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FC

Rainbow® Children's Hospital
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DISCHARGE SUMMARY

Name	Master KASALA JAINESH	**UHID**	HNH-00004561
Father/Guardian	Mr KASALA TARUN PRABHUKAR	**Age/Gender**	1 Y 9 M 7 D/ Male
Address	H.NO: 1-3-1/5., Kavadi Guda, Hyderabad, Telangana, INDIA, 500080		
IP No	IP26-00006866	**Admission Date**	16-07-2026
Ref Doctor	Self.		
Discharge Date	18.07.2026		

Consultant:
Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

DIAGNOSIS	ICD CODE
ACUTE DYSENTERY WITH DEHYDRATION	

History: Master KASALA JAINESH, 1 Y 9 M 7 D , old boy presented with history of fever since 2 days, multiple episodes of loose stools & vomitings, few episodes of blood in stool and decreased oral intake since 1 day prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

Examination: He was febrile(103*F). His heart rate was 115/min and Respiratory Rate - 29/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination signs of dehydration were present- dry lips, oral mucosa, delayed skin turgor, decreased urine output, sunken

Name	Master KASALA JAINESH	UHID	HNH-00004561
IP No	IP26-00006866	Admission Date	16-07-2026

eyes. On auscultation, air entry was bilaterally equal were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, he 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: 11.07 kilo grams.

Investigations: Enclosed reports.

VBG showed pH of 7.36, pCO2 of 29.9 mmHg, pO2 of 60 mmHg, HCO3 of 18.1 mmol/L and BE of -8.4 mmol/L.

Initial hemogram showed Hemoglobin of 10.2 gm%, White Blood Cell count of 7440 cells/cumm, platelet count of 3.60 lakhs/cumm and C-Reactive Protein of 67 mg/l.
Blood culture and sensitivity shows no growth after 24 hours of incubation.
Complete urine examination was normal.

Complete stool examination shows

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COLOUR	YELLOWISH			
CONSISTENCY	S. FORMED			
pH	8.0	5 - 8.5		-
MUCUS	PRESENT	ABSENT		-
BLOOD	ABSENT			
UNDIGESTED FOOD	PRESENT + +	ABSENT		-
HELMINTHES	NIL	NIL		-
PUS CELLS	25 - 30			
RED BLOOD CELLS (Stool)	1 - 2	NIL	HPF	L
STARCH GRANULES	ABSENT	ABSENT		-
YEAST CELLS	PRESENT + +	NIL		-
FAT GLOBULES	ABSENT	ABSENT		-
PROTOZOA	NIL	NIL		

Stool culture & sensitivity report awaited

Ultrasound abdomen shows

* Prominent extrarenal pelvis on the right side - likely variant.
* Internal echoes in urinary bladder.

Management: He was admitted in the ward and was started on Intra Venous fluids and Intra Venous antibiotics. He was treated symptomatically with

Name	Master KASALA JAINESH	UHID	HNH-00004561
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probiotics, zinc and antipyretics.

He was regularly monitored for further blood in stools, hydration status, fever spikes, hemodynamic status. His loose stools, fever spikes and other symptoms gradually settled. Child maintaining saturations on room air.

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

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

Medication during hospital stay:
Injection. Ceftriaxone
Z & D drops
Pro GG sachet

Advice:
* Diet as advised.

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S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. ZIPRAX (Cefixime - 5ml/100mg)	3 ml	8am - 8pm (after food)	For 5 days.
2	Pro GG SACHET	1 SACHET	9am-9pm (after food)	For 3 days
3	Z & D drops (1ml/20mg)	1 ml	9am (after food)	For 11 days
4	Nasoclear nasal drops, 2 drops in each nostril **SOS** for nose block			

Plan: To collect final blood culture report and stool culture report on followup.

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 3.5 ml 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(20.07.2026) at Himayatnagar in OPD with prior appointment **(Review consultation will be charged)**.

Food instructions while taking medications:
* **Antibiotics** along with food & milk products prevent their absorption of drugs & supplements. Antibiotics can be given 1 hour before food or 2 hours after food based on tolerance of stomach.

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* By consuming your **probiotic** with food you provide a buffering system for the supplement and ensure its safe passage through the digestive tract. Aside from protection, food also provides the friendly bacteria in your probiotic the proper food and nourishment to ensure it survives, grows and multiplies in your gut. It is recommended to take probiotics at the END of a meal. Concurrent administration of antibiotics could kill a large number of the organisms, reducing the efficacy of probiotics. Separate administration of antibiotics from probiotics by **atleast two hours.**

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

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 **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**

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IP No	IP26-00006866	**Admission Date**	16-07-2026

CHILDREN'S MEDICARE LIMITED HYDERABAD

Registrar/Resident/C.M.O

Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

HNH-00004561 IP26-00006866
Master KASALA JAINESH
11-10-2024 1 Y 9 M 6 D (M)
Dr. SINDHURA MUNUKUNTLA

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	4			
7	Nursing plan of care and handover sheets	3			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaestesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	2			
30	Intake and Out take chart (fluid chart)	2			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale				
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Billing	1			
	Others	5			
	Total No. of Pages	29			

Doc. No. : RCH/ FRM / GENERAL / 126

Signature and Date : 18/08/26

(P.T.O)

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU / 2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006866 **Admit Date** : 16-Jul-2026 **Admit Time** : 09:13 PM **UHID** : HNH-00004561

Patient Details :

Patient Name	: Master KASALA JAINESH	**Age**	: 1 Y 9 M 5 D
Guardian	: Mr KASALA TARUN PRABHUKAR	**DOB**	: 11-10-2024 10:10 PM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H.NO: 1-3-1/5. Kavadi Guda Hyderabad Telangana INDIA 500080	**Phone No**	: 8519863723/ 8074533255
		E-mail	: TARUNPRABHUKAR@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 KASALA TARUN PRABHUKAR **Relationship** : Father

Contact Address : H.NO: 1-3-1/5. Kavadi Guda Hyderabad Telangana INDIA 500080 **Phone No** : 8074522355

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** : BAJAJ ALLIANZ GENERAL INSURANCE CO LTD.

