

219
A.C

DISCHARGE SUMMARY

Name	Baby JAANVI MAKADIA	UHID	HNH-00014097
Father/Guardian	Mr PRATIK KUMAR MAKADIA	Age/Gender	1 Y 2 M 4 D/ Female
Address	14-9-828, oppsite lala bhawan jumnerath bazar, Chudi Bazar, Hyderabad, Telangana, INDIA, 500012		
IP No	IP26-00006425	Admission Date	25-05-2026
Ref Doctor	DR. VINAY KUMAR MANTHATI		
Discharge Date	27.05.2026		

Consultant:

Dr. VINAY KUMAR MANTHATI

MBBS DNB (Pediatrics)

Reg No:91733

Consultant:

Dr. ANIKET ANIL PARASHAR

MBBS - MD

TSMC/FMR/08568, dr.aniket.p@rainbowhospitals.in

DIAGNOSIS	ICD CODE
INFLUENZA A ILLNESS	

History: Baby JAANVI MAKADIA , 1 Y 2 M 4 D , old girl presented with the history of fever since 4 days, poor oral intake, dull activity since 3 days, excessive cry while passing urine since 2 days, cold since 1 day, prior to admission. For the above complaints she was admitted at Rainbow Children's

Name	Baby JAANVI MAKADIA	UHID	HNH-00014097
IP No	IP26-00006425	Admission Date	25-05-2026

Hospital - for further management.

Examination: She was febrile(100°F). Her heart rate was 122/min and Respiratory Rate - 28/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination signs of dehydration were present- dry lips, dry oral mucosa, sunken eyes were present. On auscultation, air entry was bilaterally equal were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, 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: 8.4 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

Adenovirus PCR was not detected.

VBG showed pH of 7.36, pCO2 of 34.7 mmHg, pO2 of 46 mmHg, HCO3 of 19.6 mmol/L and BE of -5.4 mmol/L.

Urine culture and sensitivity shows : No growth after 24 hrs of incubation

Blood culture and sensitivity shows : No growth after 24 hrs of incubation

Name	Baby JAANVI MAKADIA	UHID	HNH-00014097
IP No	IP26-00006425	Admission Date	25-05-2026

Serum Creatinine was 0.4 g/dl, Serum Calcium was 9.6 mg/dl, Magnesium was 1.9 mg/dl.

VITAMIN D (25 HYDROXY) - 29.7

Liver function test showed total SBR of 0.2 mg/dl with indirect fraction of 0.1 mg/dl, SGOT - 43 U/L, SGPT - 17 U/L, ALP - 148 U/L, protein - 6.9 gm/dl, albumin - 4.0 gm/dl, globulin - 2.9 gm/dl, A/G ratio of 2.9. Complete urine examination shows 6-8 pus cells, 5-7 epithelial cells.

Ultrasound abdomen shows

- * Mild left sided pelvic fullness.
- * Rest appears normal.

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 chest signs, she was frequently nebulised with 3% NaCl. As Influenza A was positive, child was started on Oseltamivir.

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

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.

Name	Baby JAANVI MAKADIA	UHID	HNH-00014097
IP No	IP26-00006425	Admission Date	25-05-2026

Medication during hospital stay:

Injection. Augmentin
Nasoclear nasal drops
Neb with 3% NS
Syp. Oseltamivir

Advice:

* Diet as advised.

S.N	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. FLUVIR (OSELTAMIVIR - 5ml/60mg)	2.5 ml	9am-9pm (after food)	For 3 days.
2	NEBULISATION with 3% NaCl (Hyperneb)	1 respule	8th hourly	For 3 days
3	Nasoclear nasal drops, 2 drops in each nostril SOS for nose block			

Fever Management

* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 2.5ml 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. VINAY KUMAR M on (29.05.2026) Friday at his clinic.

Food instructions while taking medications:

* **Antibiotics** along with food & milk products prevent their absorption of

Name	Baby JAANVI MAKADIA	UHID	HNH-00014097
IP No	IP26-00006425	Admission Date	25-05-2026

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 **Himayathnagar / Banjara Hills / Rainbow Clinic Madhapur / Kukatpally / Vikrampuri / LB Nagar / dial just one toll free number 18002122.**

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

Registrar/Resident/C.M.O

Consultant:
Dr. VINAY KUMAR MANTHATI
MBBS DNB (Pediatrics)
Reg No:91733



*31 NSG th
 Hourly*

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
	01.00			
	02.00			
<i>27/3/26</i>	<u>03.00</u>	<i>31-NS</i>		
	<u>04.00</u>	<i>31-NS</i>	<i>MS</i>	<i>Salsani</i>
	05.00		<u>①</u> <i>2312</i>	
	06.00	<i>Cross checked done by @ Vinay Kumar.</i>		
	07.00			
	08.00			
	09.00			
	10.00			
	11.00	<u><i>POTAL WBS = 05</i></u>		
	<u>12.00</u>			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			



3% NS 8H

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
	01.00			
26/5/26	02.00			
	03.00	3% NS	Sneha [2117]	Palani
	04.00			
	05.00			
	06.00			
	07.00			
	08.00			
	09.00			
	10.00			
26/5/26	11.00	3% NS	AA [2207]	Palani
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00	3% NS	Neetu	
	20.00			
	21.00			
	22.00			
	23.00			

HNH-00014097 IP26-00006425
 Baby JAANVI MAKADIA
 21-03-2025 1 Y 2 M 4 D (F)
 Dr. VINAY KUMAR M



3% NS @ 8th hourly



NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
	01.00			
	02.00			
	03.00			
	04.00			
	05.00			
	06.00			
	07.00			
	08.00			
	09.00			
25/3/22	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00	3% NS	(1)	
	20.00			
	21.00			
	22.00			
	23.00			

2085
~~2087~~

Signature

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006425 Admit Date : 25-May-2026 Admit Time : 10:13 AM UHID : HNH-00014097

Patient Details :

Patient Name : Baby JAANVI MAKADIA Age : 1 Y 2 M 4 D
Guardian : Mr PRATJK KUMAR MAKADIA DOB : 21-03-2025 01:00 AM
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : 14-9-828, oppsite lala bhawan jummerath bazar Chudi Bazar Hyderabad Telangana INDIA 500012 Phone No : 9030750581/ 9030931474
E-mail : mpratikkumar21@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 PRATIK KUMAR MAKADIA Relationship : Father
Contact Address : 14-9-828, oppsite lala bhawan jummerath bazar Chudi Bazar Hyderabad Telangana INDIA 500012 Phone No : 9030750581

Signature

Doctor Details :

Doctor Name : Dr. VINAY KUMAR M Specialisation : GENERAL PEDIATRICS
Referral Doctor : DR. VINAY KUMAR MANTHATI Phone No : 8639024469
Co-Consultant : Dr. ANIKET ANIL PARASHAR

Payment Details :

Payment Mode : Cash Deposit Amount : 5000.00
Payor Name : HDFC ERGO GENERAL INSURANCE CO LTD

HNH-00014097 IP26-00006425
Baby JAANVI MAKADIA
21-03-2025 1 Y 2 M 4 D (F)
Dr. VINAY KUMAR M

ACTING

Name: _____



UHID No : _____ IP No : _____ Consultant : _____ Dept : pediatric

Date of Admission : _____ Time : _____ Date of Discharge : _____ Time : _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
25/05/26	11:37 Am	GR	ward	<i>[Signature]</i>

Cross Consultation Visit

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



INVESTIGATIONS

Date	Investigations	Order No.	Sign
25/5/26	blood culture and sensitivity.	08806	Sey
	CUE urine culture and sensitivity.	08806	
	Respiratory panel (5 viruses)	08806	
	Creatinine	08806	
	VBG	08805	
<i>Cross checked done by Sale</i>			
26/5/26	USG abdomen & pelvis	6351	A
27/5/26	Vita D (25 Hydroxy), LFT, Calcium, Mg	8886	Sey
<i>Cross checked by Gaurika 26/5/26 @ 1000</i>			

Ref.No. F/IN/PR/10



**Rainbow[®]
Children's
Hospital**

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

HNH-00014097 IP26-00006425
Baby JAANVI MAKADIA
21-03-2025 1 Y 2 M 4 D (F)
Dr. VINAY KUMAR M

Patient Name :

Patient ID# :

Consultant :

Final Diagnosis :



Pediatric Multiorgan History & Physical Examination

HNH-00014097 IP26-00006425
Baby JAANVI MAKADIA
21-03-2025 1 Y 2 M 4 D (F)
Dr. VINAY KUMAR M



Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

Cl^o fever since 4 days.

