

**DISCHARGE SUMMARY**

|                        |  |                       |                       |
|------------------------|--|-----------------------|-----------------------|
| <b>Name</b>            | Baby K AARADHYA                                  | <b>UHID</b>           | HNH-00015551          |
| <b>Father/Guardian</b> | Mr K SRINIVASULU                                 | <b>Age/Gender</b>     | 11 Y 1 M 25 D/ Female |
| <b>Address</b>         | Ashok Nagar, Hyderabad, Telangana, INDIA, 500020 |                       |                       |
| <b>IP No</b>           | IP26-00006435                                    | <b>Admission Date</b> | 27-05-2026            |
| <b>Ref Doctor</b>      | Self.  |                       |                       |
| <b>Discharge Date</b>  | 29.05.2026                                       |                       |                       |

**Consultant:**

**Dr. SINDHURA MUNUKUNTLA**  
MBBS, DCH, DNB PEDIATRICS  
66970

| <b>DIAGNOSIS</b>                  | <b>ICD CODE</b> |
|-----------------------------------|-----------------|
| LOWER RESPIRATORY TRACT INFECTION |                 |
| MACULOPAPULAR RASH PRESENT        |                 |

**History:** Baby K AARADHYA , 11 Y 1 M 25 D , old girl presented with the history of fever since 6 days, rash all over the body and decreased oral intake, dull activity since 5 days, cough since 4 days prior to admission. For the above complaints she was admitted at Rainbow Children's Hospital - for further management.

|              |                 |                       |              |
|--------------|-----------------|-----------------------|--------------|
| <b>Name</b>  | Baby K AARADHYA | <b>UHID</b>           | HNH-00015551 |
| <b>IP No</b> | IP26-00006435   | <b>Admission Date</b> | 27-05-2026   |

**Examination:** She was febrile(100°F), maintaining saturations at room air and was hemodynamically stable. Her heart rate was 92/min and Respiratory Rate - 22/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On auscultation, air entry was bilaterally equal with bilateral crepitations were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, she was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure.

Weight on admission: 40 kilo grams.

**Investigations:** Enclosed reports

GeneXpert FluA+FluB+RSV, SARS-CoV-2 were sent, which was negative. Adenovirus PCR was not detected.

Initial hemogram showed Hemoglobin of 10.8 gm%, White Blood Cell count of 12000 cells/cumm, platelet count of 2.64 lakhs/cumm and C-Reactive Protein of 126 mg/l. Blood culture and sensitivity shows no growth after 24 hours of incubation.

Repeat hemogram showed Hemoglobin of 10.7 gm%, White Blood Cell count of 6520 cells/cumm, platelet count of 2.86 lakhs/cumm and C-Reactive Protein of 51 mg/l.

Chest X-ray was normal.

**Management:** She was admitted in the ward and started on Intra Venous

|       |                 |                |              |
|-------|-----------------|----------------|--------------|
| Name  | Baby K AARADHYA | UHID           | HNH-00015551 |
| IP No | IP26-00006435   | Admission Date | 27-05-2026   |

fluids and Intra Venous antibiotics.

Dermatology consultation was taken in view of itching all over the body and wheals on the lower abdomen, Acute urticaria was suspected and advised to start on antihistaminics.

Flupanel and adenovirus PCR was sent IVO high grade fever spikes and persistant cough and were negative. Blood culture was sent in view of suspected bacteremia.

She was regularly monitored for fever spikes, hemodynamic status. Her fever spikes and other symptoms gradually settled. Child maintaining saturations on room air. Blood culture, 48 hours report is awaited, So child is being discharged on IV antibiotics.

She remained hemodynamically stable during the hospital stay. She improved with the above line of management and is being discharged with the following advice.

**At the time of discharge :** She is active, afebrile and hemodynamically stable.

**Medication during hospital stay:**

Tablet. Atarax  
Injection. Ceftriaxone  
Tablet. Xyzal

**Advice:**

\* Diet as advised.

|              |                 |                       |              |
|--------------|-----------------|-----------------------|--------------|
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| <b>IP No</b> | IP26-00006435   | <b>Admission Date</b> | 27-05-2026   |

| <b>S.N<br/>o</b> | <b>MEDICATION</b>       | <b>DOSE</b>                                   | <b>TIMINGS</b>            | <b>DURATION</b>              |
|------------------|-------------------------|---|---------------------------|------------------------------|
| 1                | IV. Ceftriaxone         | 2 gm<br>Slow infusion<br>over 1 to 2<br>hours | 8am - 8pm<br>(after food) | Till blood<br>culture report |
| 2                | Tablet. Atarax 25 mg    | 1 tablet                                      | 7pm                       | For 8 days                   |
| 3                | Tablet. Xyzal - 5mg     | 1 tablet                                      | 8am                       | For 8 days                   |
| 4                | Cetaphil lotion         | apply for local<br>application                | twice daily               | For 5 days                   |
| 5                | Atarax anti itch lotion | for local<br>application                      | 6th hourly                | For 5 days                   |

**Plan: To collect blood culture report on followup.**

**Fever Management**

\* Tablet. Crocin 500mg, 1 tablet after food as and whenever required, if temperature > 100 \*F (maximum 4 times a day at 6 hour intervals).

\* Tepid sponging if fever > 101 \*F.

Review consultation with Dr. SINDHURA MUNUKUNTLA on Monday(01.06.2026) at Himayatnagar in OPD with prior appointment (**Review consultation will be charged**).

|              |                 |                       |              |
|--------------|-----------------|-----------------------|--------------|
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**Food instructions while taking medications:**

\* Food can decrease the absorption of **antihistamines**. Antihistamines can be taken on an empty stomach /before food to increase their effectiveness.

Follow up immediately in Emergency Room if high grade fever, vomiting, breathlessness or refusal to feed occurs.

**If any Intra Venous antibiotics - will be given in Emergency Room between 7am - 8am for morning dose, between 2pm-3pm for afternoon dose and between 8pm-9pm for evening dose (Outside medication shall not be allowed within the hospital as per the hospital protocol).**

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctor ..... in a language that I can understand and I acknowledge.

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty. To take appointment for OPD consultation at Rainbow **Himayatnagar / Banjara Hills / Rainbow Clinic Madhapur / Kukatpally / Vikrampuri / LB Nagar /** dial just one toll free number **18002122**.

You can also take appointments at any time by going **online** to our website **[www.rainbowhospitals.in](http://www.rainbowhospitals.in)**

|              |                 |                       |              |
|--------------|-----------------|-----------------------|--------------|
| <b>Name</b>  | Baby K AARADHYA | <b>UHID</b>           | HNH-00015551 |
| <b>IP No</b> | IP26-00006435   | <b>Admission Date</b> | 27-05-2026   |



**Registrar/Resident/C.M.O**

**Dr. SINDHURA MUNUKUNTLA**  
**MBBS, DCH, DNB PEDIATRICS**  
**66970**

ADMISSION SHEET



Registration Details :

Admission No : IP26-00006435      Admit Date : 27-May-2026      Admit Time : 12:31 PM      UHID : HNH-00015551

Patient Details :

Patient Name : Baby K AARADHYA      Age : 11 Y 1 M 25 D  
Guardian : Mr K SRINIVASULU      DOB : 02-04-2015  
Gender : Female      Religion :  
Occupation :      Martial Status :  
Address (H) : Ashok Nagar Hyderabad Telangana INDIA      Phone No : 8142850050  
500020      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 K SRINIVASULU      Relationship : Father  
Contact Address : Ashok Nagar Hyderabad Telangana INDIA      Phone No : 8142850050  
500020

  
Signature


Doctor Details :

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


Payment Details :

Deposit Amount : 10000.00  
Payment Mode : DC/CC Card      Payor Name : STAR HEALTH AND ALLIED INSURANCE CO LTD

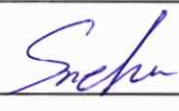
### ACTIVITY RECORD FOR BILLING

Name: **HNM-00015551 IP26-00006435** -----  
**Baby K AARADHYA** -----  
**02-04-2015 11 Y 1 M 25 D (F)** -----  
**Dr. SINDHURA MUNUKUNTLA** -----  
 UHID No:  ----- Consultant : ----- Dept : -----  
 Date of Adm. : ----- Date of Discharge : ----- Time: -----  
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

### WARD TRANSFERS

| Date    | Time    | From | To  | Signature of Nurse  |
|---------|---------|------|-----|---|
| 28/5/26 | 1:20 PM | ER   | 213 |  |
|         |         |      |     |   |
|         |         |      |     |   |
|         |         |      |     |   |
|         |         |      |     |   |

### Cross Consultation Visit

|     | Doctors Name       | Date    | Order No. | Signature   |
|-----|--------------------|---------|-----------|---|
| 1.  | Dr. G. Sneha Reddy | 28/5/26 | 2678      |  |
| 2.  |                    |         |           |   |
| 3.  |                    |         |           |   |
| 4.  |                    |         |           |   |
| 5.  |                    |         |           |   |
| 6.  |                    |         |           |   |
| 7.  |                    |         |           |   |
| 8.  |                    |         |           |   |
| 9.  |                    |         |           |   |
| 10. |                    |         |           |   |





**PROCEEDURE**

| Date    | Proceedure   | Quantity | Order No.                | Signature          |
|---------|--------------|----------|--------------------------|--------------------|
| 27/5/26 | 1W placement | 1        | <del>2383</del>          | <i>[Signature]</i> |
| 27/5/26 | NHA          | ①        | 2454                     | <i>[Signature]</i> |
| 29/5/26 | Iv placement | ①        | 2182<br><del>89070</del> | <i>[Signature]</i> |
|         |              |          |                          |                    |
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|         |              |          |                          |                    |

**ANY OTHER INFORMATION**

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Date :

Time :

Prepared By :

|             |              |                   |                    |
|-------------|--------------|-------------------|--------------------|
| Staff Nurse | Shift / Ward | Billing Assistant | Billing Supervisor |
|-------------|--------------|-------------------|--------------------|

Ref.No. F/IN/PR/10



**Rainbow<sup>®</sup>  
Children's  
Hospital**

**PEDIATRIC IN-PATIENT  
MEDICAL RECORD**

Patient Name :

HNH-00015551 IP26-00006435

Baby K AARADHYA

02-04-2015 11 Y 1 M 25 D (F)

Dr. SINDHURA MUNUKUNTLA

Patient ID# :



Consultant :

Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : \_\_\_\_\_ Age/Sex \_\_\_\_\_

Informant \_\_\_\_\_ Reliability \_\_\_\_\_

Chief Presenting Complaints & Duration (Chronologically):

no fever since 6 days

no rash all over the body since 5 days

no decreased oral intake since 5 days

History of present illness : no dull activity since 5 days

no cough since 4 days

patient was apparently alright 6 days before then had fever on & off type high degree, not relieved with medication.

no rash all over the body, maculopapular type. also itching.

no cough since 4 days, dry cough.

no decreased oral intake since 5 days

**Pediatric Multiorgan History & Physical Examination**

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

Nothing significant

Birth & Neonatal History :

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Developmentally normal.

