-ALL Induction wk-2 Neutropenia	Plan ⊖
	No fever.	
	Loose stools.	Plan
	o/e	1. Trace CBP
	child active	2. Kcl correction today.
	q-BLAE ⊕	3. Rb LP today Tms
	PA soft	4. Vincristine Tms today
	BS ⊕	5. Trace stool cl.
	Amikacin / D3	6. App today
	vor.	
3/7/2023 4:30pm	Scull Aul I-wk 2 / Fish o/ febrile neutropenia No fever / loose stools / vomit I / appropriate input / output Dv nle of	Plan DRN LP tms 2. Urine test 3. monitor vitals 4. Inform SAs. Aharshah

Sandhya V
3/7/23
@ 10:00 AM
Dr. SANDHYA VADDADI
Reg No: 21664 /
10-B-3/23
3/7/23



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26 9:00 AM	B- ALL / Induction wk-2 / FISH ⊕ Neutropenia. 3 episodes of febrile chills - overnight. No fever spikes.	
	O/E Child Alert & Active. Vitals Stable Chest ⊕ RU: B/LAC ⊕ FLA: soft CNS: NAD.	plan P/K LP - today S/E during LP. - CRP - Tm. RBS RZ - monitor vitals.
4/2/16 2 PM	Procedure notes Under sterile aseptic precaution CP done inhalational medication administered procedure uneventful. vitals stable	Dr. Sirisha Rani 4/2/26 VADDADI Reg. No: 71064 Dr. Sirisha Rani 4/2/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/2/26 9 AM	B-ALL Induction - wk-2 Severe neutropenia	
	Stools - 8 episodes semi solid	
	No fever No cough perianal rash - ↓	Plan 1. Continue IV antibiotics dry fever spike tachycardia ↑ loose stools upgrade Abx to PIPTAZ
	Ceftriaxone Amikacin Vori	2. CBP 1. Extraplain, LF creat. RBS 3. chest X ray today / T/M - hold 4. stop amikacin after evening dose. Hold Daunorubicin
		5/2 @ 10 AM Dr. SANDHYA VADDE Reg. No: 71664



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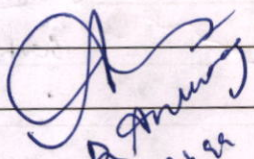
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/2/23 9 AM	<u>Morning rounds</u> Still out Intubation - W-2 / Entubated. A/D Hts / severe neutropenia 8 loose stools to diarrhoeal. No fever feeding fair Vitals (N) S/E → MF = SGT, A SGT. Pipha D2 Vomonaale D2	1) out in fluid. 2) to A/D 3) take labo. 4) monitor hydrate 5) take CRV S/E SGT. 6) Inform SGT. <u>Amritha</u> → do CRP. → 50% unit today → CRP thr. Dr. Amritha 9:54 AM Dr. Amritha Reedy 21B Savittre @ 12 PM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/2/23 9 AM	Morning rounds Bell Bluff Endotracheal - w- / Severe neuroprotection/ Enteroislets	
	Aptite, Alert Feeding fair V, hls ⊕ Lungs clear - 4 till 4pm No further S/E → P/A → soft, RS ⊕ gaseous distension	Ado 1) It drugs as per chart 2) Urine & Hare 3) (R/V) Decontamination → yoyo 4) monitor vitals
	X-ray chest with Abdomen	EXR, today Add Ampho B 500 Shamshay D. PANDHYA VADDADI Reg. No: 7166 @ 10 AM
17/2/23 4 PM	cl/B Rendu	noted by nurse 17/2/23 4 PM
	Nonrespirator Vital stable Feeding well. CU M P/A → NAB. CN	Plan - Continue drugs as per chart. - Sip Duphalar 12 hourly (10ml). - monitor vitals - Inform for noted by nurse 17/2/23 6 PM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26 9 AM	B-ALL / Induction Severe neutropenia Enterocolitis	
	No fever 6 stools - semi solid	
		<u>Plan</u> 1. ct IV antibiotics 2. CBP extra plate } T/m 3. R/v galactomannan, β -glucan. To send in Evening 1 Extra EDTA Sample <u>harai</u> T/m.
	Urine cl stool cl } no growth	
		- Decitin oral L/A AH T TBACT oral - sitz bath
	 29/07/2023 9:30 AM Dr. Anurag Reddy	Noted by Nandini 8/7/26 1 PM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/9/26 8:30 PM	Bcell A12 / Induction Severe Neutropenia Enterocolitis. 2 stimulated stools : mrg. No fever spikes.	
4/0 - Adverse 0/I - Better.	0/E Child Alert & Active. Vitals stable.	plan
	US M P/A CNS	CBP, Extrapykin-Tfm. tDFA.
	NAB.	Send galactomannan, β-glucan in the mrg.
		Continue IV Antibiotics.
		Continue G12 bath.
		Depressants.
		Peg laccaschet 1 1/2 sachet now.
		Syp Melatonin 7.5ml today
	Noted by Gargi 8/11 6 AM	Shanai

BAH-00659186

IP5-00175816

Master SOMASEKHAR SHARMA

21-02-2023

3 Y 4 M 17 D

(M)

Dr. SIRISHA RANI

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/2023 9 AM	Morning rounds B cell ALL / Induction Severe Neutropenia Enterocolitis 2 Loose stools. - Watery stools Vitals stable CNS P/A CHF Linezolid D ₃ PIPTAZ D ₅	Plan - To trace Galactomannan VB - Glucan levels. → Continue IV Antibiotics → Continue Sitz bath. → IV vincristine 1mg 14 days. Dexamethasone today Rpt CBP, SE, PPS, fibroblast on LFT 10/7/2023 @ 2pm Dr. Sandhya Vaddadi Reg. No: 71664
	WBC 60638 9/7/2023 @ 9:30 AM	

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Date & Time	Progress Notes	Doctor's Order
1/17/26 11:00pm	<u>Cle/B Resident</u> Bcell ALL Induction febrile neutropenia antecedents. Chem Alert Vital stable CMV: (-) M. Ab: (-) P/A: Gt CNS: NAD. Catalase - Negative. 2/B Veen 606384 9/7/26 @ 5	<u>plan</u> - Traa β-D-glucan levels. - Vincristine - T/m - CBP, S/E RBS, LFT - T/m @ 2pm. - Continue IV antibiotics. - monitor vital - Tylenol (PRN) <u>PR</u>

BAH-00659186 IP5-00175816
Master SOMASEKHAR SHARMA
21-02-2023 3 Y 4 M 18 D (M)
Dr. SIRISHA RANI



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Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/2/26 8:30 AM	<u>CS/B Resident</u> Bcell ALL / Induction / Severe neutropenia / enterocolitis. 3-4 Solid stools - yesterday. No New issues. <u>o/e</u> Child Alert & Active. Vitals Stable Inf. piptaz - Db. Tab. vori - Db. Sip. hincalid - Dy Sip. kephran Tab. ncyd. Tab. tranvaq. CX: C13A H: B1000 P/A: Soft CNS: NAD.	<u>Plan</u> - Vincristine - Now ^{given} - PEG asparaginase - today. - CRP, s/e, RAS, LFT - today @ 2pm. - Continue IV medication. - Monitor vitals - Tpm (to) - Plan for d/c after sepsis. <i>[Signature]</i> Dr. SANDHYA V Reg. No: 71664

N/B
Veena
606384
10/2/26 @ 12pm



Date & Time	Progress Notes	Doctor's Order
10/7/26 2pm	C: 2-6 → 1 in 7.5ml correction of after correction in cephalaxone 1500 kg day div in 12/7 CRP SE in OP of Transpa vibrantly, lined dorsal level of Antelope SD N/B Ulcus G0628N 10/7/26 @ 12pm	Paul Amuly

BAH-00659186
Master SOMASEKHAR SHARMA
21-02-2023 3 Y 4 M 10 D (M)
Dr. SIRISHA RANI

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MEDICATION RECONCILIATION FORM

Drug Allergies:

☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER

Shifted to: Ward

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. Ramya

Date & Time: 11/7/26; 11:30am

Nurse Name & Signature: Nr. Sushmita

Date & Time: 1.7.26 @ 11:42am



Sheet No:

REGULAR PRESCRIPTIONS

Weight 15 kg.

Ward 0210

DRUG : <u>Tcb TRANEXA (500mg)</u>				Date Time																
Dose <u>1/2 tcb</u>	Route <u>PO</u>	Frequency <u>BD</u>	Start Dt. <u>11/7/26</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>A Ranga</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Tcb VORICONAZOLE</u>				Date Time																
Dose <u>1/2 tcb</u>	Route <u>PO</u>	Frequency <u>OD</u>	Start Dt. <u>11/7/26</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>A Ranga</u>																				
Additional Instructions: <u>(1 tcb = 200mg)</u>																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Syp. SEPTERRAN</u>				Date Time																
Dose <u>2.5ml</u>	Route <u>PO</u>	Frequency <u>BD</u>	Start Dt. <u>11/7/26</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>A Ranga</u>																				
Additional Instructions: <u>mon / wed / fri</u>																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Syp 2INCOVIT</u>				Date Time																
Dose <u>2.5ml</u>	Route <u>PO</u>	Frequency <u>OD</u>	Start Dt. <u>11/7/26</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>A Ranga</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

Sheet No:

REGULAR PRESCRIPTIONS

Weight 15.65kg Ward

DRUG : Symp. CALCIMAX PLUS				Date/Time	1/7/26	3/7/26	4/7/26	5/7/26	6/7/26	7/7/26	8/7/26	9/7/26	10/7/26	11/7/26	12/7/26
Dose	Route	Frequency	Start Dt.												
5ml	PO	OD	1/7/26												
Name & Signature of the Doctor Starting the Drugs:				11am 12pm 1pm 2pm 3pm 4pm 5pm 6pm 7pm 8pm 9pm 10pm 11pm 12am											
Additional Instructions:															
Daily Doctor's Endorsement by a Sign				11am 12pm 1pm 2pm 3pm 4pm 5pm 6pm 7pm 8pm 9pm 10pm 11pm 12am											
DRUG : Symp. MOKTEL				Date/Time	1/7/26										
Dose	Route	Frequency	Start Dt.												
2.5ml	PO	BD	1/7/26												
Name & Signature of the Doctor Starting the Drugs:				10am 11am 12pm 1pm 2pm 3pm 4pm 5pm 6pm 7pm 8pm 9pm 10pm 11pm 12am											
Additional Instructions:															
Daily Doctor's Endorsement by a Sign															
DRUG : ZQ D drops				Date/Time	1/7/26	3/7/26	4/7/26	5/7/26	6/7/26	7/7/26	8/7/26	9/7/26	10/7/26	11/7/26	12/7/26
Dose	Route	Frequency	Start Dt.												
1ml	PO	OD	1/7/26												
Name & Signature of the Doctor Starting the Drugs:				6pm 7pm 8pm 9pm 10pm 11pm 12am											
Additional Instructions:															
Daily Doctor's Endorsement by a Sign				6pm 7pm 8pm 9pm 10pm 11pm 12am											
DRUG : INT AMIKACIN				Date/Time	1/7/26	3/7/26	4/7/26	5/7/26							
Dose	Route	Frequency	Start Dt.												
125mg	IV	BD	1/7/26												
Name & Signature of the Doctor Starting the Drugs:				6am 7am 8am 9am 10am 11am 12pm 1pm 2pm 3pm 4pm 5pm 6pm 7pm 8pm 9pm 10pm 11pm 12am											
Additional Instructions:															
Daily Doctor's Endorsement by a Sign				6am 7am 8am 9am 10am 11am 12pm 1pm 2pm 3pm 4pm 5pm 6pm 7pm 8pm 9pm 10pm 11pm 12am											

Signature

VERIFIED BY : Name



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : 2 + D drops				Date Time																
Dose 1ml	Route PO	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG : INT PIPERACILLIN				Date Time	5/7	6/7	7/7	8/7	9/7	10/7										
Dose 2.25gm	Route IV	Frequency BD	Start Dt. 5/7																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG : Tab VORICONAZOLE				Date Time	5/7	6/7	7/7	8/7	9/7											
Dose 1/2	Route PO	Frequency BD	Start Dt. 5/7																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG : SYPLINGZOLID				Date Time	7/7	8/7	9/7	10/7												
Dose 7.5ml	Route PO	Frequency TID	Start Dt. 7/7																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : <i>SR. DULHABAC</i>				Date Time	<i>11/8/23</i>														
Dose	Route	Frequency	Start Dt.																
<i>10ml</i>	<i>PO</i>	<i>OD</i>	<i>7/7</i>																
Name & Signature of the Doctor Starting the Drugs:				<i>[Signature]</i>															
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign				<i>[Signature]</i>															
DRUG : <i>MUOOT 84P-</i>				Date Time	<i>11/8/23</i>														
Dose	Route	Frequency	Start Dt.																
<i>10ml</i>	<i>PO</i>	<i>twice daily</i>	<i>10/8/23</i>																
Name & Signature of the Doctor Starting the Drugs:				<i>[Signature]</i>															
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																			

Signature
VERIFIED BY : Name



Name:

Weight: kgs

Sheet No:

[illegible]

Docu. No. : RCHBH /FRM / CLINICAL / 136

VERIFIED BY: N

Doctor's Signature	Valid Period	Page No.	
Additional Instructions:			

Page: 1/4 (P.T.O.)