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ACTIVIT[Y] ... [G]

HNH-00004561 IP26-00006866
Master KASALA JAINESH
11-10-2024 1 Y 9 M 5 D (M)
Dr. SINDHURA MUNUKUNTLA

Name: ---- ---

UHID No : ---------- IP No : ---------- Consultant : ------------------------ Dept : pediatric

Date of Admission : 16/7/26 Time : -------------- Date of Discharge : ---------------- Time: -----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
16/7/26	12:15pm	ER	3rd. floor	[signature]

Cross Consultation Visit

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

HNH-00004561 IP26-00006866
Master KASALA JAINESH
11-10-2024 1 Y 9 M 5 D (M)
Dr. SINDHURA MUNUKUNTLA

INVESTIGATIONS

Date	Investigations	Order No.	Sign
16/7/26	CBP CRP Blood c/s	11897	
	VBG	11896	[illegible]
		1900	[illegible]
17/7/26	CUE	11922 ~~8647~~	[illegible]
17/7/26	stool c/s	8647	[illegible]
17/7/26	USG abdomen	11989	[illegible]
18/7/26	CSE		

cross checked done by
Amrutha 18/7/26
c/llr

HNH-00004561 IP26-00006866
Master KASALA JAINESH
11-10-2024 1 Y 9 M 5 D (M)
Dr. SINDHURA MUNUKUNTLA

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
16/7/26	Infusion pump	10:15pm	18/7/26 @8am	4538	
				CJ7055 checked done by Amrutha 18/7/26 @ 11AM	

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Master KASALA JAINESH
11-10-2024 1 Y 9 M 5 D (M)
Dr. SINDHURA MUNUKUNTLA

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
16/7/26	[illegible] placement	1	14490	[illegible]
17/7/26	NWA	1	4570	[illegible]

Cross checked done by Amrutha 18/7/26 @ 10Am

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow® Children's Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

HNH-00004561 IP26-00006856
Master KASALA JAINESH
11-10-2024 1 Y 9 M 5 D (M)
Dr. SINDHURA MUNUKUNTLA

Patient Name : _____

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____

HNH-00004561 IP26-00006866
Master KASALA JAINESH
11-10-2024 1 Y 9 M 5 D (M)
Dr. SINDHURA MUNUKUNTLA

Pedi ... sical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

c/o 1) Fever since 2 days
2) Loose stools since yesterday
3) Vomitings since yesterday
4) Decreased oral intake since many

History of present illness :

Child was apparently asymptomatic 2 day back after which he had fever which is high grade, intermittent responding to oral paracetamol

Loose stools started yesterday 10-12 episodes of watery loose stools associated with blood in stool

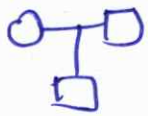
Multiple episodes of vomitings non-bilious non-projectile Contain food variety

Child has decreased oral intake since many.

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

Birth & Neonatal History :

Term / NVD / 3.5kg / CIAB



1y 9 mon

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Normal

Immunization History :

Mixed Schedule

NIS + IAP - Upto 18 months
updated

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11-10-2024 1 Y 9 M 5 D (M)
Dr. SINDHURA MUNUKUNTLA

Anthropometry

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

Weight (kgs) 11.0 kg (Centile _____)

On Examination :

Temperature : 98.3 F Pulse Rate: _____ Description _____

B.P. _____ SPO2 96 % at RA.

Resp. rate and type of breathing : _____

dry lips ①

Rash dry oral mucosa ②

Lymphadenopathy ↓ skin turgor

Oedema : sunken eyes

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BLE AEF ③

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1S2 ④

Any murmur : _____

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

Per Abdomen :

Inspection P/A Tol

Palpation : _____

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

Cranial Nerves : _____

_____

_____

Motor System :

Nutrition : _____ No rw

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR **Superficials :**

Plantars _____

Sensory System :

_____

_____

_____

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

_____

D Acute Dysentry & Dehydration

_____

_____

_____

HNH-00004561 IP26-00006866
Master KASALA JAINESH
11-10-2024 1 Y 9 M 5 D (M)
Dr. SINDHURA MUNUKUNTLA

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

IV Fluids

IV Antibiotics

Desired goals of the treatment :

Dehydration improvement

Planned Labs :	Planned Management :
CBC	
CRP	– CEFTRIAXONE
VBG	
Blood C/S	– ~~Syp~~ Drop Zad Inj OD
CUE - due	
Stool C/S - due	– Pro Cal drops 1 ml BD
~~CUE~~	
USG Abdomen - T/m	

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 Dr. Sindhura. M on whose name the patient is being referred

Doctor's Signature Name Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970 Date 16/7/20 Time 9PM

HNH-00004561 IP26-00006866
Master KASALA JAINESH
11-10-2024 1 Y 9 M 5 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/26 9PM	S/B Dr - Sindhura M	
	Acute Dysentery with Dehydration	
	c/o Fever since morning	
	Loose stools multiple episodes.	
	Blood in stool.	
	Reduced urine output.	
	O/E - Child dull	
	irritable	
	Pulse wk - [illegible]	
	Signs of dehydration (+)	
		- eyes - sunken
		- Skin turgor reduced.
	Adv	N
	- CBP - VBG.	1) Inj CEFTRIAXONE.
	- CRP	2) Zn
	- Blood c/s	3) Pro [illegible]
	- Stool R/E	
	- Stool c/s	
	- CUE.	
	- USG abdomen T/M.	
		[signature] Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970 (SINDHURA M)

HNH-00004561 IP26-00006866
Master KASALA JAINESH
11-10-2024 1 Y 9 M 5 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00004561 IP26-00006866
Master KASALA JAINESH
11-10-2024 1Y9M5D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/26 10:30 pm	c/l/o Dr. sindhuree	
	Acute dysentery c dehydration	
	signs of dehydration (+)	
		Plan
		1) 10ml/kg bolus now
		↓ Hb
		full maintenance fluids
		2) Reassess after 4hours for change.
		3) Rest tt. as per Rx sheet.
		N/B Supriy 10:30pm

HNH-00004561 IP26-00006866
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/02/26 7:30 AM	C/o/s - D. Sunitha / D. Tanvi	
	Acute Dysentery with dehydration	
	fever (+)	
	No fresh loose stools	
	O/E: GC fair	
	vitals stable	
	Hydration - ok	
		Adv
		- IV fluids (2/3 m)
		- Inj Ceftriaxone
		- Supportive care
		- Monitor vitals and inform SOS
		[signature]
		D.B Supriya C8AM

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)GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/7/26	S/B Dr. Sindhura	
9:50 AM	Δ Acute Dysentery	ē dehydration
		P/a
	Fever spikes (+)	
		- c/t CEFTRIAXONE
	CVS - S1, S2 (+)	
	RS - BL - AE (+)	- c/t IV fluids
		@ 30 ml/h
	P/A - Soft	
	conscious	- Enzomeg orally
	c/o loose stools	- USG Abdomen - Now
		- send complete stool examination
		N.B Amrutha c PAM

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No: 66970

HNH-00004561 IP26-00006866
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11-10-2024 1 Y 9 M 6 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/7 2pm	c/s/B Dr. Pavan	
	Acute Dysentery c̄ Dehydration	
	Loose stool - Both	
	Fever ↓.	Pl
		1) IVF
	Vitals stable	2) Inj Ceftriaxone
		3) PRO-GG Sachet
	Afebrile	4) Z & D
	RS - B/L AE ⊕	5) Trace [Blood C/S, Stool C/S
	P/A - Soft.	
		6) Monitor vitals
		D.B Amruthe.
		Pm
17/7/26 5:45 pm	S/B Dr. Aniket	
	D Dysentery c̄ dehydration Plan	
	No loose stools	
		- c/f CEFTRIAXONE
	CVS - S₁S₂ ⊕	
	RS - B/L AE ⊕	- c/f Z & D
		Pro-GG
	P/A - soft	
	conscious	- Trace < Blood C/S, Stool C/S
		- c/f IV fluid @ dose
		S/B Dr. Aniket P
		N/B Mouthushi 5:45 pm

Dr. ANIKET PARASHAR
Reg. No: 08568

HNH-00004561 IP26-00006866
Master KASALA JAINESH
11-10-2024 1 Y 9 M 6 D (M)
Dr. SINDHURA MUNUKUNTLA

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GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B Dr. Naipurya / Dr. Archana.	
18/7 7:00 AM.	Dysentry c̄ dehydration.	
		Plan
	No loose stools.	
		- Cont ceftriaxone.
	Vitals - stable.	
		- Cont Z & D drops PROCAL
	R/S - B/L AE (+)	
	P/A - Soft, NAD.	- ~~Proce~~ B/Cls S/Cls.
		- Stop IVF
		N/B Supriya @AF @MA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/07/26 10AM	C/C. Dr Sindhura Acute Dysentery c dehydration Afebrile No loose stools 1 - episode of semisolid stool O/E: AC free Vitals: Stable Hydration - good S/E: PA: soft	Blood C/S - Negative (24hrs) Adv - discharge today on oral Antibiotics (Cefixime) f/u with final Blood C/S & Stool c/s reports f/u on Monday - Give IV ceftriaxone today and remove canula. [signature] SINDHURA-M

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No: 66970

HNH-00004561 IP26-00006866
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11-10-2024 1 Y 9 M 5 D (M)
Dr. SINDHURA MUNUKUNTLA

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... nil ..... ☐ Not known any Drug Allergies

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

Shifting From: ..... ER ..... Shifted to: ..... ward .....

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : ..... Dr. Pavan .....

Date & Time : ..... 10/7/26 @ 9:30pm .....

Nurse Name & Signature: ..... [illegible] .....

Date & Time : ..... 10/7/26 @ 9:30pm .....

HNH-00004561 IP26-00006866
Master KASALA JAINESH
11-10-2024 1 Y 9 M 5 D (M)
Dr. SINDHURA MUNUKUNTLA

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DRUG CHART

Date of Admission: 16/7/26 Drug Allergies: Nill ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG : Syp. CROCIN-DS

Dose	Route	Frequency	Start Date
3ml	p.o	SOS/6th	16/7

Doctor's Signature | Valid Period | Pharm.

Additional Instructions: Paracetamol (5ml/24kg)

Date / Time: n/a; 2AM

DRUG : PROMITE ORS

Dose	Route	Frequency	Start Date
50-100ml	PO	SOS	16/7

Doctor's Signature | Valid Period | Pharm.

Additional Instructions: after every loose stool

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Doctor's Signature | Valid Period | Pharm.

Additional Instructions:

Date / Time

VERIFIED BY : Name ..... Signature .....

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REGULAR PRESCRIPTIONS

Weight. 11 kg Ward. .....

DRUG : Inj-CEFTRIAXONE

Dose	Route	Frequency	Start Date
2gm	IV	OD	16/7

Name & Signature of the Doctor Starting the Drugs: B.Sneha M

Additional Instructions: 1 dilute in 30ml give over 2 hours

Daily Doctor's Endorsement by a Sign

Date	16/7	17/7
Time	11:45pm	
	11pm	

DRUG : Drop. 2*D

Dose	Route	Frequency	Start Date
1ml	oral	OD	16/7

Name & Signature of the Doctor Starting the Drugs: B.Sneha M

Additional Instructions: ZINC (1ml/20kg)

Daily Doctor's Endorsement by a Sign

Date	16/7	17/7
Time		
	11pm	

DRUG : Pro Calc drops

Dose	Route	Frequency	Start Date
15°	oral	BD	16/7

Name & Signature of the Doctor Starting the Drugs: B.Sneha M

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	16/7
Time	
	11AM X
	11pm X

change

DRUG : PRO 44 SACHET

Dose	Route	Frequency	Start Date
1sachet	PO	BD	16/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	16/7	17/7
Time		
	11AM X	
	11pm	

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
16/7/24	10:25pm	IVF – NS @ 100 ml	100 ml over 20 min	IV		

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I.V. FLUIDS CHART

Weight. 11 Ward. .....

		Position of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
16/7	10 PM	DNS (fluid main)	IV	40 ml			17/7		
17/7	8 AM	DNS	IV	30 ml/hr			17/7		
17/7	5:50 PM	DNS	IV	20 ml			18/7		

VERIFIED BY : Name ..... Signature .....

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RESULT SHEET

Date	16/7/26					
Time						
Hb	10.2					
PCV	29.9					
RBC	4.67					
WBC	7.44					
N/L	43.0/50.7					
Platelets	360					
CRP	67.0					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date	17/7/25					
Time						
CUE - Alb	Nil					
CUE - Sugar	Nil					
CUE - Ketones	present +++					
CUE - PUS Cells	2-4					
CUE - RBC Cells	Nil					
CUE - Nitrite	Negative					
Epithelial Cells	1-2					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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Pati

IM / CLINICAL / 125

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

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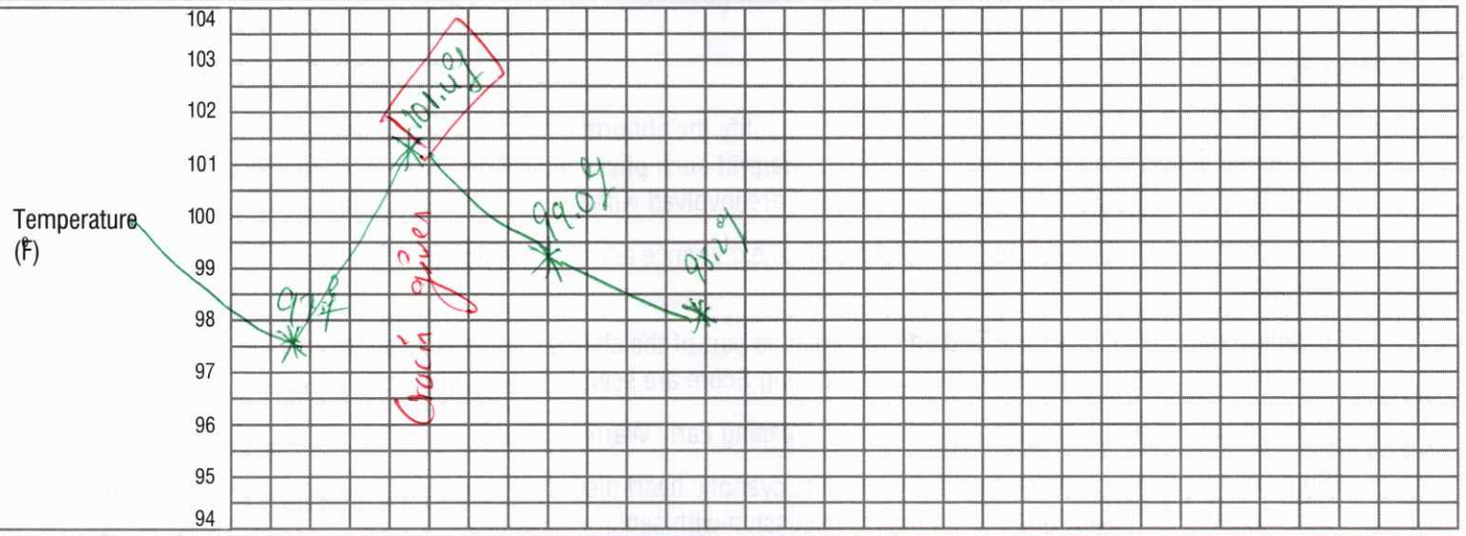
EARLY WARNING SCORE: CHILDREN'S UNIT

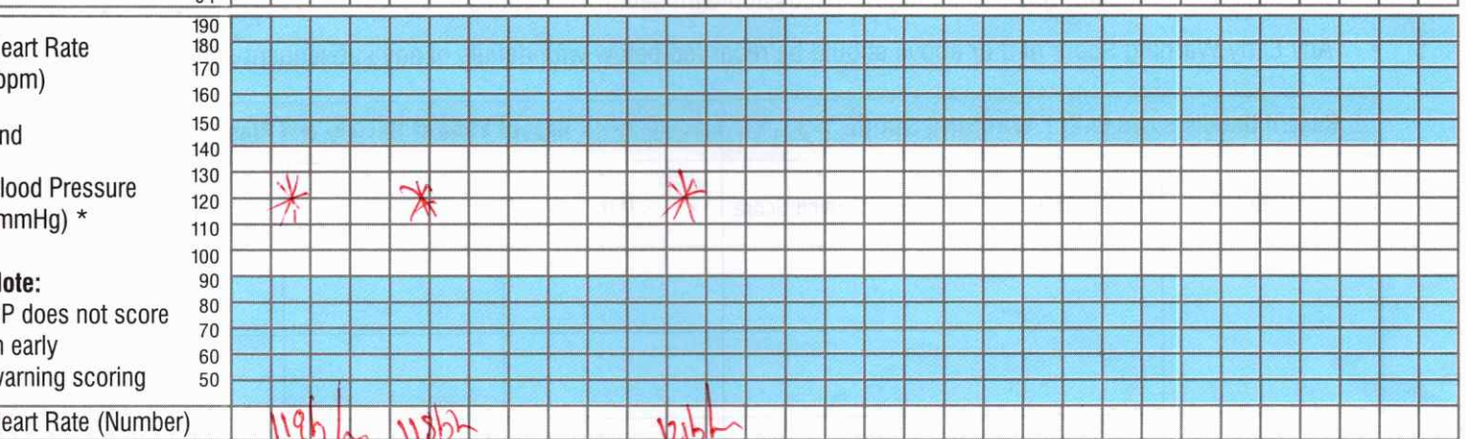
Date : 16/7/24 Time: 10:30pm 2am 3am 6am

Doctor / Nurse / Family Concern?

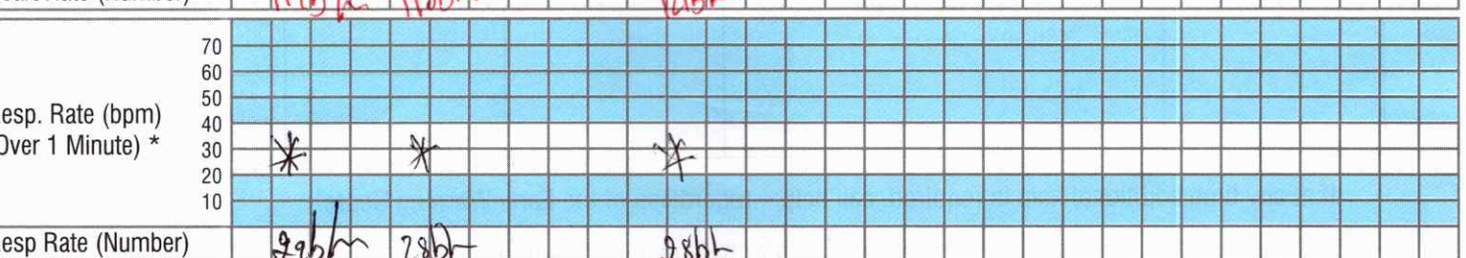


Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring



Heart Rate (Number) 119bpm 118bpm 126bpm



Resp Rate (Number) 29bpm 28bpm 28bpm

Resp Distress	Mod/ Severe / None / Mild			
Receiving O_2(l/min)				
O_2Saturations (%)		99%	99%	99%
Conscious Level	Normal / Altered			
GCS *				
TOTAL SCORE Number of shaded boxes		0	0	0
Pain Score		0	0	0
Observer's Initials				

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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

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WARNING SCORE: CHILDREN'S UNIT

Date : 12/7 Time:	10AM	2PM	8 PM	10PM	2AM	6AM
Doctor / Nurse / Family Concern?						

Temperature (F) — 104 103 102 101 100 99 98 97 96 95 94

98.1F | 98.5F | 99.1F | 98.2F | 98.5F | 98.4F

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

Note: BP does not score in early warning scoring

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

Heart Rate (Number)	129bpm	115bpm	128bpm	130bpm	129bpm	130bpm

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

70 60 50 40 30 20 10

Resp Rate (Number)	38bpm	35bpm	32bpm	36bpm	35bpm	35bpm
Resp Distress: Mod/ Severe / None / Mild						
Receiving O_2(l/min) O_2Saturations (%)	100%	100%	100%	99%	99%	99%
Conscious Level: Normal / Altered						
GCS *						
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials						

ACTIONS

NB: Scores 3 should be recorded overleaf

Score 1	: Continue normal observation by staff nurse
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* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

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A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
16/12/24	08:00 pm	I		~~40 ml~~								
	09:00 pm			~~40 ml~~								
	10:00 pm	DNS	Milk	40 ml								
	11:00 pm			40 ml								
	12:00 am	I		40 ml								
	01:00 am		Milk	40 ml						✓		
Total Intake :		Taken				**Total Output :**						
17/12/24	02:00 am	I		40 ml								
	03:00 am			40 ml								
	04:00 am	DNS	Milk	40 ml			✓					
	05:00 am			40 ml								
	06:00 am	I		40 ml								
	07:00 am			40 ml								
Total Intake :		Taken				**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : 2

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
17/7	08:00 am	DNS	10ml + H_2O	30ml	NA	NA	✓	NA	✓	✓	0	
	09:00 am			30ml							0	
	10:00 am			30ml							0	
	11:00 am			30ml						✓	0	
	12:00 pm	DNS		30ml							0	
	01:00 pm			30ml							0	
Total Intake : Taken						Total Output : M-1					U-1	
17/7/26	02:00 pm			30ml								
	03:00 pm			30ml								
	04:00 pm	DNS		30ml								
	05:00 pm			20ml		NA		NA		✓	0	
	06:00 pm			20ml								
	07:00 pm			20ml								
Total Intake :						Total Output : U-1					M-	
17/9/26	08:00 pm			20ml								
	09:00 pm			20ml								
	10:00 pm	DNS		20ml								
	11:00 pm			20ml		NA		NA			0	
	12:00 am			20ml			✓			✓		
	01:00 am			20ml								
Total Intake :						Total Output :						
18/7/26	02:00 am			20ml								
	03:00 am			20ml								
	04:00 am	DNS		20ml						✓		
	05:00 am			20ml		NA		NA				
	06:00 am			20ml								
	07:00 am			20ml								
Total Intake :						Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

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Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
18/7/26	08:00 am											
	09:00 am											
	10:00 am	0			NA			NA			0	
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**				U-	M-	
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	

Patient Sticker

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

Total 24 hrs. Intake		Total 24 hrs. Output	

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NURSING CARE RECORD

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Date: 16/7/2.

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		N A					
Night	10pm 8Am	-) Assm the pt Condition -) Monitor vitals & I/O chart -) drug as per chart -) proved Comfortable position		-) Assmed the pt Condition -) Monitored vitals & I/O chart -) drugs as per chart -) proveded Comfortable position	pt is stable	Recheded vitals	

HNH-00004561 IP2600006866
Master KASALA JAINESH 1 Y 9 M 5D
11-10-2024 (M)
Dr. SINDHURA MUNUKUNTLA

NURSING CARE RECORD

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Date: 17/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am – 2pm	→ Assess the pt condition → monitoring vitals checked and recorded → I/O chart maintain	8Am – 2pm	→ Assessed the pt condition → Administration & medication given as per doctor order's → I/O chart maintain	→ pt is stable	→ Re-checked vitals	[signature]
Afternoon	2pM – 8pM	→ Assess the general Condition of pt. → Monitor vitals → Maintain I/O chart. → Administer medication.	2pM – 8pM	→ Assessed the general Condition of pt. → Monitored vitals → Maintaind I/O chart. → Administered medication	Pt is stable.	Re-assess vitals.	[signature] Moulvah
Night	8pM	→ Assess the pt Condition → Monitor vitals & I/O chart → Administer drug as per chart		→ Assessed the pt Condition → Monitored vitals & I/O chart → drug as per chart → proved Comfortable position	pt is stull	Rechecked vital	[signature]

HNH-00004561 IP26-00006866
Master KASALA JAINESH
11-10-2024 1 Y 9 M 6 D (M)
Dr. SINDHURA MUNUKUNTLA

NURSING CARE RECORD

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Date: 18/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am 2pm	- Assess the Pt Condition - Monitor vitals - Maintain I/O Chart - Medication Given as per drug chart	8am 2pm	- Assessed the Pt Condition - Monitored vitals - maintain I/O Chart - medication Given as per drug chart	Pt is stable	Rechecked vitals	Maintained
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD

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Date: .....

Goals

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

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

HNH-00004561 IP26-00006866
Master KASALA JAINESH
11-10-2024 1 Y 9 M 5 D (M)
Dr. SINDHURA MUNUKUNTLA

Patient Sti

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NURSE SHIFT HAND OVER FORM

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift	16/7/26 N1	17/7/26 M6	17/7/26 E	17/7/26 N1	18/7/26 M6	
	Medical Condition (Any special condition to be noted):		—	—	—	—	
	Diet:	—	—	—	—	—	
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	—	—	—	—	—	
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.1°F	98.3°F	98.4°F	98.5°F	98.6°F	
	Res:	34b/m	30b/m	32b/m	32b/m	32b/m	
	SpO_2:	99%	100%	100%	100%	99%	
	Pulse:	132b/m	125b/m	128b/m	129b/m	128b/m	
	BP:	96/65	101/60	100/58	110/75	108/72	
	LOC:	—	—	—	—	—	
	Fall Risk Score:	—	—	—	—	—	
	Pain Score:	—	—	—	—	—	
	Skin Integrity	—	—	—	—	—	
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	—	—	—	—	—	
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	—	—	—	—	—	
	Critical Lab Test / Values:	—	—	—	—	—	
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	—	NA	NA	NA	NA	
Post Operative Procedure Special Orders:			NA	NA	NA	NA	
Handed Over By Name :		[signature]	Amrutha	Mounika	[signature]	Amrutha	
Signature / ID :		[signature]	[signature]	[signature]	[signature]	[signature]	
Date:		16/7/26	17/7	17/7/26	18/7/26	18/7/26	
Time:		8AM	2pm	8PM	8AM	2pm	
Taken Over By Name :		Amrutha	Mounika	[signature]	Amrutha		
Signature / ID :		[signature]	[signature]	[signature]	[signature]		
Date:		17/7	17/7/26	17/7/26	18/7/26		
Time:		8AM	8PM	8pm	8am		

Patient Sticker

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

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Master KASALA JAINESH
11-10-2024 1 Y 9 M 8 D (M)
Dr. SINDHURA MUNUKUNTLA

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	16/7/25 DAY-1			17/7/25 DAY-2			18/7/25 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	0			
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			NA	NA	NA	NA	NA			
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA	NA	NA	NA	NA			
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			NA	NA	NA	NA	NA			
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			NA	NA	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	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 : ..... Name : Amrutha

Signature of Ward In Charge :

Signature : ..... Name : Balaram

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CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature : ..... Name : .....

Signature of Ward In Charge :

Signature : ..... Name : .....

HNH-00004561 IP26-00006866
Master KASALA JAINESH
11-10-2024 1 Y 9 M 5 D (M)
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PAIN ASSESSMENT FORM

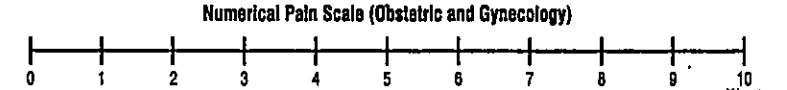
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
16/7/26	11pm	0/10	NA	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	[signature]
17/7/26	10AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
17/7/26	6Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
17/7/26	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
17/7/26	10pm	0/10	NA	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	[signature]
18/7/26	10Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
18/7/26	2pm	0/10	NA	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

PATIENT TRANSFER FORM

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HNH-00004561 IP26-00006866 Master KASALA JAINESH 11-10-2024 1 Y 9 M 5 D (M) Dr. SINDHURA MUNUKUNTLA	Date & Time of Admission 16/7/26 @ 9:13 pm	Date & Time of Transfer Order 16/7/26 @ 10:15 pm
	Transfer Ordered by Dr. Jamil	Reason for Transfer Admission.
From Unit ER	To Unit ward	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 14	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
[signature]	Dr. Jamil

Patient & Clinical Records Received by : [signature] 16/7/26 @ 10:15pm

Date & Time of Patient Received :

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

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

HNH-00004561 IP26-00006866
Master KASALA JAINESH
11-10-2024 1 Y 9 M 5 D (M)
Dr. SINDHURA MUNUKUNTLA

wt 11.07 kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master - Kasala Jainesh Age : 1 year 9 m Gender: ☐ Male ☐ Female

Date : 16/7/26 Time of Arrival : 9:20 pm.

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: 97°F PR: 115b/m BP: .... RR: .... SpO₂: 97%

Chief Complaints: c/o fever since morning loose stools one [illegible]

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 9:30 pm.

Communicable Disease Triage Screening

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

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☑ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☑ No
3. 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**

1. 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: ....

2. 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 : K. Vijaya

Signature of Triage Nurse : [signature]

Date & Time : 16/7/26 @ 9:30 pm

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

HNH-00004561 IP26-00006866
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11-10-2024 1 Y 9 M 5 D (M)
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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 16/7/26 Time of arrival : 9:20 pm

Chief Complaints: c/o fever since morning loose stools RBS: .....

Height : ..... Weight : 11.07kg BMI : ..... Head Circumference (<2 years) .....

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

If yes , identify .....

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

☐ Character N/A ☐ Location N/A ☐ Frequency N/A ☐ Duration N/A

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

- Wheelchair ☐ Yes ☐ No
- Uses furniture for support ☐ Yes ☐ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☐ No
- Weak ☐ Yes ☐ No
- Impaired ☐ Yes ☐ No

Mental Status: Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

If Yes Consultant Notified: ..... (Date/Time): .....

Social History: Lives With .....

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

Time of Initial assessment completed by ER Nurse : ..... @ 9:30 pm

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

Time	Nursing Notes
9:20pm	=> Assessed the general condition
	=> vitals checked and recorded
	=> iv cann[illegible]

Samples collected by: Time:

Samples sent by : vijay Time: 9:30pm

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 136b BP: ...... CFT: <2s	Shift - out from ER to: ward
RR: 26b SPO_2 : 99%	Time of Shift - out: 10:15pm
GCS: 15 Temperature :	Handover given to: ...... (Nurse's Name)
Pain Score: 0	
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): iv placement done

Name of the Nurse : Deepthy Signature of the Nurse : [signature]

Date & Time : 16/7/20 9:20pm

HNH-00004561 IP26-00006866
Master KASALA JAINESH
11-10-2024 1 Y 9 M 6 D (M)
Dr. SINDHURA MUNUKUNTLA

307

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 17/7/26 Time: 8 & 8:45 am

Weight: 11.07 Kg Centile: 40th

Height: ..... Centile: .....

Inference: Underweight child.

RDA: - Calories: 1200 Kcal/day Protein: 20 gms/day

Diet Recommendations: High fiber diet with liquids

Re-Assesment: No Junk, Oily, Spicy food.

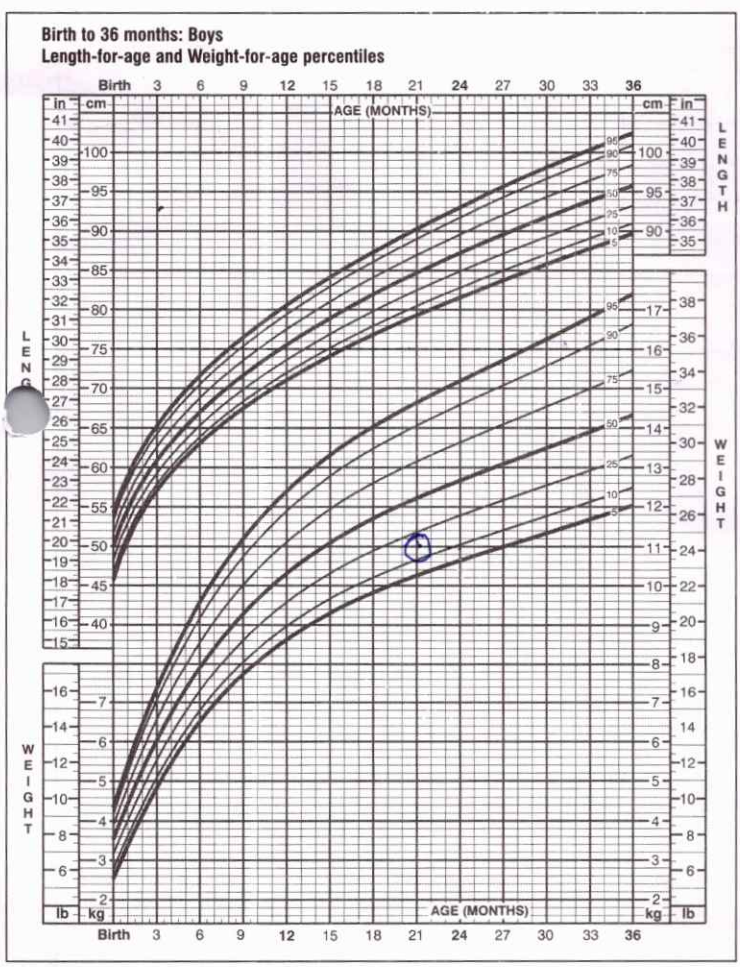
Food Allergies: No Veg/Non-veg Non veg.

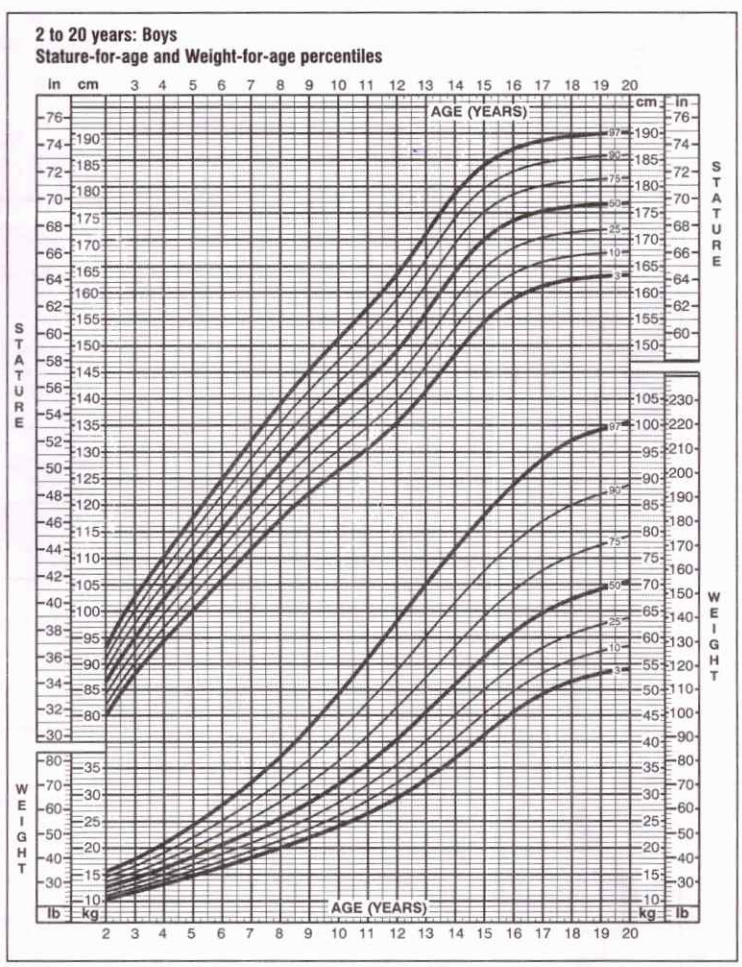
Diagnosis: Acute dysentry & dehydration.

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Shashirekha

GROWTH CHART (BOYS)





Dietician's Name Syeda Sobiya Zaheer Dietician's Signature Sobiya

Docu. No. : RCH /FRM / CLINICAL / 160 (P.T.O.)

Daily Notes: