

ADMISSION SHEET



Registration Details :

Admission No : IP26-00006685 **Admit Date :** 29-Jun-2026 **Admit Time :** 02:45 PM **UHID :** HNH-00016246

Patient Details :

Patient Name	: Master POKALA PRANAV RAJGOPAL	Age	: 16 Y 5 M 0 D
Guardian	: Mr POKALA LAXMAIAH	DOB	: 29-01-2010
Gender	: Male	Religion	:
Occupation	:	Martial Status	:
Address (H)	: H.NO:-4-1-821/B,VIKARABAD Vikarabad Ranga Reddy Telangana INDIA 501101	Phone No	: 9052614468
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : ER01 **Ward Name** : GF -EMERGENCY
Room No : ER01 **Admission Type** : First Visit

Contact Details :

Name : Mr POKALA LAXMAIAH **Relationship** : Father
Contact Address : H.NO:-4-1-821/B,VIKARABAD Vikarabad
Ranga Reddy Telangana INDIA 501101 **Phone No** : 9052614468

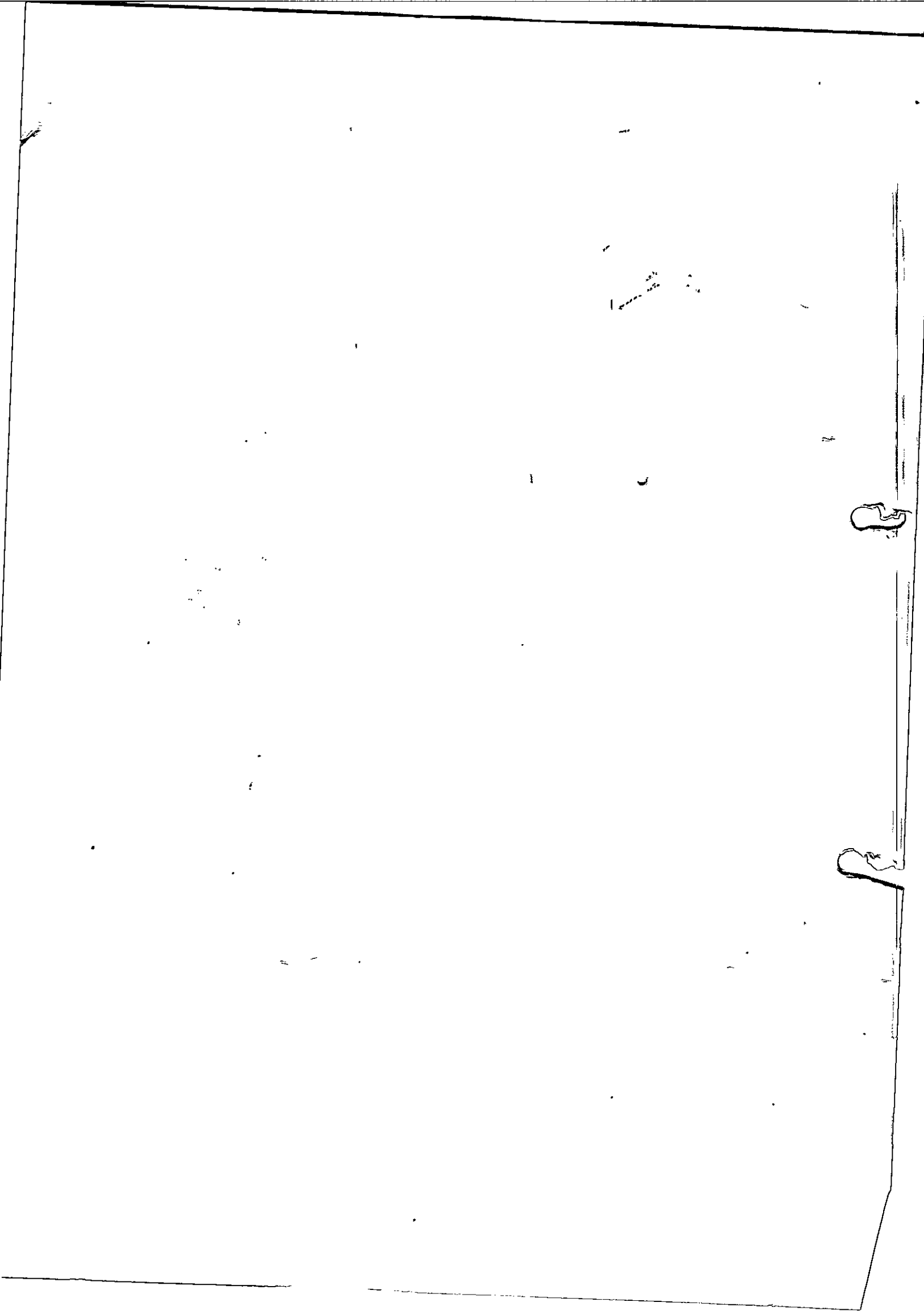
P. Laxmaiah
Signature

Doctor Details :

Doctor Name : Dr. SINDHURA MUNUKUNTLA **Specialisation** : GENERAL PEDIATRICS
Referral Doctor : Dr Haranath M **Phone No** : 9391013987
Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 10000.00
Payor Name : ICICI ICICI LOMBARD GENERAL INSURANCE



ACTIVITY

HNH-00016246 IP26-00006685
Master POKALA PRANAV RAJGOPAL
29-01-2010 16 Y 5 M 0 D (M)
Dr. SINDHURA MUNUKUNTLA

Name: -----
UHID No: --  ----- Consultant: ----- Dept: -----

Date of Admission: 29/06/26 Time: 2:45PM Date of Discharge: ----- Time: -----

Room / Bed No: 3rd floor Ward: 213 Suggested Billable bed type: -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<u>29/06/26</u>	<u>3:40PM</u>	<u>ER</u>	<u>3rd floor/313</u>	<u>[Signature]</u>

Cross Consultation Visit

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

INVESTIGATIONS

Dr. SINDHURA MUNUKUNTLA

29-01-2010

16 Y 5 M 0 D

(M)

Master POKALA PRANAV RAJGOPAL

29-01-2010

16 Y 5 M 0 D

(M)

Dr. SINDHURA MUNUKUNTLA

29-01-2010

16 Y 5 M 0 D

(M)

Date	Investigations	Order No.	Sign
	CAR (PA)	7741	
29/6/20	CBP, CRP, Blood c/s Respiratory panel	10606	
	Dengue NS1 + Dengue Igm	10634	
29/6/20	CUE	106150	
cross checked done by maheshwari			

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

Date	Procedure	Quantity	Order No.	Signature
26/06/26	Iv placement	(1)	9279	
27/6/26	NHA	(1)	9308	

cross checked done by maheshwarji

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10



Rainbow[®] Children's Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : _____

HNH-00016246 IP26-00006685
Master POKALA PRANAV RAJGOPAL
29-01-2010 16 Y 5 M 0 D (M)
Dr. SINDHURA MUNUKUNTLA

Patient ID# : _____



Consultant : _____

Final Diagnosis : _____

Pediatric Multisystem History & Physical Examination

HNH-00016246 IP26-00006685
Master POKALA PRANAV RAJGOPAL
29-01-2010 16 Y 6 M 0 D (M)
Dr. SINDHURA MUNUKUNTALA

Name :

Age/Sex

Informant

Reliability



Chief Presenting Complaints & Duration (Chronologically):

History of present illness :

40 km :: day
Cough :: 5 days
Poor oral intake

Reduced urine output
dull activity

fever x 5 days, high grade, documented up to 104 F, also chills, partially relieved on oral medications also abdominal pain in right iliac region

Cough x 5 days, dry, type, aggravated during night

Also poor oral intake
Reduced urine output
dull activity

Reduced Tachycardia x 2 days

Outside reports: CBCP:- Hb:- 14.9 / TLC:- 6.66k

plt:- 2.34 lakh

(MC/L - 70.5/10.7)

CRP:- 9

Widal:- (1:80) -> Typhoid & H Ag
Malaria - Negative

Pediatric Multiorgan History & Physical Examination

HNH-00016246 IP26-00006685
Master POKALA PRANAV RAJGOPAL
29-01-2010 16 Y 5 M 0 D (M)
Dr. SINDHURA MUNUKUNTALA

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

Birth & Neonatal History :

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Immunization History :

Pediatric Multiorgan History & Physical Exam

HNH-00016246 IP26-00006685
Master POKALA PRANAV RAJGOPAL
29-01-2010 16 Y 5 M 0 D (M)
Dr. SINDHURA MUNUKUNTALA



Anthropometry

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

Weight (kgs) 53 kg (Centile _____)

On Examination :