Page: 1/4

(P.T.O)

Docu. No. : RCHBH / FRM / CLINICAL / 118

[illegible]

Weight. 15.6 kg Ward.



CHEMOTHERAPY PRESCRIPTION

All the chemotherapy medications are high risk / high alert drugs.
While administering chemotherapy drugs watch for nausea, vomiting, rashes,
urine output and any local extravasation of the drug.

Sheet No. ①		Weight (kg): 15.66	Body Surface Area: 0.65	Diagnosis: B'AU		Protocol: Induction wk-2				
DATE	TIME	Composition of Chemotherapy (if infusion, mention ml / hr = Mcg / kg / min. etc.)	DOSE	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
9/7/21	4:50 pm	ly DAUNORUBICIN in 300ml 1/2 ons	14mg	IV	60ml/h	d	Jeerg Anuradha	9/7	KS	Sabhankeer Savitri.
10/7	7:40 Am	INT VINCRISTINE with 10ml NS	0.9mg	IV	all 10min	KS	Jeerg Subhanke	10/7	KS	Jeerg Subhanke



1

RESULT SHEET

Date	11/2/26	3/2/26	4/2/26	6/7	7/7	9/07
Time	1:25 PM	6:30am	5pm	8am	8am	5:55Am
Hb	7.6	12.9	11.6	11	11.1	10.0
PCV	28.4	35.9	32.9	30.8	30.6	27.4
RBC	2.76	4.60	4.10	3.86	3.87	3.49
WBC	7300	520	0.29	0.38	0.37	0.53
N/L	42.4/56.2	25/67	31.1/65.5	31/65	29/59	43/54
Platelets	0.24	58000	39,000	16,000	45,000	38,000
PLP				24,000		
ESR				5		
PCT						
RBS	161	110		91		
Na	136	137	139	136		
K	4.4	2.7	3.7	3.4		
Cl	118	106	113	104		
Ca/Mg						
Phosphate						
Urea						
Creatinine				0.2		
ALP		109				
SGPT		83				
SGOT		18				
T.Bill/Conj		0.5/0.1				
T.Protein		6.2				
S.Albumin		3.5				
S.Globulin		2.7				
A/G Ratio		1.3				
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
	3/7/26					
fibrinogen	90.0					

Culture and Sensitivities : stool cl - sterile

Urine cl -

6/7/26 -

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc..) :

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: 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		
8/7	2PM	3	Pain Management	M	1	1	0	1	NA	AS.
9/7	8AM	7	infection control measure	m/f	1	1	1	1	NA	Cleary.
10/7	8AM	3	pain management	M	1	0	1	1	NA	Umy.

Part - III: CODES

Who was taught:	PT: Patient	F: Father	M: Mother	S: Spouse	Sn: Son	D: Daughter	C: Caregiver	O: Other (Specify)															
Learning Barriers: <table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>									1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice	2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)	3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	
1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice																			
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3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing																				
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed																							
Mechanism/s to overcome barrier/s: <table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td colspan="2">7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td colspan="2"></td> </tr> </table>									1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify		2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference							
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2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference																					
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review																							



ARY PATIENT / FAMILY EDUCATION RECORD

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		
4/7/26	8am	1	Infection control measurement	M	4	0	7	2	NA	Shrey
5/7	9am	3	Pain management	M	1	1	0	0	NA	Sony
6/7	9am	3	Pain management	M	1	1	0	1	NA	Sony
7/7	12pm	5	medication	M	1	1	0	4	NA	Wener

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 2. Physical Impairment 3. Emotional Barriers 4. Language Barrier 5. Educational Level 6. Desire / Motivate to Learn 7. Impaired Thought Process/Cognitive Limitations 8. Responsibilities at Home 9. Cultural Differences 10. Financial Difficulties 11. Beliefs and Values 12. Impaired Vision/ or Hearing 13. Cultural/Religion Practice 14. Others (Specify)							
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed							
Mechanism/s to overcome barrier/s: 1. None 2. Obtain translator 3. Reassurance & Support 4. Teach Family / Others 5. Respect values & beliefs 6. Respect Cultural / Religion Preference 7. Other, Specify							
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review							



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		
1.7.26	11:41 am	7	Infection control measures	m	4	0	1	1	-	<i>[Signature]</i>
11.7.26	12:45 pm	9	child is on NPO	M	1	0	1	1	-	<i>Nicholas</i>
21.7	10 am	7	maintain personal hygiene	m	1	0	1	1	-	<i>[Signature]</i>
31.7	10 am	9	maintain personal hygiene	m	1	0	1	1	-	<i>[Signature]</i>

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
1/7/26	☒ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	B cell ALL E AGE	Hemodynamic stability	IV medication + chemotherapy + LP.		☐ Nursing ☐ Others:
1.7.26 11:41 am	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	B. cell ALL E AGE	H. Stable	IV Medication + chemotherapy + LP.		☒ Medical ☐ Others:
1/7/26 12:15 PM	☐ Medical ☐ Nursing ☒ Others: Dietician	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	K1C10 B cell ALL E AGE	child is on NPO	NPO till further advice	Nicitha	☐ 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:



10

PRESCHOOL (1-5 years)
Children's Observation &
Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/2 Time: 9 AM 1 PM

Doctor / Nurse / Family Concern?

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94

* 98.5 F 98.6 F

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

99 (61) 100 81 60

Heart Rate (Number)

102 bpm 106 bpm

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

70
60
50
40
30
20
10

26 bpm 26 bpm

Resp Mod/ Severe
Distress None / Mild

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

98% 100%

Conscious Normal
Level Altered

C C

GCS *

15/15 15/15

TOTAL SCORE

Number of shaded boxes

0 0

Pain Score

0 0

Observer's Initials

Dr. Sirisha Rani

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

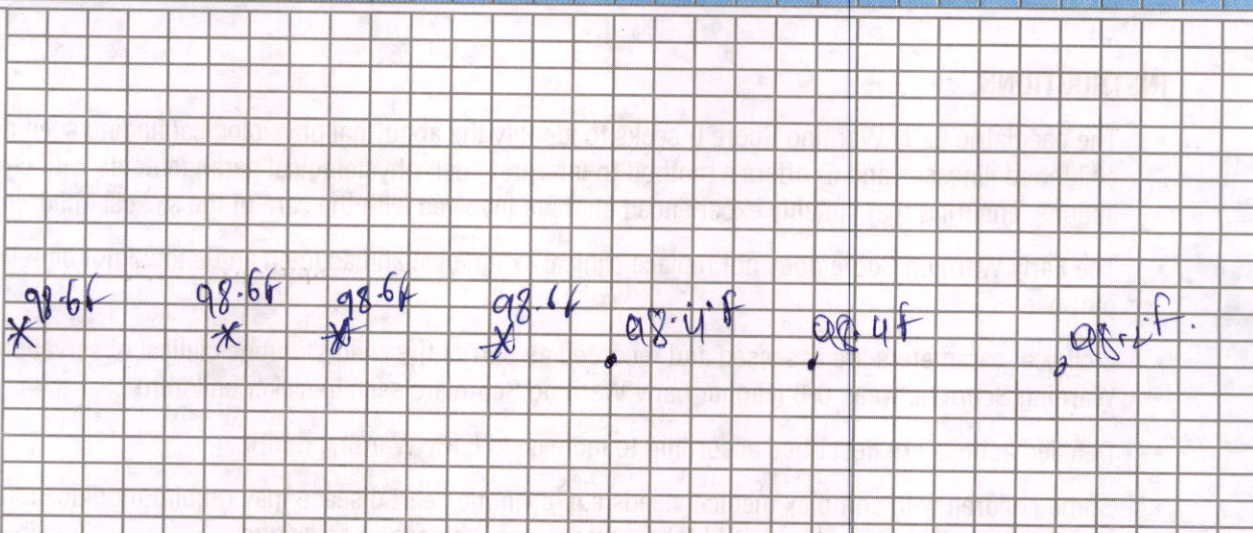
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/2/23 Time: 9Am 1pm 4pm 7pm 10pm 3Am 6Am

Doctor / Nurse / Family Concern?

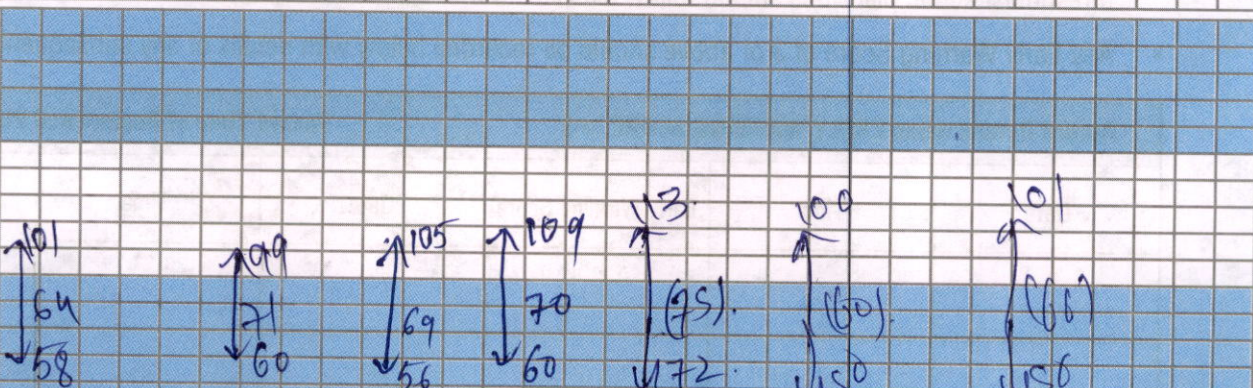
Temperature
(F)

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

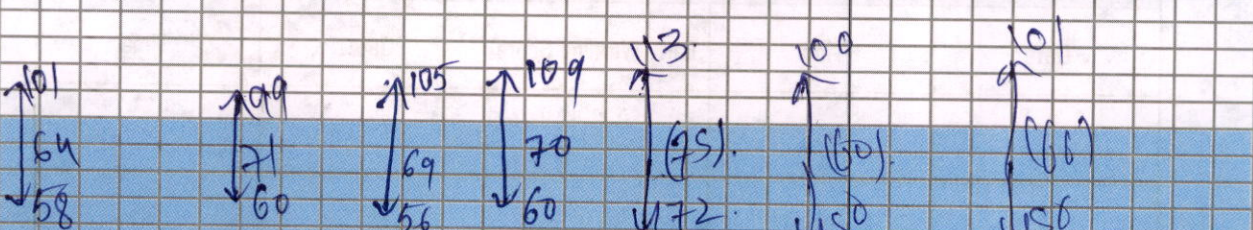


and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

110
100
90
80
70
60
50

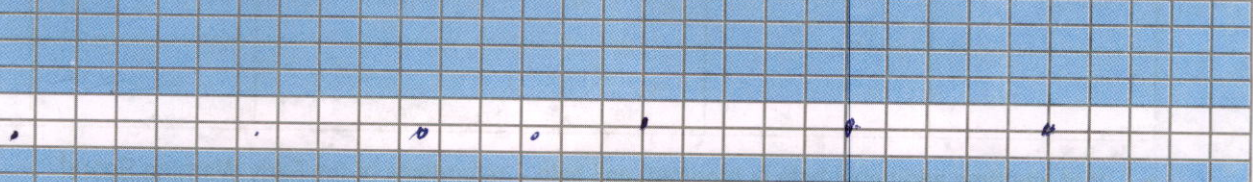


Heart Rate (Number)

101b/m 106b/m 110b/m 113b/m 123b/m 119b/m 104b/m

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

70
60
50
40
30
20
10



Resp Rate (Number)

23b/m 26b/m 25b/m 23b/m 23b/m 23b/m 23b/m

Resp Distress
Mod/ Severe
None / Mild

0 0 0 0 0 0 0

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

100% 100% 100% 100% 100% 100% 100%

Conscious Level
Normal
Altered

C C C C C C C

GCS *

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

TOTAL SCORE

Number of shaded boxes

0 0 0 0 0 0 0

Pain Score

0 0 0 0 0 0 0

Observer's Initials

in in in in in in in

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

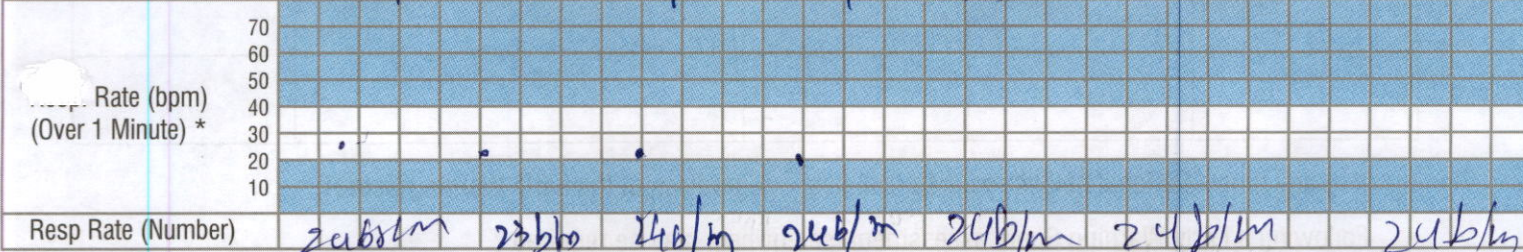
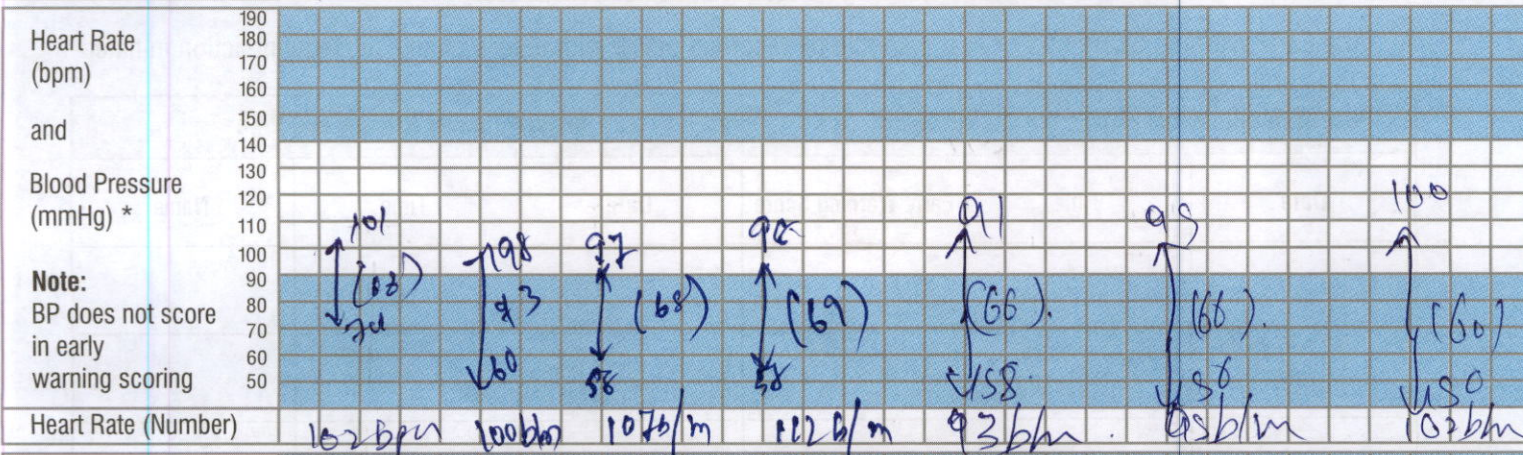
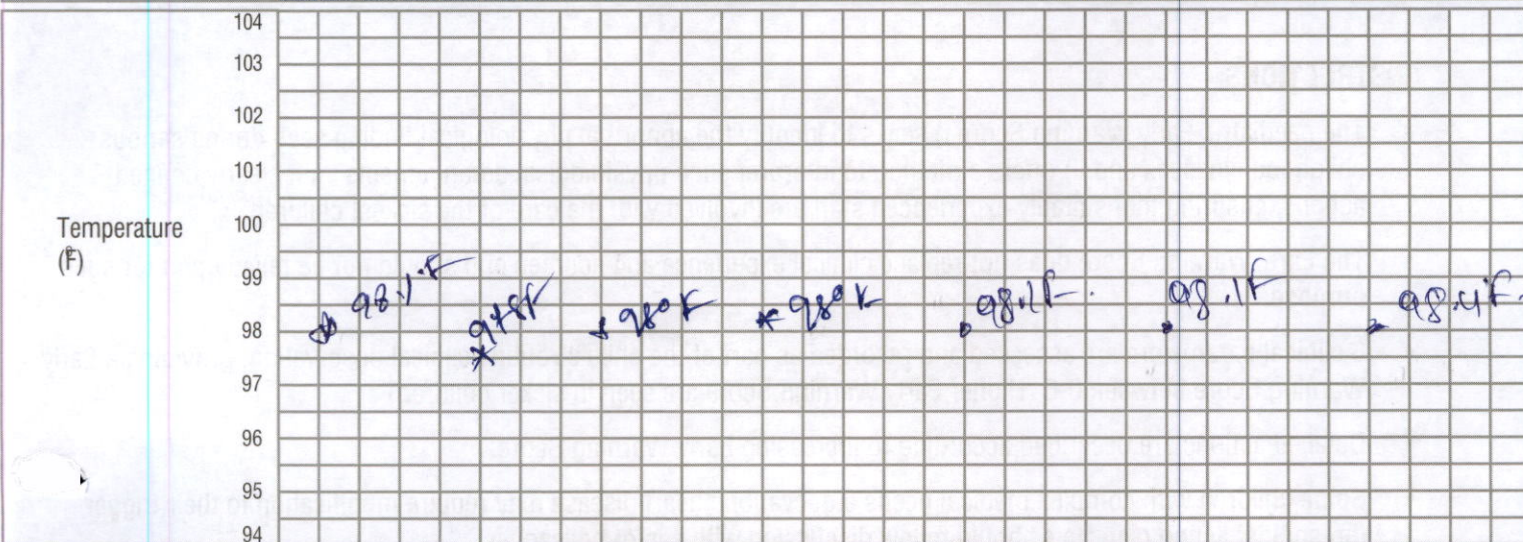
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A	ASSESSMENT : I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : 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)



PRE-SCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 8/1/24 Time: 9AM 1PM 4PM 7PM 10PM 3AM 6AM
Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)	99%	100%
O ₂ Saturations (%)	99%	100%
Conscious Level	Normal	Altered
GCS *	15/15	15/15

TOTAL SCORE	
Number of shaded boxes	0
Pain Score	0
Observer's Initials	S

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

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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)



PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 1/7/23	Time: 9am	1pm	4pm	7pm	10pm	3Am	6Am
Doctor / Nurse / Family Concern?							
Temperature (°F)	104						
	103						
	102						
	101						
	100						
	99						
	98	98.3°F	98.4°F	98.3°F	98.8°F	98.1°F	98.4°F
	97						
	96						
	95						
94							
Heart Rate (bpm)	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100	110	108	110	109	100	107
Blood Pressure (mmHg) *	90	70	75	78	68	67	60
	80						
	70						
	60						
	50						
	100	100	100	100	100	100	100
	90						
	80						
	70						
	60						
50							
Note: BP does not score in early warning scoring							
Heart Rate (Number)	110b/m	108b/m	110b/m	109b/m	100b/m	107b/m	100b/m
Resp. Rate (bpm) (Over 1 Minute) *	70						
	60						
	50						
	40						
	30						
	20						
	10						
	70						
	60						
	50						
40							
30							
20							
10							
Resp Rate (Number)	23b/m	21b/m	23b/m	21b/m	24b/m	24b/m	24b/m
Resp Distress	Mod/ Severe						
None / Mild							
Receiving O ₂ (l/min)							
O ₂ Saturations (%)	99%	98%	99%	98%	98%	98%	99%
Conscious Level	Normal						
Altered							
GCS *	15/15	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE							
Number of shaded boxes	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0
Observer's Initials	S	S	S	S	S	S	S

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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.

*Parents saw,
Not willing
for wheel chair*

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.
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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.

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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)

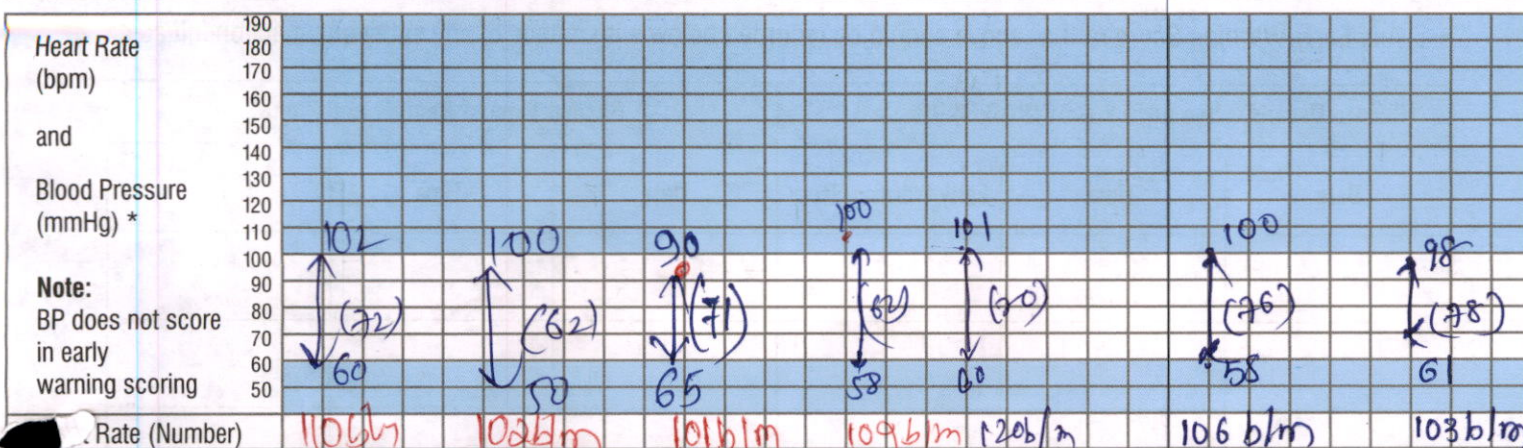
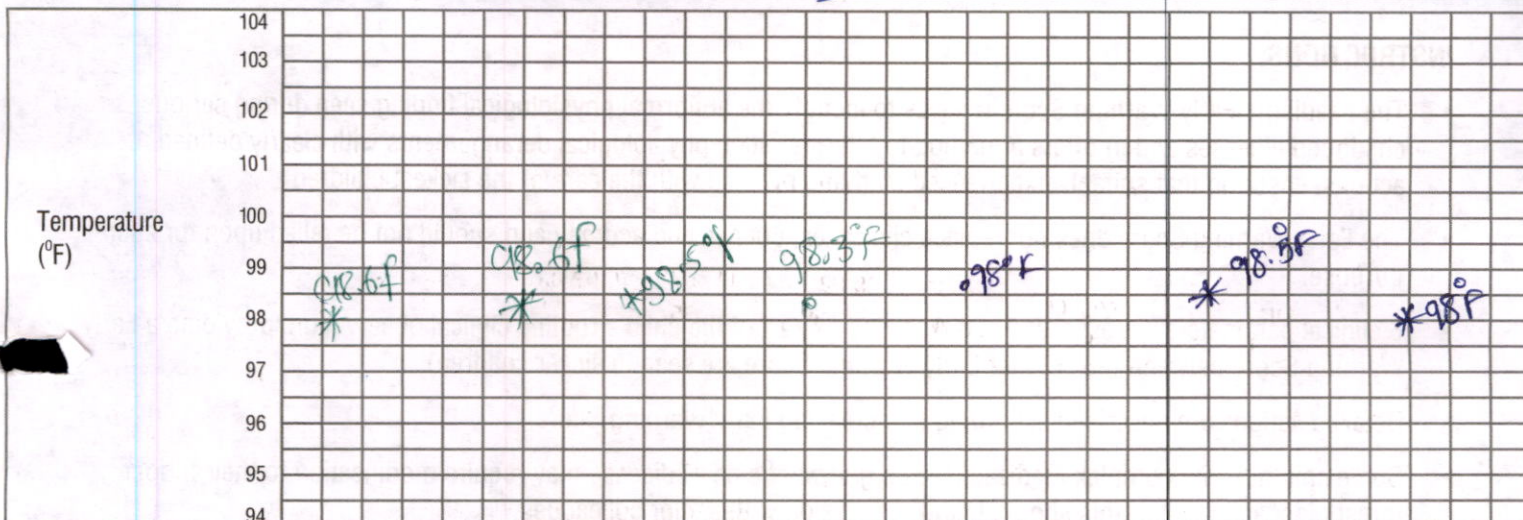


TEENAGE (12 + years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 6/2 Time: 9am 1pm 4pm 7:30 pm 10pm 3am 6am
Doctor / Nurse / Family Concern?



Rate (Number)

Resp. Rate (bpm) (Over 1 Minute)

Resp Rate (Number)

Time	Rate (Number)	Resp. Rate (bpm)	Resp Rate (Number)
9am	110b/m	28b/m	28b/m
1pm	102b/m	26b/m	26b/m
4pm	101b/m	26b/m	26b/m
7:30 pm	109b/m	26b/m	26b/m
10pm	120b/m	26b/m	26b/m
3am	106b/m	26b/m	26b/m
6am	103b/m	22b/m	22b/m

Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		
Conscious Level		
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 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:

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

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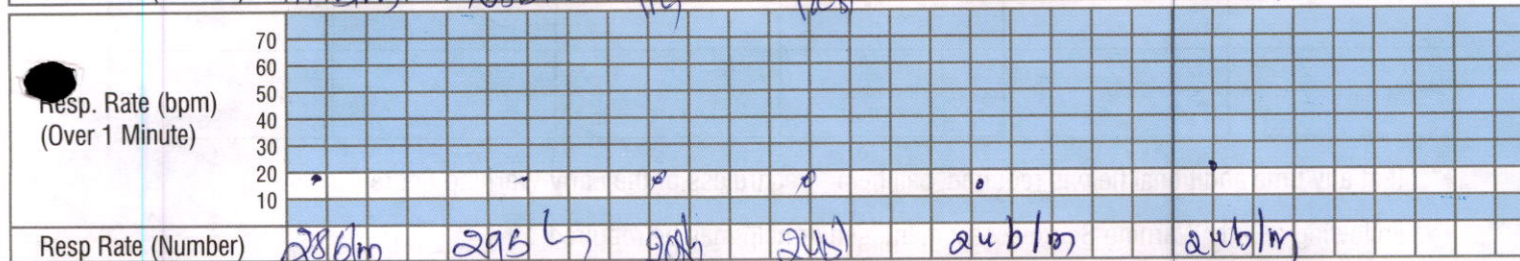
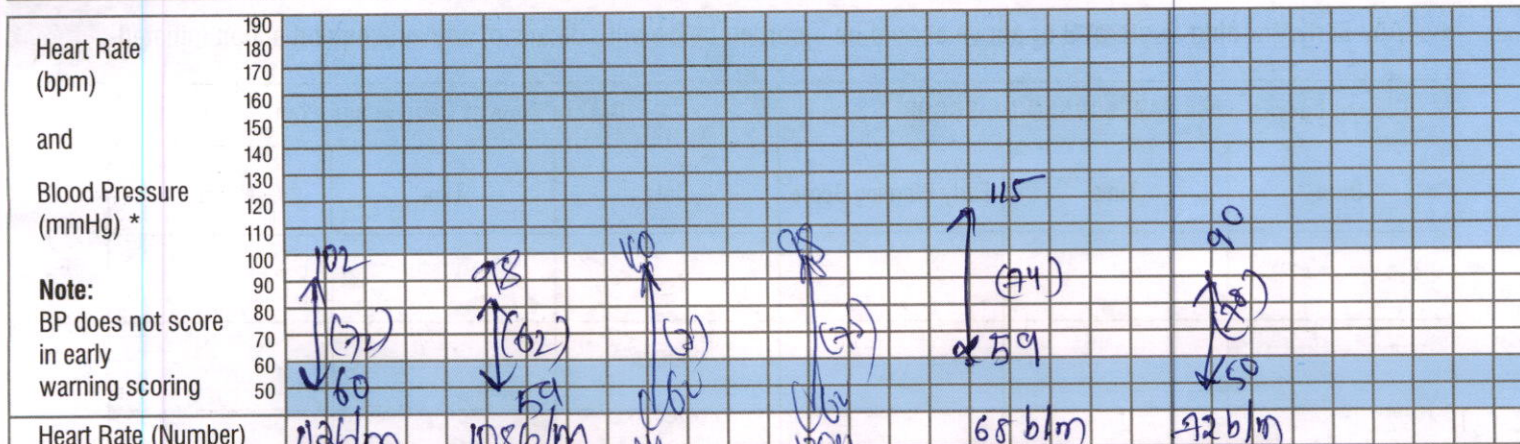
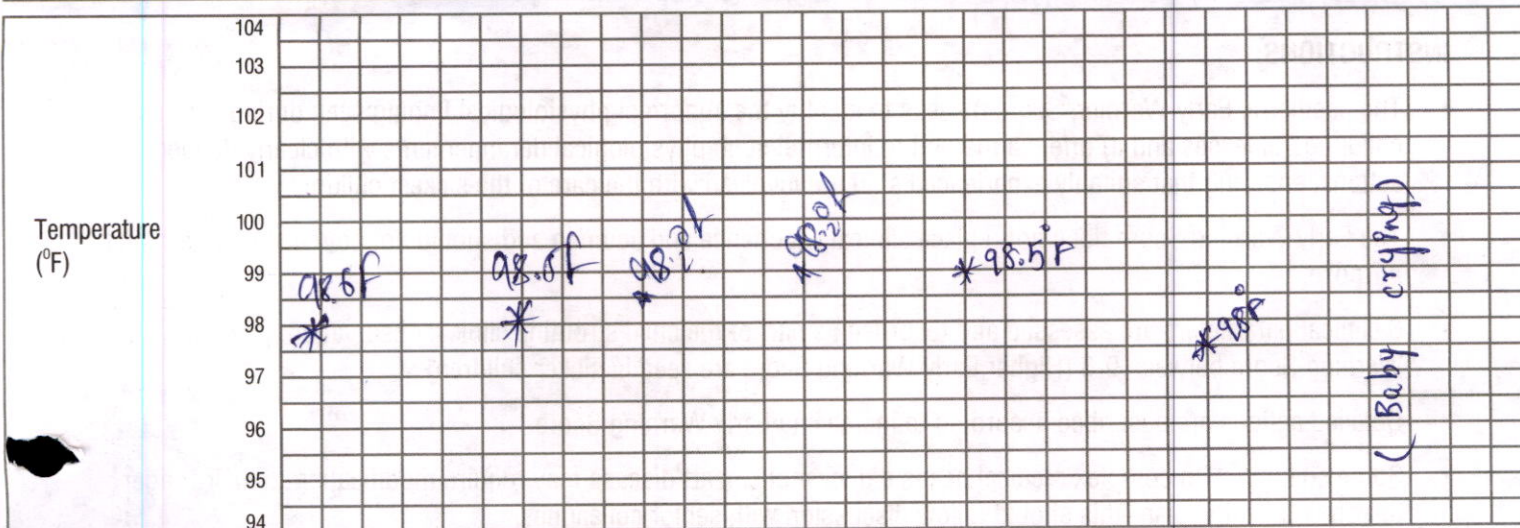
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TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 5/7 Time: 9am 1pm 3pm 7pm 10pm 3am 6am
Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)		
O ₂ 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 to hourly Observation to continue.
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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

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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)

Date: 4/17	Time: 9am	1pm	4pm	7pm	10pm	3am	6am
Doctor / Nurse / Family Concern?							

Heart Rate (bpm)	Blood Pressure (mmHg) *	Heart Rate (Number)
190		
180		
170		
160		
150		
140		
130		
120		
110		
100		
90		
80		
70		
60		
50		
and Note: BP does not score in early warning scoring		112b/min 108b/min 109b/min 102b/min 113b/min 112b/min

Resp Rate (bpm) (over 1 Minute) *	Resp Rate (Number)
28 bpm	28 bpm
29 bpm	29 bpm
28 bpm	28 bpm
29 bpm	29 bpm
28 bpm	28 bpm
29 bpm	29 bpm

Resp Distress	Mod/ Severe None / Mild	-	-	-	-	0	0
Receiving O ₂ (l/min)							
O ₂ Saturations (%)		100 %	100 %	100 %	100 %	99 %	100 %
Conscious Level	Normal Altered	C	C	C	C	C	C
GCS *		15/15	15/15	15/15	15/15	15/15	15/15

[illegible]

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.	
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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)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 3/7..... Time:		9am	10am	11am	12pm	3pm	6pm	
Doctor / Nurse / Family Concern?								
Temperature (F)	104							
	103							
	102							
	101							
	100							
	99	98.2	98.2	98.5	98.6	98.0	98.0	
	98							
	97							
	96							
	95							
94								
Heart Rate (bpm) and Blood Pressure (mmHg) *	190							
	180							
	170							
	160							
	150							
	140							
	130							
	120							
	110							
	100	90 (70)	90 (60)	98 (62)	100 (72)	98 (80)	92 (68)	
90								
80								
70								
60								
50								
Note: BP does not score in early warning scoring								
Heart Rate (Number)		110b/min	110b/min	106b/min	126b/min	102b/min	120b/min	
Resp. Rate (bpm) (Over 1 Minute) *	70							
	60							
	50							
	40							
	30							
	20							
	10							
	Resp Rate (Number)		24b/min	20b/min	26b/min	24b/min	24b/min	24b/min
	Resp Mod/ Severe Distress None / Mild		-	-	-	-	-	-
	Receiving O ₂ (l/min)							
O ₂ Saturations (%)		100%	98%	100%	98%	97%	99%	
Conscious Level		Normal	Normal	Normal	Normal	Normal	Normal	
GCS *		15/15	15/15	15/15	15/15	15/15	15/15	
TOTAL SCORE		0	0	0	0	0	0	
Number of shaded boxes		0	0	0	0	0	0	
Pain Score		0	0	0	0	0	0	
Observer's Initials		SR	SR	SR	SR	SR	SR	

ACTIONS

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 2/2	Time: 9AM	1pm	3PM	7PM	10PM	3AM	6AM	
Doctor / Nurse / Family Concern?								
Temperature (F)	104							
	103							
	102							
	101							
	100							
	99	98.1 F	98.4 F	98.2 F	98.2 F	* 98.5 F	* 98.0 F	
	98							
	97							
	96							
	95							
94								
Heart Rate (bpm) and Blood Pressure (mmHg) *	190							
	180							
	170							
	160							
	150							
	140							
	130							
	120							
	110							
	100							
90								
80								
70								
60								
50								
Note: BP does not score in early warning scoring								
Heart Rate (Number)	102 bpm	102 bpm	112 bpm	100 bpm	102 bpm	100 bpm	102 bpm	
Resp. Rate (bpm) (Over 1 Minute) *	70							
	60							
	50							
	40							
	30							
	20							
	10							
	Resp Rate (Number)							
	22 bpm	22 bpm	22 bpm	20 bpm	20 bpm	22 bpm	22 bpm	
	Resp Distress	Mod / Severe	None / Mild					
Receiving O ₂ (l/min)								
O ₂ Saturations (%)	99%	99%	100%	99%	98%	99%	99%	
Conscious Level	Normal	Altered						
GCS *	15/15	15/15	15/15	15/15	15/15	15/15	15/15	
TOTAL SCORE								
Number of shaded boxes	0	0	0	0	0	0	0	
Pain Score	0	0	0	0	0	0	0	
Observer's Initials	A	S	e	O	B	S	L	

ACTIONS

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Doc. 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 : 11/7/23 Time: 3 PM		10 PM	3 AM	6 AM	
Doctor / Nurse / Family Concern?					
Temperature (F)	104				
	103				
	102				
	101				
	100				
	99				
	98	98.2	98.5	98.0	98.4
	97				
	96				
	95				
Heart Rate (bpm)	190				
	180				
	170				
	160				
	150				
	140				
	130				
	120				
	110				
	100				
Blood Pressure (mmHg) *	130				
	120				
	110				
	100				
	90				
	80				
	70				
	60				
	50				
	40				
Heart Rate (Number)	190				
	180				
	170				
	160				
	150				
	140				
	130				
	120				
	110				
	100				
Resp. Rate (bpm) (Over 1 Minute) *	70				
	60				
	50				
	40				
	30				
	20				
	10				
	0				
	0				
	0				
Resp Rate (Number)	70				
	60				
	50				
	40				
	30				
	20				
	10				
	0				
	0				
	0				
Resp Mod/ Severe Distress None / Mild	70				
	60				
	50				
	40				
	30				
	20				
	10				
	0				
	0				
	0				
Receiving O ₂ (l/min) O ₂ Saturations (%)	70				
	60				
	50				
	40				
	30				
	20				
	10				
	0				
	0				
	0				
Conscious Level Normal Altered	70				
	60				
	50				
	40				
	30				
	20				
	10				
	0				
	0				
	0				
GCS *	70				
	60				
	50				
	40				
	30				
	20				
	10				
	0				
	0				
	0				
TOTAL SCORE	70				
	60				
	50				
	40				
	30				
	20				
	10				
	0				
	0				
	0				
Pain Score	70				
	60				
	50				
	40				
	30				
	20				
	10				
	0				
	0				
	0				
Observer's Initials	70				
	60				
	50				
	40				
	30				
	20				
	10				
	0				
	0				
	0				

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1	: Continue normal observation by staff nurse
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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 Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

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Master SOMASEKHAR SHARMA
21-02-2023 3 Y 4 M 18 D (M)
Dr. SIRISHA RANI



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FLUID CHART

Sheet No. : 10

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
10/2	08:00 am	Pdly					✓				300ml	Clean	
	09:00 am	HRD	200ml										
	10:00 am												
	11:00 am	PDG											
	12:00 pm	Jule	50ml										
	01:00 pm	HRD	150ml							250ml			
Total Intake : 400ml						Total Output : 550ml + 1ml							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake													
Total 24 hrs. Output													



FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
9/2	08:00 am	idly	2							150ml		
	09:00 am	H ₂ O	100ml				✓ (S)					
	10:00 am											
	11:00 am	fruit								200ml		
	12:00 pm	H ₂ O	100ml									
	01:00 pm	Rice								60ml		
Total Intake : 250ml			Total Output : 410ml + 1m									
9/2	02:00 pm											
	03:00 pm	H ₂ O	150ml							200ml		
	04:00 pm	Rice										
	05:00 pm			30ml			✓ (M)					
	06:00 pm	H ₂ O	100ml	30ml								
	07:00 pm	Rice		50ml						190ml		
Total Intake : 400ml			Total Output : 390ml + 1m									
9/2	08:00 pm	fruit		50ml								
	09:00 pm	Rice	100ml	50ml						120ml		
	10:00 pm	fruit		50ml								
	11:00 pm			30ml								
	12:00 am	H ₂ O		30ml								
	01:00 am			30ml						300ml		
Total Intake : 360ml			Total Output : 320ml									
10/2	02:00 am			30ml								
	03:00 am			30ml								
	04:00 am			30ml								
	05:00 am			30ml								
	06:00 am			30ml								
	07:00 am			30ml						300ml		
Total Intake : 180ml			Total Output : 300ml									

Total 24 hrs. Intake

1190 ÷ 49.58 c/kg

Total 24 hrs. Output

1420 ÷ 3.76 c/kg

FLUID CHART

Sheet No. : (2)

- All measurements in ml.
- 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	H ₂ O 100ml									
	09:00 am	100ml					✓			100ml	
	10:00 am										
	11:00 am	H ₂ O 150ml									
	12:00 pm	100ml								80ml	
	01:00 pm										
Total Intake :			250ml			Total Output :			m=1=180ml		
	02:00 pm										
	03:00 pm	Idly					✓ (S)			100ml	
	04:00 pm	H ₂ O 100ml					✓ (S)				
	05:00 pm						✓ (S)				
	06:00 pm	H ₂ O 100ml								150ml	
	07:00 pm						✓ (S)				
Total Intake :			200ml			Total Output :			250ml		
	08:00 pm	Tonote									
	09:00 pm	fruit 200ml									
	10:00 pm	curd									
	11:00 pm	fruit									
	12:00 am						✓ (S)				
	01:00 am	H ₂ O								300ml	
Total Intake :			200ml			Total Output :			300ml		
	02:00 am										
	03:00 am						✓ (S)				
	04:00 am										
	05:00 am									250ml	
	06:00 am										
	07:00 am	100ml									
Total Intake :			100ml			Total Output :			250ml		

Total 24 hrs. Intake

750 ÷ 31.25cc/kg

Total 24 hrs. Output

980 ÷ 2.72cc/kg

m (S)



FLUID CHART

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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.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
7/7	08:00 am	H ₂ O					✓ (M)			100ml		
	09:00 am	H ₂ O					✓ (M)					
	10:00 am											
	11:00 am	H ₂ O					✓ (M)					
	12:00 pm									150ml		
	01:00 pm	Rice										
Total Intake : 150ml						Total Output : 250ml m=2						
7/7	02:00 pm	Rice					✓ (M)					
	03:00 pm	H ₂ O								120ml		
	04:00 pm	H ₂ O					✓ (M)					
	05:00 pm											
	06:00 pm						✓ (M)			100ml		
	07:00 pm	H ₂ O					✓ (S)					
Total Intake : 200ml						Total Output : 120ml n=2						
7/7	08:00 pm	Snacks										
	09:00 pm	Rice								100ml		
	10:00 pm											
	11:00 pm	H ₂ O										
	12:00 am	H ₂ O										
	01:00 am									100ml		
Total Intake : 100ml						Total Output : 200ml						
8/7	02:00 am											
	03:00 am	H ₂ O										
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am									30ml		
Total Intake : 100ml						Total Output : 30ml						

Total 24 hrs. Intake

600 ÷ 25cc/kg

Total 24 hrs. Output

720 ÷ 25cc/kg

m=6



FLUID CHART

Sheet No. : 6

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								
6/7	08:00 am										I	Sany	
	09:00 am	Idly		20ml		✓ (S)							
	10:00 am	H ₂ O 100ml		20ml									
	11:00 am			20ml		✓ (S)							
	12:00 pm			20ml					200ml				
	01:00 pm			20ml									
Total Intake : 200ml					Total Output : 200ml + 20ml								
	02:00 pm	upma		20ml		✓ (S)					I	Sany	
	03:00 pm	Idly		20ml									
	04:00 pm	Water 100ml		20ml		✓ (S)							
	05:00 pm			20ml					120ml				
	06:00 pm	Idly							150ml				
	07:00 pm	Water 100ml											
Total Intake : 280ml					Total Output : 270ml + 10ml								
	08:00 pm		150ml	20ml							I	Sany	
	09:00 pm	Idly	20ml										
	10:00 pm								250ml				
	11:00 pm	H ₂ O 100ml											
	12:00 am												
	01:00 am								100ml				
Total Intake : 250ml					Total Output : 350ml								
	02:00 am										I	Sany	
	03:00 am												
	04:00 am								100ml				
	05:00 am												
	06:00 am												
	07:00 am		150ml						150ml				
Total Intake : 150ml					Total Output : 250ml								
Total 24 hrs. Intake		880 ml ; 56 cc/kg				Total 24 hrs. Output		1,070 ; 2.8 cc/kg/hr					

FLUID CHART

Sheet No. : 5

- All measurements in ml.
- 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		
5/7			Mouth	I.V	N.G							
	08:00 am			50ml			✓			70ml	}	}
	09:00 am	2dy		50ml								
	10:00 am	1ho	100ml	50ml					50ml			
	11:00 am	upr		50ml								
	12:00 pm			50ml			✓					
	01:00 pm			50ml					60ml			
Total Intake :					400ml					Total Output : 180ml + 2(m)		
	02:00 pm	2dy 1plate										
	03:00 pm	1ho	100ml							100ml		
	04:00 pm						✓ (m)					
	05:00 pm											
	06:00 pm	1ho	200ml							200ml		
	07:00 pm						✓ (S)					
Total Intake :					300 ml					Total Output : 300 ml		
	08:00 pm											
	09:00 pm	2dy					✓ (S)			150ml	}	}
	10:00 pm	1ho	150ml									
	11:00 pm											
	12:00 am	1ho	100ml				✓ (D)			250ml		
	01:00 am											
Total Intake :					250 ml					Total Output : 400 ml		
	02:00 am						✓ (S)				}	}
	03:00 am											
	04:00 am									100ml		
	05:00 am											
	06:00 am											
	07:00 am	1ho	100ml				✓ (S)			150ml		
Total Intake :					100 ml					Total Output : 250 ml		

Total 24 hrs. Intake 1,050ml ; 67cc/kg

Total 24 hrs. Output 1,130 ; 3.0cc/kg/hr



FLUID CHART

Sheet No. : 4

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
4/7			Mouth	I.V	N.G						I	R
	08:00 am			50ml								
	09:00 am	N		50ml								
	10:00 am	P		50ml								
	11:00 am			50ml		✓(m)						
	12:00 pm	O		50ml					100			
	01:00 pm			50ml								
Total Intake :					300ml					Total Output : 100		
	02:00 pm			50ml		✓(m)				120ml	I	R
	03:00 pm	Play		50ml								
	04:00 pm	H ₂ O	100ml	50ml								
	05:00 pm			50ml								
	06:00 pm			50ml					200ml			
	07:00 pm			50ml								
	Total Intake :					400ml						
	08:00 pm	adi		50ml							I	R
	09:00 pm			50ml						120ml		
	10:00 pm	H ₂ O	100ml	50ml								
	11:00 pm			50ml						100ml		
	12:00 am			50ml								
	01:00 am			50ml						120ml		
	Total Intake :					400ml						
	02:00 am			50ml							I	R
	03:00 am			50ml						120ml		
	04:00 am			50ml								
	05:00 am			50ml						150ml		
	06:00 am	H ₂ O	50ml	50ml								
	07:00 am			50ml								
	Total Intake :					950ml						

Total 24 hrs. Intake

1450 ÷ 92.9 c/kg/day

Total 24 hrs. Output

1030 ÷ 2.7 c/kg/hr



FLUID CHART

Sheet No. : 3

- All measurements in ml.
- 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							
3/7	08:00 am		27	50ml						100ml		dy
	09:00 am		10	25ml			✓(s)					
	10:00 am	H2O	100ml	100ml						120ml		
	11:00 am			25ml								
	12:00 pm			85ml						50ml		
	01:00 pm			25ml								
Total Intake : 350ml						Total Output : 300ml						
	02:00 pm			50ml			✓(s)			80ml		dy
	03:00 pm	Drug		50ml								
	04:00 pm	H2O	100ml	50ml								
	05:00 pm			50ml			✓(s)					
	06:00 pm			50ml								
	07:00 pm			50ml								
Total Intake : 400ml						Total Output : 80ml						
	08:00 pm			50ml						120ml		pooja
	09:00 pm	Rice		50ml						120ml		
	10:00 pm	H2O	100ml	50ml			✓(s)					
	11:00 pm			50ml						100ml		
	12:00 am			50ml			✓(s)					
	01:00 am			50ml						100ml		
Total Intake : 400ml						Total Output : 440ml						
	02:00 am			50ml			✓(s)					pooja
	03:00 am			50ml						120ml		
	04:00 am			50ml								
	05:00 am			50ml						100ml		
	06:00 am			50ml								
	07:00 am			50ml			✓(M)			100ml		
Total Intake : 300ml						Total Output : 320ml						

Total 24 hrs. Intake

1450 ÷ 92.9 cefg/day

Total 24 hrs. Output

1140 ÷ 73.07 cefg/hr.



FLUID CHART

Sheet No. :

(15.65 kgs)

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
2/2	08:00 am			50ml			✓ (M)			100ml		Gauge
	09:00 am			50ml								
	10:00 am		80ml	50ml						110ml		
	11:00 am			50ml								
	12:00 pm			50ml						120ml		
	01:00 pm			50ml			✓ (M)					
Total Intake : 380ml						Total Output : 330ml						
2/2	02:00 pm			80ml								plus
	03:00 pm	com	100ml	50ml								
	04:00 pm			60ml			✓ (H)			200ml		
	05:00 pm			60ml			✓ (H)					
	06:00 pm			50ml			✓ (SD)					
	07:00 pm	H/O	100ml	50ml						120ml		
Total Intake : 480ml						Total Output : 320ml + 3						
	08:00 pm			50ml								poor
	09:00 pm	Rice		50ml						150ml		
	10:00 pm	H/O	100ml	50ml								
	11:00 pm			50ml								
	12:00 am			50ml								
	01:00 am			50ml						150ml		
Total Intake : 400 ml						Total Output : 300ml						
	02:00 am			50ml								Sonam
	03:00 am			50ml						120ml		
	04:00 am			50ml								
	05:00 am			50ml								
	06:00 am			50ml								
	07:00 am			50ml						130ml		
Total Intake : 300ml						Total Output : 250ml						

Total 24 hrs. Intake

1566 : 100 cc/kg

Total 24 hrs. Output

1200 : 3.1 cc/kg/hr

FLUID CHART

Sheet No. : 1

- All measurements in ml.
- 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			53ml						100ml		
	03:00 pm			53ml						150ml		
	04:00 pm			53						120ml		
	05:00 pm			50ml						216ml		
	06:00 pm			50ml								
	07:00 pm			50ml						200ml		
Total Intake : 309ml						Total Output : 780ml						
	08:00 pm	curd		50ml								
	09:00 pm	rice H ₂ O	100ml	50ml						200ml		
	10:00 pm			50ml								
	11:00 pm			50ml								
	12:00 am			50ml						150ml		
	01:00 am			50ml						100ml		
Total Intake : 400ml						Total Output : 450ml						
	02:00 am			50ml								
	03:00 am			50ml						150ml		
	04:00 am			50ml								
	05:00 am			50ml								
	06:00 am			50ml						250ml		
	07:00 am			50ml								
Total Intake : 300ml						Total Output : 400ml						

Total 24 hrs. Intake

1009; 64 cc/kg.

Total 24 hrs. Output

11630; 4.3 cc/kg/hr

BAH-00659186 IP5-00175816
Master SOMASEKHAR SHARMA
21-02-2023 3 Y 4 M 17 D (M)
Dr. SIRISHA RANI



24

NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 10/2/28

Assessment: patient having weakness

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
8 AM	Assess the patient general condition	8:30 AM	Assessed the patient general condition	
9 AM	monitor vitals	9:20 AM	monitored vitals	patient feels better.
10 AM	maintain fluid balance	10:10 AM	maintained fluid balance	
11 AM	Ensure safety needs	12:20 AM	provided side rails	
2 PM	maintained O/R chart	2 PM	maintained O/R chart	

Re-Assessment: patient is stable

Special Notes:

Nurse Signature: Luna

Nurse Name: Luna

Date & Time: 10/2/28 @ 2 PM

BAH-00659186 IP5-00175816
Master SOMASEKHAR SHARMA
21-02-2023 3 Y 4 M 17 D (M)
Dr. SIRISHA RANI



NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 10/7/26

Assessment: Patient having weakness

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 patient General condition.	8:30pm	→ Assessed the patient General condition.	Patient feel Better
10pm	→ Maintain personal hygiene.	10:30pm	→ Maintained personal hygiene.	
12am	→ Ensure Safety.	12:30am	→ Provided Side rail	
4am	→ Maintain fluid Balance	4:30am	→ maintained fluid Balance	
6am	→ Given medications as order	6:30am	→ Given medications as order.	

Re-Assessment: Patient is active

Special Notes:

Nurse Signature:

Nurse Name: Savitri

Date & Time: 10/7/26 8am

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 9/7/26

Assessment: patient having weakness & Nausea

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 pt general condition	9AM	→ Assessed the pt general condition	pt feels better
10AM	→ Monitor the vital signs	11AM	→ IO clunk & Recorded the vital signs	
12pm	→ provide the supportive care	1pm	→ IO given the oral medication	
2pm	→ Ensure the safety needs	3pm	→ IO provided the side rails	
4pm	→ plan to give chemo	5pm	→ IO connected the chemo as per doctor's order	
6pm	→ maintain the I/O chart	8pm	→ IO clunk & Recorded the vitals → Administered the medication	

Re-Assessment:

Special Notes: TLM CBP, pt feels better

Nurse Signature: [Signature] Nurse Name: Cleary Date & Time: 9/7/26 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/7/20

Assessment: Baby having constipation looking good

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 child General condition	9pm	* Assess the child General condition	Baby for good
10pm	~ monitor vital signs	11pm	~ monitor vital signs	
12Am	~ maintain 2/0 clamp	1Am	~ maintain 2/0 clamp	
2Am	~ Administer medication per a/c	3am	* Administer medication as per doctor order	
4am	~ provide comfort per	5am	~ provide comfort per	
6am		7am		

Re-Assessment: with hourly vital monitoring

Special Notes: watch for diet & any changes

Nurse Signature: [Signature]

Nurse Name: Shree

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



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 8/2

Assessment: Pt having weakness.

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
2 PM	Assess the pt general condition.	2 PM	Assessed the pt general condition.	
4 PM	Maintain I/O chart.	4 PM	continue IV fluid.	
6 PM	Monitor vitals.	6 PM	checked and monitoring vitals.	
8 PM	Maintain personal hygiene.	8 PM	Maintain hand hygiene.	
				Pt felt comfortable.

Re-Assessment: Pt felt comfortable.

Special Notes:

Nurse Signature: (Signature)

Nurse Name: Gargi

Date & Time: 8/2, 8 PM

19

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 8/2/26

Assessment: patient having is anxious

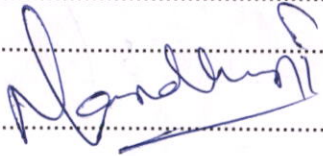
Goals

- | | | | | | |
|---|--|--|---|--|--|
| ☒ 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 general condition of the patient	9am	Assessed general condition of the patient	Patient is stable
10am	Monitor vital signs	11am	monitored vital signs	
12pm	maintain hygiene	12:30pm	maintained hygiene	
1:30pm	Administer medication	1:30pm	Administered medication	
1:45pm	Ensure safety	2:00pm	provided safety	

Re-Assessment: patient is stable

Special Notes:

Nurse Signature: 

Nurse Name: Nandhini

Date & Time: 8/2/26 @ 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/1/26

Assessment: patient is having weakness

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	8:30pm	* Assessed the general condition	patient is comfortable
10pm	* Monitor & note vitals	10:30pm	* Monitored & noted vitals	
12am	* Provide comfortable position	12:30am	* Provided comfortable position	
2am	* Provide supportive care.	2:30am	* Provided supportive care	
4am	* Ensure safety.	4:30am	* Provided pillows & siderails	
6am	* Monitor output	6:30am	* Monitoring output by diaper weight	
7am	* Administer medications	7:30am	* Administered medications as per order.	

Re-Assessment: patient is comfortable

Special Notes:

Nurse Signature: *Ar m*

Nurse Name: Ar m

Date & Time: 8/1/26 @ 8am

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NURSING CARE RECORD

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Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 7 Feb 20

Assessment:

patient having leg pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8:40 AM	→ Assess the patient general condition	9:35 AM	→ assessed the patient general condition	pt was stable
10:35 AM	→ monitor the vital and record	11 AM	→ monitored the vital and record	
12 PM	→ provide ensure safety	1 PM	→ provided ensure safety	
12:35 PM	→ maintain personal Hygiene	3:40 PM	→ maintained personal Hyg	
3 PM	→ prevent infection	4:15 PM	→ prevent infection	
4 PM	→ provide side rail	7 PM	→ provided side rail	
6:45 PM	→ provide patient & family care		→ provide care	

Re-Assessment:

patient was stable

Special Notes:

Path continue same

Nurse Signature: Nandini

Nurse Name: Nandini

Date & Time: 7 Feb 20 8 PM



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6/7/26

Assessment:

patient is having weakness.

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
8 pm	* Assess the general condition	8:30 pm	* Assessed the general condition	
10 pm	* Monitor & note vitals	10:30 pm	* Monitored & noted vitals	Patient is comfortable
12 am	* Provide Comfort position	12:30 am	* Provided Comfort position	
2 am	* Provided Supportive care.	2:30 am	* Provided Supportive care.	
4 am	* Ensure safety,	4:30 am	* Provide side rail & pillows.	
6 am	* Monitor output	6:30 am	* Monitor output by diaper weight	
7 am	* Administer medication as per order.	7:30 am	* Administered medication as per order.	

Re-Assessment:

patient is comfortable

Special Notes:

Nurse Signature:

Am m

Nurse Name:

Am m

Date & Time:

7/7/26 @ 8 am



13

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 6/7/26

Assessment: Patient Having doll activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2PM	TO Assess the baby condition	2:30PM	Assessed the baby condition	Patient feel better
3PM	to monitor vitals and Record	3:30PM	monitored vitals and Recorded	
4PM	to maintain fluid balance	4:30PM	Maintained fluid balance	
5PM	TO Ensure safety	5:30PM	Provided supportive care	
6PM	Administer medication as per doctor's order	6:30PM	Medication given as per doctor's order	
7PM	to maintain Personal Hygiene	7:30PM	Maintained I/O charting	

Re-Assessment: Re-assessment done

Special Notes:

Nurse Signature:

Nurse Name: Moumita

Date & Time: 6/7/26 8PM

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 6/7/26

Assessment: patient having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the patient General condition	8:30am	→ Assessed the patient condition	Feel Better
10am	→ maintain personal hygiene	10:30am	→ Maintained personal hygiene	
11am	→ Maintain fluid Balance.	11:30am	→ Maintained fluid Balance	
12pm	→ Ensure Safety.	12:30pm	→ Ensure Safety	

Re-Assessment:

patient is active

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Swastika

Date & Time: 6/7/26



13

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/2/26

Assessment: Patient having weakness

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 patient.	9Am	→ Assessed the general condition of the patient.	Patient felt better
10Am	→ Monitor vital signs.	11Am	→ Monitored vital signs.	
12Am	→ Provide side rails.	1Am	→ Provided side rails.	
2Am	→ Maintain hygiene.	3Am	→ Maintained side rails.	
5Am	→ Administer medication.	6Am	→ Administered medication.	
7Am	→ Maintain I/O chart.	8Am	→ Maintained I/O chart.	

Re-Assessment: Patient felt better

Special Notes:

Nurse Signature: \$

Nurse Name: Sonam

Date & Time: 6/2 @ 8Am



12

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/7/26

Assessment: Baby having ct hydration looking good

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 child Genis condition	2:30pm	* Assessed the child Gen condition	
3pm	* monitor vital signs	3:30pm	* monitor vital signs	
4pm	* maintain I/O chart	4:40pm	* maintained I/O chart	* Body for good
5pm	* Administer medication as per doctor order	5:10pm	* Administer medication given as per doctor	
6pm	* ct care further	7:10pm	* ct care as per chart	

Re-Assessment: with body water sounds

Special Notes: watch for diet & any changes

Nurse Signature: 

Nurse Name: Shreen

Date & Time: 5/7/26 @ 8pm

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NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 8/6/20

Assessment: patient having weakness

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

Time	Plan of Care	Time	Implementation	Evaluation
8 am	→ Assess the patient	8:30 am	→ Assessed the patient	Feel Better
9 am	General Condition.		General condition.	
	→ Maintain fluid	9:30 am	→ Maintained fluid	
	Balance.		Balance.	
10 am	→ Ensure Safety.	10:30 am	→ Provided Side rail	
11 am	→ Monitor vital signs.	11:30 am	→ Monitored vital signs	
12 pm	→ Monitor Dp chart.	12:30 pm	→ monitored Dp chart	

Re-Assessment: patient is active

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Swiltire

Date & Time: 8/7/2020

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/26

Assessment: patient is having weakness.

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 general condition	8:30pm	* Assessed the general condition	patient is comfortable
10pm	* Monitor vitals and note	10:30pm	* Monitored and noted vitals	
11pm	* Provide comfortable position	12:30am	* Provided comfortable position	
2am	* Provide supportive care.	2:30am	* Provided supportive care.	
4am	* Ensure safety.	4:30am	* Provided pillows & side rail	
6am	* Monitor output.	6:30am	* Monitoring output by diaper weight.	
11am	* Administer medications as per order.	11:30am	* Administered medication as per order.	

Re-Assessment: patient is comfortable

Special Notes:

Nurse Signature: Anu m

Nurse Name: Anu m

Date & Time: 5/7/26 @ 8pm

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21-02-2023 3 Y 4 M 12 D (M)
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NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 4/2/26

Assessment: Patient having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the patient General Condition	8:30am	→ Assessed the patient condition	Patient feel better
10am	→ maintain fluid Balance	10:30am	→ maintained fluid Balance	
12pm	→ Ensure Safety	12:30pm	→ Provided Side rails	
2pm	→ Monitor vital signs	2:30pm	→ monitored vital signs	
4pm	→ monitor I/O chart	4:30pm	→ monitored I/O chart	
6pm	→ Administer medication as order.	6:30pm	→ Given medications as order.	

Re-Assessment: Patient is active

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Sawitri

Date & Time: 4/2 @ 8pm

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7

Assessment: patient having weakness

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 patient general condition	9pm	Assessed the patient general condition	patient is stable.
10pm	monitor vitals	10:15pm	monitored vitals	
12am	Ensure safety.	1am	provided side rails	
2am	Maintain personal hygiene.	3am	To explained personal hygiene	
4am	Administer medications.	5am	Administered medications	
6am	maintain glv chart.	8am	maintained glv chart	

Re-Assessment: patient feels better.

Special Notes:

Nurse Signature: [Signature]

Nurse Name: pooja

Date & Time: 7/7/25 @ 8am

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NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 3/2/26

Assessment: Patient having weakness

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 patient General condition	2:30pm	→ Assessed the patient General condition	Patient feel Better
4pm	→ maintain fluid Balance	4:30pm	→ Maintained fluid Balance	
5pm	→ Ensure Safety	5:30pm	→ provided side rail	
6pm	→ maintain personal hygiene	6:30pm	→ maintained personal hygiene	
7pm	→ Monitor Dp chart	7:30pm	→ monitored Dp chart	

Re-Assessment: Patient feel Better

Special Notes:

Nurse Signature:

Nurse Name: Swathi

Date & Time: 3/2/26 8pm



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 31/2/20

Assessment: Baby hungry & hydration

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 child Genoveses condition	9am	* Assess the child Genoveses condition	
10am	* monitor vital signs	11Am	* monitor vital signs	
11:30Am	* maintain I/O chart	11:40Am	* maintained I/O chart	Baby doing good & feel comfortable
12pm	* Administer medication given as per doctor order	12:30pm	* Administer medication given as per doctor order	
1pm	* Baby for stool	1:30pm	* Baby for stool	

Re-Assessment: with hourly vitals monitor

Special Notes: watch for chills & any other

Nurse Signature: [Signature]

Nurse Name: Shweta

Date & Time: 31/2/20

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 27

Assessment: patient heaving weakness.

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 patient general condition	9pm	assessed the patient general condition	patient feels better.
10pm	monitor vitals	10:15pm	monitored vitals	
12am	maintain personal hygiene.	11am	to explained personal hygiene	
2am	ensure safety needs	3am	provided side rails	
4am	administer medications	5am	administered medications	
6am	maintain I/v chart.	8am	maintained I/v chart.	

Re-Assessment: patient is stable.

Special Notes:

Nurse Signature: pooja

Nurse Name: pooja

Date & Time: 31/28 @ 8am



4

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 21/7/20

Assessment: loose stool baby having ct head cord

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 child Genaral condition	3pm	* Assessed the child Gen condition	* Baby for good
4pm	* monitor vital sign	4:30pm	* monitor vital sign	
5pm	* maintain I/O chart	5:30pm	* maintained I/O chart	
6pm	* Administer medication as per doctor order	6:30pm	* Administered rectal sugar per doctor order	
7pm	* ct care taken	7:30pm	* ct care taken	

Re-Assessment: with hourly vitals monitoring

Special Notes: watch for d/d & any change

Nurse Signature: [Signature]

Nurse Name: Shweta

Date & Time: 21/7/20 @ 8pm

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 2/2/26

Assessment: patient looks anxious

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 general condition of the patient	8:50	Assessed general condition of the patient	Patient is stable
9am	monitor vital signs	9:30am	monitored vital signs	
10am	maintain hygiene	10:30am	maintained hygiene	
11am	Administer medication	11:30am	Administered medication	
1pm	Ensure Safety	1:30pm	provided safety	
12:00pm	maintain I/O chart	2:00pm	maintained I/O chart	

Re-Assessment: patient is stable

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Gayathri

Date & Time: 2/2/26 2:30pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 1/7/26

Assessment: patient is having weakness.

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	8:30pm	* Assessed the general condition	
10pm	* Monitor and note vitals	10:30pm	* Monitored and noted vitals.	patient is
12pm	* Provide comfortable position	12:30pm	* Provided comfortable position	Comfortable
2pm	* Provide supportive care	2:30pm	* Provided supportive care.	
4pm	* Ensure safety.	4:30pm	* Provided pillows & side rails	
6pm	* Monitor output	6:30pm	* Monitoring diaper weight	
7pm	* Administer medications	7:30pm	* Administered medications as per order.	

Re-Assessment:

patient is comfortable

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Anna M

Date & Time: 2/7/26 @ 8pm

BAH-00659186 IPS-00175816
Master SOMASEKHAR SHARMA
21-02-2023 3 Y 4 M 10 D (M)
Dr. SIRISHA RANI



NURSING CARE RECORD

Rainbow[®]
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BirthRight[™]
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Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 1/7/26

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
2pm	Assess the general condition of the baby.	2.40pm	Assessed the general condition of the baby.	Implemented all the procedure.
2.30pm	Monitor vital signs.	2.40pm	Monitored vital signs	
3.10pm	Continue w fluids.	3.10pm	Continued w fluids	
3.30pm	Administer medication as per doctor order.	3.40pm	Administered medication as per doctor order.	
4pm	Watch for loose stool Shift to oncology	4.30pm	Watched for loose stool Shifted to oncology.	

Re-Assessment:

Special Notes: Dates for loose stool

Nurse Signature:

Nurse Name: Merlin

Date & Time: 1/7/26 @

BAH-00859186 IP5-00175816
Master SOMASEKHAR SHARMA
21-02-2023 3 Y 4 M 10 D (M)
Dr. SIRISHA RANI



①

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sirisha Rani Department: Med. Date of Admission: 01/07/20

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known	
BACKGROUND		Medical Condition (Any special condition to be noted):		If Yes Specify: <u>Nil</u>	
ASSESSMENT	Area	Shift Time	12:00 PM - 1:00 PM	1:00 PM - 2:00 PM	2:00 PM - 3:00 PM
	Area	Shift Time	3:00 PM - 4:00 PM	4:00 PM - 5:00 PM	5:00 PM - 6:00 PM
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	98.1°F	98°F	98.0°F
	Res:	22b/m	26	26b/m	
	SpO ₂ :	98%	100%	100%	
	Pulse:	92b/m	110	100b/m	
	BP:	113/60(72)	98/59	93/69(70)	
	Fall Risk Score:	10	10	10	
	Pain Score:	0/10	0/10	0	
	Safety Needs:	Yes	Yes	Side rails	
Recommendations	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:	<u>Nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:	<u>Nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Post Operative Procedure Special Orders:	<u>Nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Handed Over By Name :	<u>Mr. Suresh</u>	<u>Meelin</u>	<u>Anu M</u>	<u>Gangathi</u>	<u>poorja</u>
Signature:	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:	<u>1-7-26</u>	<u>17/26</u>	<u>21/26</u>	<u>27/26</u>	<u>3/7</u>
Time:	<u>12:00 PM</u>	<u>08:00 PM</u>	<u>08:00 PM</u>	<u>08:00 PM</u>	<u>08:00 PM</u>
Taken Over By Name :	<u>Aradhana</u>	<u>Anu M</u>	<u>Gangathi</u>	<u>[Signature]</u>	<u>[Signature]</u>
Signature :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:	<u>17/26</u>	<u>17/26</u>	<u>21/26</u>	<u>27/26</u>	<u>3/7</u>

BAH-00659186
Master SOMASEKHAR SHARMA
21-02-2023 3 Y 4 M 10 D (M)
Dr. SIRISHA RANI



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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. SIRISHA Department: ONCO Date of Admission: 1/2

SITUATION	Diagnosis: <u>1st Bron</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify: <u>1</u>				
	Area	Shift Time	<u>ONCO 8M</u>	<u>ONCO 8PM</u>	<u>ONCO 8AM</u>	<u>ONCO 8AM-8PM</u>	<u>ONCO 8PM-8AM</u>
BACKGROUND	Medical Condition (Any special condition to be noted):		<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
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:		Temp: <u>98.2</u>	<u>98.6</u>	<u>98.4</u>	<u>98.6</u>	<u>98.8</u>
			Res: <u>24</u>	<u>26</u>	<u>26</u>	<u>24</u>	<u>26</u>
			SpO ₂ : <u>99%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>	<u>100%</u>
			Pulse: <u>112</u>	<u>108</u>	<u>102</u>	<u>112</u>	<u>113</u>
			BP: <u>102/61</u>	<u>106/60</u>	<u>98/61</u>	<u>100/62</u>	<u>100/62</u>
			Fall Risk Score: <u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Recommendations	Safety Needs:		<u>Side rails</u>	<u>Side rails</u>	<u>Side rails</u>	<u>Side rails</u>	<u>Side rails</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>Blue</u>	<u>Santhia</u>	<u>Pooja</u>	<u>Santhia</u>	<u>Anam</u>	<u>Blue</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>3/2/23</u>	<u>3/2</u>	<u>4/2</u>	<u>1/2</u>	<u>5/2</u>	<u>5/2</u>
Time:		<u>2M</u>	<u>8PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8AM</u>	<u>8AM</u>
Taken Over By Name :		<u>Santhia</u>	<u>Pooja</u>	<u>Blue</u>	<u>Anam</u>	<u>Santhia</u>	<u>Blue</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>3/2</u>	<u>3/2</u>	<u>4/2</u>	<u>4/2</u>	<u>5/2</u>	<u>5/2</u>



8

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Sirisha Ram Department: Oncology Date of Admission: 1/7

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known				
	B- ALL		If Yes Specify:				
BACKGROUND	Area	Onco 8am-2pm	Onco 2pm-8pm	Onco 8pm-11pm	Onco 11pm-8am	Onco 8am-11pm	Onco 11pm-8am
	Shift Time	Onco 8am-2pm	Onco 2pm-8pm	Onco 8pm-11pm	Onco 11pm-8am	Onco 8am-11pm	Onco 11pm-8am
ASSESSMENT	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	NA	NA
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
RECOMMENDATIONS	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp: 98.6°F Res: 24b/m SpO ₂ : 99% Pulse: 106b/m BP: 100/60/60	Temp: 98.6°F Res: 28b/m SpO ₂ : 100% Pulse: 126b/m BP: 98/50/60	Temp: 98.5°F Res: 26b/m SpO ₂ : 100% Pulse: 105b/m BP: 100/50	Temp: 98°F Res: 26b/m SpO ₂ : 100% Pulse: 106b/m BP: 98/60/20	Temp: 98.3°F Res: 23b/m SpO ₂ : 99% Pulse: 103b/m BP: 96/60	Temp: 98°F Res: 26b/m SpO ₂ : 108b/m Pulse: 118b/m BP: 93/60/20
RECOMMENDATIONS	Safety Needs:	Side rail	Side rail	Side rail	Side rail	Side rail	Side rail
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
RECOMMENDATIONS	Others Specify:	NA	NA	NA	NA	NA	NA
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
RECOMMENDATIONS	Other Special Orders / Medications:	NA	NA	NA	NA	NA	NA
	Post Operative Procedure Special Orders:	NA	NA	NA	NA	NA	NA
RECOMMENDATIONS	Handed Over By Name :	Sarom	Savitter	Moornita	Amam	Amam	Amam
	Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
RECOMMENDATIONS	Date:	6/7	6/7	6/7	7/7	7/7	8/7
	Time:	8am	2pm	8pm	8pm	8pm	8pm
RECOMMENDATIONS	Taken Over By Name :	Savitter	Moornita	Amam	Amam	Amam	Amam
	Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
RECOMMENDATIONS	Date:	6/7	6/7	6/7	7/7	7/7	7/7
	Time:	8am	2pm	8pm	8am	8pm	8pm

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. SIRISHA RANI Department: Oncology Date of Admission: 1/2

SITUATION		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify: <u>NA</u>						
BACKGROUND	Area	0800-2000	0800-1200	0800-1200	0800-1200	0800-1200	0800-1200	
	Shift Time	0800-2000	0800-1200	0800-1200	0800-1200	0800-1200	0800-1200	
ASSESSMENT	Medical Condition (Any special condition to be noted):	NA	NA	NR	NA	NA	NA	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ASSESSMENT	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	98.1°F	98.0°F	98.0°F	98.6°F	98.6°F	98.4°F
		Res:	22b/m	28b/m	24b/m	26b/m	28b/m	28b/m
		SpO ₂ :	99%	99%	100%	100%	100%	99%
		Pulse:	102bpm	120b/m	122b	106b/m	112b/m	112b/m
		BP:	101/62	90/60	100/60	96/60	108/60	106/60
		Fall Risk Score:	10	10	10	10	10	10
	Pain Score:	0	0	0	0	0	0	
Recommendations	Safety Needs:	yes	yes	yes	side rails	side rails	side rails	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NA	NR	NR	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NR	NR	NA	NA	NA	
Handed Over By Name :		Nandini	Gargi	Blay	Veeng	Subhanur	Veeng	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		8/2/26	8/2	8/2/26	9/7/26	10/2	10/7/26	
Time:		2pm	8pm	8am	8pm	8am	2pm	
Taken Over By Name :		Gargi	Subhanur	Veeng	Subhanur	Veeng	Veeng	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		8/2	8/7	9/7/26	9/7	10/7/26	10/7	
Time:		2pm	8pm	8:05pm	8pm	8:05am	2pm	



PAIN ASSESSMENT FORM

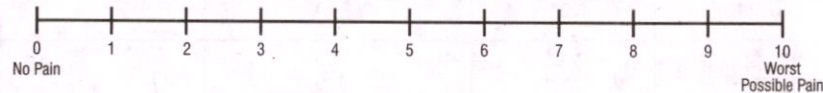
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
8/1	2AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Am m
8/1	10AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Nausea
8/2	6PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	SL
9/1	2AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shy
9/1	12AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Clear
9/1	6PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Clear
10/1	2am	0	ND	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	ND	Sang
10/1	12AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Clear
				☐ 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

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years



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

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 - slow recovery - 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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
4/2	6pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
5/7	2Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
5/2	10am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
5/2	6pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
6/2	2Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
6/2	10am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
6/2	6PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
7/7	2Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
7/7	10Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
8/2	6pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]

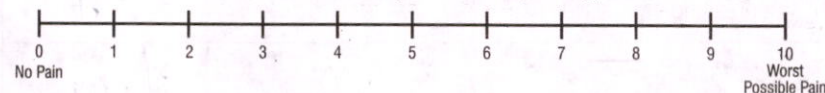
Re-assessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
a) At least every 2 hours for the first 24 hours
b) Then every 4 hours.
c) Prior to pain pain-relieving intervention.
d) Within 30 – 60 minutes 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

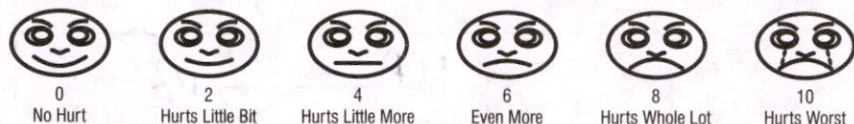
Numerical Pain Scale (Obstetric and Gynecology)



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





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
01/07/16	11:15 AM	0/10	Uterus	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil Nil	Doc
1/7	7pm	0	N/A	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	N/A	Form
2/7	3PM	0	N/A	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	N/A	Doc
2/7	12pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	G
2/2	6pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shrey
3/7	2AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	et.
3/7	10am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sey
3/7	6pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sey
4/7	2AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	(P)
4/7	10am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	(P)

Re-assessment Frequency:

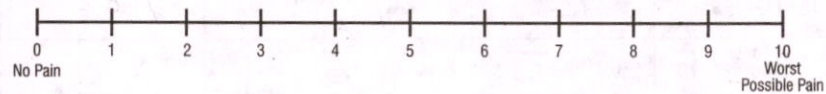
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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	Archng, 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





THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	6/7	7/7	8/7	9/7	10/7
	3 to less than 7 years old	3	3	3	3	3	3
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	1
Diagnosis	Neurological Diagnosis	4				1	1
	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				1	
	Forget Limitations	2					
	Oriented to own ability	1	1	1	1	1	1
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	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			10	10	10	10	10

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		Yes	Yes	Yes	Yes	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	No	No	No	No
Other Intervention(s) Specify		No	No	No	No	No
Nurse's Name:		Ann	Ann	Ann	Ann	Ann
Signature:		Ann	Ann	Ann	Ann	Ann
Date:		6/7	7/7	8/7	9/7	10/7
Time:		8:00	8:00	8:00	8:00	8:00



THE HUMPTY DUMPTY SCALE

01/07/26
2/7

3/7 4/7 5/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	2	3	3	3
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	1
agnosis	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					
	Oriented to own Ability	1	1	1	1	1	1
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	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			10	10	10	10	10

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	Yes	Yes	Yes	Yes	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	No	No	No	No
Other Intervention(s) Specify	No	No	No	No	No
Nurse's Name :	Arun	Arun	Pooja	Pooja	Arun
Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :	01/07	2/7	3/7	4/7	5/7
Time :	11:41	8 AM	8 AM	8 AM	8 AM

BRADEN 'Q' SCALE



					Date : 17/2/23	Time : 8:15 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 extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	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		
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		
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		
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		
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		
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		
TOTAL SCORE					18	18		
Evaluator's Name								

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



BRADEN 'Q' SCALE

					Date :	5/2	6/2	7/2	8/2
					Time :	8 am	8 am	8 am	8 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 extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	Y	Y	Y	Y	
"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.	Y	Y	Y	Y	
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.	Y	Y	Y	Y	
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.	Y	Y	Y	Y	
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."	Y	Y	Y	Y	
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.	Y	Y	Y	Y	
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.	Y	Y	Y	Y	
TOTAL SCORE					28	28	28	28	
Evaluator's Name					SS	SS	SS	SS	

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)
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BAH-00659186

IP5-00175816

Master SOMASEKHAR SHARMA

21-02-2023

3 Y 4 M 11 D

(M)

Dr. SIRISHA RANI



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 :	01/07/21	27	31	4/7
					Time :	11:15a	8:00a	8:00a	8:00a
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
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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	
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				
					Evaluator's Name				
					28 / 28 / 28 / 28				
					Rani / Anam / [Signature] / [Signature]				



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

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00659186 IP5-00175816 Master SOMASEKHAR SHARMA 21-02-2023 3 Y 4 M 10 D (M) Dr. SIRISHA RANI 		Date & Time of Admission 01/04/26 @ 11:35am	Date & Time of Transfer Order 01/04/26 @ 12 pm
		Transfer Ordered by Dr. Ramya	Reason for Transfer Admission.
From Unit ER	To Unit ONCO.	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 19	Number of Imaging Films nil.	Personal belongings including clinical documents. If any handed over to attendant OP file Yes ☒ No ☐ If yes, what?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	nil		
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Mr. Sushrta		Name of Person Ordered Transfer Dr. Ramya	
Patient & Clinical Records Received by : Sushrta			
Date & Time of Patient Received : 11/2/26 12:12pm			

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



NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 17/2/26 Time: 12:15 PM

Weight: 15.6 kgs Centile: > 50th

Height: 98 cms Centile: > 50th

Inference: well child

RDA: - Calories: 1300 kcal/d Protein: 22 g/d

Diet Recommendations: child is on NPO

Re-Assessment:

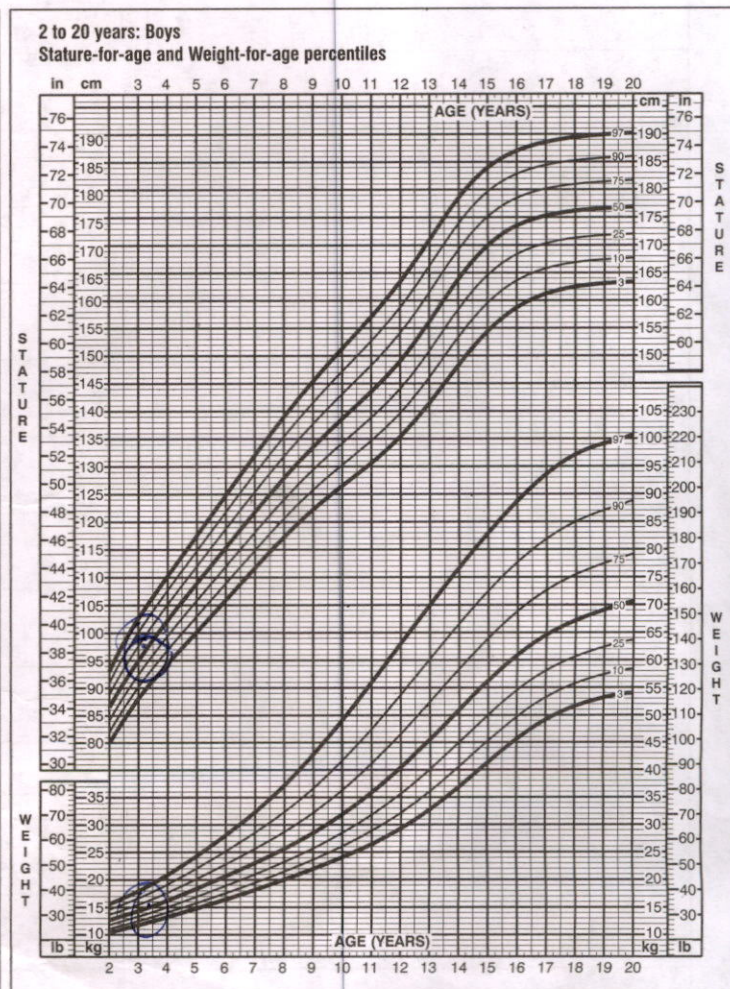
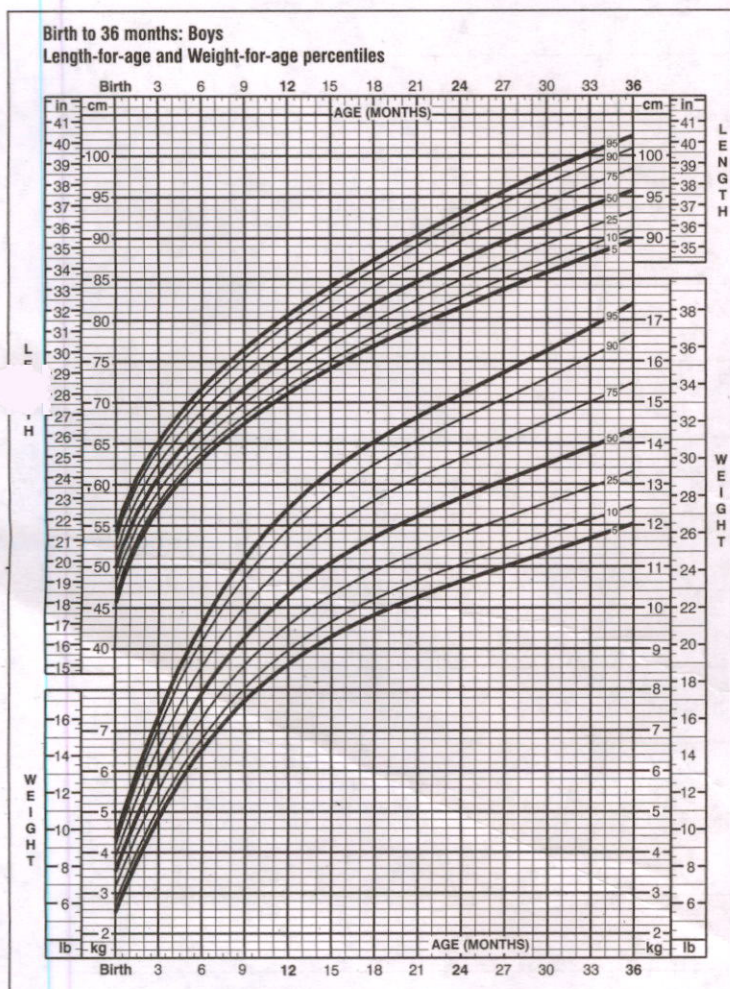
Food Allergies: NO Veg/Non-veg: veg

Diagnosis: c/clo B cell ALL E AGE

Nutritional Intervention - ☐ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: parent's don't need dietitian. Don't charge for NHA.

GROWTH CHART (BOYS)



Dietician's Name: Niritha

Dietician's Signature: Niritha

Daily Notes: