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DISCHARGE AT REQUEST SUMMARY

Name	Master RAYANSH V	**UHID**	LBH-00125961
Father/Guardian	Mr V GANESH	**Age/Gender**	0 Y 7 M 16 D/ Male
Address	Chilkanagar, Uppal, Hyderabad, Telangana, INDIA, 500039		
IP No	IP26-00006696	**Admission Date**	30-06-2026
Ref Doctor	Self.		
Discharge Date	01.07.2026		

Consultant:
Dr. PRITESH NAGAR
MBBS MD
Medical Registration No. 47184

DIAGNOSIS	ICD CODE
SIMPLE FEBRILE SEIZURE	
SARS-CoV-2 POSITIVE	

History: Master RAYANSH V , 0 Y 7 M 16 D , old boy presented with the history of fever since 1 day, 1 episode of seizure in the form of uprolling of eyeballs and no noticeable stiffening of limbs lasting for 30-40 seconds followed by post ictal drowsiness on the day of admission. For the above complaints, he was admitted at Rainbow Children's Hospital - Himayatnagar for further

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management.

Examination: He was febrile (100.6*F), maintaining saturations at room. His heart rate was 140/min and Respiratory Rate - 32/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On auscultation, air entry was bilaterally equal. 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 : 7.8 kilograms.

Investigations: Enclosed reports.

GeneXpert SARS-CoV-2, FluA+FluB+RSV were sent, which shows:

SARS-CoV-2	**POSITIVE**
Influenza A	NEGATIVE
Influenza B	NEGATIVE
Respiratory Syncytial Virus (RSV)	NEGATIVE

Initial hemogram showed Hemoglobin of 11.6gm%, White Blood Cell count of 7610 cells/cumm, platelet count of 3.38 lakhs/cumm and C-Reactive Protein of 5.0 mg/l. Complete urine examination was normal.

Management: He was admitted in the ward and started on Intra Venous fluids and Intra Venous antibiotics. He was treated symptomatically with antacids and antipyretics. He was started on febrile seizure prophylaxis with Frisium.

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He was regularly monitored for fever spikes, hemodynamic & neurological status. His fever spikes gradually settled and there were no further seizure episodes during hospital stay.

He remained hemodynamically stable and is being discharged with the following advice.

Parents were counselled regarding the nature of febrile seizures and measures to reduce fever during future febrile episodes. They were also educated regarding use of intranasal Midazolam spray for termination of future seizure episodes, if any.

Parents are counselled about the nature severity of illness and possible prognosis of the childs condition. They were also counselled about the need for further hospital stay. How ever parents were unwilling for further management on personal grounds and requested the child to be discharged. Hence child is being Discharge on Request.

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

Medication during hospital stay:
Inj. Ceftriaxone
PCM Drops
Syp. Clobazam.

Advice:
* Diet as advised.

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S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	NEBULISATION with 3% N	1 respule	6TH hourly	For 3 days
3	Nasoclear nasal drops, 2 drops in each nostril **SOS** for nose block			

Febrile Seizure Prophylaxis:
* Crocin Drops (Paracetamol = 1ml/100mg) 1.2 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.
* Syrup. Clobium (Clobazam - 1ml/2.5mg) 1 ml twice daily for 3 days every time with fever.
* Medistat - nasal spray (Midazolam = 1.25mg/puff), 1 puff intranasal (into each nostril) for future seizures.

Review consultation with Dr. PRITESH NAGAR on Friday(03.07.2026) at 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.

Follow up immediately in Emergency Room if high grade fever, vomiting, abnormal behavior, altered sensorium or seizure 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

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Name	Master RAYANSH V	**UHID**	LBH-00125961
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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**

Registrar/Resident/C.M.O

Dr. PRITESH NAGAR
MBBS MD
Medical Registration No. 47184

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 : IP26-00006696 **Admit Date** : 30-Jun-2026 **Admit Time** : 01:49 PM **UHID** : LBH-00125961

Patient Details :

Patient Name	: Master RAYANSH V	**Age**	: 0 Y 7 M 16 D
Guardian	: Mr V GANESH	**DOB**	: 14-11-2025 06:30 AM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: Chilkanagar Uppal Hyderabad Telangana INDIA 500039	**Phone No**	: 8639006877
		E-mail	: sowjanyashivarathri197@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 V GANESH **Relationship** : Father