Immunization History :

upto date. acc to NICE.

**Pediatric Multiorgan History & Physical Examination**

**Anthropometry**

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_) Height (cm) : \_\_\_\_\_ (Centile \_\_\_\_\_)

Weight (kgs) 40 kg (Centile \_\_\_\_\_)

**On Examination :**

Temperature : 100° F Pulse Rate: 92. Description 13-1

B.P. 112/74. SPO2 98% at RA.

Resp. rate and type of breathing : 22cpm.

Rash \_\_\_\_\_

Lymphadenopathy \_\_\_\_\_

Oedema : \_\_\_\_\_



**Respiratory system :**

Inspection (any s/o distress) : \_\_\_\_\_

Air entry & breath sounds : B/L AE ⊕

Any addes sounds : B/L Crepts ⊕

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

**Cardiovasclular System :**

Inspection of procordium : \_\_\_\_\_

Heart Sounds : S1 S2 heard.

Any murmur : NO Murmur.

Relevant date from outside (Chest X-Ray, ECG, ECHO, Etc.,) \_\_\_\_\_

**Per Abdomen :**

Inspection \_\_\_\_\_

Palpation : soft, nontender.

Auscultation : NO murmurs

Spine: \_\_\_\_\_ External Genitalia : \_\_\_\_\_

Relevant data from outside (CT, USG etc.,) \_\_\_\_\_

**Pediatric Multiorgan History & Physical Examination**

**Central Nervous System :**

Level of Consciousness : AVPU/GCS Score : \_\_\_\_\_

Cranial Nerves : \_\_\_\_\_

**Motor System :**

Nutrition : \_\_\_\_\_

Tone : \_\_\_\_\_ Power \_\_\_\_\_

Co-ordinator : \_\_\_\_\_

Posture : \_\_\_\_\_

Involuntary Movements : \_\_\_\_\_

**Reflexes :**

**DTR**

Plantars \_\_\_\_\_

**Superficials :**

**Sensory System :**

Bladder / Bowel : \_\_\_\_\_

**Clinical Summary & Diagnostic :**

LRTI & dehydration

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

CBP, CRP,  
Blood C/s (2 samples)  
Chest X-ray PA view.  
Respiratory panel  
(5 viruses)

Planned Management :

Inj. ceftriaxone  
T. Atarax 25mg  
T. XYZAL. 10mg  
IVF DNS 2/3. max  
Pediatric dermatologist  
opinion

**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 \_\_\_\_\_

*[Handwritten signature]*  
22/5/16 6pm



**PROGRESS NOTES AND DOCTOR'S ORDER**

| Date & Time       | Progress Notes   | Doctor's Order                          |
|-------------------|--|---|
| 29/5<br>2:30pm.   | <p>CIC/13 Dr. Naipuyen</p> <p>LRTI &amp; dehydration.</p> <p>Maculopapular rash (P).</p> |   |
|                   | <p>fever (P)</p> <p>rash (P)</p> <p>cough (P)</p>  | <p>Plan</p> <p>- cont ceftriaxone.</p>  |
|                   | <p>oral intake - poor.</p>   | <p>- cont Atarax.</p> <p>Xyzal.</p>     |
|                   | <p>R/S - BIL AE (P)</p> <p>BIL crepts (P)</p>  | <p>- Dermatologist opinion tomorrow</p> |
|                   | <p>PLA - soft, not</p>   | <p>- trace reports.</p>                 |
|                   |  | <p>- Monitor vitals.</p>                |
| 29/5/15<br>2:30pm | <p>S/B Dr. Sindhura</p> <p>S LRTI &amp; dehydration</p>                                  | <p>Plan</p> <p>- CF CEFTRIAXONE</p>     |
|                   | <p>CVS - S1, S2 @</p>  |   |
|                   | <p>M - BL - ACE @</p>  | <p>- CF ATARAX</p> <p>XYZAL</p>         |
|                   | <p>PLA - SOL</p> <p>consistency</p>  | <p>- Dermatologist opinion</p>          |
|                   |  | <p><del>Autism</del></p>                |



**PROGRESS NOTES AND DOCTOR'S ORDER**

| Date & Time        | Progress Notes  | Doctor's Order            |
|--------------------|---|---------------------------|
| 27/5/20<br>5:50 PM | S/A Dr. Sindhura<br>D LRTI Dehydration                      |                           |
|                    | Maculopapular rash @ P <sub>6</sub><br>Tongue pink @ - 104F |                           |
|                    | CVS - S <sub>4</sub> S <sub>1</sub> @                       | - Ceftriaxone             |
|                    | RS - B <sub>1</sub> - A <sub>1</sub> @                      | - IF ATARAB               |
|                    | PIA - S <sub>0</sub> @                                      | XYZAL                     |
|                    | Co - 1104   |                           |
|                    |   | - Trace CRP               |
|                    |   | Resp. panel.              |
|                    |   | - Encourage orally        |
|                    |   | NB - Mouthwash @ 8 PM     |
|                    |   | <del>Stop IV fluids</del> |
|                    |   | Sindhura                  |
|                    |   | Munukuntla                |

HNH-00015551 IP26-00006435  
 Baby K AARADHYA  
 02-04-2015 11 Y 1 M 25 D (F)  
 Dr. SINDHURA MUNUKUNTLA



## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes                                      | Doctor's Order   |
|-------------|---|------------------|
| 28/5/2015   | S/B Dr. Sreeghan                                    | Play             |
| 7:45 Am     | D LRTI Dehydration                                  |                  |
|             | Fever spikes  | ✓ CF CEFTRIAZONE |
|             | WS - S, S, S  | - These reports  |
|             | M - 311 - AIFA                                      | ✓ CF ATARAX      |
|             | PLA - SOL   | LEVOCETIRIZINE   |
|             | Cough   | Encourage oral   |
|             | [A large blue scribble covers the text in this row] | Stop IV fluids   |
|             | [A large blue scribble covers the text in this row] | N/B [Signature]  |
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**PROGRESS NOTES AND DOCTOR'S ORDER**

| Date & Time            | Progress Notes   | Doctor's Order   |
|------------------------|--|--|
| 28/5/15<br>6 AM        | <p><u>CLSB - Dr Sindhura</u></p>   |  |
|                        | <p>LATENT dehydrator<br/>           Continuous fever spikes<br/>           High grade F.</p> | <p>① CBC (tomorrow morning)<br/>           CRP<br/>           (if BL visit &amp; flagged)<br/>           ④ Treac Blood Culture</p> |
| Ole-                   | <p>Vitals stable</p>   | <p>④ Stop Dr fluids</p>  |
| ④                      |  | <p>NB Suck @ 6 PM</p>  |
| ews<br>43 gmms.<br>PIV |  | <p>④ Sindhura<br/>           Dr Sindhura</p>   |

**PROGRESS NOTES AND DOCTOR'S ORDER**

| Date & Time    | Progress Notes   | Doctor's Order                                    |
|----------------|--|---|
|                |  |   |
| 29/1/16<br>7am | <u>0/0/0 - Dehydration</u>                                   |   |
|                | JRTT & dehydration   |   |
|                | fever spikes @ @   | <u>Advice:-</u>                                   |
|                | Oral intake - fair.  | (1) Continue ceftriaxone                          |
|                | Ole -<br>Vitals stable<br>CRT - green<br>Warm per. reflexes. | (2) O.B.C.G to base<br>CAP                        |
|                | (3) fle  | (3) Trace PIC -                                   |
|                | ess<br>18<br>0/0/0   | (4) Monitor vitals.<br>NB. Monitor <del>STW</del> |
|                |  |   |
|                |  |   |
|                |  |   |
|                |  |   |
|                |  |   |





# CROSS CONSULTATION FORM

Doctor Name: Dr. G. Sruja Reddy Date: 5:30pm Time: 28/5/2026  
Diagnosis: Acute Urticaria

Hospital: .....

**Type of Referral :**

- Emergency
- Urgent
- Non Urgent

Referred for:  Opinion  Co-Management  Transfer of care

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

Signature: \_\_\_\_\_

**Findings and Recommendations :**

efo itching all over the body since  
1 week.  
o/e few wheals present on the  
lower abdomen.

Acute Urticaria

1) T. Afarax 25mg

7pm 10 days

2) T. Xyzal 5mg

8am 10 days

**Consultant :**

Name : ..... Signature : ..... Date & Time : .....

3) Ataca auri iker lotoi

✓ — ✓ — ✓ — ✓

4) Continue Citaphil Kutoadun.

h — n





# DRUG CHART

Date of Admission: ..... Drug Allergies: .....  Not known any Drug Allergies

## FOR THE SAFETY OF THE PATIENT

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

## SOS / PRN (As Required Medication)

|                          |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------|-------|--------------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG:</b> Tab Crocin  |       |              |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 650mg                    | PO    | SOS          | 27/5       |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Aef                      |       | >100%        |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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|--------------------------|-------|--------------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG:</b> Tab. CROCIN |       |              |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 500mg                    | PO    | SOS          | 27/5       |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| RV                       |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Paracetamol-500mg        |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|                          |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------|-------|--------------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b>            |       |              |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                          |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                          |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

VERIFIED BY : Name ..... Signature



REGULAR PRESCRIPTIONS

Weight. 40 kg Ward. ....

**DRUG :** 3mg. ceftriaxone Date/Time 27/5

| Dose       | Route     | Frequency | Start Date      |
|------------|-----------|-----------|-----------------|
| <u>2Gm</u> | <u>IV</u> | <u>BD</u> | <u>27/5 6pm</u> |

Name & Signature of the Doctor Starting the Drugs:  
(Signature)

Additional Instructions:  
6pm 2:57

**Daily Doctor's Endorsement by a Sign**

**DRUG :** Tab. ATARAX Date/Time 27/5 29/5

| Dose        | Route      | Frequency | Start Date  |
|-------------|------------|-----------|-------------|
| <u>25mg</u> | <u>P/O</u> | <u>OD</u> | <u>27/5</u> |

Name & Signature of the Doctor Starting the Drugs:  
(Signature) (morning)

Additional Instructions:  
10:10 2:47 4pm

**Daily Doctor's Endorsement by a Sign**

**DRUG :** Tab. XYZAL Date/Time 27/5

| Dose        | Route      | Frequency | Start Date  |
|-------------|------------|-----------|-------------|
| <u>10mg</u> | <u>P/O</u> | <u>OD</u> | <u>27/5</u> |

Name & Signature of the Doctor Starting the Drugs:  
(Signature) (Night)

Additional Instructions:

**Daily Doctor's Endorsement by a Sign**

**DRUG :** Date/Time

| Dose | Route | Frequency | Start Date |
|------|-------|-----------|------------|
|      |       |           |            |

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

**Daily Doctor's Endorsement by a Sign**

HNH-00015551 IP26-00006435  
 Baby K AARADHYA 11 Y 1 M 26 D (F)  
 02-04-2015  
 Dr. SINDHURA MUNUKUNTLA



Sheet No: .....

**REGULAR PRESCRIPTIONS**

Weight ..... Ward .....

|  |       |           |           |              |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|-------|-----------|-----------|--------------|---------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b> T. XYZAL   |       |           |           | Date<br>Time | 28/5/25 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose   | Route | Frequency | Start Dt. |              |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1 tab  | PO    | OD        | 8/5/25    |              |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor Starting the Drugs: Dr. Prathap Kumar |       |           |           | [Signature]  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: 1 tab = 5-g. (H/S)                          |       |           |           |              |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Daily Doctor's Endorsement by a Sign</b>                          |       |           |           |              |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b>  |       |           |           | Date<br>Time |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose   | Route | Frequency | Start Dt. |              |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor Starting the Drugs:                   |       |           |           |              |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:   |       |           |           |              |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Daily Doctor's Endorsement by a Sign</b>                          |       |           |           |              |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b>  |       |           |           | Date<br>Time |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose   | Route | Frequency | Start Dt. |              |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor Starting the Drugs:                   |       |           |           |              |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:   |       |           |           |              |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Daily Doctor's Endorsement by a Sign</b>                          |       |           |           |              |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b>  |       |           |           | Date<br>Time |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose   | Route | Frequency | Start Dt. |              |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor Starting the Drugs:                   |       |           |           |              |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:   |       |           |           |              |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Daily Doctor's Endorsement by a Sign</b>                          |       |           |           |              |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Signature  
Verified by: Name







MNH-00015551 IP26-00006435  
 Baby K AARADHYA  
 02-04-2015 11 Y 1 M 25 D (F)  
 Dr. SINDHURA MUNUKUNTLA



213  
**RESULT SHEET**

Rainbow<sup>®</sup>  
 Children's  
 Hospital  
 It takes a lot to treat the little.

**BirthRight**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

|                   |           |           |  |  |  |
|-------------------|-----------|-----------|--|--|--|
| Date              | 27/5/26   | 29/5/26   |  |  |  |
| Time              | .         |           |  |  |  |
| Hb                | 10.8      | 10.7      |  |  |  |
| PCV               | 29.9      | 29.9      |  |  |  |
| RBC               | 3.98      | 3.99      |  |  |  |
| WBC               | 12.00     | 6.52      |  |  |  |
| N/L               | 91.8/13.7 | 52.6/37.8 |  |  |  |
| Platelets         | 264       | 286       |  |  |  |
| CRP               | 126       | 51        |  |  |  |
| 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             |           |           |  |  |  |

|                                     |  |  |  |  |  |  |
|-------------------------------------|--|--|--|--|--|--|
| Date                                |  |  |  |  |  |  |
| Time                                |  |  |  |  |  |  |
| CUE-Alb                             |  |  |  |  |  |  |
| CUE-Sugar                           |  |  |  |  |  |  |
| CUE - Ketones                       |  |  |  |  |  |  |
| CUE-PUS Cells                       |  |  |  |  |  |  |
| CUE - RBC Cells                     |  |  |  |  |  |  |
| CUE                                 |  |  |  |  |  |  |
|                                     |  |  |  |  |  |  |
|                                     |  |  |  |  |  |  |
|                                     |  |  |  |  |  |  |
| Stool Pus Cell                      |  |  |  |  |  |  |
| OVA/Cyst                            |  |  |  |  |  |  |
| Occult Blood                        |  |  |  |  |  |  |
|                                     |  |  |  |  |  |  |
|                                     |  |  |  |  |  |  |
| <i>flu - negative (oral Report)</i> |  |  |  |  |  |  |
|                                     |  |  |  |  |  |  |
|                                     |  |  |  |  |  |  |
|                                     |  |  |  |  |  |  |
|                                     |  |  |  |  |  |  |
|                                     |  |  |  |  |  |  |

Culture and Sensitivities : .....

.....

.....

.....

Radiology:      USG : .....

                    X-Ray:.....

                    ECHO: .....

                    CT: .....

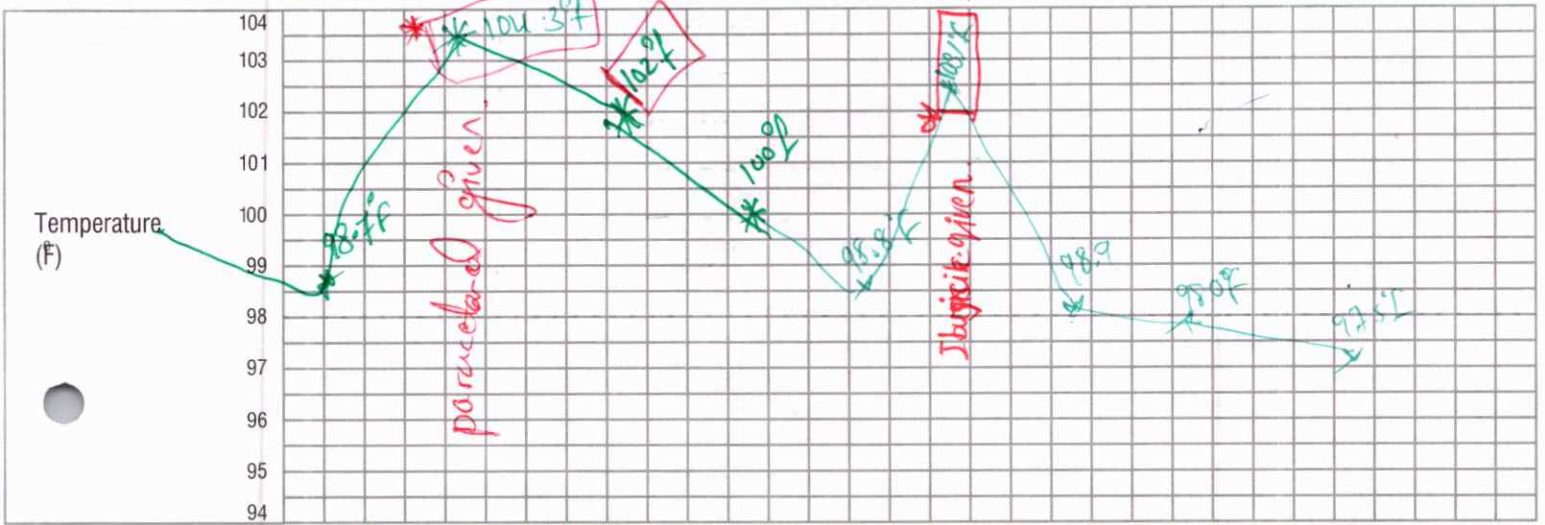
                    MRI .....

                    Others (ECG, Contrast Studies etc.): .....



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 2/4/15 Time: 2pm 6pm 9pm 10pm 11pm 12Am 2Am 6Am  
 Doctor / Nurse / Family Concern? PH PM



|                         |        |       |       |       |     |     |     |     |     |     |    |    |    |    |    |
|-------------------------|--------|-------|-------|-------|-----|-----|-----|-----|-----|-----|----|----|----|----|----|
| Heart Rate (bpm)        | 190    | 180   | 170   | 160   | 150 | 140 | 130 | 120 | 110 | 100 | 90 | 80 | 70 | 60 | 50 |
| Blood Pressure (mmHg) * | 111    | 107   | 105   | 104   |     |     |     |     |     |     |    |    |    |    |    |
| Heart Rate (Number)     | 106b/m | 95b/m | 98b/m | 92b/m |     |     |     |     |     |     |    |    |    |    |    |

|                                    |       |       |       |    |    |    |    |
|------------------------------------|-------|-------|-------|----|----|----|----|
| Resp. Rate (bpm) (Over 1 Minute) * | 70    | 60    | 50    | 40 | 30 | 20 | 10 |
| Resp Rate (Number)                 | 22b/m | 28b/m | 22b/m |    |    |    |    |

|                                  |             |             |
|----------------------------------|-------------|-------------|
| Resp Distress                    | Mod/ Severe | None / Mild |
| Receiving O <sub>2</sub> (l/min) |             |             |
| O <sub>2</sub> Saturations (%)   | 99%         | 99%         |
| Conscious Level                  | Normal      | Altered     |
| GCS *                            | 1           |             |

|                        |    |    |   |   |   |   |   |
|------------------------|----|----|---|---|---|---|---|
| TOTAL SCORE            |    |    |   |   |   |   |   |
| Number of shaded boxes | 0  | 0  | 0 | 0 | 0 | 0 | 0 |
| Pain Score             | 0  | 0  | 0 | 0 | 0 | 0 | 0 |
| Observer's Initials    | LS | MS |   |   |   |   |   |

**ACTIONS**

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

NB: Scores 3 should be recorded overleaf

\* 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 |
|   |      |                     |                                |      |      |
|   |      |                     |                                |      |      |
|   |      |                     |                                |      |      |
|   |      |                     |                                |      |      |

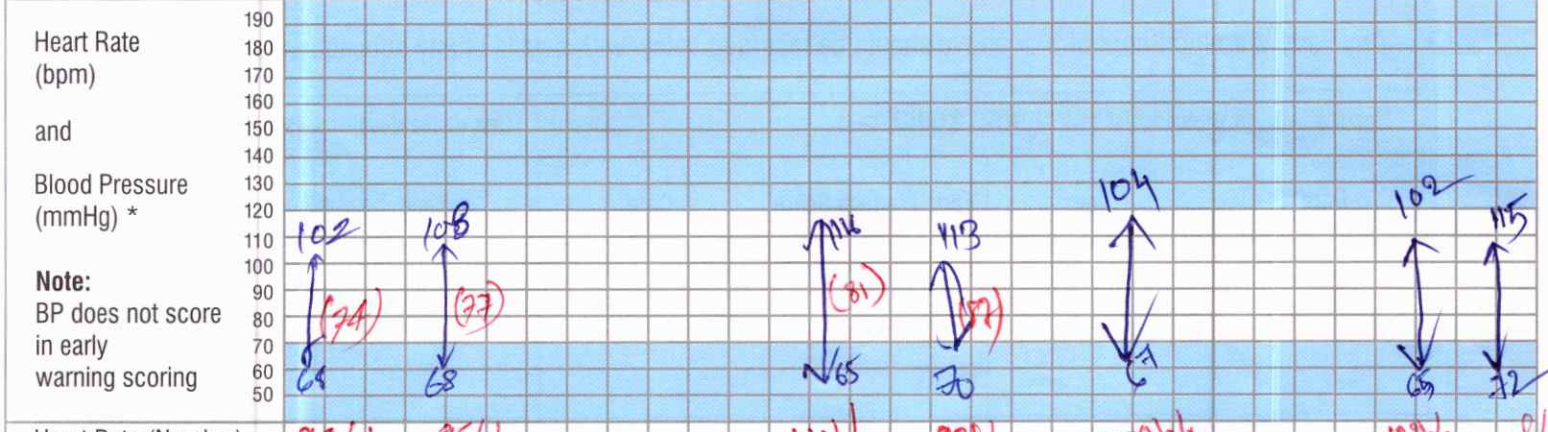
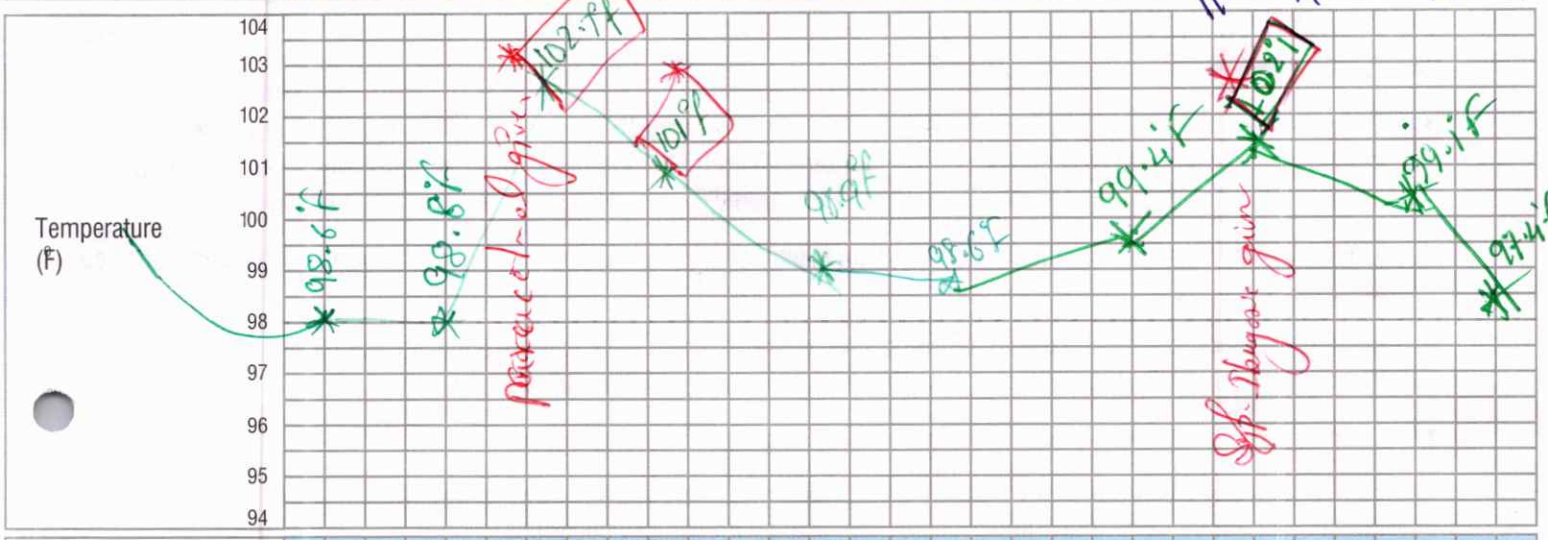
- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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.

|          |   |
|----------|---|
| <b>I</b> | <b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)   |
| <b>S</b> | <b>SITUATION:</b> 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>B</b> | <b>BACK GROUND:</b> 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) |
| <b>A</b> | <b>ASSESSMENT:</b> 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.   |
| <b>R</b> | <b>RECOMMENDATION:</b> 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

Date: 22/5/26 Time: 10Am 2pm 3pm 4pm 6pm 10pm 2 AM 3 AM 6 AM 8 AM  
 Doctor / Nurse / Family Concern?



|                                  |                  |     |      |      |      |      |      |
|----------------------------------|------------------|-----|------|------|------|------|------|
| Resp Distress                    | None / Mild      |     |      |      |      |      |      |
| Receiving O <sub>2</sub> (l/min) |                  |     |      |      |      |      |      |
| O <sub>2</sub> Saturations (%)   | 100%             | 99% | 100% | 100% | 100% | 100% | 100% |
| Conscious Level                  | Normal / Altered |     |      |      |      |      |      |
| GCS *                            |                  |     |      |      |      |      |      |

|                        |    |    |    |    |    |    |    |
|------------------------|----|----|----|----|----|----|----|
| TOTAL SCORE            |    |    |    |    |    |    |    |
| Number of shaded boxes | 0  | 0  | 0  | 0  | 0  | 0  | 0  |
| Pain Score             | 0  | 0  | 0  | 0  | 0  | 0  | 0  |
| Observer's Initials    | 15 | 10 | 10 | 10 | 10 | 10 | 10 |

**ACTIONS**

- 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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- 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.

|          |  |
|----------|--|
| <b>I</b> | <b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)  |
| <b>S</b> | <b>SITUATION:</b> 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>B</b> | <b>BACKGROUND:</b> 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) |
| <b>A</b> | <b>ASSESSMENT:</b> 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.  |
| <b>R</b> | <b>RECOMMENDATION:</b> 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. : .....

- 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 |                                |             |  |
| 27/5 | 08:00 am              |                 |          |      |     |        |                       |       |          |       |                                |             |  |
|      | 09:00 am              |                 |          |      |     |        |                       |       |          |       |                                |             |  |
|      | 10:00 am              |                 |          |      |     |        |                       |       |          |       |                                |             |  |
|      | 11:00 am              |                 |          |      |     |        |                       |       |          |       |                                |             |  |
|      | 12:00 pm              |                 |          |      |     |        |                       |       |          |       |                                |             |  |
|      | 01:00 pm              | DNS             |          | 53ml | NA  |        |                       | NA    |          |       |                                |             |  |
|      | <b>Total Intake :</b> |                 |          |      |     |        | <b>Total Output :</b> |       |          |       |                                |             |  |
| 27/5 | 02:00 pm              |                 |          | 53ml |     |        |                       |       |          |       |                                |             |  |
|      | 03:00 pm              |                 |          | 53ml |     |        |                       |       |          |       |                                |             |  |
|      | 04:00 pm              | DNS             | rice     | 53ml |     |        |                       |       |          |       |                                |             |  |
|      | 05:00 pm              |                 | dal +    | 53ml |     |        |                       |       |          |       |                                |             |  |
|      | 06:00 pm              |                 | tho.     | 53ml |     |        |                       |       |          |       |                                |             |  |
|      | 07:00 pm              |                 |          | 53ml |     |        |                       |       |          |       |                                |             |  |
|      | <b>Total Intake :</b> |                 |          |      |     |        | <b>Total Output :</b> |       |          |       |                                |             |  |
| 27/5 | 08:00 pm              |                 |          | 53ml |     |        |                       |       |          |       |                                |             |  |
|      | 09:00 pm              |                 |          | 53ml |     |        |                       |       |          |       |                                |             |  |
|      | 10:00 pm              |                 | rice     | 53ml |     |        |                       |       |          |       |                                |             |  |
|      | 11:00 pm              | DNS             | chapatis | 53ml |     |        |                       |       |          |       |                                |             |  |
|      | 12:00 am              |                 |          | 53ml |     |        |                       |       |          |       |                                |             |  |
|      | 01:00 am              |                 |          | 53ml |     |        |                       |       |          |       |                                |             |  |
|      | <b>Total Intake :</b> |                 |          |      |     |        | <b>Total Output :</b> |       |          |       |                                |             |  |
| 28/5 | 02:00 am              |                 |          | 53ml |     |        |                       |       |          |       |                                |             |  |
|      | 03:00 am              |                 |          | 53ml |     |        |                       |       |          |       |                                |             |  |
|      | 04:00 am              |                 | H2O      | 53ml |     |        |                       |       |          |       |                                |             |  |
|      | 05:00 am              | DNS             |          | 53ml |     |        |                       |       |          |       |                                |             |  |
|      | 06:00 am              |                 |          | 53ml |     |        |                       |       |          |       |                                |             |  |
|      | 07:00 am              |                 |          | 53ml |     |        |                       |       |          |       |                                |             |  |
|      | <b>Total Intake :</b> |                 |          |      |     |        | <b>Total Output :</b> |       |          |       |                                |             |  |

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

# FLUID CHART

Sheet No. : .....

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

| Date                        | Time     | Nature of Fluid | Intake |     |     | Output                      |           |       |          |       | IV Site Thrombo-phlebitis Score | Sign. Nurse |  |
|-----------------------------|----------|-----------------|--------|-----|-----|-----------------------------|-----------|-------|----------|-------|---------------------------------|-------------|--|
|                             |          |                 | Mouth  | I.V | N.G | NG                          | Diarrhoea | Vomit | Drainage | Urine |                                 |             |  |
| 28/5/26                     | 08:00 am |                 |        |     |     |                             |           |       |          |       |                                 |             |  |
|                             | 09:00 am |                 |        |     |     |                             |           |       | ✓        |       |                                 |             |  |
|                             | 10:00 am | Sup             |        |     |     |                             |           |       |          |       |                                 |             |  |
|                             | 11:00 am |                 |        |     |     |                             |           |       |          |       |                                 |             |  |
|                             | 12:00 pm |                 |        |     |     |                             |           |       | ✓        |       |                                 |             |  |
|                             | 01:00 pm |                 |        |     |     |                             |           |       |          |       |                                 |             |  |
| <b>Total Intake :</b>       |          |                 |        |     |     | <b>Total Output :</b>       |           |       |          |       |                                 | U-2 M-      |  |
| 29/5                        | 02:00 pm |                 |        |     |     |                             |           |       |          | 0     |                                 |             |  |
|                             | 03:00 pm |                 |        |     |     |                             |           |       |          | 0     |                                 |             |  |
|                             | 04:00 pm | Chapati Rice    |        |     |     |                             |           |       | ✓        | 0     |                                 |             |  |
|                             | 05:00 pm |                 |        |     |     |                             |           |       |          | 0     |                                 |             |  |
|                             | 06:00 pm | H2O             |        |     |     |                             |           |       | ✓        | 0     |                                 |             |  |
|                             | 07:00 pm |                 |        |     |     |                             |           |       |          | 0     |                                 |             |  |
| <b>Total Intake :</b>       |          |                 |        |     |     | <b>Total Output :</b>       |           |       |          |       |                                 | U- 100- M-  |  |
| 28/5                        | 08:00 pm |                 |        |     |     |                             |           |       |          |       |                                 |             |  |
|                             | 09:00 pm |                 |        |     |     |                             |           |       |          |       |                                 |             |  |
|                             | 10:00 pm | Rice            |        |     |     |                             |           | ✓     |          |       |                                 |             |  |
|                             | 11:00 pm | Chapati         |        |     |     |                             |           |       |          |       |                                 |             |  |
|                             | 12:00 am |                 |        |     |     |                             |           |       |          |       |                                 |             |  |
|                             | 01:00 am |                 |        |     |     |                             |           |       |          |       |                                 |             |  |
| <b>Total Intake :</b>       |          |                 |        |     |     | <b>Total Output :</b>       |           |       |          |       |                                 | U- M-       |  |
| 29/5                        | 02:00 am |                 |        |     |     |                             |           |       |          |       |                                 |             |  |
|                             | 03:00 am |                 |        |     |     |                             |           |       |          |       |                                 |             |  |
|                             | 04:00 am |                 |        |     |     |                             |           |       |          |       |                                 |             |  |
|                             | 05:00 am |                 |        |     |     |                             |           |       |          |       |                                 |             |  |
|                             | 06:00 am |                 |        |     |     |                             |           |       |          |       |                                 |             |  |
|                             | 07:00 am |                 |        |     |     |                             |           |       |          |       |                                 |             |  |
| <b>Total Intake :</b>       |          |                 |        |     |     | <b>Total Output :</b>       |           |       |          |       |                                 | U- M-       |  |
| <b>Total 24 hrs. Intake</b> |          |                 |        |     |     | <b>Total 24 hrs. Output</b> |           |       |          |       |                                 |             |  |



# FLUID CHART

Sheet No. : .....

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

| Date                  | Time     | Nature of Fluid | Intake |     |     | Output                |           |       |          |       | IV Site Thrombo-phlebitis Score | Sign. Nurse |  |
|-----------------------|----------|-----------------|--------|-----|-----|-----------------------|-----------|-------|----------|-------|---------------------------------|-------------|--|
|                       |          |                 | Mouth  | I.V | N.G | NG                    | Diarrhoea | Vomit | Drainage | Urine |                                 |             |  |
| 29/5                  | 08:00 am |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
|                       | 09:00 am |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
|                       | 10:00 am |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
|                       | 11:00 am |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
|                       | 12:00 pm |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
|                       | 01:00 pm |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       |                                 |             |  |
|                       | 02:00 pm |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
|                       | 03:00 pm |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
|                       | 04:00 pm |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
|                       | 05:00 pm |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
|                       | 06:00 pm |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
|                       | 07:00 pm |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       |                                 |             |  |
|                       | 08:00 pm |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
|                       | 09:00 pm |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
|                       | 10:00 pm |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
|                       | 11:00 pm |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
|                       | 12:00 am |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
|                       | 01:00 am |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       |                                 |             |  |
|                       | 02:00 am |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
|                       | 03:00 am |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
|                       | 04:00 am |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
|                       | 05:00 am |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
|                       | 06:00 am |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
|                       | 07:00 am |                 |        |     |     |                       |           |       |          |       |                                 |             |  |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       |                                 |             |  |

|                             |  |
|-----------------------------|--|
| <b>Total 24 hrs. Intake</b> |  |
|-----------------------------|--|

|                             |  |
|-----------------------------|--|
| <b>Total 24 hrs. Output</b> |  |
|-----------------------------|--|

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.

| 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 |                 |        |     |     |                       |           |       |          |       |                                | X           |  |
|                       | 11:00 am |                 |        |     |     |                       |           |       |          |       |                                | X           |  |
|                       | 12:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 01:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       |                                |             |  |
|                       | 02:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 03:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 04:00 pm |                 |        |     |     |                       |           |       |          |       |                                | /           |  |
|                       | 05:00 pm |                 |        |     |     |                       |           |       |          |       |                                | /           |  |
|                       | 06:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 07:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       |                                |             |  |
|                       | 08:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 09:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 10:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 11:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 12:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 01:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       |                                |             |  |
|                       | 02:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 03:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 04:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 05:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 06:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 07:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       |                                |             |  |

**Total 24 hrs. Intake**

**Total 24 hrs. Output**



Patient Sticker

# NURSING CARE RECORD



Date: 27/5/16

- 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   | 1pm  | Assess the pt. condition  | 1pm  | Assessed the pt. condition  | Patient is Stable                  | Re-checked vitals      |                        |
|           | 2pm  | - Monitor vitals & records<br>- maintain I/O chart<br>- I/F started   | 2pm  | - Monitored vitals & records<br>- maintained I/O chart<br>- continue I/F fluids   |                                    |                        |                        |
| Afternoon | 3pm  | - Assess the pt Condition<br>- monitor vitals & I/O chart<br>- drug as per chart<br>- provided Comfortable position | 3pm  | - Assessed the pt Condition<br>- Monitored vitals & I/O chart<br>- druged as per chart<br>- provided Comfortable position | pt is stable she feel comfortable. | Rechecked vitals       |                        |
|           | 8pm  |   |      |   |                                    |                        |                        |
| Night     | 8pm  | - Assess the pt condition.<br>- monitor the vitals.<br>- drugs give as per drug chart.                              | 8pm  | - Assessed the pt condition.<br>- monitored the vitals.<br>- drugs given as per drug chart.                               | pt is stable now.                  | Re assessed the vitals |                        |
|           | 8AM  | - maintain I/O chart.   | 8AM  | - maintained I/O chart.   |                                    |                        |                        |

JH-00015551  
 Baby K AARADHYA IP26-00006435  
 02-04-2015 11 Y 1 M 25 D (F)  
 Dr. SINDHURA MUNUKUNTLA

# NURSING CARE RECORD

Date: 28/5/20

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   | 8 AM | - Assess the pt condition<br>- Monitor vitals<br>- maintain I/O chart<br>- medication given as per doctor order   | 8 AM | - Assessed the pt condition<br>- monitored vitals<br>- maintain I/O Chart<br>- medication given as per doctor order  | pt is stable     | Re-Assessment vitals   | [Signature]            |
|           | 2 PM |   | 2 PM |  |                  |                        |                        |
| Afternoon | 2 PM | Assess the pt condition.<br>Monitor vitals & record<br>maintain I/O chart<br>provide the comfortable position.<br>medication give as per as doctor order. | 2 PM | Assessed the pt condition.<br>Monitored vitals & recorded<br>maintained I/O charts<br>provided the comfortable position.<br>medication given as per as doctor order. | pt is stable     | monitor vitals         | Sneha                  |
|           | 8 PM |   | 8 PM |  |                  |                        |                        |
| Night     | 8 PM | - Assess the pt condition.<br>- monitor the vitals.<br>- maintain I/O chart.<br>- drugs give as per drug chart.   | 8 PM | - Assessed the pt condition.<br>- monitored the vitals.<br>- maintained I/O chart.<br>- drugs given as per drug chart.   | pt is stable now | Re-assessed the vitals | [Signature]            |
|           | 8 PM |   | 8 PM |  |                  |                        |                        |

HNH-00015551 IP26-00006435  
 Baby K AARADHYA  
 02-04-2015 11 Y 1 M 26 D (F)  
 Dr. SINDHURA MUNUKUNTLA



# NURSING CARE RECORD



Date: 29/12

**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   | 8:00 | Assess the baby<br>vitals<br>administer pain<br>meds<br>cl | 8:00 | Assess the baby<br>vitals<br>administer pain<br>meds<br>cl | Administer<br>cl | Reassess<br>cl | NSH<br>[Signature]     |
| Afternoon |      |  |      |  |                  |                |                        |
| Night     |      |  |      |  |                  |                |                        |

Patient Sticker

# NURSING CARE RECORD

Date: .....

**Goals**

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

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

### ING SHIFT HAND OVER FORM

|  |  |  |   |   |   |   |   |               |
|--|--|--|---|---|---|---|---|---------------|
| SITUATION                                | Diagnosis: <u>LRTI &amp; dehydration</u>               | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known<br>If Yes Specify: ..... |   |   |   |   |   |               |
|  | Surgery / Procedure:                                   | Post OP Day:   |   |   |   |   |   |               |
| BACKGROUND                               | Date   | <u>27/5</u>  | <u>27/5</u>   | <u>27/5</u>   | <u>28/5</u>   | <u>28/5</u>   | <u>28/5</u>   |               |
|  | Shift  | <u>M6</u>  | <u>E2</u>   | <u>N1</u>   | <u>M6</u>   | <u>E2</u>   | <u>N1</u>   |               |
|  | Medical Condition (Any special condition to be noted): | -  | -   | -   | -   | -   | -   |               |
| ASSESSMENT                               | Allergy:   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |               |
|  | Ventilation (RA, NP, NIV, VENTI):                      | -  | -   | -   | -   | -   | -   |               |
|  | Tubes/Drains/Catheter:                                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |               |
|  | Vital Signs:   | Temp:  | <u>97.5f</u>  | <u>98.1f</u>  | <u>98.1f</u>  | <u>98.6f</u>  | <u>98.2f</u>  | <u>98.1f</u>  |
|  |  | Res:   | <u>20b/m</u>  | <u>21b/m</u>  | <u>20b/m</u>  | <u>20b/m</u>  | <u>20b/m</u>  | <u>20b/m</u>  |
|  |  | SpO <sub>2</sub> :   | <u>99%</u>  | <u>99%</u>  | <u>99%</u>  | <u>100%</u>   | <u>99%</u>  | <u>100%</u>   |
|  |  | Pulse:   | <u>106b/m</u>   | <u>110b/m</u>   | <u>110b/m</u>   | <u>108b/m</u>   | <u>108b/m</u>   | <u>100b/m</u> |
|  |  | BP:  | -   | -   | -   | <u>104/69 mmHg</u>  | <u>104/69 mmHg</u>  | -             |
|  |  | LOC:   | -   | -   | -   | -   | -   | -             |
|  |  | Fall Risk Score:   | -   | -   | -   | -   | -   | -             |
| Pain Score:                              | -  | -  | -   | <u>0</u>  | <u>0</u>  | -   |   |               |
| Skin Integrity                           | -  | -  | <u>Good</u>   | <u>Good</u>   | <u>Good</u>   | <u>Good</u>   |   |               |
| Recommendations                          | Safety Needs:  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |               |
|  | Physiotherapy:   | -  | -   | -   | -   | -   | -   |               |
|  | Others Specify:  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |               |
|  | Special Diet:  | -  | -   | -   | -   | -   | -   |               |
|  | Critical Lab Test / Values:                            | -  | -   | -   | -   | -   | -   |               |
|  | Other Special Orders / Medications:                    | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |               |
|  | ADL (Dependent / Non Dependent):                       | -  | -   | -   | -   | -   | -   |               |
| Post Operative Procedure Special Orders: | -  | -  | -   | -   | -   | -   |   |               |
| Handed Over By Name :                    | <u>Priyanka</u>  | <u>Suryya</u>  | <u>mahi</u>   | <u>Manisha</u>  | <u>Sru</u>  | <u>mahi</u>   |   |               |
| Signature / ID :                         | <u>[Signature]</u>                                     | <u>[Signature]</u>   | <u>[Signature]</u>  | <u>[Signature]</u>  | <u>[Signature]</u>  | <u>[Signature]</u>  |   |               |
| Date:                                    | <u>27/5/26</u>   | <u>27/5/26</u>   | <u>28/5/26</u>  | <u>28/5/26</u>  | <u>28/5</u>   | <u>29/5/26</u>  |   |               |
| Time:                                    | <u>2pm</u>   | <u>8pm</u>   | <u>9am</u>  | <u>2pm</u>  | <u>8pm</u>  | <u>8am</u>  |   |               |
| Taken Over By Name :                     | <u>Priya</u>   | <u>Mahi</u>  | <u>Manisha</u>  | <u>Sru</u>  | <u>mahi</u>   | <u>[Signature]</u>  |   |               |
| Signature / ID :                         | <u>[Signature]</u>                                     | <u>[Signature]</u>   | <u>[Signature]</u>  | <u>[Signature]</u>  | <u>[Signature]</u>  | <u>[Signature]</u>  |   |               |
| Date:                                    | <u>27/5/26</u>   | <u>27/5/26</u>   | <u>28/5/26</u>  | <u>28/5</u>   | <u>28/5</u>   | <u>29/5/26</u>  |   |               |
| Time:                                    | <u>2pm</u>   | <u>9pm</u>   | <u>8am</u>  | <u>2pm</u>  | <u>8pm</u>  | <u>9am</u>  |   |               |

## NURSING SHIFT HAND OVER FORM

|  |  |   |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|
| <b>SITUATION</b>                         | Diagnosis:   | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |  |  |  |  |  |  |
|  | Surgery / Procedure:                                   | Post OP Day:  |  |  |  |  |  |  |
| <b>BACKGROUND</b>                        | Date   | 24/10/2015  |  |  |  |  |  |  |
|  | Shift  | AM  |  |  |  |  |  |  |
|  | Medical Condition (Any special condition to be noted): | -   |  |  |  |  |  |  |
|  | Diet:  | -   |  |  |  |  |  |  |
| <b>ASSESSMENT</b>                        | Allergy:   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | Ventilation (RA, NP, NIV, VENTI):                      | -   |  |  |  |  |  |  |
|  | Tubes/Drains/Catheter:                                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | Vital Signs:   | Temp:   | 98.6 F   |  |  |  |  |  |
|  |  | Res:  | 20   |  |  |  |  |  |
|  |  | SpO <sub>2</sub> :  | 98   |  |  |  |  |  |
|  |  | Pulse:  | 100  |  |  |  |  |  |
|  |  | BP:   | -  |  |  |  |  |  |
|  |  | LOC:  | -  |  |  |  |  |  |
|  |  | Fall Risk Score:  | -  |  |  |  |  |  |
| Pain Score:                              | -  |   |  |  |  |  |  |  |
| Skin Integrity                           | -  |   |  |  |  |  |  |  |
| <b>Recommendations</b>                   | Safety Needs:  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | Physiotherapy:   | -   |  |  |  |  |  |  |
|  | Others Specify:  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | Special Diet:  | -   |  |  |  |  |  |  |
|  | Critical Lab Test / Values:                            | -   |  |  |  |  |  |  |
|  | Other Special Orders / Medications:                    | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | PU Prophylaxis:  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | DVT Prophylaxis:                                       | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| ADL (Dependent / Non Dependent):         | -  |   |  |  |  |  |  |  |
| Post Operative Procedure Special Orders: |  | -   |  |  |  |  |  |  |
| Handed Over By Name :                    |  | Sindhura  |  |  |  |  |  |  |
| Signature / ID :                         |  | [Signature]   |  |  |  |  |  |  |
| Date:                                    |  | 24/10/2015  |  |  |  |  |  |  |
| Time:                                    |  | 10:30 AM  |  |  |  |  |  |  |
| Taken Over By Name :                     |  |   |  |  |  |  |  |  |
| Signature / ID :                         |  |   |  |  |  |  |  |  |
| Date:                                    |  |   |  |  |  |  |  |  |
| Time:                                    |  |   |  |  |  |  |  |  |



# CHECKLIST FOR THROMBOPHLEBITIS

27/5/26

| S. No.                 | SITE OBSERVATION   | STAGE / ACTION  | SCORE | DAY-1 |     |     | 28/5/26 DAY-2 |    |     | DAY-3 |   |   | Remarks |
|------------------------|--|---|-------|-------|-----|-----|---------------|----|-----|-------|---|---|---------|
|                        |  |   |       | M     | (E) | (N) | M             | E  | (N) | M     | E | N |         |
| 1                      | IV site appears healthy  | No signs of phlebitis / Observe cannula   | 0     |       | 0   | 0   | 0             | 0  |     |       |   |   |         |
| 2                      | One of the following signs is evident :<br>* Slight pain near the IV Site /<br>* Slight redness near IV Site                                 | Possibly first signs of phlebitis / Observe cannula   | 1     |       | NA  | NA  | NA            | NA |     |       |   |   |         |
| 3                      | Two of the following Signs are evident:<br>Pain at IV site Redness   | Early stage of phlebitis / Resite Cannula   | 2     |       | NA  | NA  | NA            | NA |     |       |   |   |         |
| 4                      | All of the following Signs are evident :<br>Pain along Path of cannula<br>Redness around Site Swelling                                       | Medium stage of phlebitis / Resite Cannula Consider Treatment                                     | 3     |       | NA  | NA  | NA            | NA |     |       |   |   |         |
| 5                      | All of the following Signs are evident and Extensive :<br>Pain along Path of cannula<br>Redness around Site<br>Swelling palpable Venous cord | Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment | 4     |       | NA  | NA  | 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  | 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 : *Sreha* Name : *Sreha*

Signature of Ward In Charge :

Signature : *Balarani* Name : *Balarani*

HNH-00015551  
 Baby K AARADHYA  
 02-04-2016  
 Dr. SINDHURA MUNUKUNTLA



IP26-00008433  
 11 Y 1 M 26 D (F)

# PAIN ASSESSMENT FORM

| Date    | Time | Pain Score (0/10) | Location | Duration  | Acuity  | Character   | Modifying Factors   | Patient / Family Educated  | Intervention | Sign        |
|---------|------|-------------------|----------|---|---|---|---|--|--------------|-------------|
| 27/5    | 2pm  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input checked="" type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | [Signature] |
| 27/5    | 4pm  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input checked="" type="checkbox"/> Intermittent | <input checked="" type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input checked="" type="checkbox"/> Decreasing | <input checked="" type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | [Signature] |
| 28/5    | 6Am  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA           | [Signature] |
| 28/5/20 | 10Am | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input checked="" type="checkbox"/> Intermittent | <input checked="" type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input checked="" type="checkbox"/> Decreasing | <input checked="" type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | [Signature] |
| 28/5/20 | 2pm  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input checked="" type="checkbox"/> Intermittent | <input checked="" type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input checked="" type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA           | [Signature] |
| 28/5    | 8pm  | 0                 | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA           | [Signature] |
| 29/5    | 8Am  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA           | [Signature] |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            |              |             |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            |              |             |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            |              |             |

**Re-assessment Frequency:**

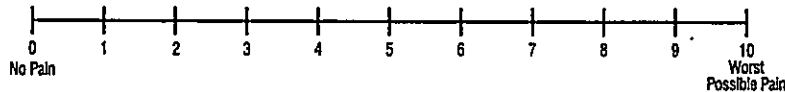
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
  - At least every 2 hours for the first 24 hours
  - Then every 4 hours.
  - Prior to pain relieving intervention.
  - Within 30 – 60 minutes after pain relief intervention.

# PAIN ASSESSMENT TOOLS

## FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

## Numerical Pain Scale (Obstetric and Gynecology)



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

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

## Wong - Baker (Pediatrics) Above 7 Years



HNH-00015551  
 Baby K AARADHYA IP26-00006435  
 02-04-2015 11 Y 1 M 25 D (F)  
 Dr. SINDHURA MUNUKUNTLA

# BRADEN 'Q' SCALE



|   |  |  |   |  | Date: | 27/8/2015 | 28/5/2015 | 28/5/15 | 28/5/15 |
|---|--|--|---|--|-------|-----------|-----------|---------|---------|
|   |  |  |   |  | Time: | 02        | 01        | 06      | 02      |
| Mobility  | <b>1. Completely immobile:</b><br>Does not make even slight changes in body or extremity position without assistance.  | <b>2. Very limited:</b><br>Makes occasional slight changes in body or extremity position but unable to completely turn self independently.   | <b>3. Slightly limited:</b><br>Makes frequent through slight changes in body or extremity position independently.   | <b>4. No limitations:</b><br>Makes major and frequent changes in position without assistance.  |       | 4         | 4         | 4       | 4       |
| "Activity The degree of physical activity"  | <b>1. Bedfast:</b><br>Confined to bed  | <b>2. Chairfast:</b><br>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."  | <b>3. Walks occasionally:</b><br>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.  | <b>4. All patients too young to ambulate; OR walks frequently:</b><br>Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.  |       | 4         | 4         | 4       | 4       |
| Sensory Perception  | <b>1. Completely limited:</b><br>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.  | <b>2. Very limited:</b><br>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.   | <b>3. Slightly limited:</b><br>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.   | <b>4. No impairment:</b><br>Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.  |       | 4         | 4         | 4       | 4       |
| Moisture Degree to which skin is exposed to moisture  | <b>1. Constantly moist:</b><br>Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.   | <b>2. Very moist:</b><br>Skin is often, but not always, moist. Linen must be changed at least every 8 hours.   | <b>3. Occasionally moist:</b><br>Skin is occasionally moist, requiring linen change every 12 hours.   | <b>4. Rarely moist:</b><br>Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.   |       | 4         | 4         | 4       | 4       |
| <b>FRICITION-SHEAR</b><br><b>Friction</b> Occurs when Skin moves against support surfaces<br><b>Shear</b> Occurs when skin and adjacent bony surface slide across one another | <b>1. Significant problem:</b><br>Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.  | <b>2. Problem:</b><br>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.  | <b>3. Potential problem:</b><br>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.            | <b>4. No apparent problem:</b><br>Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."                         |       | 4         | 4         | 4       | 4       |
| Nutritional Usual food intake pattern   | <b>1. Very Poor:</b><br>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. | <b>2. Inadequate:</b><br>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. | <b>3. Adequate:</b><br>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. | <b>4. Excellent:</b><br>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 mean and dairy products. Occasionally eats between meals. Does not require supplementation. |       | 4         | 4         | 4       | 4       |
| Tissue Perfusion & Oxygenation  | <b>1. Extremely compromised:</b><br>Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.   | <b>2. Compromised:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.  | <b>3. Adequate:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.  | <b>4. Excellent:</b><br>Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.   |       | 4         | 4         | 4       | 4       |
| <b>TOTAL SCORE</b>  |  |  |   |  |       | 28        | 28        | 28      | 28      |
| <b>Evaluator's Name</b>   |  |  |   |  |       | S         | 12        | 15      | 12      |

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   | <b>Support Surfaces</b><br>(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       | <ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul> | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay  |
| 13-14       | Moderate Risk | <ul style="list-style-type: none"> <li>• Use the Same Protocol as for "At Risk" Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>   | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay  |
| 10-12       | High Risk     | <ul style="list-style-type: none"> <li>• Follow the same protocol as for "Moderate Risk" Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>  | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay  |
| Less than 9 | Severe Risk   | <ul style="list-style-type: none"> <li>• Use same protocol as for "High Risk" Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>  | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay  |

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 Baby K AARADHYA  
 02-04-2016 11 Y 1 M 26 D (F)  
 Dr. SINDHURA MUNUKUNTLA



## MEDICATION RECONCILIATION FORM

Drug Allergies: .....  Not known any Drug Allergies

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

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

Shifting From: ..... ER ..... Shifted to: ..... 213 .....

| S.No | MEDICATION NAME<br>(GENERIC NAME CAPITAL LETTERS) | DOSE<br>(mg, mcg) | ROUTE<br>(PO, NG, SC, IV) | FREQUENCY | LAST DOSE<br>Date / Time | ON<br>ADMISSION<br>/ SHIFTING                          |
|------|---|-------------------|---------------------------|-----------|--------------------------|--|
| 1    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 2    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 3    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 4    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 5    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 6    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 7    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 8    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 9    |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 10   |   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |

\* C- Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : ..... Dr. N. Sripada .....

Date & Time : ..... 27/5 .....

Nurse Name & Signature: ..... Amritha .....

Date & Time : ..... 27/5/16 @ 12:30 PM .....

Docu. No. : RCH / FRM / GENERAL / 090

Cfrizell

Dr.

10/10/1954  
10/10/1954  
10/10/1954  
10/10/1954

Patient Sticker  
11/11M

213

### NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 27/5/26 Time: 5:30pm

Weight: 40kg Centile: >50th

Height: - Centile: -

Inference: well nourished child

RDA: - Calories: 1700kcal/d Protein: 30gms/d

Diet Recommendations: Normal high protein diet

Re-Assessment: Avoid spicy, chilled & outside foods

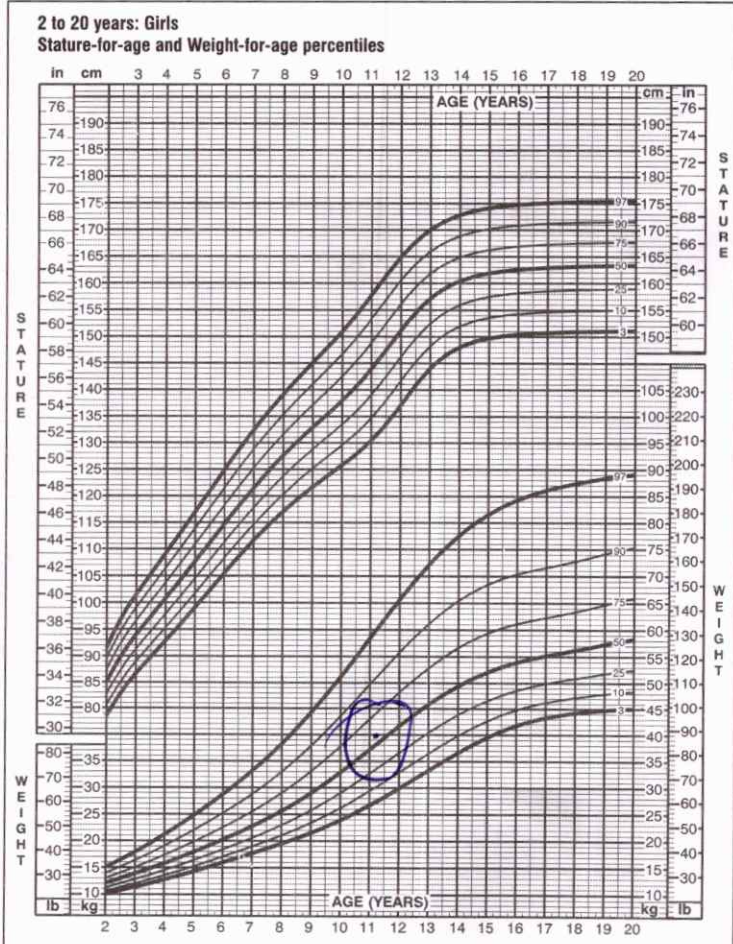
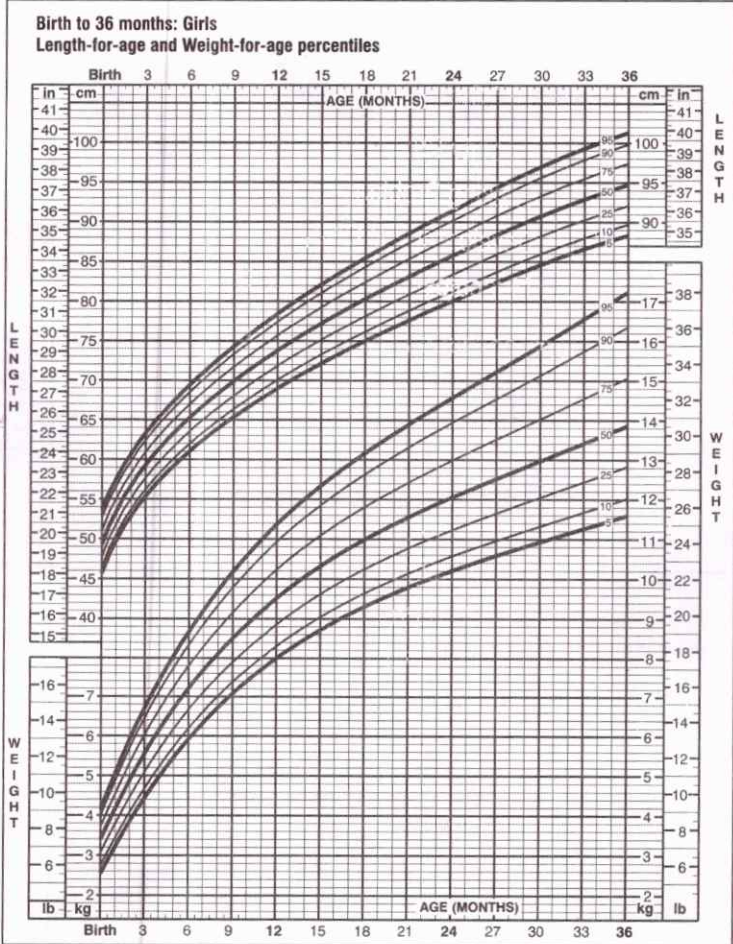
Food Allergies: NO Veg/Non-veg: NON-veg

Diagnosis: LPTI & dehydration

Nutritional Intervention -  Oral  Enteral  Parenteral

Patient's Signature: [Signature]

#### GROWTH CHART (GIRLS)



Dietician's Name: Sathwikas

Dietician's Signature: [Signature]





*wt - 40 kg*

## EMERGENCY ROOM TRIAGE FORM

Patient's Name : K Aaradhya Age : 11y Gender:  Male  Female  
 Date : 27/5/26 Time of Arrival : 12:20pm  
 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: 99.1 PR: 105 BP: 112/74 RR: 21 SpO<sub>2</sub>: 100%  
 Chief Complaints: no fever since 6 days

|   |  |   |  |
|---|--|---|--|
| <b>INITIAL PHYSIOLOGICAL CATEGORIZATION</b><br>Appearance<br><input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sick Looking<br>Circulation / Colour<br><input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding |  | Work of Breathing<br><input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased<br><input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea | <b>INITIAL PHYSIOLOGICAL STATUS</b><br><input checked="" type="checkbox"/> Stable<br><input type="checkbox"/> Unstable :<br><input type="checkbox"/> Not - Life - Threatening<br><input type="checkbox"/> Life - Threatening |
|---|--|---|--|

| Triage Classification  | CTAS                                       |
|--|--|
| <input type="checkbox"/> Level 1 : Resuscitation   | <input type="checkbox"/> Immediate         |
| <input type="checkbox"/> Level 2 : EMERGENT : Life or limb threatening   | <input type="checkbox"/> < 15 min          |
| <input type="checkbox"/> Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening | <input type="checkbox"/> 30 min            |
| <input type="checkbox"/> Level 4 : LESS URGENT : Significant illness but not life threatening                              | <input checked="" type="checkbox"/> 60 min |
| <input type="checkbox"/> Level 5 : NON - URGENT : May receive care when convenient   | <input type="checkbox"/> 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 : 12:22pm

### 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 : Amalam

Signature of Triage Nurse : [Signature]

Date & Time : 27/5/26 @ 12:28pm

## NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 27/5/20 Time of arrival : 12:20 PM

Chief Complaints: fever since 6 days.

Height : ..... Weight : 10 kg Head Circumference (<2 years) .....

Allergies:  Yes  No  Medications  Blood Transfusion  Food  Other: .....  
 If yes, identify .....

Pain Screening:  Yes  No If Yes, Pain Score: ..... Pain Tool Used:  N Pass  FLACC  Wong Baker  
 Character .....  Location .....  Frequency .....  Duration .....

**RISK FOR FALL:**  
 If patient is < 6 years  Yes  No  
 If 'Yes' tick below fall risk intervention directly  
 If Patient is > 6 years  
 If 'Yes' 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 : 12:30 PM

**Nursing Care Plan (Including Labs / Medications / Other Care):**

| Time | Nursing Notes                                    |
|------|--|
|      | Assessed The patient condition<br>vital checked. |
|      |  |
|      |  |
|      |  |
|      |  |
|      |  |
|      |  |
|      |  |

Samples collected by:

Samples sent by :

*Sufanida*

Time:

Time:

*12:45 PM*

**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: <i>102</i> ..... BP: <i>110/70</i> CFT: .....<br>RR: <i>22</i> ..... SPO2 at FiO2: <i>99.1</i> .....<br>GCS: ..... Temperature : <i>99</i> .....<br>Pain Score: <i>0</i> .....<br>Repeat RBS (if applicable): ..... | Shift - out from ER to: <i>213</i> .....<br>Time of Shift - out: <i>1:20 PM</i> .....<br>Handover given to: .....<br>(Nurse's Name) |

Tick as applicable:  MLC  LAMA  BROUGHT DEAD


Procedures done with details (if any): .....

Name of the Nurse : *AmePan* .....

Signature of the Nurse : *A.E* .....

Date & Time : *27/5/26 @ 12:30 PM* .....

# PATIENT TRANSFER FORM

|  |                                  |   |  |
|--|----------------------------------|---|--|
| Patient Name & UHID No.<br><br>HNH-00015551      IP26-00006435<br>Baby K AARADHYA<br>02-04-2015      11 Y 1 M 25 D (F)<br>Dr. SINDHURA MUNUKUNTLA<br> |                                  | Date & Time of Admission<br><br>27/5/26   | Date & Time of Transfer Order<br><br>27/5/26 |
|  |                                  | Transfer Ordered by<br><br>Dr. vaishunya.   | Reason for Transfer<br><br>Admission         |
| From Unit<br><br>ER  | To Unit<br><br>Q13               | Information to Attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  |
| Number of Sheets in Clinical File<br><br>21  | Number of Imaging Films<br><br>1 | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input type="checkbox"/> No <input type="checkbox"/><br><br>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 <input checked="" type="checkbox"/> No <input type="checkbox"/>  |                                  |   |  |
| Name & Signature of Person who is Transferring<br><br>Amrtaam  |                                  | Name of Person Ordered Transfer<br><br>Dr. vaishunya.   |  |
| Patient & Clinical Records Received by :<br><br>Priyanka   |                                  |   |  |
| Date & Time of Patient Received :<br><br>27/5/26 @ 10:20pm.  |                                  |   |  |

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

LRT 1 2  
Dehydration

BABY K AARADHYA 117 CM 25D - FHH 00015551 CHEST PA 20 MAR 2011 11 PM  
RAINBOW CHILDREN'S HOSPITAL HIMAYATHI NAGAR

R

R

RAINBOW CHILDREN'S HOSPITAL, HIMAYALH NAGAR  
B-6, K. VARDHANA 11A, NEW DELHI-00015523. OFFICE: 11A, NEW DELHI  
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