Temperature : 102 F Pulse Rate: 136/min Description _____

B.P. 116/67 mm Hg SPO2 98% @ RA at _____

Resp. rate and type of breathing : _____

Rash _____

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any added sounds : _____

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

*Redness of eyes ⊕
Throat - congested
Sign of dehydration ⊕
dry tongue, lips
Tender eyes ⊕, dull activity
reduced ↓ urine output
BAC ⊕ B/L crackles ⊕
B/L crepts ⊕*

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S₁ S₂ ⊕

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : S₁ S₂ ⊕

Auscultation : _____

Spine: _____ External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

HNH-00016246 IP26-00006685
Master POKALA PRANAV RAJGOPAL
29-01-2010 16 Y 5 M 0 D (M)
Dr. SINDHURA MUNUKUNTLA



Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

Cranial Nerves : _____

Motor System :

Nutrition : _____

Tone : _____

Power _____

NAD

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

(Lower Respiratory LRTI + Dehydration,
Tract Infection)

Pediatric Multiorgan History & Physical Exam

HNH-00016246 IP26-00006685
Master POKALA PRANAV RAJGOPAL
29-01-2010 16 Y 6 M 0 D (M)
Dr. SINDHURA MUNUKUNTLA



Preventive aspects of the treatment :

prevent complications

Desired goals of the treatment :

Planned Labs :

CBP, CRP,

TB cood C/S

CVE + (DUE)

C 2 Plani smears

Chest x-ray 1 A view

Respiratory panel (5 viruses)

Planned Management :

- IV fluids 2/3rd way

- TAB. PARACETOMOL

- Ijg Ondansetron 50%

- Run OP

Notes by Dr. Harekrishna

Please fill up the following details

1. Name of the Referring Doctor : *Dr. Harekrishna*

2. Name of the Referring Hospital :
(Including the name of City)

3. Contact number of the Referring Doctor :
(Preferring Mobile #)

4. Name of the doctor in Rainbow Team *Dr. Sindhu - M* on
whose name the patient is being referred

Doctor's Signature Name *[Signature]* Date *30/8/26* Time *2:15pm*

Patient Sticker



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

HNH-00016246 IP26-00006685
Master POKALA PRANAV RAJGOPAL
29-01-2010 16 Y 5 M 0 D (M)
Dr. SINDHURA MUNUKUNTLA

Page: 2/4



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : NACIMON DROPS				Date Time	29/6	9/6														
Dose	Route	Frequency	Start Dt.																	
20	Nose	TID	29/6	6AM																
Name & Signature of the Doctor Starting the Drugs:				[Signature]																
Additional Instructions:				[Signature]																
Daily Doctor's Endorsement by a Sign																				
DRUG : 2gm. CEFTRIAXONE				Date Time	29/6	20/6														
Dose	Route	Frequency	Start Dt.																	
2gm	IV	BD	29/6	6AM																
Name & Signature of the Doctor Starting the Drugs:				[Signature]																
Additional Instructions:				[Signature]																
Daily Doctor's Endorsement by a Sign																				
DRUG : Cap FUWIR				Date Time																
Dose	Route	Frequency	Start Dt.																	
1 cap	PO	BD	30/6/26																	
Name & Signature of the Doctor Starting the Drugs:				[Signature]																
Additional Instructions:				[Signature]																
(OSELTAMIVIR 75mg)																				
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																				

Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

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

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

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

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

Dr. SINDHURA MUNDKUNTER

Date Time								
		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.

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

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

[illegible]

Weight. 53 kgs Ward.

[illegible]

Signature

VERIFIED BY: Name: _____



MEDICATION RECONCILIATION FORM

Drug Allergies: Nil ☐ 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: 3rd floor / 1313

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. S. Suresh

Date & Time: 29/06/2010 @ 2:40 PM

Nurse Name & Signature: Atanu

Date & Time: 29/06/2010 @ 3:40 PM

1114

Dr. Phrasph...

09/01/2015 9:22/2015

Attest: _____

20/06/2019 3:06 PM

313

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 29/6/28 Time: 5pm

Weight: 52kg Centile: 50th

Height: 5.8 Centile:

Inference: well nourished child

RDA: Calories: 1900kcal/d Protein: 34gms/d

Diet Recommendations: Normal high protein diet with more liquids

Re-Assessment: Avoid spicy, chutney & outside foods

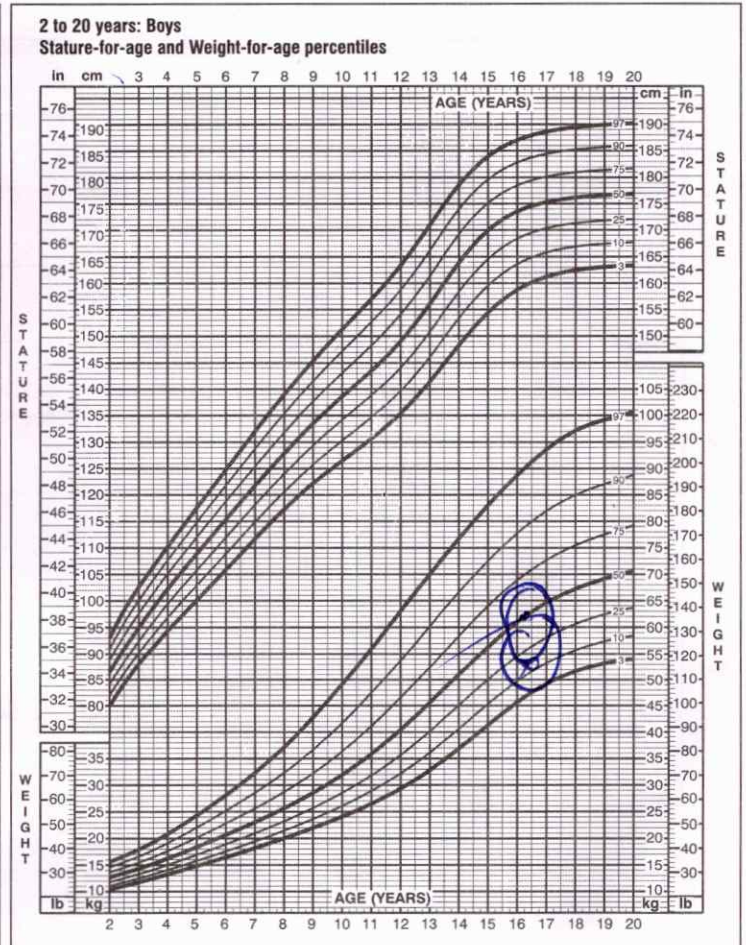
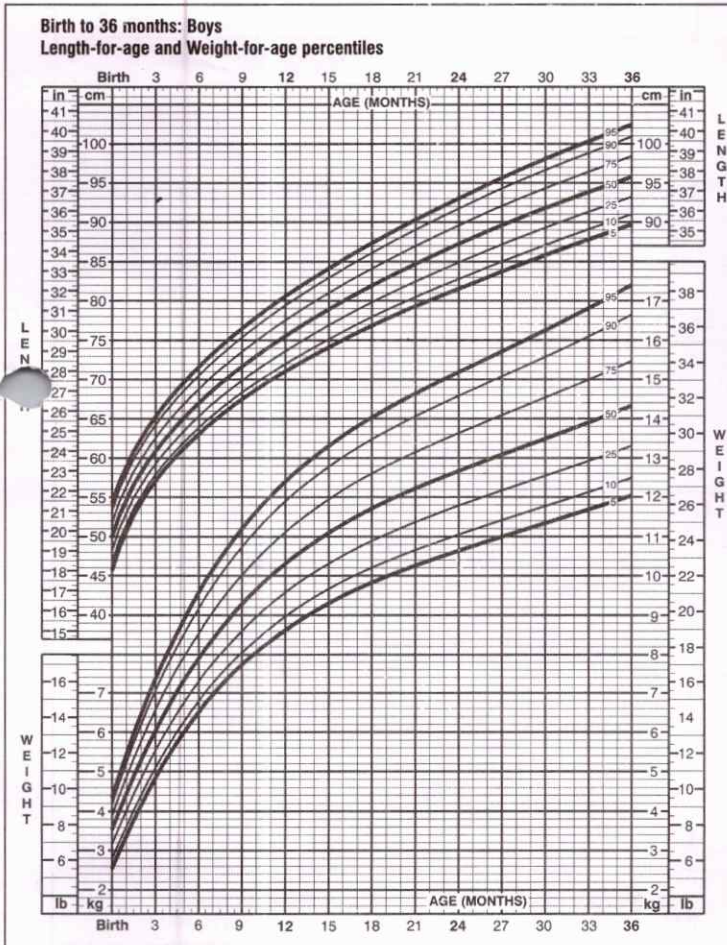
Food Allergies: NO Veg/Non-veg: veg.

Diagnosis: LRTI & dehydration

Nutritional Intervention - ☐ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: P. Laxmi

GROWTH CHART (BOYS)



Dietician's Name: Sathwik
Dietician's Signature: S

[illegible]



wt - 53 kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name: Baby Pranav Rajgopal Age: 16y. Gender: ☒ Male ☐ Female
Date: 29/6/16 Time of Arrival: 2:10pm

Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Blood Transfusion ☐ Other (Specify): ☐ Not known

Source of Information: ☒ Parents ☐ Others (Specify):

Mode of Arrival: ☒ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 102.2°F PR: 102b/m BP: 116/65/81 RR: 100% SpO₂: 100%

Chief Complaints: elo Fever, cold cough x 5 days.

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance	Work of Breathing	☒ Stable
☒ Normal	☒ Normal	☐ Unstable:
☐ Sick Looking	☐ Increased	☐ Not - Life - Threatening
☒ Normal	☐ Decreased	☐ Life -Threatening
☐ Abnormal	☐ Gasping / Apnea	
☐ Bleeding		

Triage Classification	CTAS
☐ Level 1: Resuscitation	☐ Immediate
☐ Level 2: EMERGENT: Life or limb threatening	☐ < 15 min
☐ Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening	☒ 30 min
☐ Level 4: LESS URGENT: Significant illness but not life threatening	☐ 60 min
☐ Level 5: NON - URGENT: May receive care when convenient	☐ 120 min

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time: 2:12pm

Communicable Disease Triage Screening

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

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

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

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

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

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

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

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse: Atanu

Signature of Triage Nurse: [Signature]

Date & Time: 29/06/2016 @ 2:12pm

10. 10. 1971

10. 10. 1971
10. 10. 1971
10. 10. 1971

10. 10. 1971
10. 10. 1971
10. 10. 1971

10. 10. 1971

10. 10. 1971

10. 10. 1971
10. 10. 1971



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 29/06/2010 Time of arrival: 2:14 PM

Chief Complaints: elo Fever cold cough x5 days RBS:

Height: Weight: 10.62 kg BMI: Head Circumference (<2 years)

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

If yes, identify

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

☐ Character ☐ Location ☐ Frequency ☐ Duration

RISK FOR FALL:

☐ If patient is < 6 years
tick below fall risk intervention directly

☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☒ No

Ambulatory Aids:

• Wheelchair ☐ Yes ☒ No
• Uses furniture for support ☐ Yes ☒ No

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

If Yes Consultant Notified: (Date/Time): 29/06/2010 2:14 PM

Social History: Lives With Family

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

Time of Initial assessment completed by ER Nurse: 2:14 PM / [Signature]

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

Time	Nursing Notes
	Assess the Patient general condition
	monitor vitals

Samples collected by:

Samples sent by:

Apurba @ 20/06/26

Time:

Time:

3:15pm

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 110b/m BP: CFT: RR: SPO ₂ : 98% GCS: Temperature: 99.3°F Pain Score: 0 Repeat RBS (if applicable):	Shift - out from ER to: 2nd floor / 813 Time of Shift - out: 3:40pm. Handover given to: [Signature] (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

IV Phenylnet Dom

Name of the Nurse :

Alana

Signature of the Nurse :

[Signature]

Date & Time :

20/06/26 @

PATIENT TRANSFER FORM

HNH-00016246 IP26-00006685 Master POKALA PRANAV RAJGOPAL 29-01-2010 16 Y 5 M 0 D (M) Dr. SINDHURA MUNUKUNTLA 		Date & Time of Admission 29/06/26 @ 3:15 pm	Date & Time of Transfer Order 29/06/26 @ 3:30 pm
		Transfer Ordered by Dr. Shrusantha.	Reason for Transfer Admission.
From Unit ETZ	To Unit	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 2	Number of Imaging Films 1	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring Atanu / [Signature]		Name of Person Ordered Transfer Dr. Shrusantha.	
Patient & Clinical Records Received by : [Signature] : 29/6/26 @ 3:30 pm			
Date & Time of Patient Received :			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

4, 37, 1

2, 57, 1

1, 1, 1

1, 1, 1

1, 1, 1

1, 1, 1

8

HNH-00016246 IP26-00006685
Master POKALA PRANAV RAJGOPAL
29-01-2010 18 Y 5 M 0 D (M)
Dr. SINDHURA MUNUKUNTLA



30

307

RESULT SHEET

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date	29/6/26					
Time						
Hb	14.5					
PCV	41.2					
RBC	4.82					
WBC	4.94					
N/L						
Platelets	206					
CRP	20					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein/Sugar						
Cells						
N/L						

Date	29/6/26					
Time						
CUE-Alb						
CUE-Sugar	NIL					
CUE - Ketones	(+)					
CUE-PUS Cells	5-6					
CUE - RBC Cells	8-10					
CUE - Epithelial	3-5					
Nitroite	(-)ve					
Stool Pus Cell						
OVA/Cyst						
Occult Blood						
Dengue NSI +						
IgM	(-)ve					
* Influenza B	(+)ve					

Culture and Sensitivities : Blood c/s

Radiology: USG :

X-Ray:

ECHO:

CT:

MRI

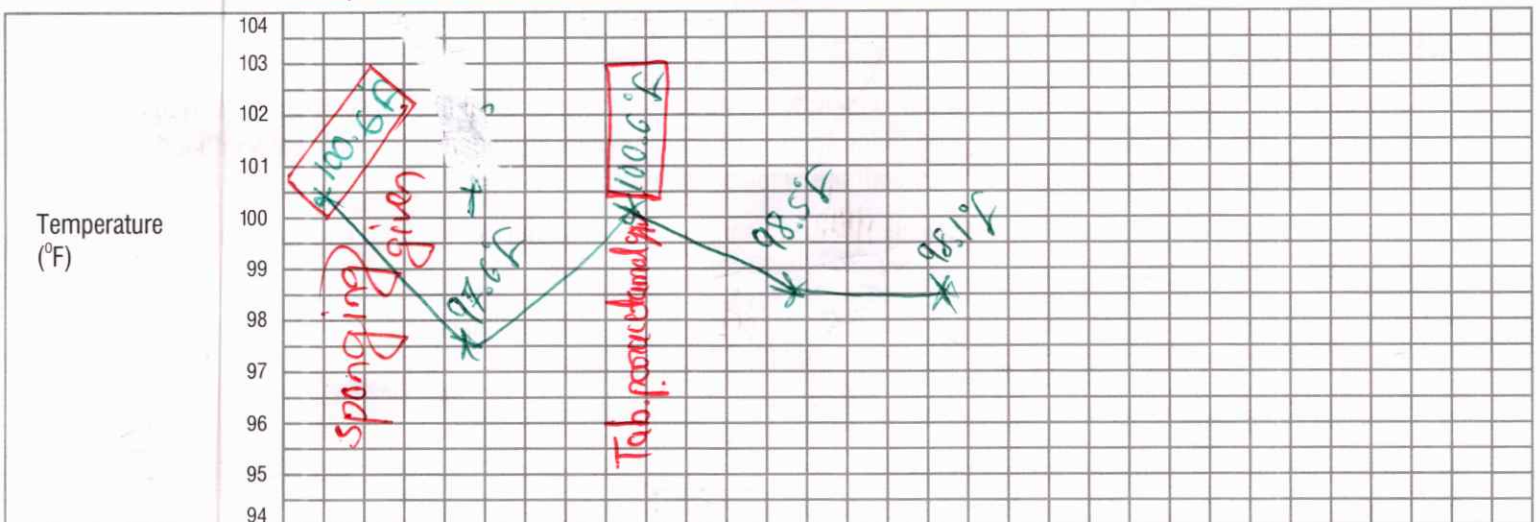
Others (ECG, Contrast Studies etc.):

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 6 30pm 10pm 12Am 2Am 4Am

Doctor / Nurse / Family Concern?



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

Note: BP does not score in early warning scoring

Heart Rate (Number)

Time	Heart Rate (bpm)	Blood Pressure (mmHg)
6 30pm	98b/m	107/65 (78)
10pm	95b/m	105/68
12Am	99b/m	108/70
2Am	84b/m	109/72

Resp. Rate (bpm) (Over 1 Minute)

Resp Rate (Number)

Time	Resp. Rate (bpm)
6 30pm	20b/m
10pm	20b/m
12Am	20b/m
2Am	20b/m

Resp Mod/ Severe Distress None / Mild

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

Conscious Level Normal Altered

GCS *

Time	Resp Mod/ Severe Distress	Receiving O ₂ (l/min)	O ₂ Saturations (%)	Conscious Level	GCS *
6 30pm		99%	99%		
10pm		98%	98%		
12Am		98%	98%		
2Am		99%	99%		

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

Time	TOTAL SCORE	Number of shaded boxes	Pain Score	Observer's Initials
6 30pm	0	0	0	
10pm	0	0	0	
12Am	0	0	0	
2Am	0	0	0	

ACTIONS

NB: Scores 3 should be recorded overleaf

Score	Action
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 Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

HNH-00016246 IP26-00006685
Master POKALA PRANAV RAJGOPAL
29-01-2010 16 Y 5 M 0 D (M)
Dr. SINDHURA MUNUKUNTALA

1 / CLINICAL / 127

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

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

WARNING SCORE: CHILDREN'S UNIT

Date : 30/8 Time: 10pm

Doctor / Nurse / Family Concern?

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94

101.2°F

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

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

107

120

Heart Rate (Number)

87bpm

Resp. Rate (bpm)
(Over 1 Minute)

70
60
50
40
30
20
10

Resp Rate (Number)

20bpm

Resp Mod/ Severe
Distress None / Mild

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

Conscious Normal
Level Altered

GCS *

15/14

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0

20

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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* 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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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)

Patient Sticker

Doc. No. : RCHBH/ FRM / CLINICAL / 127

TEENAGE (12 + years)

Children's Observation & Early Warning Scoring Chart



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



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time:

[illegible]

Temperature (°F)

104

103

102

101

100

99

98

97

96

95

94

[illegible][illegible][illegible][illegible][illegible]

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1 : Continue normal observation by staff nurse
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	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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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)

EARLY WARNING SCORE: CHILDREN'S UNIT

[illegible][illegible][illegible][illegible][illegible][illegible][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
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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)



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
29/6	02:00 pm			60ml								
	03:00 pm			60ml								
	04:00 pm	DNS	apple	60ml					✓			
	05:00 pm		Juice	60ml					✓			
	06:00 pm			60ml					✓			
	07:00 pm			60ml								
Total Intake : Taken						Total Output : U - 2 mto						
29/6	08:00 pm			60ml								
	09:00 pm			60ml					✓			
	10:00 pm		Salty	60ml								
	11:00 pm	DNS	*	60ml					✓			
	12:00 am		the	60ml								
	01:00 am			60ml								
Total Intake :						Total Output :						
30/6	02:00 am			60ml								
	03:00 am			60ml								
	04:00 am			60ml								
	05:00 am	DNS		60ml								
	06:00 am			60ml					✓			
	07:00 am			60ml								
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output



FLUID CHART

Sheet No. :

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

		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								
30/6.	08:00 am	↓									↓		
	09:00 am										↓		
	10:00 am	↓									↓	Ⓢ	
	11:00 am	↓									↓		
	12:00 pm	↓									↓		
	01:00 pm	↓									↓		
Total Intake <i>taken</i>						Total Output : <i>0 - m -</i>							
	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

Patient Sticker

FLUID CHART

Sheet No. :

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

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

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

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

HNH-00016246 IP26-00006685
 Master POKALA PRANAV RAJGOPAL
 29-01-2010 18 Y 5 M 0 D (M)
 Dr. SINDHURA MUNUKUNTALA

NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Date: 29/6/20

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon	2pm to 8pm	→ assess the pt condition → monitor vitals & record → maintain z/o chart → administer medication as per drug chart	2pm to 8pm	→ assessed the pt condition → monitored vitals & recorded → maintained z/o chart → administered medication as per drug chart	⇒ pt is stable	⇒ Rechecked vitals	(Signature)
Night	8pm to 8Am	→ Assess the pt condition. → monitor the vitals. → maintain z/o chart. → drugs give as per drug chart.	8pm to 8Am	→ Assessed the pt condition. → monitored the vitals. → maintained z/o chart. → drugs given as per drug chart.	→ pt is stable now.	→ Reassessed the vitals.	(Signature)

HNH-00016246 IP26-00006685
 Master POKALA PRANAV RAJGOPAL
 29-01-2010 16 Y 6 M 0 D (M)
 Dr. SINDHURA MUNUKUNTLA



NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Date: 30/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am to 2pm	⇒ Assess the pt condition ⇒ monitor vitals & record ⇒ maintain I/O chart ⇒ Administer medication as per drug chart	8am to 2pm	⇒ assessed the pt condition ⇒ monitored vitals & recorded ⇒ maintained I/O chart ⇒ administered medication as per drug chart	⇒ pt is stable	⇒ Rechecked vitals	
Afternoon							
Night							

Patient Sticker

NURSING-CARE-RECORD



Date:

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							



NURSING CARE RECORD

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

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

Date:

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	29/6 DAY-1			80/6 DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		NA	NA							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		NA	NA							
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		NA	NA							
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		NA	NA							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		NA	NA							
Signature of the Nurse													

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

Signature of Shift In Charge :

Signature : [Signature] Name : Sun

Signature of Ward In Charge :

Signature : [Signature] Name : Bala

CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category			Date / Time	29/1	29/01/20	30/1	Fall Risk Grading		
			Score	29/1	29/01/20	30/1	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25					Risk Level	Morse Fall Score (MFS)	Action
	No	0							
Secondary Diagnosis (more than one diagnosis)	Yes	15					Low Risk	0 - 24	Standard Fall Precaution
	No	0							
Ambulatory Aid	Furniture	30					Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15							
	None /Bed Rest /Nurse Assist	0	0	0	0				
IV / Heparin Lock or Saline	Yes	20	20	20	20		High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0							
GAIT / Transferring	Impaired	20					High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10							
	Normal /On Bed Rest /Immobile	0							
Mental Status	Forgets limitations	15					High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0							
Total Morse Fall Scale Score:				20	20	20			
Signature									

Tick (✓) whichever precaution taken.

Risk Level and Interventions

Low Risk (0 - 24) (Standard Falls Precautions)

- ☐ Ensure patients use their prescribed eye glasses if any, in the hospital
- ☐ Use chairs with arm rests
- ☐ Use safety straps on stretchers and wheelchairs while transporting patients

Moderate Risk (25-50) Apply all low risk intervention and

- ☐ Assist and/or supervise ambulation. Reinforce to always call for assistance
- ☐ Hourly safety check
- ☐ Assess patient after visitors, leave to ensure safety measures in place

High Risk (≥ 51) Apply all low and moderate risk interventions, and.

- ☐ Initiate constant observation by healthcare provider as appropriate to patient's needs



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time				Fall Risk Grading		
		Score						
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15				Low Risk	0 - 24	Standard Fall Precaution
	No	0						
Ambulatory Aid	Furniture	30				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0						
IV / Heparin Lock or Saline	Yes	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0						
Mental Status	Forgets limitations	15						
	Oriented to own ability	0						
Total Morse Fall Scale Score:								
Signature								

Tick (✓) whichever precaution taken.

Risk Level and Interventions

Low Risk (0 – 24) (Standard Falls Precautions)

- ☐ Ensure patients use their prescribed eye glasses if any, in the hospital
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- ☐ Hourly safety check
- ☐ Assess patient after visitors, leave to ensure safety measures in place

High Risk (≥ 51) Apply all low and moderate risk interventions, and.

- ☐ Initiate constant observation by healthcare provider as appropriate to patient's needs

PAIN ASSESSMENT FORM

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

Re-assessment Frequency:

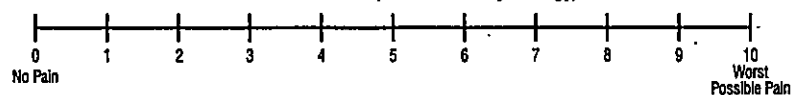
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain relieving intervention.
 - d) Within 30 – 60 minutes after pain relief 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 or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





BRADEN 'Q' SCALE

					Date : 29/6/2016	29/6/2016	30/6/2016	
					Time : 12:00	14:00	16:00	
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	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings 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	3	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	3	4	
TOTAL SCORE					22	26	28	
Evaluator's Name					22	26	28	

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 :				
					Time :				
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.					
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TOTAL SCORE									
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
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HNH-00016246 IP26-00006685
Master POKALA PRANAV RAJGOPAL
29-01-2010 18 Y 5 M 0 D (M)
Dr. SINDHURA MUNUKUNTALA

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

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NURSING SIGNATURE AND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
	LPTST Dehydration						
BACKGROUND	Area	Shift Time	29/6/26	29/6/26	30/6/26		
	Medical Condition (Any special condition to be noted):		NA	NA	NA		
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	100.6°F	98.1°F	98.1°F		
		Res:	20b/min	20b/min	20b/min		
		SpO ₂ :	99%	99%	99%		
		Pulse:	87b/min	89b/min	87b/min		
		BP:	110/70	105/65	107/62		
		Fall Risk Score:	—	—	—		
Pain Score:	—	—	—				
Recommendations	Safety Needs:		—	yes	yes		
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:		—	—	—		
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:		NA	—	—		
Post Operative Procedure Special Orders:			NA	—	—		
Handed Over By Name :			Suethu	mahi	Suethu		
Signature :			(Signature)	(Signature)	(Signature)		
Date:			29/6/26	30/6/26	30/6/26		
Time:			8pm	8Am	2pm		
Taken Over By Name :			mahi	Suethu			
Signature :			(Signature)	(Signature)			
Date:			29/6/26	30/6/26			
Time:			8pm	8Am			



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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