Contact Address : Chilkanagar Uppal Hyderabad Telangana INDIA 500039 **Phone No** : 8639006877

Signature

Doctor Details :

Doctor Name : Dr. PRITESH NAGAR **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : Self. **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

PATIENT TRANSFER FORM

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Master RAYANSH V
14-11-2025 0 Y 7 M 16 D (M)
Dr. PRITESH NAGAR

	Date & Time of Admission: 30/6/26 @ 1:14pm	Date & Time of Transfer Order: 30/6/26 @ 2:30pm
Treating Consultant Name	Transfer Ordered by: Dr. Archana	Reason for Transfer: Admission
From Unit: ER	To Unit: Ward 6	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: 20	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
Babin	Dr. Archana

Patient & Clinical Records Received by : Sr. Sandhya.

Date & Time of Patient Received : 30/6/26 3:pm

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

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ACTIVITY RECORD FOR BILLING

LBH-00125961 IP26-00006696
Master RAYANSH V
14-11-2025 0 Y 7 M 16 D (M)
Dr. PRITESH NAGAR

Name: ---------- ----------

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

Date of Admission : 30/6/26 -- Time : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
30/6/26	2:30pm	ER	ward	B) /sandhya

Cross Consultation Visit

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

INVESTIGATIONS

LBH-00125961 IP26-00006696
Master RAYANSH V
14-11-2025 0 Y 7 M 16 D (M)
Dr. PRITESH NAGAR

Date	Investigations	Order No.	Sign
30/6/26	CBP, RFT, panel, CRP	0673	
	urine culture	106780	
	CVE		

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Master RAYANSH V
14-11-2025   0 Y 7 M 16 D   (M)
Dr. PRITESH NAGAR

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
30/6	Infusion pump	5pm	1/7/26 @ 2pm	~~9671~~	Sy

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PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
30/6/26	IV Placement	(1)	9526	
30/6/26	NHA	(1)	9591	

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : Rayansh .

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Master RAYANSH V
14-11-2025 0 Y 7 M 16 D (M)
Dr. PRITESH NAGAR

Patient ID# :

Consultant : Dr. Pritesh Nagar .

Final Diagnosis : S.

Pediatric Multiorgan History & Physical Examinati

Name : Rayansh . Age/Sex 7M / MCH

Informant mother . Reliability reliable

Chief Presenting Complaints & Duration (Chronologically):

c/o fever : yesterday (2 episodes)
c/o one episode of ? seizure yesterday night .

History of present illness :

Patient was apparently asymptomatic 2 days ago, when he developed fever, undocumented spikes (2 spikes) not c rigors, reduced with medication .

one episode of ? seizure yesterday night, with deviation of both eyes, not responding to voices for 30 - 40 secs, self aborted, not ass. with tightening of limbs .

No family history of febrile seizures .

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

Birth & Neonatal History :

born @ KIMS hospital
FT / SVD / BNC / AB / ? sepsis c NNH

Birth & Socio Economic History :

About Father :

About Mother : N

Any additional Information :

Developmental History : N

GM - sits with support
FM - unidextrous grasp.
Language - bisyllables (mama, baba)
Social - stranger anxiety (P)

Immunization History :

upto date

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 7.8 kgs (Centile _____)

On Examination :

Temperature : 100.6°F Pulse Rate: 140 bpm Description _____

B.P. _____ SPO2 98% at RA

Resp. rate and type of breathing : 32/min

Rash (-)

Lymphadenopathy (-)

Oedema : (-)

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : AEBE, B/L clear.

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1S2 (+)

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : soft, non-tender.

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

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14-11-2025 0 Y 7 M 16 D (M)
Dr. PRITESH NAGAR

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

Cranial Nerves : _____

_____

_____

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR **Superficials :**

Plantars _____

Sensory System :

_____

_____

_____

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

Simple febrile seizure.

_____

_____

_____

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14-11-2025 0 Y 7 M 16 D (M)
Dr. PRITESH NAGAR

Pediatric Multiorgan History & Physical Examinatio

Preventive aspects of the treatment :

IV Fluids

IV Antibiotic

Desired goals of the treatment :

Fever Subsidence

Planned Labs :

CBP

CRP

Blood culture - collect.

CVC

Urine C/S] Catheter Sample

Extra plain - 1

Resp. panel (5 viruses)

Planned Management :

- Inj. CEFTRIAXONE 350 mg IV BD.

- Drop. CROCIN 6 hrly

-

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 Dr. Pritesh Nagar Consultant Pediatrician & Intensivist Reg. No: 47184 Date _____ Time _____

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Dr. PRITESH NAGAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/26. 9pm.	S/B Dr. Archana.	
	Simple febrile seizure.	Advice.
	On Room Air Temp - 100.6°F fever spikes (+) oral acceptance - fair	- (T) labs. - Ct Inj Ceftriaxone. - Ct PCM drops. - TPR/IOC.
	O/E HR - 138 bpm. RR - 36/min PP - wf CRT < 3secs CTA - good.	
	S/E CNS - active, alert. RS - AEBE P/A - soft. Noted by Anuroba.	Dr. Archana.

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/26 3:30 PM	S/B Dr. Sneghan	P Lay
	D Simple febrile seizure	
		- C/F CEFTRIAXONE
	No further seizure	
		- C/F CROCIN 6th L
	CVS - S1 S2 (+)	
	RS - BL - AE (+)	- C/F CLOBAZAM
	P/A - Soft	- W/F seizure
	Conscious	
		- Trace reports
		Dr. Sag
		noted by Sr. Sandhya 30/6/26 4pm

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Dr. PRITESH NAGAR

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OGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6 5 pm	c/s/b Dr. Pritesh Sir	
	D - Simple Febrile Seizures	
	Fever (+)	Rx
	No further Seiz	1) If Flu - Negative by Night ↓ Send Dengue NS1
	Child irritable - consolable	
	Vitals stable	2) Inj Ceftriaxone
	R-S - B/L AE (+), conducted sounds	Cont - Paracetamol
	P/A - Soft (crying)	Cont - Clobazam
	Oral intake - less	3) IVF - 2/3 rd (M)
		4) Monitor Vitals
	Appears - Tachypneic (crying)	5) Trace labs
		6) Encourage orally
		7) Reassess Respiratory when child settled
	Dr. Pritesh Nagar Consultant Pediatrician & Intensivist Reg. No: 47184	
	[signature]	noted by Sr. Sandhya 30/6/26 5pm

Docu. No. : RCH /FRM / CLINICAL / 088

(P.T.O)

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Master RAYANSH V   IP26-00006696
14-11-2025   0 Y 7 M 16 D   (M)
Dr. PRITESH NAGAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/s/b Dr. Varun/Dr. Sushanth.	
1/7/26 7AM	D - ? Simple febrile seizures. SOLD +ve.	
	- fever - Afebrile.	
	- No further c/o seizures.	
	- Oral intake - Good.	
		Plan
	O/E - vitals stable.	- C/F. Approach Clobazam.
	S/E - WNL.	- Trans RS pand. - Continue cfs. - Can stop IVF.
		Noted by Divya 1/7/26

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
01/07/26, 9:15AM	C/s/b Dr. Pritesh	
	D - ? Simple febrile seizure / COVID +ve	
	- Afebrile since admission.	
	- No further c/o seizures.	
	- Active, taking well orally.	
	- O/E - vitals stable.	
		Plan
	O/E - WNL.	- Trace respiratory panel report.
		- Ct. ceftriaxone ↓ stop if official RS panel is COVID +ve.
		- Trace urine C/S.
		- Make IVF @ 8ml/hr.

Dr. Pritesh Nagar
Consultant Pediatrician & Intensivist
Reg. No: 47184

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/12/26 2pm	S/B Dr. Archana C/D/W Dr. Pritesh	
	Pt is afebrile No further seizure episodes after admission.	
	o/E Vitally stable	
	Patient is requesting for discharge ∴ Discharge on request.	
		Adv • Nasoclear nasal drops • Nebs c 3% NS BD. • Paracetamol syrup SOS. • Discharge on request.
		Dr. Archana.

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RESULT SHEET

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Date	30/6/26					
Time						
Hb	11.6					
PCV	32.9					
RBC	4.76					
WBC	7.61					
N/L	36/44					
Platelets	3.35					
CRP	5					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein/Sugar						
Cells						
N/L						

P.T.O.

Date	30/6/26					
Time						
CUE-Alb	Nil					
CUE-Sugar	Nil					
CUE - Ketones	negative					
CUE-PUS Cells	2-3					
CUE - RBC Cells	Nil					
CUE - Nitrite	Negative					
Stool Pus Cell						
OVA/Cyst						
Occult Blood						
Respiratory Panel						

Culture and Sensitivities : ..... Urine c/s ⟶ .....

.....

.....

.....

Radiology: USG : .....

X-Ray: .....

ECHO: .....

CT: .....

MRI .....

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

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INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

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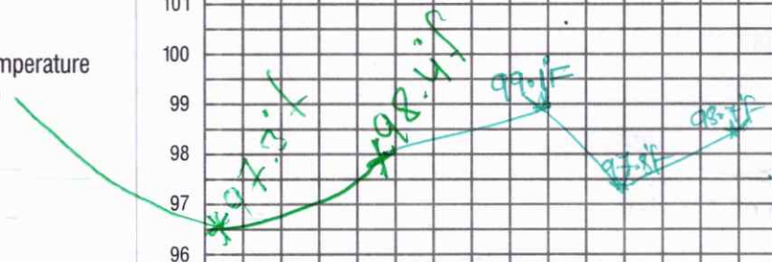
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 20/6/26 Time:	3 pm	6 pm	10 pm	2 am	6 am
Doctor/Nurse/Family Concern?					

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



Heart Rate (bpm) and Blood Pressure (mmHg) * — 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

Note: BP does not score in early warning scoring

Heart Rate (Number)	140b/m	145b/m	130b/m	138b/m	147b/m

Resp. Rate (bpm) (Over 1 Minute) * — 70 60 50 40 30 20 10

Resp Rate (Number)	36b/m	30b/m	30b/m	30b/m	40b/m
Resp Distress: Mod/ Severe / None / Mild					
Receiving O_2(l/min) O_2Saturations (%)	99%	99%	100%	99%	99%
Conscious Level: Normal / Altered					
GCS *					
TOTAL SCORE Number of shaded boxes	0	6	0	6	6
Pain Score	0	0	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 incharge and PICU /NICU fellow or PICU/NICU 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.

* 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

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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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 :**						
30/6/26	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm	DNS		20ml		NA		NA		✓	0	
	06:00 pm	DNS		20ml								
	07:00 pm	DNS		20ml								
Total Intake : Taken						**Total Output :** U - 1 M - 0						
30/6/26	08:00 pm			20ml								
	09:00 pm		Milk	20ml								
	10:00 pm			20ml								
	11:00 pm	DNS	Milk	20ml		NA	1	NA		—	0	
	12:00 am		Milk	20ml						—		
	01:00 am			20ml								
Total Intake :						**Total Output :** U - M -						
1/7/26	02:00 am			20ml								
	03:00 am			20ml								
	04:00 am			20ml		NA	—	NA		—	0	
	05:00 am	DNS		20ml								
	06:00 am			20ml						—		
	07:00 am			20ml								
Total Intake :						**Total Output :** U - M -						

Total 24 hrs. Intake		Total 24 hrs. Output	

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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							
17/12/26	08:00 am	1		20 ml								
	09:00 am											
	10:00 am	20 ml			NA			NA			0	
	11:00 am											
	12:00 pm	1		30 ml								
	01:00 pm											
Total Intake :						**Total Output :**						
17/12/26	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm										0	
	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: 30/6/26

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	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 → Maintained I/O chart. → Administered medication	Pt is Stable	Re-assessed vitals.	Monitored
Night	8PM / 8AM	→ Assess the pt condition → monitor vitals → maintain I/O chart → administer medication as per drug chart → I/V fluids.	8PM / 8AM	→ Assessed the pt condition → Monitored Vitals → Maintained I/O chart → medication as per drug chart → I/V cannula presented → I/V fluids	→ Pt is stable	→ rechecked Vitals	

Patient S

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NURSING CARE RECORD

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Date: 1/7/26

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	8AM / 2PM	→ Assess the General Condition of pt. → Monitor vitals. → Maintain I/O chart. → Administered medication.	8AM / 2PM	→ Assess the General Condition of pt. → Monitored vitals → Maintained I/O chart. → Administered medication.	Pt is stable.	Re assessed VS	
Afternoon				Day Duty			
Night							

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BRADEN 'Q' SCALE

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					Date : 30/6/25	30/6/25	2/7/25	
					Time : 6PM	AM	MS	
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	
					TOTAL SCORE	28	28	28
					Evaluator's Name			

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

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Risk Score	Category	Action	Support Surfaces (**Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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PAIN ASSESSMENT FORM

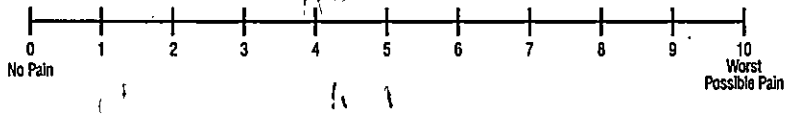
Date	Time	[illegible]e [illegible]0)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
30/6/26	6pM	0/6	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
30/6/26	10Pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
1/7/26	10AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
1/7/26	6PM	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		
				☐ 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

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CHECKLIST FOR THROMBOPHLEBITIS

30/6/26 30/7/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0					
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			0	0	0					
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			0	0	0					
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			0	0	0					
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			0	0	0					
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			0	0	0					
		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 : .....

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
BACKGROUND	Area / Shift Time	30/6/26 E2	30/6/26 N1	1/7/26 M5			
	Medical Condition (Any special condition to be noted):	—	—	—			
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.4°F	98.1°F	98.1°F			
	Res:	40bpm	40bpm	40bpm			
	SpO_2:	100%	99%	99%			
	Pulse:	75bpm	136bpm	136bpm			
	BP:	—	—	—			
	Fall Risk Score:	—	—	—			
	Pain Score:	—	—	—			
Recommendations	Safety Needs:	—	—	—			
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	—	—	—			
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	—	—	—			
Post Operative Procedure Special Orders:		—	—	—			
Handed Over By Name :		Sonkya	Divya	Sunidhi			
Signature :							
Date:		30/6/26	30/6/26	1/7/26			
Time:		8pm	8AM	8PM			
Taken Over By Name :		Divya	Sunidhi				
Signature :							
Date:		30/6/26	1/7/26				
Time:		8pm	8AM.				

Docu. No. : RCH /FRM / CLINICAL / 097

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

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DRUG CHART

Date of Admission: 30/6/26 Drug Allergies: NKA ☐ 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 : MIDAZOLAM Nasal Spy

Dose	Route	Frequency	Start Date
	Nasal	SOS	30/6

Doctor's Signature: | Valid Period: | Pharm.:

Additional Instructions: 1 puff (RP) nostril 0.1-0.2 mg - MIDAZOLAM

Date / Time

DRUG : Syp. GLUCOSE

Dose	Route	Frequency	Start Date
	oral	SOS	30/6

Doctor's Signature: | Valid Period: | Pharm.:

Additional Instructions: 2 ml

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Doctor's Signature: | Valid Period: | Pharm.:

Additional Instructions:

Date / Time

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani

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

LBH-00125951 IP26-00006696
Master RAYANSH V
14-11-2025 0 Y 7 M 16 D (M)
Dr. PRITESH NAGAR

REGULAR PRESCRIPTIONS

Weight. 7.8 kgs. Ward. ....

Verified by Dr. Dhakshayani

DRUG : Inj CEFTRIAXONE

Dose	Route	Frequency	Start Date
350mg	IV	BD	30/6/26

Name & Signature of the Doctor Starting the Drugs: [signature]

Additional Instructions: dilute in 50 ml NS, give over 2 hours

Date/Time	30/6	1/7/26
6am	X	[signature]
3:30 pm		
6PM	[signature]	
Daily Doctor's Endorsement by a Sign	[signature]	✓

Stop

Verified by Dr. Dhakshayani

DRUG : (PARACETAMOL) PCM drops

Dose	Route	Frequency	Start Date
1.2 ml	PO	QID8	30/6/26

Name & Signature of the Doctor Starting the Drugs: [signature] Dr. Achar

Additional Instructions: (100 mg/ml)

Date/Time	30/6	1/7/26
12AM	X	[signature]
6AM	X	[signature]
12PM	X	[signature]
6PM 3:30p	[signature]	
Daily Doctor's Endorsement by a Sign	[signature]	✓

Verified by Dr. Dhakshayani

DRUG : Syp. CLOBAZAM

Dose	Route	Frequency	Start Date
1ml	oral	BD	30/6

Name & Signature of the Doctor Starting the Drugs: B. Sag [signature]

Additional Instructions: (1ml/2.5mg) - CLOBAZAM

Date/Time	30/6	1/7/26
6am	X	[signature]
3:30 pm		
6Pm	[signature]	
Daily Doctor's Endorsement by a Sign	[signature]	✓

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Date/Time	
Daily Doctor's Endorsement by a Sign	

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Signature .....

VERIFIED BY : Time .....

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I.V. FLUIDS CHART

Weight. 7.5 Ward. .....

Date	Time	Composition 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
30/6	3:30 pm	DNS	IV	20 ml	—		1/7		
1/7/26	12 pm	"	IV	↓ 8 cc/hr					

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

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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: ..... E.R ..... Shifted to: ..... Ward 6 .....

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. Archana

Date & Time : 30/6/26 @ 2 PM

Nurse Name & Signature: Prabin

Date & Time : 30/6/26 @ 2 PM

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 30/6/26 Time: 5:40pm

Weight: 7.8kg Centile: 10th

Height: 64cm Centile: —

Inference: underweight child

RDA: — Calories: 98 kcal/kg/d Protein: 1-6 gms/kg/d

Diet Recommendations:

Re-Assesment: stage (1) weaning foods & HEE advised

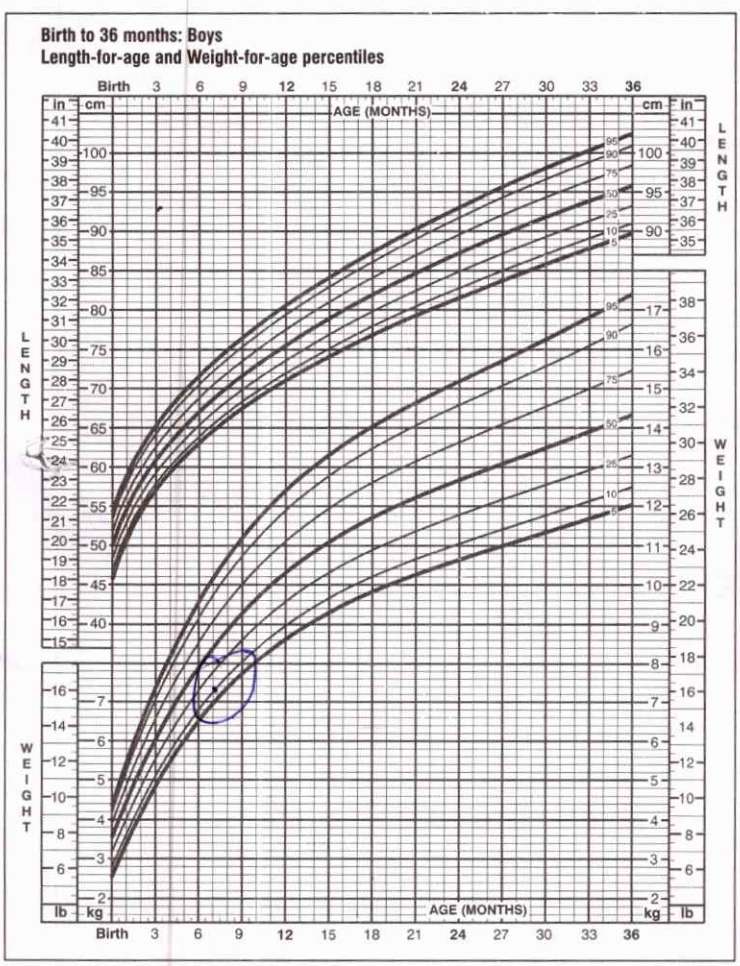
Food Allergies: NO Veg/Non-veg NON-veg

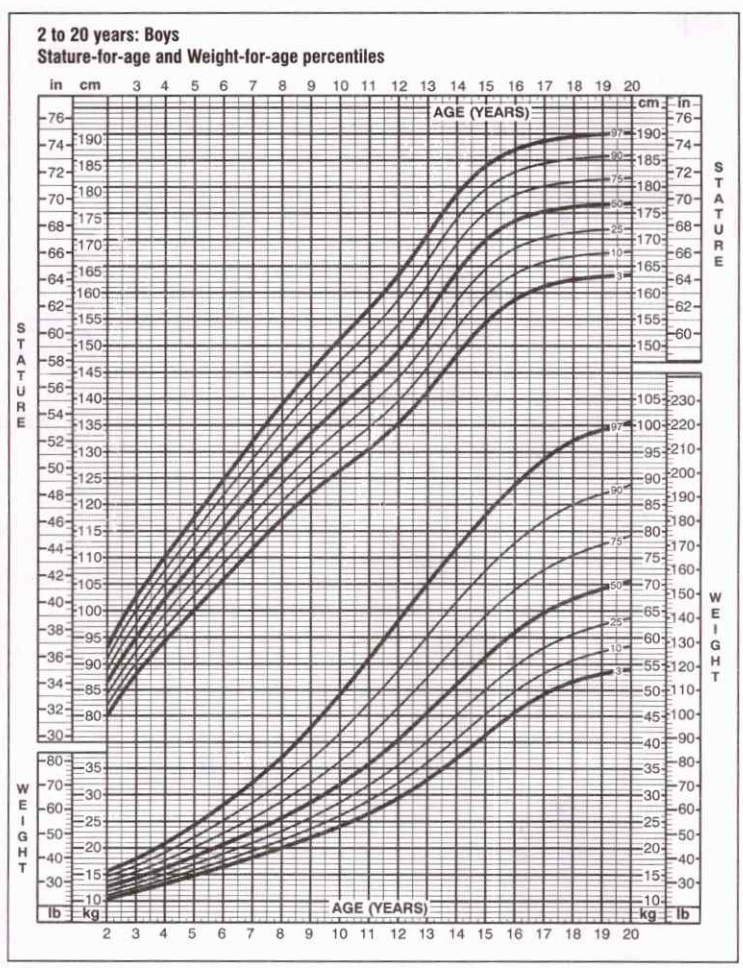
Diagnosis: Simple febrile seizures

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature:

GROWTH CHART (BOYS)





Dietician's Name Sathwika.G Dietician's Signature

Daily Notes:

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wt - 18kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Mast Rayansh Age : 7m(m) **Gender:** ☐ Male ☐ Female

Date : 30/6/26 Time of Arrival : 1pm

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: 142b/mt BP: ..... RR: ..... SpO_2: 98%

Chief Complaints: c/o : fever since yesterday seizure one episode

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☐ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing
☑ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS
☑ 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 : 1:10pm

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 : Sugendar

Signature of Triage Nurse : .....

Date & Time : 30/6/26 @ 1:10pm

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

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 30/6/26 Time of arrival : 7pm

Chief Complaints: c/o- fever since yesterday RBS: .....

Height : ..... Weight : 7.8 kg BMI : ..... Head Circumference (<2 years) .....

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

If yes , identify .....

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

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With family

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

Time of Initial assessment completed by ER Nurse : 7:-7 pm

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

Time	Nursing Notes
1:9pm	Assess the pt Condition monetore the vitals

Samples collected by: / sugandha Time:

Samples sent by : Time: / 2pm

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: 142 b/m BP: ..... CFT:	Shift - out from ER to: ward
RR: ..... SPO_2 : 98%	Time of Shift - out: 2:30pm
GCS:..... Temperature : 97°F	Handover given to: .....
Pain Score:	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

IV placement Done

Name of the Nurse : Bhargavi Signature of the Nurse : B

Date & Time : 30/6/21 @ 1:11pm