

304

DISCHARGE SUMMARY

Name	Baby B NAKSHATRA	UHID	BAH-00538181
Father/Guardian	Mr B.MADHUSUDHAN	Age/Gender	11 Y 8 M 27 D/ Female
Address	FLAT NO:102,FORTUNE SUDHARMA APRT,C COLONY ,FORTUNE SUDHARMA APRT,C COLONY , Bagh Amberpet, Hyderabad, INDIA, 400015		
IP No	IP26-00006439	Admission Date	27-05-2026
Ref Doctor	Sanjay Srirampur		
Discharge Date	30.05.2026		

Consultant:

Dr. SANJAY SRIRAMPUR
MBBD,Md(Pead),DCH
HMC9465

Co-Consultant:

Dr. ANIKET ANIL PARASHAR
MBBS - MD
TSMC/FMR/08568, dr.aniket.p@rainbowhospitals.in

DIAGNOSIS	ICD CODE
ADENOVIRAL ILLNESS	
E.COLI URINARY TRACT INFECTION	

Name	Baby B NAKSHATRA	UHID	BAH-00538181
IP No	IP26-00006439	Admission Date	27-05-2026

History: Baby B NAKSHATRA , 11 Y 8 M 27 D , old girl presented with the history of cold since 6 days associated with fever since 3 days, vomitings since 2 days, pain abdomen since 1 day, prior to admission. For the above complaints she was admitted at Rainbow Children's Hospital - for further management.

Examination: She was afebrile, maintaining saturations at room air. Her heart rate was 132/min and Respiratory Rate - 36/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination Signs of some dehydration were present, dry lips, oral mucosa, delayed skin turgor, decreased urine output, throat - congested, tonsillar hypertrophy were present. 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, she was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure.

Weight on admission: 41 kilo grams.

Investigations: Enclosed reports

GeneXpert FluA+FluB+RSV, SARS-CoV were sent, which was negative. Adenovirus PCR was detected.

Initial hemogram showed Hemoglobin of 13.2 gm%, White Blood Cell count of 7790 cells/cumm, platelet count of 1.90 lakhs/cumm and C-Reactive Protein of 28 mg/l.

Complete urine examination shows 4-6 pus cells, 3-5 epithelial cells. Blood culture and sensitivity shows no growth after 48 hours of incubation.

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Throat swab Culture report awaited.

Urine culture and sensitivity shows

Gross examination : Yellow in colour, clear

Gram stained smear - Shows haemorrhagic background with few polymorphs, no organisms.

Colony count: - 10^3 cfu/ml

Culture : - **E. coli isolated.**

Susceptible to -

Cephalexin, Cefotaxime, Ceftriaxone, Cefpodoxime, Cefixime, Tazobactam-Piperacillin, Gentamicin, Amikacin, Tobramycin and Nitrofurantoin.

Resistant to -

Ampicillin, Amoxicillin-Clavulanic acid, Ampicillin-sulbactam, Cefuroxime, Cefoxitin, Ticarcillin-Clavulanic Acid, Ciprofloxacin, Ofloxacin, Levofloxacin, Moxifloxacin, Norfloxacin, Nalidixic acid, Sulfamethoxazole-Trimethoprim, Piperacillin and Trimethoprim.

Ultrasound abdomen shows

* No significant abnormality detected.

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

In view of culture positive UTI antibiotics were continued.

She was regularly monitored for fever spikes, hemodynamic status, vital parameters, oxygen saturations. Her fever spikes and other symptoms

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gradually settled.

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

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

Medication during hospital stay:

Injection. Ceftriaxone
Injection. Esmoprazole
Nasivion P nasal drops

Advice:

* Diet as advised.

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Tablet. Taxim O (Cefixime - 200mg)	1 tablet	8am - 8pm (after food)	For 6 days.
2	Tablet. Pantodac (Pantoprazole - 40mg)	1 tablet	7am (before breakfast)	For 6 days
3	Nasivion P nasal drops, 2 drops in each nostril twice daily for 5 days			

Plan: To collect throat swab report on followup.

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Fever Management

- * Tablet. Crocin (Paracetamol - 500mg) 1 tablet after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
- * Tepid sponging if fever > 101 *F.

Review consultation with Dr. SANJAY SRIRAMPUR on Wednesday(03.06.2026) at his OPD.

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, 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 **Himayatnagar / Banjara Hills / Rainbow Clinic Madhapur / Kukatpally / Vikramपुरi / LB Nagar /** dial just one toll free number **18002122.**

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You can also take appointments at any time by going **online** to our website www.rainbowhospitals.in


Registrar/Resident/C.M.O

Dr. SANJAY SRIRAMPUR
MBBD,Md(Pead),DCH
HMC9465

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006439 Admit Date : 27-May-2026 Admit Time : 07:48 PM UHID : BAH-00538181

Patient Details :

Patient Name : Baby B NAKSHATRA Age : 11 Y 8 M 26 D
Guardian : Mr B.MADHUSUDHAN DOB : 01-09-2014
Gender : Female Religion :
Occupation : Martial Status : Single
Address (H) : FLAT NO:102,FORTUNE SUDHARMA APRT,C COLONY ,FORTUNE SUDHARMA APRT,C COLONY Bagh Amberpet Hyderabad INDIA 400015 Phone No : 9032159601/ 8125173893
E-mail : madhusudhanbardhipuram@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 B.MADHUSUDHAN Relationship : Father
Contact Address : FLAT NO:102,FORTUNE SUDHARMA APRT,C COLONY ,FORTUNE SUDHARMA APRT,C COLONY Bagh Amberpet Hyderabad INDIA 400015 Phone No : 9032159601

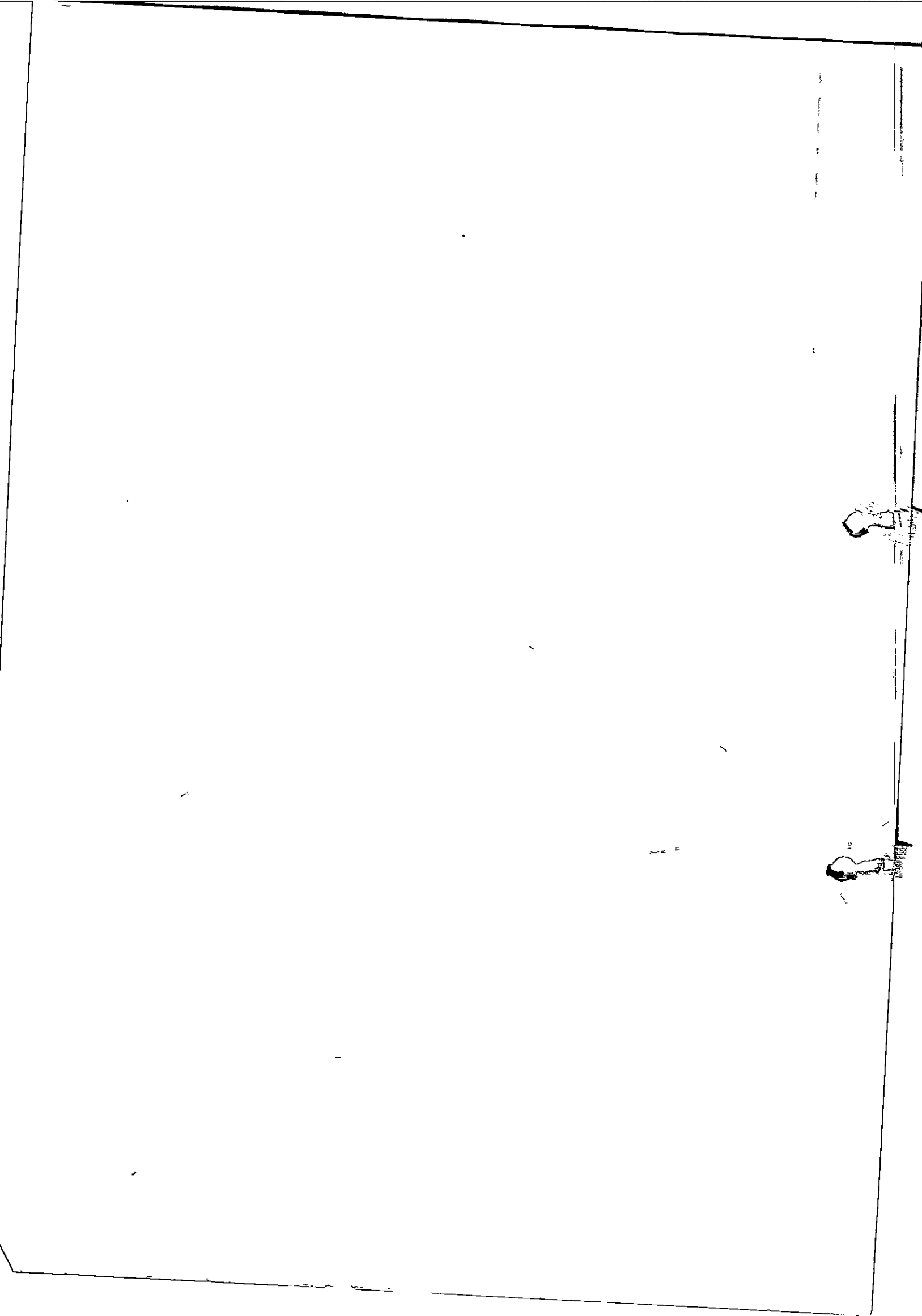
B. Jalh...
Signature

Doctor Details :


Doctor Name : Dr. SANJAY SRIRAMPUR Specialisation : GENERAL PEDIATRICS
Referral Doctor : Sanjay Srirampur Phone No : 9440698109
Co-Consultant : Dr. ANIKET ANIL PARASHAR

Payment Details :


Payment Mode : Cash Deposit Amount : 0.00
Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD



ACTIVITY RECORD FOR BILLING

Name: ----- **BAH-00538181** **IP26-00006439** -----
Baby B NAKSHATRA
 UHID No : --- **01-09-2014** **11 Y 8 M 26 D** (F) ----- Consultant : ----- Dept : -----
Dr. SANJAY SRIRAMPUR
 Date of Adm  ----- Date of Discharge : ----- Time: -----
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
27/5/26	8:25pm	ER	Ward	

Cross Consultation Visit

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

Pediatric Multiorgan History & Physical Examination

Name: Nakshatra Age/Sex 11y 8m

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

cb fever since 2 days ; cb Gld x 5-6 days.
cb Vomiting since 2 days.
cb pain abdomen x 1 day

History of present illness:

Fever high grade ; gradual in onset
not due to illness/ infection.

Vomiting non projectile 2-3 episodes
contents being passed intact.

cb pain abdomen ; epigastric pain
since 2 days.

cb Gld x 6 days

cb decreased oral intake
cb decreased activity } x 1 day.

Pediatric Multiorgan History & Physical Examination

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Baby B NAKSHATRA
01-09-2014 11 Y 8 M 26 D (F)
Dr. SANJAY SRIRAMPUR



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

Not Significant

Birth & Neonatal History :

Normal.

Birth & Socio Economic History :

About Father :

About Mother :

Normal.

Any additional Information.

Developmental History :

Normal.

Immunization History :

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 4.1 kg (Centile _____)

On Examination :

Temperature : 100.8°F Pulse Rate: 122 Description _____

B.P. _____ SPO2 96% at _____

Resp. rate and type of breathing : _____

RR - 26 cpm

Rash _____

Lymphadenopathy enlarged throat ++; sub points ++

Oedema : tonsillar hypertrophy +; No significant

Respiratory system :

Signs of dehydration Cervical LNE ++

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any added sounds : RI AE +

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S12 +

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Epigastric tenderness; tenderness in

Auscultation : right hypochondrium

Spine: _____ External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : CCS 15/15

Cranial Nerves : Normal.

Motor System :

Nutrition : Normal

Tone : Normal Power Normal

Co-ordinator : Normal

Posture : Normal

Involuntary Movements : Normal

Reflexes :

DTR

Plantars

Superficials :

Sensory System :

Bladder / Bowel : Normal.

Clinical Summary & Diagnostic :

Acute febrile illness & dehydration

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

Planned Management :

CRC

CRP

Blood Culture

CUE (DUE)

Urine Culture (DUE)

Respiratory Panel

USG Abdomen & Pelvis (DUE)

Noted By Prabhu

(i) IV fluids.

(ii) Ij Fenopazole
Ij Ondem.

(iii) Ij Cytidine.

Noted By Prabhu

Please fill up the following details

1. Name of the Referring Doctor : _____

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

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

4. Name of the doctor in Rainbow Team _____ on
whose name the patient is being referred

Doctor's Signature Name _____ Date _____ Time _____

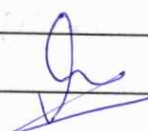
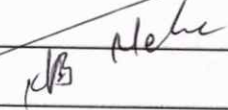


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/05/2026 @ 9.00pm.	Dr. Sanjay. S/B Do. Shreuti.	
	Fever spikes (+)	
	Active.	
	Flushed face	
	Conjunctival Congestion (+)	
	Vitals - Stable.	
	Throat => Mild Congestion (+).	
		Adv
		-> CST
		=> Throat Swab for
		germs stain
		Culture sensitivity
		Alberts stain
		HB Mehta



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/20	<u>Dr. Thanni</u>	
8 am	<u>AFIC dehydration</u>	
	- fever spikes (+)	
	- one episode of vomiting (+)	
	- oral intake fair	
	- Painig urine	Plan
	vitals: stable	1) ct. ceftriaxone
	S/E - (-)	2) base blood cts
	RS: RPE (+)	urine cts
	clear	resp. panel
		throat swab for gram stain
		3) use abdomen & pelvic vent
		4) Rest ct. as per Rx chart
		5) monitor vitals
		

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/16	<p>USG ABDOMEN Liver (N) in size & echotexture (13cm) GB partially distended PV, CBD & pancreas (N) Spleen 9.6 cm (N) RK 10x5cm (N) LC 10.3x4.0cm (N)</p>	No HNH/O.
	<p>no ascites; no pleural effusion lung no significant abnormality detected</p>	<p><u>Done</u> Dr. P. Komalar</p>
28/5/16 10 AM	<p>C/d/c Dr. Sanjay ATT & delay</p>	
	<p>- fever spikes (+) - one ep. vomiting (+)</p>	<p>Plan <input checked="" type="checkbox"/> Trace Resp. Panel/blood <input checked="" type="checkbox"/> ATT urine q.s. <input checked="" type="checkbox"/> Trace to rest away <input checked="" type="checkbox"/> Alt. Pctt C. Study <input checked="" type="checkbox"/> Start pantoprazole <input checked="" type="checkbox"/> Rest ct. as per <input checked="" type="checkbox"/> Rx chest.</p>
	<p>oral intake - fair O/E - (R) PDU - complete ulcer (+)</p>	
	<p>O/E - normal</p>	

NA: Supriya am @ 28/5/16



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/09/20	S/S. Pn Prabhath.	
→ pm.	Δ AFI = Dehydration	
	Fever spikes 11:30 AM 100.3° F. low grade.	
Fluparol ⊖	Noisy breathing ⊕	<u>Adv</u>
	Oral intake - better.	
	No fresh c/o	① Trace Adenovirus PCR Blood c/s
	O/G Vitals Stable.	Urine c/s
	Rs: BA++.	② Trace throat swab
	No added sounds.	③ Alt-PCM of Uulgenic.
	Pro	④ CT. Rest.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/5/16	c/s/by Dr Anisheth	
	AFI is dehydrated	
	-fuss spike (+)	
	oral Intake - Moderate	
o/e	vital stable	Adeno Throat Blis u/ds } (+)
	Exudate on tonsil	ct PCM IBUGESIC
		ct CEFTRIAXONE
		stop IV
		Enhance cord
		ct Not tal - (rustat fluid)
		Dr. D. Anisheth Ms Suvanda

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 Baby B NAKSHATRA
 01-09-2014 11 Y 6 M 27 D (F)
 Dr. SANJAY SRIRAMPUR



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/5 7:00 AM	<p>CLs Dr. Naipya / Dr. Alekya</p>	
	<p>AFB \pm dehydration</p>	
	<p>Fever spikes - noisy breathing (P)</p>	<p>Plan</p>
	<p>Oral intake - vitals - stable</p>	<p>- (T) Bkls vcls</p>
	<p>R/S - B/L AEP P/A - soft, NT</p>	<p>- Cont ceftriaxone</p>
		<p>- IVP to continue</p>
		<p>- Monitor vitals</p>
		<p>Beef</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/2014	c/s/r - Dr Shruuti	
9:30 PM		
	ADENOVIRAL	
	ILLNESS	Advise.
	Fever spikes @	
	ole-	① Nasal drops 1° - 2° - 2°
	Throat Gyanon - better	② Trace Cultures.
	Vitals stable	③ Continue Ceftriaxone
	see	④ Monitor vitals.
	C/S - L/S 2	⑤ IVF 1/2 maintenance
	R - R/L WBS	
	P/A 10/6	

MB Mohan



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/5/26 10:30 AM	c/s/by Dr. Smith	Adenoviral illn
	nb fever	
	<u>vital</u> stab	
	S/G (R/S) Bk AC(+) INVB (F)	✓ stop IVf ✓ Enhance orally
	(P/A) soft non tender	✓ (T) culture ^{Abc} that Abc d/s y/ds ✓ d/s plan tomorrow
		✓ Monitor vital, SpO ₂ , Bp
		✓ ct CE-FRIAXONE
		NB Suranda



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/5/14	S/S. Dr. Prabhathi.	
3:00 PM	<p>△ Adenoviral culture</p> <p>Urine Last fever yesterday Morning 11:AM</p> <p>C/S No further swabs</p> <p>E-coli No fresh c/o</p>	
	<p><u>O/S GI-</u></p> <p>fast.</p> <p>Vital stable</p>	<p><u>ADV</u></p>
	PA - SGT	<p>① Entoluz orally</p>
		<p>② Trace c/s ← All throat</p> <p style="margin-left: 150px;">← Blood c/s</p>
		<p>③ CT Ceftriaxone</p>
		<p>④ Monitor U/O, BP,</p>
		<p>⑤ Plan O/S T/m.</p>
		<p>NB Sunanda</p>

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 Baby B NAKSHATRA 11 Y 8 M 27 D (F)
 01-09-2014
 Dr. SANJAY SRIRAMPUR



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/02/20	d/s. Dr. Shree / Dr. Sanjay	
9 AM	D: Admitted Illness	
	Sore @ - big patch in throat	
	no frank exudate	
	O/GC AC fair	
	leucocytosis with shift	
	S/G. NAO	
		Adm
		- plan d/s T/M on
		oral Cefixime
		- Ceftriaxone
		Rect coat same
		- Monitor vitals and Temp
		OK
		Sanjay



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/8 8 pm	<p><u>ck/B D. Amket</u></p>	
	<p><u>Adenoviral ill. c</u> <u>E-Coli UTI</u></p>	<p>Ph ✓ 2g Ceftriaxone 2g Bismuth</p>
	<p>Karen L V Dehydration - both</p>	<p>✓ 2) Mometil VIV</p>
	<p>Vital Stable</p>	
	<p>R-S - BLEED</p>	<p>✓ 3) Zofran 50 Encourage orally</p>
	<p>PA - safe</p>	
		<p>Dr. Amket</p>
		<p>MB Suranda</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/12/14	clsb - Dr. Subhankar D. Varny	
6 AM	Dr. Adhishiral Thrun	
	No fever	
	no febrile convulsion	
	O/E w.c. fair	
	Hemodynamically stable	
	Hydration - good	
		<p>4th</p>
		- dis on oral cefixime
		Rest continue same
		<p>Sandhya</p>
		<p>noted by Sr. Sandhya</p>
		<p>30/12/14</p>
		<p>6: -</p>

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 Baby B NAKSHATRA
 01-09-2014 11 Y 8 M 27 D (F)
 Dr. SANJAY SRIRAMPUR



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/5/14	Sts R. Anitha	
10:20 am		
	Afebrile	
	vitals stable	
	oral intake better.	
		Advice:
		Discharge
		- oral Cefixime x 5 days
		- Review after 5 days
		N/B Supine @ 10 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/5	CL/B A. Shanthi	
11 AM	Adrenalitis + E. Col. UTI	
	Keren L	PK
	renal with better	1) D/C
	Vitals stable	(Tefixine x 7 days total)
	R-S - B/LPPE ⊕	Probiotics
	PIA - soft	Lanzol
		F/O on Tuesday
		<i>[Signature]</i>



DRUG CHART

Date of Admission: 21/5/20 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

Verified by: D. Dhakshayani

DRUG : <u>T. PARACETAMOL</u>				Date/Time	<u>20/5</u>																	
Dose	Route	Frequency	Start Date		<u>3:30 PM</u>																	
<u>500mg</u>	<u>oral</u>	<u>10/15</u>	<u>28/5</u>		<u>10:50 AM</u>																	
Doctor's Signature		Valid Period	Pharm.																			
<u>[Signature]</u>			<u>[Signature]</u>																			
Additional Instructions:																						
<u>1 tablet - 500mg.</u>																						

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

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

REGULAR PRESCRIPTIONS

Weight. Ward.

DRUG :				Date Time																	
Dose	Route	Frequency	Start Date																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG :				Date Time																	
Dose	Route	Frequency	Start Date																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
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DRUG :				Date Time																	
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Baby B NAKSHATRA 11 Y 8 M 26 D (F)
 01-09-2014 Dr. SANJAY SRIRAMPUR



DRUG CHART

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SOS / PRN (As Required Medication)

DRUG: TAB. DROUERIC				Date Time
Dose	Route	Frequency	Start Date	
400mg	1 tab	bd	27/5	
Doctor's Signature	Valid Period	Pharm.		
[Signature]		[Signature]		
Additional Instructions:				

DRUG: TAB. Dolo				Date Time
Dose	Route	Frequency	Start Date	
500mg	pb	bd	27/5	
Doctor's Signature	Valid Period	Pharm.		
[Signature]				
Additional Instructions:				

DRUG: INT. ONDEX				Date Time
Dose	Route	Frequency	Start Date	
4mg	iv	bd	27/5	
Doctor's Signature	Valid Period	Pharm.		
[Signature]		[Signature]		
Additional Instructions:				

Verified by Dr. Dhakshayani



REGULAR PRESCRIPTIONS

Weight 41 Ward.

Verified by Dr. Dhakshayani

DRUG : INT-CEFTADIAZONE				Date Time	27/5	28/5	29/5	30/5													
Dose	Route	Frequency	Start Date																		
25m	IV	BD	27/5																		
Name & Signature of the Doctor Starting the Drugs:				10AM x 10 10PM Helu Helu Helu Helu																	
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign				[Signature]																	
DRUG : INT-EMOMADLE				Date Time	27/5	28/5	29/5	30/5													
Dose	Route	Frequency	Start Date																		
Yomg	IV	OD	27/5		8PM																
Name & Signature of the Doctor Starting the Drugs:				6AM x Helu Helu Helu																	
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign				[Signature]																	
DRUG : NASIVION-P NASAL Drop				Date Time	27/5	28/5	29/5	30/5													
Dose	Route	Frequency	Start Date																		
2°	Plr	BD	28/5		6AM																
Name & Signature of the Doctor Starting the Drugs:				Com x Helu Helu																	
Additional Instructions:				[Signature]																	
Daily Doctor's Endorsement by a Sign				[Signature]																	
DRUG :				Date Time																	
Dose	Route	Frequency	Start Date																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					

6

Patient Sticker

Weight. 41kg Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
22/5/16	8 PM	INS. ONITEM	4mg	IV	[Signature]	[Initials]

Signature

VERIFIED BY: Name



I.V. FLUIDS CHART

Weight. 41kg Ward.

Signature
 VERIFIED BY: Name

Date	Time	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
27/5	8pm	I.V.F PLASMAALYTE (2/3rds)		50ml/hr Iv	<i>SA</i>	<i>[Signature]</i>	28/5	<i>A</i>	<i>[Signature]</i>
		iv fluid plawhte	4ome/h		<i>A</i>	<i>[Signature]</i>	28/5	<i>A</i>	<i>[Signature]</i>

BAH-00538181 IP26-00006439
 Baby B NAKSHATRA
 01-09-2014 11 Y 8 M 26 D (F)
 Dr. SANJAY SRIRAMPUR



MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

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

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

Shifting From: ICU Shifted to: ward

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Akshaya

Date & Time : 27/5/26 @ 7:45 PM

Nurse Name & Signature: Preethi

Date & Time : 27/5/26 @ 7:45 PM

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Dr. SANJAY SRIRAMPUR



305 → 304

RESULT SHEET



Date	27/5/16				
Time					
Hb	13.2				
PCV	36.8				
RBC	4.40				
WBC	7.79				
N/L	76.6/15.0				
Platelets	190				
CRP	28.0				
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	22/5/16					
Time						
CUE-Alb						
CUE-Sugar						
CUE - Ketones	Negative					
CUE-PUS Cells	4-6					
CUE - RBC Cells	Mil					
CUE						
Mitrate	Negative					
Epithelial cell	3-5					
Leucocytes	Negative					
Stool Pus Cell						
OVA/Cyst						
Occult Blood						
Albest stain:-						
Respiratory panel:-	Ove					
Adm. tested						
Adenovirus -	Detected.					

Culture and Sensitivities : Urine cfs :- E-coli Isolated

Throat Swab cfs :-

Blood cfs :- 24 hr. no growth

Radiology: USG :

X-Ray:

ECHO:

CT:

MRI

Others (ECG, Contrast Studies etc.):

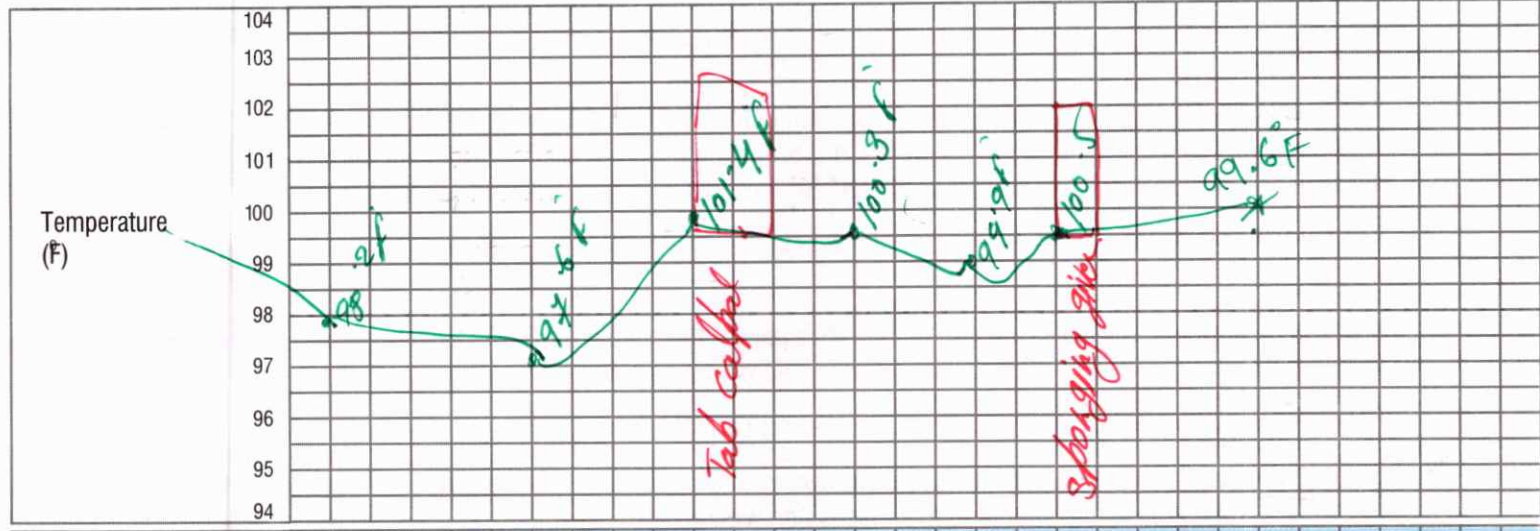
BAH-00538181
 Baby B NAKSHATRA IP26-00006439
 01-09-2014 11 Y 8 M 26 D (F) A / CLINICAL / 126
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SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart



WARNING SCORE: CHILDREN'S UNIT

Date: 22/5/24	Time: 10 PM	11:45 AM	3:30 AM	4:50 AM	5:30 AM	6:55 AM	8:30 AM
Doctor / Nurse / Family Concern?							



Heart Rate (bpm) and Blood Pressure (mmHg) *	
Note: BP does not score in early warning scoring	
Heart Rate (Number)	120b/m, 115b/m, 116b/m
Blood Pressure (mmHg)	106/71, 109/61, 101/60

Resp. Rate (bpm) (Over 1 Minute) *	
Resp Rate (Number)	28b/m, 28b/m, 28b/m

Resp Distress	Mod/ Severe / None / Mild	-
Receiving O ₂ (l/min)	O ₂ Saturations (%)	99%, 100%, 99%
Conscious Level	Normal / Altered	14/15, 14/15, 14/15
GCS *		
TOTAL SCORE		
Number of shaded boxes		0, 0, 0
Pain Score		0, 0, 0
Observer's Initials		re, Y, Y

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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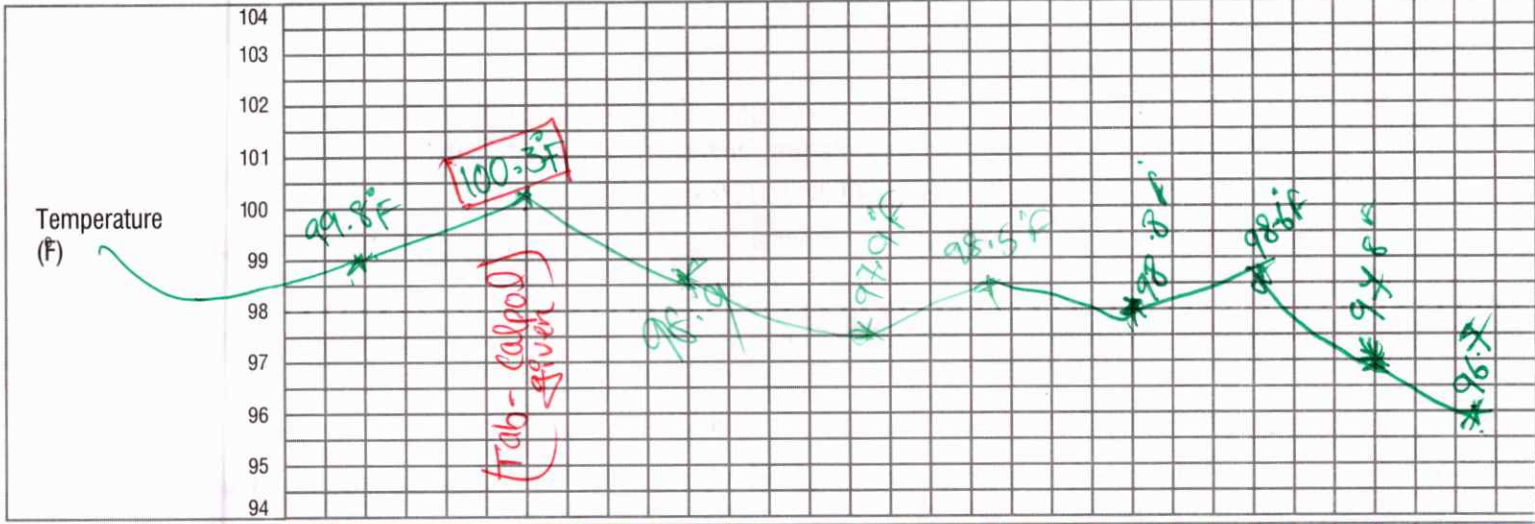
SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

/ WARNING SCORE: CHILDREN'S UNIT

Date	28/5/26	Time:	10 AM	11:30	1:30 PM	5 PM	8 PM	9:40 PM	10 PM	11 PM	11:55 PM
Doctor / Nurse / Family Concern?											



Heart Rate (bpm)										
Blood Pressure (mmHg) *	96/60 (72)	100/62	102/66 (72)		104/63	102/60	101/61			
Heart Rate (Number)	107b/m	102b/m	110b/m		99b/m	103b/m	93b/m			

Resp. Rate (bpm) (Over 1 Minute) *										
Resp Rate (Number)	20b/m	18b/m	20b/m		20b/m	20b/m	20b/m			

Resp Distress	Mod/ Severe	None / Mild								
Receiving O ₂ (l/min)										
O ₂ Saturations (%)	99%	99%	100%		99%	99%	100%			
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	SP	SP	SP		SP	SP	SP			

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1	: Continue normal observation by staff nurse
	Score 2	: Shift in charge nurse to be informed and continue hourly observations
	Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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Date	Time	Early Warning Score	Date	Time	Name

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

BAH-00538181
 Baby B NAKSHATRA IP26-00006439
 01-09-2014 11 Y 8 M 26 D (F)
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/ CLINICAL / 126

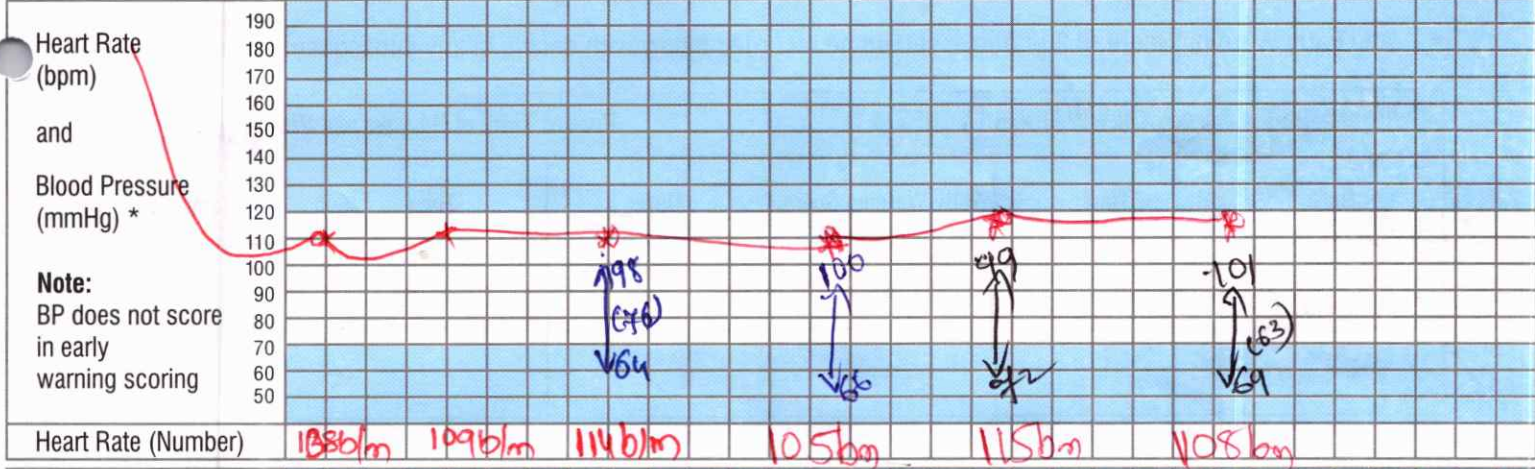
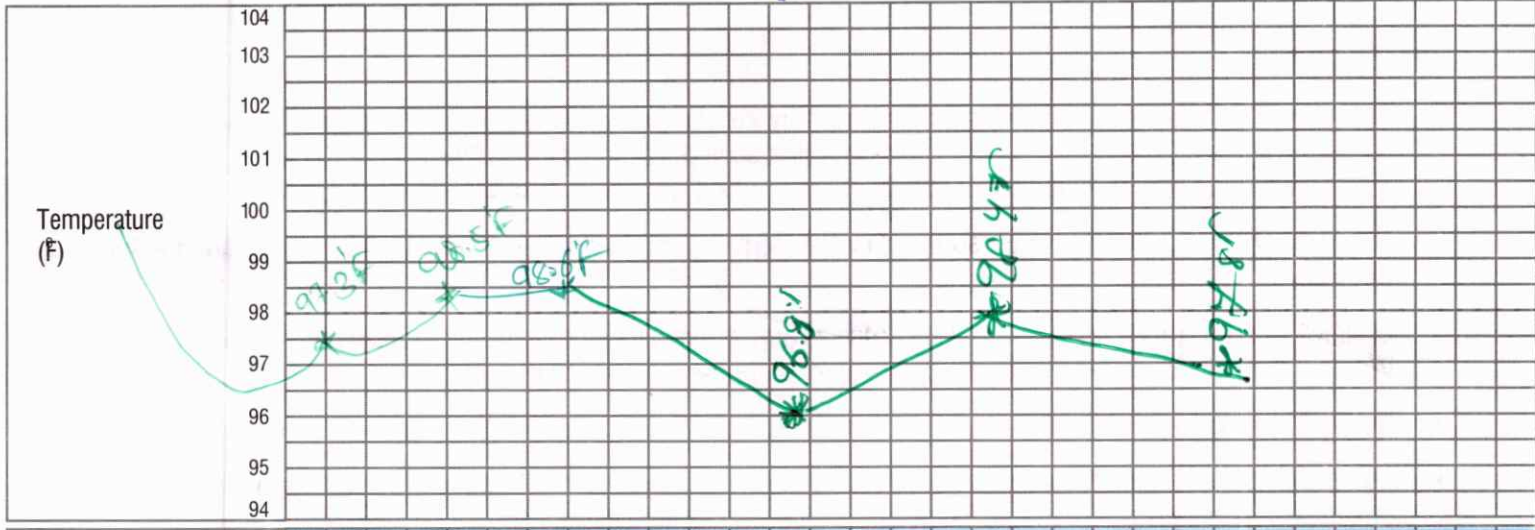
SCHOOL AGE (5-12 years)
 Children's Observation &
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 Hospital
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 29/5/20 28/5/20	Time: 10 am	2 am	6 pm	10 pm	2 AM	6 AM
Doctor / Nurse / Family Concern?						



Resp. Rate (bpm) (Over 1 Minute) *	70	60	50	40	30	2	1
Resp Rate (Number)	28	25	20	20	22	25	

Resp Distress	Mod/ Severe	None / Mild				
Receiving O ₂ (l/min)						
O ₂ Saturations (%)	99%	99%	98%	98%	98%	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	SA	SA	SA	SA	SA	SA

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1	: Continue normal observation by staff nurse
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A	ASSESSMENT: I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION: I need you to ... come to see the child in the next (XX mins) AND is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)

BAH-00538181 IP26-00006439
 Baby B NAKSHATRA
 01-09-2014 11 Y 8 M 26 D (F)
 Dr. SANJAY SRIRAMPUR



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	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 :							
27-15	08:00 pm												
	09:00 pm												
	10:00 pm	PlasmaLyte		50ml									
	11:00 pm	Rice		50ml									
	12:00 am	PlasmaLyte		50ml									
	01:00 am			50ml									
Total Intake :						Total Output : N-0 U-1							
28/15/20	02:00 am			50ml									
	03:00 am			50ml									
	04:00 am			50ml									
	05:00 am	PlasmaLyte	H2O	50ml									
	06:00 am			50ml									
	07:00 am			50ml									
Total Intake :						Total Output : N-0 U-1							
Total 24 hrs. Intake													
Total 24 hrs. Output													



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse		
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine				
28/5/2016	08:00 am			50ml										
	09:00 am	PlasmaLyte		50ml										
	10:00 am		Idly	50ml										
	11:00 am		H2O	50ml										
	12:00 pm			50ml										
	01:00 pm			50ml										
Total Intake :						Total Output :								
28/5/2016	02:00 pm			50ml										
	03:00 pm	PlasmaLyte		50ml										
	04:00 pm			50ml										
	05:00 pm			50ml										
	06:00 pm			50ml										
	07:00 pm			50ml										
Total Intake :						Total Output :								
28/5/2016	08:00 pm			40ml										
	09:00 pm	PlasmaLyte	Rice	40ml										
	10:00 pm		chapati											
	11:00 pm		H2O											
	12:00 am			40ml										
	01:00 am			40ml										
Total Intake :						Total Output :					M-0	U-1		
29/5/2016	02:00 am			40ml										
	03:00 am	PlasmaLyte	H2O	40ml										
	04:00 am		X											
	05:00 am		H2O											
	06:00 am													
	07:00 am													
Total Intake :						Total Output :					M-0	U-1		

Total 24 hrs. Intake

Total 24 hrs. Output

BAH-00538181 IP26-00006439
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FLUID CHART

Sheet No. :

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

Date	Time	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
29/5/26	08:00 am					/							
	09:00 am					/	✓			✓			
	10:00 am	stop				/		NA					
	11:00 am					/							
	12:00 pm									✓			
	01:00 pm												
Total Intake :						Total Output :							
29/5/26	02:00 pm												
	03:00 pm												
	04:00 pm	o	Rice			/				✓			
	05:00 pm		H ₂ O			/				✓			
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
29/5/26	08:00 pm					/							
	09:00 pm					/							
	10:00 pm		Rice			/				✓			
	11:00 pm		H ₂ O			/				✓			
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
30/5/26	02:00 am					/							
	03:00 am												
	04:00 am					/				✓			
	05:00 am		H ₂ O			/				✓			
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

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Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	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	
-----------------------------	--

BAH-00538181 IP26-00006439
 Baby B NAKSHATRA
 01-09-2014 11 Y 8 M 26 D (F)
 Dr. SANJAY SRIRAMPUR



NURSING CARE RECORD



Date: 28/5/16

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	8PM 10 8A	<p>Assess the Baby condition</p> <p>MONITOR the vitals</p> <p>maintain the charts</p> <p>medication given as per drug chart</p>	8PM 10 8PM	<p>Assess the Baby condition</p> <p>MONITOR the vitals</p> <p>maintain the charts</p> <p>medication given as per drug chart</p> <p>USG RT P morning</p>	Baby is here stable	MONITOR the vitals	Heba

BAH-00538181 IP26-00006439
 Baby B NAKSHATRA
 01-09-2014 11 Y 8 M 26 D (F)
 Dr. SANJAY SRIRAMPUR



NURSING CARE RECORD



Date: 28/5/26

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	→ ASSES the pt condition → Monitor the vitals → Maintain I/O chart → Administer medication as per drug chart	8AM	→ Assessed pt condition → Monitored vital → Maintained I/O chart → Administered medication as per drug chart	Patient is stable	Re-checked vitals	[Signature]
	to 2PM		to 2PM				
Afternoon	2PM	ASSESS the pt condition Monitor vitals Maintain I/O chart Drug given as per drug chart.	2PM	ASSESSED the pt condition monitored vitals Maintained I/O chart. Drug given as per drug chart.	Patient is stable now	Re-checked vitals	[Signature]
	8PM		8PM				
Night	8PM	- ASSES the pt condition - Monitor the vitals - Maintain I/O charts - Medication given as per drug chart - Trace Reports - I/O Fluids Stop	8PM	- ASSES the pt condition - Monitor the vitals - Maintain I/O charts - medication given as per drug chart - Trace Reports - I/O Fluids Stop	- pt is now stable	- Monitor the vitals	[Signature]
	to 8A		to 8A				

BAH-00538181 IP26-00006439
 Baby B NAKSHATRA
 01-09-2014 11 Y 8 M 26 D (F)
 Dr. SANJAY SRIRAMPUR



NURSING CARE RECORD



Date: 29/5/20

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 10 2pm	- Assess the pt condition - monitor the v/s - maintain the I/O Drug as per chart	8am 10 2pm	- Assess the pt condition - monitor the v/s - maintain the I/O Drug as per chart	- Now baby is stable	- Rechecked the v/s	
Afternoon	DAY						
Night	8pm 10 5am	→ Assess the pt condition. → maintain the v/s → maintain the I/O	8pm 10 5am	→ Assess the pt condition → maintain the v/s → maintain the I/O Drug as per chart	Now Baby is stable	Re-checked the v/s	

NURSING CARE RECORD

BAH-00538181 IP26-00006439
Baby B NAKSHATRA
01-09-2014 11 Y 6 M 27 D (F)
Dr. SANJAY SRIRAMPUR



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							

BAH-00538181

IP26-00006439

Baby B NAKSHATRA

01-09-2014 11 Y 8 M 26 D (F)

Dr. SANJAY SRIRAMPUR



BRADEN 'Q' SCALE

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	27/5	28/5	28/5	28/5
					Time :	12 PM	2 PM	4 PM	6 PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	4	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	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	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	4
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	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	4
TOTAL SCORE						28	28	28	28
Evaluator's Name						AS	AS	AS	AS

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

Docu. No. : RCH /FRM / CLINICAL / 119

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Use same protocol as for "High Risk" Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



BRADEN 'Q' SCALE

Date: 29/8
 Time: 11

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		
*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		
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		
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		
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4		
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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		

TOTAL SCORE 28
Evaluator's Name [Signature]

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
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Less than 9	Severe Risk	<ul style="list-style-type: none"> • Use same protocol as for "High Risk" Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
29/5	10am	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
29/5	2pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
29/5	10pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	AS
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Re-assessment Frequency:

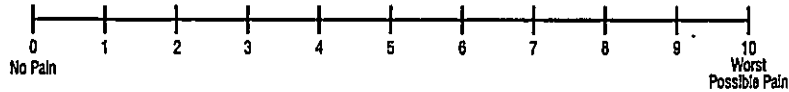
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Podiatrics) Above 7 Years



0

No Hurt

2

Hurts Little Bit

4

Hurts Little More

6

Even More

8

Hurts Whole Lot

10

Hurts Worst

BAH-00538181 IP26-00006439
 Baby B NAKSHATRA
 01-09-2014 11 Y 8 M 26 D (F)
 Dr. SANJAY SRIRAMPUR



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known					
			If Yes Specify:					
BACKGROUND	Surgery / Procedure:		Post OP Day:					
	Date	Shift	27/5/26 N1	28/5 M6	28/5 E2	28/5/26 M1	29/5/26 E2	29/5/26 N1
	Medical Condition (Any special condition to be noted):		—	—	—	—	—	—
	Diet:		—	—	—	—	—	—
ASSESSMENT	Allergy:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):		—	—	—	—	—	—
	Tubes/Drains/Catheter:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Vital Signs:		Temp: 98.5 F	98.2 F	98.2 F	98.3 F	98.2 F	98.5 F
			Res: 28b/m	22b/m	22b/m	25b/m	26b/m	26b/m
			SpO ₂ : 99.1	99.1	99.1	100.1	99.1	99.1
			Pulse: 115b/m	113b/m	110b/m	115b/m	122b/m	126b/m
			BP: 105/60	100/62	110/70b/m	105/65	102/70	103/70
			LOC: —	—	—	—	—	—
	Fall Risk Score:		—	—	—	—	—	—
Pain Score:		—	—	—	—	4/10	0	
Skin Integrity		—	—	—	—	Good	Good	
Recommendations	Safety Needs:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Physiotherapy:		—	—	—	—	—	—
	Others Specify:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Special Diet:		—	—	—	—	—	—
	Critical Lab Test / Values:		—	—	—	—	—	—
	Other Special Orders / Medications:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	PU Prophylaxis:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
DVT Prophylaxis:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
ADL (Dependent / Non Dependent):		—	—	—	—	—	—	
Post Operative Procedure Special Orders:		—	—	—	—	—	—	
Handed Over By Name :		Meha	Anuska	Sundar	Meha	Sunanda	Madhur	
Signature / ID :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
Date:		28/5/26	28/5/26	28/5/26	29/5/26	29/5/26	30/5/26	
Time:		8AM	2PM	8PM	8AM	8PM	8AM	
Taken Over By Name :		Anuska	Sundar	Meha	Sunanda	Madhur	Madhur	
Signature / ID :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
Date:		28/5/26	28/5/26	28/5/26	29/5/26	29/5/26	29/5/26	
Time:		8AM	2PM	8PM	8AM	8PM	8AM	

BAH-00538181 IP26-00006439
 Baby B NAKSHATRA
 01-09-2014 11 Y 8 M 26 D (F)
 Dr. SANJAY SRIRAMPUR



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date	/	/	/	/	/	/
	Shift						
	Medical Condition (Any-special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:	Temp:					
		Res:					
		SpO ₂ :					
		Pulse:					
		BP:					
		LOC:					
		Fall Risk Score:					
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physiotherapy:						
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	PU Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	DVT Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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:							



30th

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 28/5/26 Time: 11:11 AM

Weight: 4.1 kg Centile: 50th

Height: - Centile: -

Inference: well nourished child

RDA: - Calories: 1700 kcal/d Protein: 20 gms/d

Diet Recommendations: Normal diet with more liquids

Re-Assessment: Avoid spicy, Chilled & outside foods

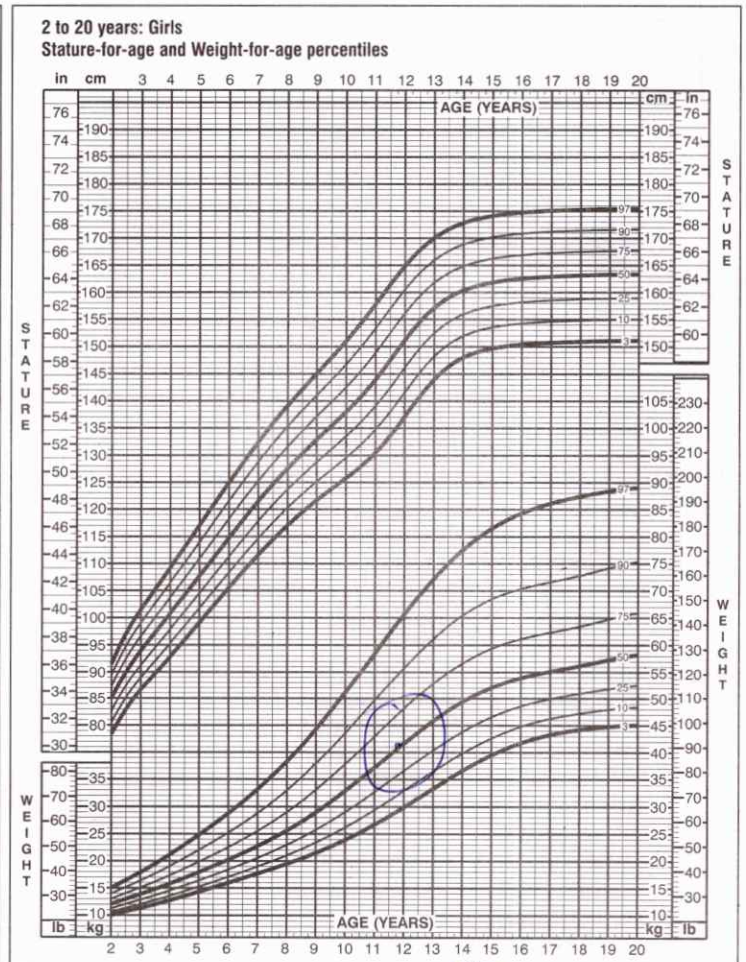
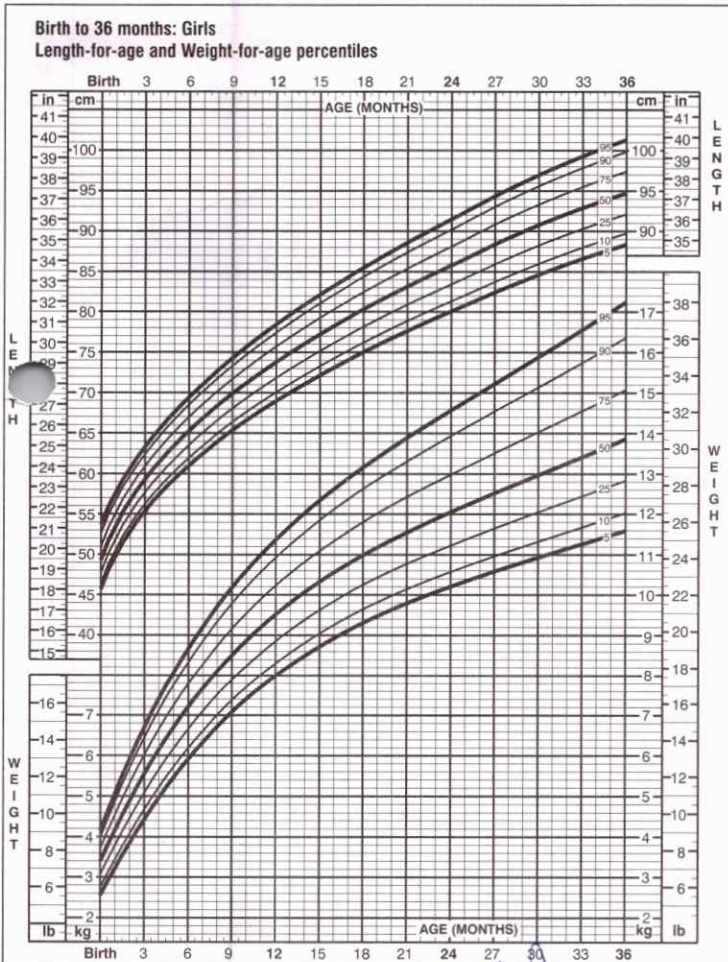
Food Allergies: - Veg/Non-veg

Diagnosis: AFI & Dehydration

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: _____

GROWTH CHART (GIRLS)



Dietician's Name: Sathulica

Dietician's Signature: [Signature]



wt - 41.58 kg



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Nakshatra Age : 11 years Gender: Male Female

Date : 27/5/20 Time of Arrival : 7:15 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: 100.8 F PR: 132b/m BP: RR: SpO₂: 97%

Chief Complaints: @/o Fever since 3 days, vomiting 2 episode, and chills

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian
Triage Completion Time : 7:18 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 : Babin

Signature of Triage Nurse : [Signature]

Date & Time : 27/5/20 @ 7:18 PM



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 27/5/20 Time of arrival : 7:15 PM

Chief Complaints: c/o

Height : Weight : Head Circumference (<2 years)

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

Pain Screening: Yes No If Yes, Pain Score: 10/10 Pain Tool Used: N Pass FLACC Wong Baker

Character Location Frequency Duration

RISK FOR FALL:

If patient is < 6 years Yes No

If 'Yes' tick below fall risk intervention directly

If Patient is > 6 years

If 'Yes' Assess the below parameters

History of Falling: within past 3 months Yes No

Ambulatory Aids:

- Wheelchair Yes No
- Uses furniture for support Yes No

Gait/Transferring:

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

Mental Status: Forgets limitations Yes No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With Family

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

Time of Initial assessment completed by ER Nurse : 7:18 PM

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

Time	Nursing Notes
	→ Assessed the pt condition
	→ checked the pt vitals
	→

Samples collected by: /

Time: /

Samples sent by: /

Time: /

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
7:25 AM	Ibuprofen	PO	400 mg		
8:10 AM	Esmolol	IV	40 mg		[Signature]
8:19 AM	Ondansetron	IV	4 mg		[Signature]

Condition of patient at time of shift - out :	Details of Shift - out
HR: 130b/m BP: CFT: 25cm	Shift - out from ER to: ward
RR: SPO2 at FiO2: 97%	Time of Shift - out: 8:12 AM
GCS: 15/15 Temperature: 99.5°F	Handover given to: (Nurse's Name)
Pain Score: 10/10	
Repeat RBS (if applicable):	

Tick as applicable: MLC LAMA BROUGHT DEAD


Procedures done with details (if any):

Name of the Nurse: Babin

Signature of the Nurse: [Signature]

Date & Time: 27/12/20 @ 7:18 AM

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00538181 IP26-00006439 Baby B NAKSHATRA 01-09-2014 11 Y 8 M 26 D (F) Dr. SANJAY SRIRAMPUR 		Date & Time of Admission 27/5/26 @	Date & Time of Transfer Order 27/5/26 @
		Transfer Ordered by Dr. Alekhya	Reason for Transfer Admission
From Unit ER	To Unit ward	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 20	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Dr. [Signature]		Name of Person Ordered Transfer Dr. Alekhya	
Patient & Clinical Records Received by : 27/5/26 @ 9:pm [Signature]			
Date & Time of Patient Received : [Signature]			

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