Rainbow® Children's Hospital
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Your Right to a Safe Delivery

DISCHARGE SUMMARY

Name	Master SHIVANSH MAKHIJA	**UHID**	HNH-00000941
Father/Guardian	Mr AMEET SINGH MAKHIJA	**Age/Gender**	9 Y 8 M 27 D/ Male
Address	16-10-182/10 mch colony near pochamma temple old malakpet hyderabad telangana, Malakpet, Hyderabad, Telangana, INDIA, 500036		
IP No	IP26-00006777	**Admission Date**	07-07-2026
Ref Doctor	Self.		
Discharge Date	09.07.2026		

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

DIAGNOSIS	ICD CODE
INFLUENZA A ILLNESS WITH	
LOWER RESPIRATORY TRACT INFECTION WITH DEHYDRATION	

History: Master SHIVANSH MAKHIJA, 9 Y 8 M 27 D , old boy presented with history of fever, cough and cold since 3 days, decreased activity since 1 day prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

Examination: He was afebrile, maintaining saturations at room air and was

Name	Master SHIVANSH MAKHIJA	UHID	HNH-00000941
IP No	IP26-00006777	Admission Date	07-07-2026

hemodynamically stable. His heart rate was 132/min, Blood pressure - 111/79 (89) mmHg and Respiratory Rate - 28 /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, sunken eyes were present. On auscultation, air entry was bilaterally equal with bilateral crepitations were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, 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: 29.2 kilo grams.

Investigations: Enclosed reports.

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

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

VBG showed pH of 7.47, pCO2 of 28 mmHg, pO2 of 66 mmHg, HCO3 of 22.2 mmol/L and BE of -3.3 mmol/L.

Initial hemogram showed Hemoglobin of 13.7 gm%, White Blood Cell count of 8510 cells/cumm, platelet count of 2.19 lakhs/cumm and C-Reactive Protein of 11 mg/l.
Adenovirus PCR was not detected.

Name	Master SHIVANSH MAKHIJA	**UHID**	HNH-00000941
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Management: He was admitted in the ward and was started on Intra Venous fluids and Intra Venous antibiotics . He was treated symptomatically with antacids and antipyretics.

In cough , cold and fever necessary investigations sent , showed positive of influenza A for which started on syp oseltamavir .

In view chest signs and significant fever Spikes started on Oral Amoxyclav and nebulizations with 3 % NS .

He was regularly monitored for fever spikes, hemodynamic status. His fever spikes and other symptoms gradually settled. Child maintaining saturations on room air.

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

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

Medication during hospital stay:
Syrup. Anti flu
Syrup. Crocin DS
Injection. Ondan
Injection. Pantop
Syrup. Augmentin

Advice:
* Diet as advised.

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IP No	IP26-00006777	Admission Date	07-07-2026

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. AUGMENTIN DDS (Amoxycillin 400 + Potassium Clavulanate 57 mg/5ml)	4.5 ml	8am-8pm (after food)	For 6 days
2	Syrup. FLUVIR (OSELTAMIVIR – 5ml/60mg)	5 ml	9am-9pm (after food)	For 2 days.
3	Syrup. RELENT PLUS (Cetrizine 5mg, Ambroxol 30mg/5ml)	5 ml	8am-8pm (1 hour before food)	For 3 days.
4	NEB WITH 3 % NS	1 respule	8th hourly	For 3 days
5	Topical DESOWEN 0.05%	For local application	twice daily	For 5 days
6	Nasoclear nasal drops, 2 drops in each nostril **SOS** for nose block			

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 9ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
* Tepid sponging if fever > 101 *F.

Review consultation with Dr. SINDHURA MUNUKUNTLA on Saturday (11.07.2026) at Himayatnagar in OPD with prior appointment **(Review**

Name	Master SHIVANSH MAKHIJA	UHID	HNH-00000941
IP No	IP26-00006777	Admission Date	07-07-2026

consultation will be charged).

DERMATOLOGY OPINION ON FOLLOW UP .

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 **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**

Name	Master SHIVANSH MAKHIJA	**UHID**	HNH-00000941
IP No	IP26-00006777	**Admission Date**	07-07-2026

Registrar/Resident/C.M.O

Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

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ACTIVITY RECORD FOR BILLING

HNH-00000941 IP26-00006777
Master SHIVANSH MAKHIJA
11-10-2016 9 Y 8 M 26 D (M)
Dr. SINDHURA MUNUKUNTLA

Name: ---

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

Date of Admission : 7/7/16 Time : 7:03pm Date of Discharge : ---------- Time: ----------

Room / Bed No : 1st floor Ward : 201 Suggested Billable bed type : ----------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
7/7/16	7:50pm.	ER	1st floor / 101	

Cross Consultation Visit

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

HNH-00000941 IP26-00006777
Master SHIVANSH MAKHIJA
11-10-2016 9 Y 8 M 26 D (M)
Dr. SINDHURA MUNUKUNTLA

INVESTIGATIONS

Date	Investigations	Order No.	Sign
7/7/26.	CBP		
	CRP }	11203	
	VBG	11202	

HNH-00000941 IP26-00006777
Master SHIVANSH MAKHIJA
11-10-2016 9 Y 8 M 26 D (M)
Dr. SINDHURA MUNUKUNTLA

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
2/7/26	Infusion pump	2/7/26 9pm.	3/7/26 @ 10am	11614	[signature]

HNH-00000941 IP26-00006777
Master SHIVANSH MAKHIJA
11-10-2016 9 Y 8 M 26 D (M)
Dr. SINDHURA MUNUKUNTLA

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
8/7/26	re placement	1	11591	Treated by
8/7/26	NHA	(1)	4942	

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow®
Children's
Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : _____ HNH-00000941 IP26-00006777
Master SHIVANSH MAKHIJA
11-10-2016 9 Y 8 M 26 D (M)
Dr. SINDHURA MUNUKUNTLA

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

HNH-00000941 IP26-00006777
Master SHIVANSH MAKHIJA
11-10-2016 9 Y 8 M 26 D (M)
Dr. SINDHURA MUNUKUNTLA

Name : Age/Sex

Informant Reliability

Chief Presenting Complaints & Duration (Chronologically):

c/o fever since 3 days
c/o cough & cold since 3 dy
c/o decreased activity &

History of present illness :

- Child presented to ER with c/o fever since 3 dys high grade Intermittent, a/w chills & rigors.
- c/o cough & cold since 3 dy, a/w noisy breath & nasal discharge. & cough progressive in nature
- c/o decreased activity & decreased acceptance of feeds
- No h/o fast breathing / chest Indrawing.
- c/o decreased urine output.

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

Nil

Birth & Neonatal History :

OTD

Birth & Socio Economic History :

About Father :

About Mother : Not Signfr.

Any additional Information :

Developmental History :

Appropriate

Immunization History :

Upto date

Anthropometry

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

Weight (kgs) 29.2kg. (Centile _____)

On Examination :

Temperature : 99.3 F Pulse Rate: 132/min Description _____

B.P. 111/79(89) SPO2 98% at _____

Resp. rate and type of breathing : _____

Sign of dehydn - dull look
- dry lips, dry oralmucosa
- sunken eyes.
- Prolong skin turgor

Rash _____

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L AE (+)

Any addes sounds : NVBS, B/L Crepts (+)

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1 S2

Any murmur : No.

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

Per Abdomen :

Inspection _____

Palpation : Soft No organomegaly

Ausculation : _____

Spine: _____ External Genitelia : _____

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

HNH-00000941 IP26-00006777
Master SHIVANSH MAKHIJA
11-10-2016 9 Y 8 M 26 D
Dr. SINDHURA MUNUKUNTLA (M)

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : (N)

Motor System :

Nutrition :

Tone : (N) Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR

Superficials :

Plantars (N)

Sensory System :

(N)

Bladder / Bowel :

Clinical Summary & Diagnostic :

Influ LRTI c̄ dehydration.

HNH-00000941 IP26-00006777
Master SHIVANSH MAKHIJA
11-10-2016 9 Y 8 M 26 D (M)
Dr. SINDHURA MUNUKUNTLA

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

VBG
CBP
CRP
CUE - Due
draw - B/c/s (Send 1/t CRP+a)

NB shirisha

Planned Management :

- IV fluid DNS (2/3).
- Inj ONDAN Q8hly
- Inj PANTOP
- CROSIN DS syp QID
- T ANTIFLU.

NB shirisha

Please fill up the following details

1. Name of the Referring Doctor :
2. Name of the Referring Hospital : (Including the name of City)
3. Contact number of the Referring Doctor : (Preferring Mobile #)
4. Name of the doctor in Rainbow Team Dr-Sindhura. M on whose name the patient is being referred

Doctor's Signature Name [signature] Date 7/7/26 Time 6:45pm

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No. 66970

HNH-00000941 IP26-00006777
Master SHIVANSH MAKHIJA
11-10-2016 9 Y 8 M 26 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/8/26 6:50 pm	c/i/by. Dr. Sindhura M.	
	Influenza A illn c̄ LRTI c̄ Dehydrati	
	vital stal	
	febrile (+).	
	dull look (+)	
	sign of dehydrat (+)	
		Plan
	S/E	- IV fluids
	B/L AE (+)	
	(R/S) NVBS (+)	- ct CROSIN QID
	Crepts.	- ct Antiflu.
		- Monitor vital
		- (T) Sample.
		Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970
		[signature] SINDHURA-M
		Quoted by Dheya 8/8/26 @ 8pm

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

(P.T.O)

HNH-00000941 IP26-00006777
Master SHIVANSH MAKHIJA
11-10-2016 9 Y 8 M 26 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26 6AM	S/B Dr-Archana/ Dr-Nazneen	
	Δ: LRTI (Influenza (A) illness) ± dehydration	
	on Room Air fever spikes - none : admission Tachypnea (-) cough (+) ↓	Advice · Ct Antiflu symp · Ct symptomatic support · Ct IVF @ 2/3 mls/hr ↓ Increase feeds orally
	o/e vitally stable	· TPR/IOC · watch for distress.
	s/e RS: AEBE	Dr. Archana noted by Dr. 8/7/26.

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26	C/O/B - Dr. Sindhura.	
10 AM	Δ - LRTI (Influenza A) c̄ dehydration	
	On Room Air	
	fever spikes Ⓧ present	Plan:
	Tachypnea ⊖	- ↓ IVF to 1/2 m
	O/E	- ct. Antiflu
	vitals stable.	- Augmentin ES
		- ↑ feeds orally
	S/E	
	RS - clear	- Dermat opinion by afternoon
	N IBC [illegible]	[signature]

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No: 66970

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

HNH-00000941 IP26-00006777
Master SHIVANSH MAKHIJA
11-10-2016 9 Y 8 M 26 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/s/b Dr. Naipriya	
8/7 2:00pm		
	Influenza A illness	
	LRTI c dehydration.	
	Cough (+).	
	No fever	Plan
	Vitals - stable.	- Syp. FLUVIR
	oral intake - fair.	- Syp. AUGMENTIN
	R/s - B/L AE (+)	
	B/L NVBS	- Cont IVF
		- Monitor vitals.
	P/A - soft, NT	
		Naipriya. [signature]

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Master SHIVANSH MAKHIJA
11-10-2016 9 Y 8 M 26 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26 6:30pm	U/B Dr. Sindhura	
	Influenza A illness	
	LRTI c̄ dehydration	
	- no fever spikes	
	- cough (+)	
	O/E	
	vitals : stable	plan
	S/E -	1) Ct. fluids
	RS : RDE (+)	augmentation
	clear	2) Syrup [illegible]
	P/A : soft	3) monitor vitals
		3) Ct. [illegible]
	1st dose	N/BO [illegible]
	one op [illegible]	
	[illegible] op [illegible]	
	- diarrhoea intake	
	- no oral ∴ admitted	
	- URI	
		Sindhura
		SINDHURA. M
		Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970

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

HNH-00000941 IP26-00006777
Master SHIVANSH MAKHIJA
11-10-2016 9 Y 8 M 26 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
09/07/26 7AM	c/s/b. Dr. Sub[illegible] / Dr. Varun[illegible]	
	Δ:- Influenza A Illness (LRTI with dehydration)	
	fever ⊕	
	cough ⊕	
	O/E: GC - fair	
	vitals: stable	
	Hydration - good	
	S/E: NAD	
		Adv
		- fluvir / Augmentin
		- Supportive care
		- Monitor vitals and Inform SOS
		N/B [illegible] [illegible]

HNH-00000941 IP26-00006777
Master SHIVANSH MAKHIJA
11-10-2016 9 Y 8 M 27 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26	c/s/by Drs Sindhu M	
10 AM	D:- Influenza A illness (LRTI with dehydration)	
	fever (+)	
	cough (+).	
	o/e f/c jaius	– Check Ear
	vital stable.	– ct Amoxy total 7 days flavir x 5 days Retent plus.
	s/e NAD	
		– ct NEB.
	on Ear Ex :-	
	Lt Ear congestion (↓)	– Monitor vitals
		– discharge
		– Topical Desonide 0.05% pearsize L/A BD x 5 days
		Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970 [signature] [signature]

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Master SHIVANSH MAKHIJA
1-10-2016 9 Y 8 M 27 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00000941 IP26-00006777
Master SHIVANSH MAKHIJA
11-10-2016 9 Y 8 M 26 D (M)
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DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG : Syp IBUGESIC				Date / Time
Dose	Route	Frequency	Start Date	
10ml	PO	SOS	7/7	
Doctor's Signature	Valid Period	Pharm.		
[signature]		[signature]		
Additional Instructions: tem 3102				

DRUG : Syp. Crocin DS				Date / Time
Dose	Route	Frequency	Start Date	
9ml	PO	SOS	8/7	
Doctor's Signature	Valid Period	Pharm.		
[signature]	3100/-	[signature]		
Additional Instructions:				

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

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani

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

HNH-00000941 IP26-00006777
Master SHIVANSH MAKHIJA
11-10-2016 9 Y 8 M 26 D (M)
Dr. SINDHURA MUNUKUNTLA

REGULAR PRESCRIPTIONS Weight. 29.2kg Ward. ....

Verified by Dr. Dhakshayani

DRUG : SYP ANTIFLU				Date/Time	7/7	8/7	9/7
Dose	Route	Frequency	Start Date				
5ml	po	BD.	7/7	10am	X		
Name & Signature of the Doctor Starting the Drugs:							
Additional Instructions: (12mg/5ml) D2				10pm			
Daily Doctor's Endorsement by a Sign					6	V	

Verified by Dr. Dhakshayani

DRUG : CROSIN DS SYP				Date/Time	7/7	8/8	
Dose	Route	Frequency	Start Date				
9ml	po	QID	7/7	6am	X		
Name & Signature of the Doctor Starting the Drugs:				12pm	X		
Additional Instructions: (240mg/5ml)				6pm	6:15 pm ER.		
				12am			
Daily Doctor's Endorsement by a Sign							

STOP

Change to SOS

Verified by Dr. Dhakshayani

DRUG : T. ONDAN.				Date/Time	7/7	8/8	9/7
Dose	Route	Frequency	Start Date				
4mg	po	TID	7/7/16	6am	X		
Name & Signature of the Doctor Starting the Drugs:				2pm	X		
Additional Instructions: (ONDENSETRON)				10pm			
Daily Doctor's Endorsement by a Sign					6	V	

Verified by Dr. Dhakshayani

DRUG : T. PANTOP.				Date/Time	7/7	8/8	9/7
Dose	Route	Frequency	Start Date				
30mg	po	OD	7/7/16				
Name & Signature of the Doctor Starting the Drugs:				6pm	9pm		
Additional Instructions: (PANTOPRAZOLE)							
Daily Doctor's Endorsement by a Sign					6	V	

HNH-00000941 IP26-00006777
Master SHIVANSH MAKHIJA
11-10-2016 9 Y 8 M 26 D (M)
Dr. SINDHURA MUNUKUNTLA

REGULAR PRESCRIPTIONS

Weight. 29.2kg Ward. ....

Verified by Dr. Dhakshayani

DRUG : SYP. AUGMENTIN ES				Date / Time	8/7	9/7
Dose	Route	Frequency	Start Date			
4.5ml	PO	BD	8/7			
Name & Signature of the Doctor Starting the Drugs: (signature)				10pm		
Additional Instructions: (642mg/5ml)				10pm		
Daily Doctor's Endorsement by a Sign						

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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:				
Daily Doctor's Endorsement by a Sign				

Patient Sticker

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DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

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

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

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

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

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11-10-2016 9 Y 8 M 26 D (M)
Dr. SINDHURA MUNUKUNTLA

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

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

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

Signature .....

VERIFIED BY : .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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I.V. FLUIDS CHART

Weight. 29.2kg Ward. .....

		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
7/8/26	2:15pm	N/fluids DNS (2/3 M).	IVS	42ml/hr	AJ				
8/7		IVF DNS (1/2 M)		35ml/hr					
				STOP 8/7/26					

Signature .....

VERIFIED BY : Name .....

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RESULT SHEET

Date	7/7/26					
Time						
Hb	13.7					
PCV	38.1					
RBC	4.95					
WBC	8.51					
N/L	22.3, 15.8					
Platelets	219					
CRP	11.0					
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						

(P.T.O)

Date	7/7/26.					
Time						
CUE - Alb						
CUE - Sugar	nill					
CUE - Ketones	Present					
CUE - PUS Cells	2-3					
CUE - RBC Cells	Absent					
CUE						
Epithelial cells	1-2.					
Leucocytes	negative					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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Patient

CLINICAL / 126

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 2/12/16. Time:	8:30PM	1AM	7AM
Doctor / Nurse / Family Concern?			
Temperature (F)	98.2F	98.6F	97.8F
Heart Rate (bpm) and Blood Pressure (mmHg) * **Note:** BP does not score in early warning scoring	106 (84) 62	95 (84) 60	100 (79) 60
Heart Rate (Number)	106/M	113/M	100/M
Resp. Rate (bpm) (Over 1 Minute) *			
Resp Rate (Number)	28/M	27/M	28/M
Resp Distress: Mod/ Severe / None / Mild			
Receiving O_2(l/min) O_2Saturations (%)	RA	100%	100%
Conscious Level: Normal / Altered			
GCS *	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	1	0	0
Pain Score	0	0	0
Observer's Initials			

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

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

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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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). : RCH/ FRM / CLINICAL / 126

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : ..... Time:

Doctor / Nurse / Family Concern?

Temperature (F)

Heart Rate (bpm)

and

Blood Pressure (mmHg) *

Note:
BP does not score in early warning scoring

Heart Rate (Number)

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

Resp Rate (Number)

Resp Distress: Mod/ Severe | None / Mild

Receiving O_2(l/min)
O_2Saturations (%)

Conscious Level: Normal | Altered

GCS *

TOTAL SCORE
Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS
NB: Scores 3 should be recorded overleaf

Score 1	: Continue normal observation by staff nurse
Score 2	: Shift in charge nurse to be informed and continue hourly observations
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Score 5 & 6	: Shift in charge AND PICU fellow or PICU consultant to be informed.

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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.

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
7/7	08:00 pm	1									0	
	09:00 pm	D		(42 ml)							0	
	10:00 pm	Ay	Rice + Dhal	(42 ml)			1			✓	0	
	11:00 pm	S		(42 ml)			0				0	
	12:00 am			(42 ml)							0	
	01:00 am	1		(42 ml)			1				0	
Total Intake :						**Total Output :** U – 1 M – 0						
8/7	02:00 am	1		(42 ml)							0	
	03:00 am	D		(42 ml)			1				0	
	04:00 am	Ay		(42 ml)			0				0	
	05:00 am	S		(42 ml)			1				0	
	06:00 am	1		(42 ml)							0	
	07:00 am			(42 ml)						✓	0	
Total Intake :						**Total Output :** U – 1 M – 0						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : 2

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
8/7	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
8/7	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
8/7	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :** U–					M	
9/7	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
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							
9/X	08:00 am			2cm								
	09:00 am		Idly	2cm								
	10:00 am		Hon	2cm								
	11:00 am			2cm								
	12:00 pm			2cm								
	01:00 pm			2cm								
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

Patient Sticker

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FLUID CHART

Sheet No. : .....

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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							
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	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: 7/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	8pm – 8Am	- assed the pt general condition. - Check the vitals - maintain I/O chart - drug ay perchart - Ct IV fluids.	8pm – 8Am	- assed the pt general condition - Check the vitals - maintain I/O chart - drug ay perchart - Ct IV fluids.	- pt condition stable.	- monitor vitals.	Dhan

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11-10-2016 9 Y 8 M 26 D
Dr. SINDHURA MUNUKUNTLA

NURSING CARE RECORD

Rainbow® Children's Hospital
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Date: 8/7/26

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 to 2pm	Assess the pt Monitor the v/s Administer medication Maintain hygiene		Assessed the pt Monitored v/s Administered medication Maintaining hygiene	Administered medication	Reassessed the pt good	[signature]
Afternoon				— [signature] —			
Night	8pm to 8am	– Assess the pt condition – monitor the v/s – maintain the I/O – Drug as per chart	8pm to 8am	– Assess the pt condition – monitor the v/s – Maintain the I/O – Drug as per chart	– Now baby is stable	– Rechecked the v/s	[signature]

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NURSING CARE RECORD

Date: 9/1/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8 ... 2	Assess the baby Monitor vitals administer medications Maintain I/O chart	800 ... 2	Assessed the baby Monitored vitals administered medications Maintained I/O chart	administer Med	Reassess the pt	[illegible]
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD

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Your Right to a Safe Delivery

Date: .....

Goals

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

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

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift	7/7	8/7/26 M6	8/7/26 M1	9/7		
	Medical Condition (Any special condition to be noted):	—	—	—	—		
	Diet:	Soft diet	Soft diet	—	—		
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	—	—	—	—		
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.3°F	98.6°F	98.6°F	98.3°F		
	Res:	28/m	28/b/m	28/b/m	28/b		
	SpO_2:	100%	100%	99%	100%		
	Pulse:	130/m	136 b/m	102 b/m	102		
	BP:	110/70	—	92/72	100/62		
	LOC:	—	—	—	—		
	Fall Risk Score:	—	—	—	—		
	Pain Score:	—	—	—	—		
	Skin Integrity	—	—	—	—		
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	—	—	—	—		
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	—	—	—	—		
	Critical Lab Test / Values:	—	—	—	—		
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	—	—	—	—		
Post Operative Procedure Special Orders:		—	—	—	—		
Handed Over By Name :		John	Mounika	Sunanda			
Signature / ID :							
Date:		8/7/26	8/7/26	9/7/26	9/7		
Time:		8AM	8pm	8pm	9pm		
Taken Over By Name :		Mounika	Sunanda				
Signature / ID :							
Date:		8/7/26	8/7/26	9/7			
Time:		8AM	8pm				

Patient Sticker

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NURSING SHIFT HAND OVER FORM

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

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11-10-2016 9 Y 8 M 26 D (M)
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CHECKLIST FOR THROMBOPHLEBITIS

7/7/26 8/7/26

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	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			QD	NA	0	NA	0			
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			QD	NA	0	NA	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			QD	NA	0	NA	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			QD	NA	0	NA	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			QD	NA	0	NA	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 : .....

Docu. No. : RCH /FRM / CLINICAL / 137

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: ..... ER ..... Shifted to: ..... 1st floor 101 .....

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. Anusha .....

Date & Time : ..... 9/7/26 @ 7:15 PM .....

Nurse Name & Signature: ....

Date & Time : ..... 7/7/26 @ 7.50pm. .....

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

PATIENT TRANSFER FORM

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HNH-00000941 IP26-00006777 Master SHIVANSH MAKHIJA 11-10-2016 9 Y 8 M 26 D (M) Dr. SINDHURA MUNUKUNTLA	Date & Time of Admission 7/7/26 @ 7:03	Date & Time of Transfer Order 7/7/26 @
	Transfer Ordered by Dr. Anushree	Reason for Transfer Admission
From Unit ER	To Unit	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 14	Number of Imaging Films –	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
K. Vijaya Lakshmi	Dr. Anushree

Patient & Clinical Records Received by :

Date & Time of Patient Received : 7/7/26 8:32

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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wt - 29kg.

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Mast Shivansh Makhija Age : 9y 8m **Gender:** ☑ Male ☐ Female

Date : 7/7/26 Time of Arrival : 5:30 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: 99.3°F PR: 132b/m BP: 111/79 (85) RR: ..... SpO_2: 99%

Chief Complaints: c/o Fever & cold cough since x2 ds vomit in Today 1 time.

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing
☑ Normal ☐ Decreased ☐ Increased ☐ 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

M Singh
Signature of Parent / Guardian

Triage Completion Time : 6:32 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 : Atoni

Signature of Triage Nurse : .....

Date & Time : 7/7/26@ 6:32 pm.

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 7/7/24 Time of arrival : 6:34 pm

Chief Complaints: c/o Fever, cold cough since 2 days, vomiting 1 time. RBS: .....

Height : ..... Weight : 20 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: '0' Pain Tool Used: ☐ N Pass ☑ FLACC ☐ Wong Baker

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

If Yes Consultant Notified: N/A (Date/Time): N/A

Social History: Lives With family

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

Time of Initial assessment completed by ER Nurse : 6:34 pm

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

Time	Nursing Notes
6:30pm	Assessed the patient condition.
	monitore vitals Done.

Samples collected by: / Vijay / 7/7/26 Time: / 7:20pm

Samples sent by : Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
7/7/26 @ 6:55pm	crossing DS	orally	0ml		

Condition of patient at time of shift - out :	Details of Shift - out
HR: 120 b/m BP: 108/75 CFT:	Shift - out from ER to: Post bed / ICU
RR: ..... SPO_2 : 98%	Time of Shift - out: 7:50pm.
GCS: 15/15 Temperature : 99.1°F	Handover given to: ..... (Nurse's Name)
Pain Score: 0	
Repeat RBS (if applicable): N/A	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV Placement Done

Name of the Nurse : Atanu Signature of the Nurse :

Date & Time : 7/7/26 @ 7:50pm