

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006694 **Admit Date** : 30-Jun-2026 **Admit Time** : 01:16 PM **UHID** : HNH-00002203

Patient Details :

Patient Name : Master VEDANSH MAKHIJA	Age : 8 Y 4 M 23 D
Guardian : Mr AMEET SINGH	DOB : 07-02-2018
Gender : Male	Religion :
Occupation :	Marital Status :
Address (H) : 16-10-182/10 NEAR POCHAMMA TEMPLE Malakpet Hyderabad Telangana INDIA 500036	Phone No : 9949379015/ 9573678411
	E-mail : shubhangani_khanna@yahoo.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER02 **Ward Name** : GF -EMERGENCY
Room No : ER02 **Admission Type** : First Visit

Contact Details :

Name : Mr AMEET SINGH **Relationship** : Father
Contact Address : 16-10-182/10 NEAR POCHAMMA TEMPLE
Malakpet Hyderabad Telangana INDIA 500036 **Phone No** : 9949379015

Net Singh
Signature

Doctor Details :

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

Payment Details :

Deposit Amount : 0.00
Payment Mode : Cash **Payor Name** : STAR HEALTH AND ALLIED
INSURANCE CO LTD

6 2

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ACTI HNH-00002203 IP26-00006694 **.ING**

Master: VEDANSH MAKHJA
07-02-2018 8 Y 4 M 23 D (M)
Dr. SINDHURA MUNUKUNTLA

Name: _____



UHID No: _____ IP No: _____ Consultant: _____ Dept: *pediatric*

Date of Admission: *30/6/26* Time: _____ Date of Discharge: _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<i>30/6/26</i>	<i>2pm</i>	<i>ER</i>	<i>ward</i>	<i>B) / to</i>

Cross Consultation Visit

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

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]



PROCEEDURE

Date	Procedure	Quantity	Order No.	Signature
30/6/26	lv placement	01	9523.	Sugandha
30/6/26 (5:40pm)	NHA	(1)	9596	

cross check by

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**

HNH-00002203 IP26-00006694
Master VEDANSH MAKHIJA
07-02-2018 8 Y 4 M 23 D (M)
Dr. SINDHURA MUNUKUNTALA

Patient Name : _____



Patient ID# : _____

Consultant : _____

Dr. Sindhura

Final Diagnosis : _____



Pediatric Multiorgan History & Physical Examination

Name : Vedansh . Age/Sex 8y/M .

Informant reliable / mother . Reliability

Chief Presenting Complaints & Duration (Chronologically):

clo fever x 2 days

clo cough & cold x 2 days .

clo reduced oral acceptance ⊕

History of present illness :

Pt was apparently asymptomatic 2 days ago, when he developed fever, undocumented high-grade, c headache & chills, reduced with medication .

clo cough & cold x 2 days , dry spasmodic in nature, no diurnal variation, c reduced oral acceptance .

No history of travel .

Family history - cold in elder brother .

ole

BL congested eyes ⊕

Pediatric Multiorgan History & Physical Examination

HNH-00002203 IP26-00006694
Master VEDANSH MAKHIJA
07-02-2018 8 Y 4 M 23 D (M)
Dr. SINDHURA MUNUKUNTALA



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

Birth & Neonatal History :

born @ Datta Shree hospital
FT/SVD/ 3.5 kgs Bwt
No n/o NNT

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

} wnl

Developmental History :

normal

Immunization History :

upto date .
Pne vaccine pending .

Pediatric Multiorgan History & Physical Examination

HNH-00002203 IP26-00006694
Master VEDANSH MAKHIJA
07-02-2018 8 Y 4 M 23 D (M)
Dr. SINDHURA MUNUKUNTALA

Anthropometry

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

Weight (kgs) 30 kgs (Centile _____)

On Examination :

Temperature : 104°F Pulse Rate: 142 bpm Description _____

B.P. 106/64 mm Hg (70) SPO2 99% at RA

Resp. rate and type of breathing : 30/min

Rash ⊖

Lymphadenopathy ⊖

Oedema : ⊖

Respiratory system :

Inspection (any s/o distress) : increased WOB ⊕

Air entry & breath sounds : A&BE

Any added sounds : B/L conducted sounds ⊕

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

Throat - congested

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S1S2 ⊕ M0

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : soft, hepatomegaly ⊕

Auscultation : _____

Spine: _____ External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

HNH-00002203 IP26-00006694
Master VEDANSH MAKHIJA
07-02-2018 8 Y 4 M 23 D (M)
Dr. SINDHURA MUNUKUNTALA

Central Nervous System :

Level of Consciousness : AVPU/GCS Score :

15/15

Cranial Nerves :

Motor System :

Nutrition :

Tone :

Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR

Superficials :

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic :

AFI & dehydration

Pediatric Multiorgan History & Physical Examination

HNH-00002203 IP26-00006694
Master: VEDANSH MAKHIJA
07-02-2018 8 Y 4 M 23 D (M)
Dr. SINDHURA MUNUKUNTALA

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

VBG

CBP

CRP

Blood culture - draw, dont send

CVE-

Resp. panel (5 viruses)

2 plain - extra

Planned Management :

2/3 mty - IUF

PCM 6 hourly

Ibuprofen (sos)

Ondansetron sos

Pan - OD

Please fill up the following details

1. Name of the Referring Doctor : _____
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 _____ on
whose name the patient is being referred

Doctor's Signature Name _____ Date _____ Time _____



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/20	SpB Dr Sindhura	
1:30 PM	Acute febrile illness - dehydration	
	child dull	
	Temp - febrile	
	HR - 80bpm	
	3) (cardiac) (inlet) (P)	
		Adx
		- 10gms 2/3rd order
		- symptomatic
		of malaria
		anemia in

Master VEDANSH MAKHIJA
07-02-2018 8 Y 4 M 23 D (M)
Dr. SINDHURA MUNUKUNTLA



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



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
01/07/26 20:00	CP/B. Dr. Sankhale / Dr. Varney Typhus A Titre fever ⊕ poor oral intake O/E: AC - fine Vitals: Stable Hydration - good	Adm. - IV fluids (2/3 on) - Sym. fluids - Supportive care Sankhale



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/26 1pm	SB Dr. Archana AF I dehydration cough ⊕ fever spike - 103°F ⊕ signs of dehydration ⊕ (chapped lips, ↑thirst, sunken eyes)	Adv • TPR/IOc • Ct IVF • ⊕ Labs • Ct PCM 6 th hourly
06	RR - 132 bpm BP - 107/60 mm Hg (74) SpO ₂ - 98% @ RA	
5E	RS - AECG, Bli. conducting sounds ⊕ PIA - soft, hepatomegaly ⊕	
		6/ Dr. Archana

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6 11:00pm	CLS/13 Dr. Naipaya AFB. c dehydration fever spikes (+) - 103°F Vitals - stable. R/S - BIL A (+) BIL Conducted Sounds (+) PIA - soft hepatomegaly (+) Oral intake - Poor.	Plan - Trace investigations - Cont PCM @ 6H. - Cont IVF. - Monitor vitals - Monitor fever spikes
30/6/20 8pm	SP/13 Dr. Sindhura. on AFB c dehydration Fever spikes (+) continue clwd d deul Teener lung - Bm (+) BIL conducted (Smelly)	Adv - As per chart M. Sindhura Dr. Sindhura - B.

Patient Sticker



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



DRUG CHART

Date of Admission: 30/6/26 Drug Allergies: None ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG : <u>Syp Ibuprofen</u>				Date Time
Dose <u>8 ml</u>	Route <u>PO</u>	Frequency <u>SOS</u>	Start Date <u>30/6/26</u>	
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm.	
Additional Instructions: <u>(900 mg/5ml) (15 ml if 100 mg/5ml)</u>				

DRUG : <u>Tab ONDANSETRON</u>				Date Time
Dose <u>4mg</u>	Route <u>PO</u>	Frequency <u>SOS</u>	Start Date <u>30/6/26</u>	
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm.	
Additional Instructions:				

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

VERIFIED BY : Name _____

Weight. Ward.

Page: 2/4

Date 

Time

Nurse Sig.

	Dose
--	-------------

Dr. Sign

Dose	100 mg
-------------	--------

Dr. Sign

Dose	
------	--

Dr. Sign

Dose	100 mg
-------------	--------

Dr. Sign

Date ▶
Time

Nurse Sig.

Dose

Dr. Sign

Dose	100 mg
-------------	--------

Dr. Sign

Dose

Dr. Sign

	Dose
1	100 mg
2	200 mg
3	300 mg
4	400 mg
5	500 mg
6	600 mg
7	700 mg
8	800 mg
9	900 mg
10	1000 mg
11	1100 mg
12	1200 mg
13	1300 mg
14	1400 mg
15	1500 mg
16	1600 mg
17	1700 mg
18	1800 mg
19	1900 mg
20	2000 mg
21	2100 mg
22	2200 mg
23	2300 mg
24	2400 mg
25	2500 mg
26	2600 mg
27	2700 mg
28	2800 mg
29	2900 mg
30	3000 mg
31	3100 mg
32	3200 mg
33	3300 mg
34	3400 mg
35	3500 mg
36	3600 mg
37	3700 mg
38	3800 mg
39	3900 mg
40	4000 mg
41	4100 mg
42	4200 mg
43	4300 mg
44	4400 mg
45	4500 mg
46	4600 mg
47	4700 mg
48	4800 mg
49	4900 mg
50	5000 mg
51	5100 mg
52	5200 mg
53	5300 mg
54	5400 mg
55	5500 mg
56	5600 mg
57	5700 mg
58	5800 mg
59	5900 mg
60	6000 mg
61	6100 mg
62	6200 mg
63	6300 mg
64	6400 mg
65	6500 mg
66	6600 mg
67	6700 mg
68	6800 mg
69	6900 mg
70	7000 mg
71	7100 mg
72	7200 mg
73	7300 mg
74	7400 mg
75	7500 mg
76	7600 mg
77	7700 mg
78	7800 mg
79	7900 mg
80	8000 mg
81	8100 mg
82	8200 mg
83	8300 mg
84	8400 mg
85	8500 mg
86	8600 mg
87	8700 mg
88	8800 mg
89	8900 mg
90	9000 mg
91	9100 mg
92	9200 mg
93	9300 mg
94	9400 mg
95	9500 mg
96	9600 mg
97	9700 mg
98	9800 mg
99	9900 mg
100	10000 mg

Dr. Sigmund

Nurses

(P.T.O.)

I.V. FLUIDS CHART

Weight. Ward.

[illegible]



MEDICATION RECONCILIATION FORM

Drug Allergies: NP ☒ Not known any Drug Allergies

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

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

Shifting From: ICU Shifted to: Ward

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Arachana

Date & Time : 30/6/26 @ 11:00pm

Nurse Name & Signature: Bhargavi

Date & Time : 30/6/26 @ 11:15pm



101-7216

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 30/6/26 Time: 6:10pm

Weight: 38.2 kg Centile: 97th

Height: Centile:

Inference:

RDA: Calories: 1550 kcal/d Protein: 27 gms/d

Diet Recommendations: Normal diet with more liquids

Re-Assessment: Avoid spicy, chilled & outside foods

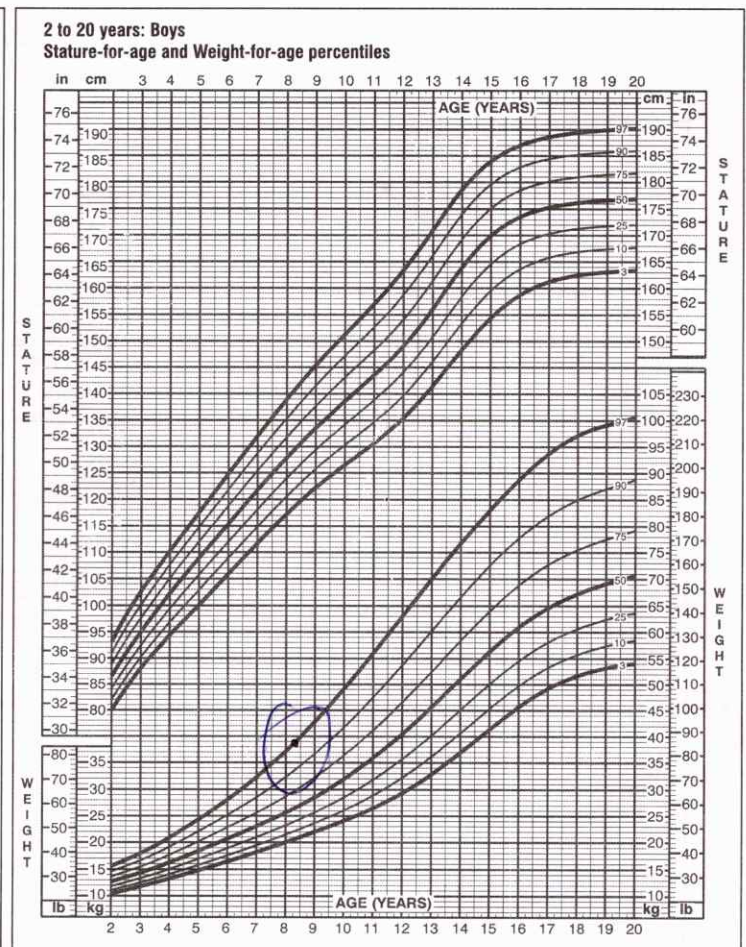
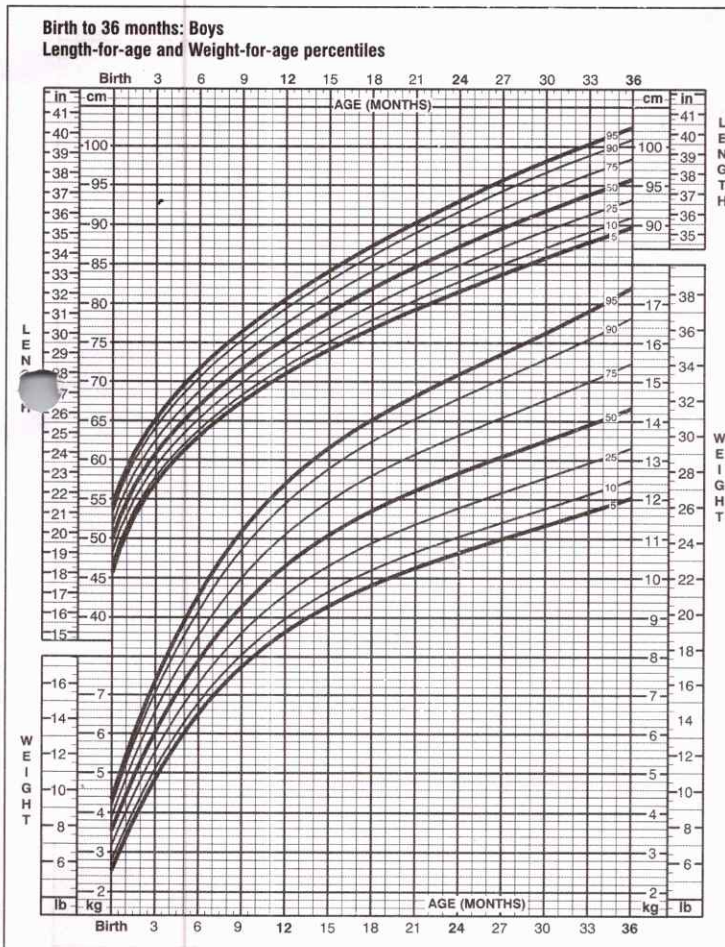
Food Allergies: NO Veg/Non-veg: NON-VEG.

Diagnosis: AFI with dehydration

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: Sathwika G.

Dietician's Signature: [Signature]

Daily Notes:



wt - 38.21 wt

EMERGENCY ROOM TRIAGE FORM

Patient's Name: Most. VEDANSH MAKHIJA Age: 8y 4m Gender: ☒ Male ☐ Female

Date: 30/06/26 Time of Arrival: 12:50pm

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: 104°F PR: 142b/m BP: 102/60(74) RR: 24 SpO₂: 98%

Chief Complaints: elo Fever since 2 days, cold cough since 2 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: Int Singh
Triage Completion Time: 12:52pm

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: Atance

Date & Time: 30/06/26 @ 12:52pm

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

Signature of Triage Nurse: [Signature]



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 30/06/26 Time of arrival: 12:54pm

Chief Complaints: elo Fever, cold cough since X 2 days RBS:

Height: Weight: 30.2kg 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):

Social History: Lives With Family

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

Time of Initial assessment completed by ER Nurse: 12:54pm / [Signature]

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

Time	Nursing Notes
	Assesses the Patient condition
	monitor vitals Done

Samples collected by:

/ Sugandha

Time:

Samples sent by :

Time:

1:30pm

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: 112b/m BP: 102/60mmHg CFT:	Shift - out from ER to: ward
RR: SPO ₂ : 98%.	Time of Shift - out: 2pm
GCS: Temperature: 104°F	Handover given to:
Pain Score:	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

IV placement Done

Name of the Nurse :

Aham

Signature of the Nurse :



Date & Time :

30/06/26 @

PATIENT TRANSFER FORM

HNH-00002203 IP26-00006694

Master VEDANSH MAKHIJA

07-02-2018 8 Y 4 M 23 D (M)

Dr. SINDHURA MUNUKUNTALA



Date & Time of Admission <i>30/6/26 @ 1:16pm</i>		Date & Time of Transfer Order <i>30/6/26 @ 2pm</i>
Treating Consultant Name	Transfer Ordered by <i>Dr. Archana</i>	Reason for Transfer <i>Admission</i>
From Unit <i>ER</i>	To Unit <i>ward</i>	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File <i>251-</i>	Number of Imaging Films	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 <i>Bhargava</i>		Name of Person Ordered Transfer <i>Dr. Archana.</i>
Patient & Clinical Records Received by : <i>Priyanka.</i>		
Date & Time of Patient Received : <i>30/6/26 @ 2:15pm</i>		

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

HNH-00002203 IP26-00006694
 Master VEDANSH MAKHIJA
 07-02-2018 8 Y 4 M 23 D (M)
 Dr. SINDHURA MUNUKUNTALA



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RESULT SHEET

Date	2pm					
Time						
Hb	13.0					
PCV	36.4					
RBC	4.82					
WBC	4.80					
N/L	72/13					
Platelets	243					
CRP	5					
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						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

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.....

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

Patient Sticker

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 30/6	Time: 1:30pm	2:30pm	4pm	5:15pm	6:40pm	10pm	12Am	2Am	7Am
Doctor / Nurse / Family Concern?									
Temperature (°F)	103.4 (COPAIN given IN ER)	100.8	103.2 (ibuprofen given)	101.1	99.4	98.1	100.4 (Tab paracetamol given)	99.5	98.0
Heart Rate (bpm)									
Blood Pressure (mmHg) *						111/73	101/70	101/70	101/70
Note: BP does not score in early warning scoring									
Heart Rate (Number)	138bpm	138bpm	116bpm		104		101bpm		100bpm
Resp. Rate (bpm) (Over 1 Minute) *									
Resp Rate (Number)		28bpm	30bpm		38bpm		30bpm		30bpm
Resp Distress									
Receiving O ₂ (l/min)									
O ₂ Saturations (%)							98%		98%
Conscious Level									
GCS *									
TOTAL SCORE									
Number of shaded boxes		0	0		0		0		0
Pain Score		1	0		0		0		0
Observer's Initials		M	M		B		E		K

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

HNH-00002203 IP26-00006694
Master VEDANSH MAKHIJA
07-02-2018 8 Y 4 M 23 D (M)
Dr. SINDHURA MUNUKUNTALA

Patient Sticker

SCHOOL AGE (5-12 years)
**Children's Observation &
Early Warning Scoring Chart**

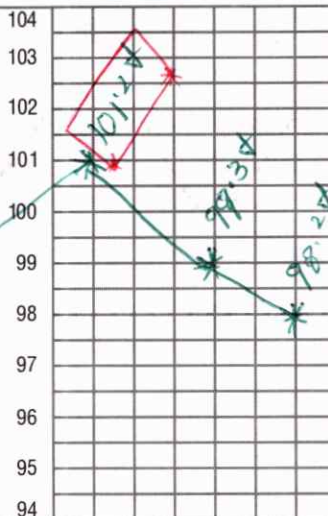
**Rainbow
Children's
Hospital**
It takes a lot to treat the little.

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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 1/7/26 Time: 9Am 10Am 11:30Am
Doctor / Nurse / Family Concern?

Temperature
(F)

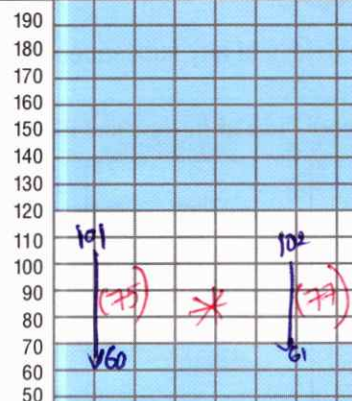


Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring



Heart Rate (Number)

107b/m 106b/m

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



Resp Rate (Number)

28b/m 26b/m

Resp Mod/ Severe
Distress None / Mild

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

100% 98%

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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- 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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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)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :		Time:																									
Doctor / Nurse / Family Concern?																											
Temperature (°F)	104																										
	103																										
	102																										
	101																										
	100																										
	99																										
	98																										
	97																										
	96																										
	95																										
94																											
Heart Rate (bpm) and Blood Pressure (mmHg) *	190																										
	180																										
	170																										
	160																										
	150																										
	140																										
	130																										
	120																										
	110																										
	100																										
Note: BP does not score in early warning scoring	90																										
	80																										
	70																										
	60																										
	50																										
Heart Rate (Number)																											
Resp. Rate (bpm) (Over 1 Minute) *	70																										
	60																										
	50																										
	40																										
	30																										
	20																										
	10																										
	1																										
Resp Rate (Number)																											
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.																									
		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.

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Patient

HNM-00002203 IP26-00006694
Master VEDANSH MAKHJA
07-02-2018 8 Y 4 M 23 D (M)
Dr. BINDHURA MUNUKUNTLA



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FLUID CHART

Sheet No. : 18

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am					NA						
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm			45ml								
	03:00 pm			45ml								
	04:00 pm			45ml								
	05:00 pm			45ml								
	06:00 pm			45ml								
	07:00 pm			45ml								
Total Intake :						Total Output :						
	08:00 pm			45ml								
	09:00 pm			45ml								
	10:00 pm			45ml								
	11:00 pm			45ml								
	12:00 am			45ml								
	01:00 am			45ml								
Total Intake :						Total Output :						
	02:00 am			45ml								
	03:00 am			45ml								
	04:00 am			45ml								
	05:00 am			45ml								
	06:00 am			45ml								
	07:00 am			45ml								
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
1/7/26	08:00 am	250 ml 100% Plasma 100% H ₂ O	Milk	45 ml	N/A	N/A	N/A	N/A	N/A	N/A	0	A
	09:00 am			45 ml							0	
	10:00 am			45 ml							0	
	11:00 am			30 ml							0	
	12:00 pm										0	
	01:00 pm										0	
Total Intake : Taken						Total Output : m - 0 -						
	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 **HNH-00002203** **IP26-00006694**
Master VEDANSH MAKHLJA
07-02-2018 **8 Y 4 M 23 D** (M)
Dr. BINDHURA MUNUKUNTLA



LUID 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						

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													



NURSING CARE RECORD

Date: 30/6/20

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				NA			
Afternoon	2pm	Assess the pt condition - Monitor vitals & record - Maintain I/O chart - Give medication as prescribed by doctor	2pm	Assessed the pt condition - Monitored vitals & record - Maintained I/O chart - Given medications as prescribed by doctor	patient is Stable now	re-checked vitals	
Night	8pm	Assess the baby Monitor the vitals Administer of order Maintain the I/O	8pm	Assessed the baby Monitored vitals Administered Maintained I/O	admission open	Reassess the pt	

HNH-00002203 IP26-00006694
 Master VEDANSH MAKHIJA
 07-02-2018 8 Y 4 M 23 D (M)
 Dr. SINDHURA MUNUKUNTALA



Patient Sticker

NURSING CARE RECORD

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

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Your Right to a Safe Delivery

Date: 1/7/26

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	8 Am 2pm	→ Assess the pt condition → monitoring vitals checked and recorded → I/O chart maintain	8 Am 2pm	→ Assessed the pt condition → Administration medication given as per doctor's orders	→ pt is stable	→ Re-checked the vitals	A Ammu
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							

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							

Patient Sticker



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>AEI & dehydration</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:			
	Surgery / Procedure:		Post OP Day:			
BACKGROUND	Date	30/6/26	1/7/26	1/7/26		
	Shift	E2	800	m6		
	Medical Condition (Any special condition to be noted):	-	flu	flu		
	Diet:	-	-	-		
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	-	-	-		
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp: 98.9F	98.5F	98.3F		
	Res: 20b/m	24b/m	25b/m			
	SpO ₂ : 100%	99%	98%			
	Pulse: 125b/m	121	105b/m			
	BP: 101/60	106/62	104/60			
	LOC: -	-	-			
	Fall Risk Score: -	-	-			
Pain Score: -	-	-				
Skin Integrity	-	-	-			
Recommendations	Safety Needs:	☒ Yes ☐ No	☐ Yes ☒ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	-	-	-		
	Others Specify:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	-	-	-		
	Critical Lab Test / Values:	-	-	-		
	Other Special Orders / Medications:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
DVT Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
ADL (Dependent / Non Dependent):	-	-	-			
Post Operative Procedure Special Orders:		-	① Repath	① NG		
Handed Over By Name :		Priyanka	Amrutha	Amrutha		
Signature / ID :		[Signature]	[Signature]	[Signature]		
Date:		30/6/26	1/7	1/7		
Time:		8pm	8am	2pm		
Taken Over By Name :		[Signature]	Amrutha			
Signature / ID :		[Signature]	[Signature]			
Date:		1/7	1/7			
Time:		8am	8am			

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
	Surgery / Procedure:		Post OP Day:				
BACKGROUND	Date						
	Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:					
	Res:						
	SpO ₂ :						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
Pain Score:							
Skin Integrity							
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ADL (Dependent / Non Dependent):							
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

Patient Sticker



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	30/6	1/7			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2			
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1			
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1			
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1			
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
Total			9	9			

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓			
Call device within reach		✓	✓			
Wheels Locked		✓	✓			
Room free of clutter		✓	✓			
Adequate lighting		✓	✓			
Wheel chair support		✓	X			
Other Intervention(s) Specify		✓	X			
Nurse's Name:		Pragathi	✓			
Signature:		P	✓			
Date:		30/6	1/7			
Time:		6pm	8am			

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100



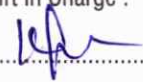
CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0		0	0						
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		0	NA						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	NA		0	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		0	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		0	NA						
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	NA		0	NA						
Signature of the Nurse				0		0	0						

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 :

HNH-00002203

IP26-00006694

Master VEDANSH MAKHIJA
07-02-2018 8 Y 4 M 23 D (M)
Dr. SINDHURA MUNUKUNTLA

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 : 30/6/2018		
					Time : 12:30 PM		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or 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
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28
Docu. No. : RCH /FRM / CLINICAL / 119					Evaluator's Name	E	E

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.					
'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.					
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.					
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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

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Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
30/6	3pm	0/10	NA	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☒ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	NA	
1/7	6am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	
1/7	10am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

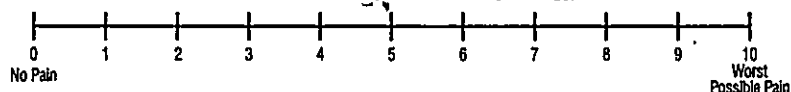
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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



NH-00002203
 Master VEDANSH MAKHIJA
 17-02-2018 8 Y 4 M 23 D (M)
 Dr. BINDHURA MUNUKUNTALA

PAIN ASSESSMENT FORM

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

BY R
 Your Rig

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sig.
				☐ 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		

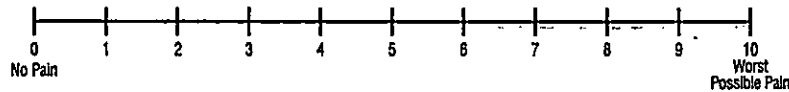
Assessment Frequency:
 a) Every 4 hours for all hospitalized patients.
 b) Then every 4 hours.
 c) Every 2 hours for the first 24 hours
 d) Within 30 – 60 minutes after pain relief intervention.

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' brawn 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 Arouses minimally (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, SaO ₂	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 75% with stimulation - slow recovery Out of fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years