Cl^o cold since 1 day.

Cl^o not taking orally well x 3 days.

History of present illness : Cl^o dull activity x 3 days

Cl^o excessive cry while passing urine x 2 days

Pt was apparently alright 4 days before then had fever on & off type. High degree fever, not relieved with medication.

Cl^o cold since 1 day, runny nose.

Cl^o not taking orally well, dull activity, decreased urine output since 3 days.

Pediatric Multiorgan History & Physical Examination

HNH-00014097 IP26-00006425
Baby JAANVI MAKADIA
21-03-2025 1 Y 2 M 4 D (F)
Dr. VINAY KUMAR M



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

Nothing Significant

Birth & Neonatal History :

T / A C I A

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Developmentally normal

Immunization History :

upto date till 9M.

Pediatric Multiorgan History & Physical Examination

HNH-00014097 IP26-00006425
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21-03-2025 1 Y 2 M 4 D (F)
Dr. VINAY KUMAR M



Anthropometry

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

Weight (kgs) 8.4 kg (Centile _____)

On Examination :

Temperature : 100° F Pulse Rate: 122 Description _____

B.P. _____ SPO2 98% at RA.

Resp. rate and type of breathing : 28 bpm

Rash (-) dry oral mucosa

Lymphadenopathy (-) sunken eyes

Oedema : (-) dry lips

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BIL AE (+)

Any addes sounds : BIL RVS (+)

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S₁, S₂ heard

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : soft, nontender

Ausculation : no organomegaly

Spine: _____ External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

HNH-00014097 IP26-00006425
Baby JAANVI MAKADIA
21-03-2025 1 Y 2 M 4 D (F)
Dr. VINAY KUMAR M



Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

Cranial Nerves : _____

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

Acute febrile illness → dehydration
? UTI.

Pediatric Multiorgan History & Physical Examination

HNH-00014097 IP26-00006425
Baby JAANVI MAKADIA
21-03-2025 1 Y 2 M 4 D (F)
Dr. VINAY KUMAR M



Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

Planned Management :

CVE, VBG
B/c/c
Respiratory panel
(5 viruses)
Urine C/S, Sr. Creatinine
levels
1 extra plain.
CBP, CRP - done OPD
basis.

2mg. AUGMENTIN
IVF DNS. 2/3 M
Syp. Crocin Ds. 2.5ml
SOS
Syp. ibuprofen 2.5ml
SOS

MB Shrivastava

MB Shrivastava

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
25/3	<u>C/S/B Do. Aniket</u>	
10:30 AM	AFB & dehydration ? VTB.	
	Fever (+)	<u>Plan</u>
	dull activity (+)	- IVF DNS 2/3 M
	decreased oral intake.	- Start Ziy Augmentin
	Vitals - stable.	- send
	RIS - B/L A (+)	- Urine C/S.
	P/A - soft, NT	- Blood C/S
		- CUE
		- Sr. Creatinine
		- Respiratory panel
		- Monitor urine output.
		- monitor vitals
		N.B Amrutha 11 AM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/3 8:30am	c/s/B D ₁ - Aniket Δ - AFI c Dehydration Fever spikes ⊕ Poor oral intake cold & sneezing ⊕ child dull vital stable	Pk 1) IVF - Temp at night 2) CF - Softisan Amoxiclav 3) Trace blood c/s, Respiratory panel Urin c/s 4) Monitor vital
		Dr. Aniket Anil Parashar Consultant Pediatrician & Intensivist Reg. No: 8568 Dr. Aniket
25/3/25 5:30 pm	S/B Dr. Vinay Δ AFI c dehydration Fever spikes ⊕ CVS - Spikes ⊕ RS - Bil - Ate ⊕ P/A - SOL dull look ⊕	Pk CF IV Fluid @ 23% BWL IV NS bolus 100ml over 3hrs USA Abdom - T/M Monitor vials Trace Resp. panel
		cold by Sachin @ 5:35 pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5 8AM	CL/B Di. Ranav / Di. Valen	
	AFI \bar{E} Dehydration	(Flu A \oplus - Viral)
	Fever spike \oplus Cough & sneeze \oplus Oral intake - less	Phn 1) Ziy Augmentin
	Child conscious Vital stable	2) Temp \bar{V} \bar{V} CLS Blood CLS Respiratory Panel
	R-S - B/L PE \oplus P/A - Soft	3) Syp Fluorid 4) IVF
	Passing Urine.	5) USS Abdomen after rounds
		6) Monitor vitals Sneezes
		Phn

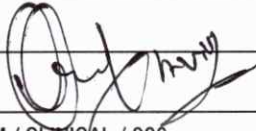


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/22 9:30am	ds/B ds. Anket AFI \bar{c} dehydration influenza A positive	
	- fever spikes (+) - cold (+) - oral intake: good	
	O/E	
	vitals: stable	plan
	S/E - (N)	1) STOP Augmentin
	RPE (+)	2) STOP IVF
	clear.	3) leave blood ds
		urine ds
		adeno
		4) ct. urine
		ds
		D. Anket
		5) usg abd & pelvic
		new
		6) monitor vitals.
		N.B Amouty
		e 10Am



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/24 5:20 PM	SIB Dr. Aniket Δ Influenza A Illness Alert	Plan ✓ CC FLUVIA
	WS - SICK PS - ALL-ALCO	✓ These Blood C's Urine C's
Urine C's ↓ 24h no growth ↓ verbal report	PIA - safe conscious	✓ Monitor vitals ✓ These Adenovirus PCR ✓ Encourage orally Noted by Divya 26/5/20
26/5/26 5:45 PM	SIB Dr. Vinay Δ Influenza A Illness Alert	- Stop AMOXICILLIN Dr. Aniket Parashar Consultant Pediatrician Reg. No: 8568 Jun 26 - Dr. Aniket
	WS - SICK PS - ALL-ALCO	Plan - Serum Calcium - 25(OH) Vitamin D - SAM Magnesium - Flu ✓ CC FLUVIA
	PIA - safe conscious	✓ Encourage orally ✓ These Adenovirus PCR
		Noted by Divya 26/5/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/5/25	S/B. Dr. Prabhath / Dr. Subhat	
8:30 AM	<p>△ Influenza A illness.</p> <p>fever spikes - Noe</p>	<p>Adv</p>
24hr	<p>Cough - (+)</p>	<p>(1) 6am T/m. LFT</p>
No growth	<p>6 Gc. fever</p>	<p>6r (a+2)</p>
	<p>CVS S₁ S₂ +</p> <p>RS BAF +</p>	<p>6 25 (OH) vet 1)</p> <p>6r mg or</p>
		(2) LG fever
		(3) WBC Bk fce
		(4) Encourage orally



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/3 9:30 AM	<u>CSIB Dr. Aniket</u>	
	<u>Dr. Influenza A/B</u>	Plan
	- Fever ↓ - Cough ⊕	1) OSELTAMIVIR 2.5 day Nebulizer NaCl Nasal saline drops
	child asleep Vital stable	2) Trache tube → LEFT Vit D, Calium, Mg
	R-S-B/LAE ⊕ PLA - Soft	3) Monitor Vital
		D/C Today & Follow up Dr. Vinay on Friday
		Dr. Aniket Anil Parashar Consultant Pediatrician & Intensivist Reg. No: 8568
		Dr. Aniket



DRUG CHART

Date of Admission: 25/05/26 Drug Allergies: N/A 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 : <u>Syp. Crocin DS</u>				Date Time																
Dose	Route	Frequency	Start Date																	
<u>2.5ml</u>	<u>P/O</u>	<u>SOS</u>	<u>25/5</u>	<u>4:30</u>																
Doctor's Signature		Valid Period	Pharm.																	
<u>[Signature]</u>		<u>>100%</u>																		
Additional Instructions:																				

DRUG : <u>Syp. ibuprofen</u>				Date Time																
Dose	Route	Frequency	Start Date																	
<u>2.5ml</u>	<u>P/O</u>	<u>SOS</u>	<u>25/5</u>																	
Doctor's Signature		Valid Period	Pharm.																	
<u>[Signature]</u>		<u>>100%</u>																		
Additional Instructions:																				

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

VERIFIED BY : Name _____ Signature _____



REGULAR PRESCRIPTIONS

Weight. 8.4 kg Ward.

DRUG : <u>30mg AUGMENTIN</u>				Date Time	<u>15/5</u>	<u>16/5</u>															
Dose	Route	Frequency	Start Date																		
<u>180mg</u>	<u>IV</u>	<u>TID</u>	<u>25/5</u>																		
Name & Signature of the Doctor Starting the Drugs: <u>Deep</u>					<u>6am</u>	<u>X</u>	<u>9am</u>	<u>X</u>	<u>12pm</u>	<u>X</u>	<u>3pm</u>	<u>X</u>	<u>6pm</u>	<u>X</u>	<u>9pm</u>	<u>X</u>	<u>12am</u>	<u>X</u>	<u>3am</u>	<u>X</u>	<u>6am</u>
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG : <u>Nasoclear nasale</u>				Date Time	<u>25/5</u>	<u>26/5</u>	<u>27/5</u>														
Dose	Route	Frequency	Start Date																		
<u>2/2</u>	<u>Nasol</u>	<u>SID</u>	<u>25/5</u>		<u>12pm</u>	<u>X</u>	<u>6pm</u>	<u>X</u>	<u>12pm</u>	<u>X</u>	<u>6pm</u>	<u>X</u>	<u>12pm</u>	<u>X</u>	<u>6pm</u>	<u>X</u>	<u>12pm</u>	<u>X</u>	<u>6pm</u>	<u>X</u>	<u>12pm</u>
Name & Signature of the Doctor Starting the Drugs: <u>Deep</u>																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG : <u>- Neb 3% M</u>				Date Time																	
Dose	Route	Frequency	Start Date																		
<u>One puff Neb</u>	<u>Neb</u>	<u>8th h</u>	<u>25/5</u>																		
Name & Signature of the Doctor Starting the Drugs: <u>B. Singh</u>																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG : <u>Syp OSELTAMIVIR</u>				Date Time	<u>25/5</u>	<u>26/5</u>	<u>27/5</u>														
Dose	Route	Frequency	Start Date																		
<u>2.5ml</u>	<u>PO</u>	<u>BD</u>	<u>25/5</u>		<u>10pm</u>	<u>X</u>	<u>10pm</u>	<u>X</u>	<u>10pm</u>	<u>X</u>	<u>10pm</u>	<u>X</u>	<u>10pm</u>	<u>X</u>	<u>10pm</u>	<u>X</u>	<u>10pm</u>	<u>X</u>	<u>10pm</u>	<u>X</u>	<u>10pm</u>
Name & Signature of the Doctor Starting the Drugs: <u>P. Kumar</u>																					
Additional Instructions: <u>(5ml = 60mg)</u>																					
Daily Doctor's Endorsement by a Sign																					

HNH-00014097 IP26-00006425
Baby JAANVI MAKADIA
21-03-2025 1 Y 2 M 4 D (F)
Dr. VINAY KUMAR M



219

RESULT SHEET

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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date	20/4/26	25/5/26			
Time					
Hb	10.7				
PCV	31.1				
RBC	4.7				
WBC	7010				
N/L	47/40				
Platelets	2.16				
CRP	5				
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine		0.4			
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	25/5/26					
Time						
CUE-Alb						
CUE-Sugar	Nil					
CUE - Ketones	Present					
CUE-PUS Cells	6-8					
CUE - RBC Cells	Nil					
CUE						
Stool Pus Cell						
OVA/Cyst						
Occult Blood						
Flu A	+ve					
Adeno	→ negative					

25/5/26

Culture and Sensitivities : Blood (S-)
 Urine (S-)

Radiology: USG :
 X-Ray:
 ECHO:
 CT:
 MRI
 Others (ECG, Contrast Studies etc.):

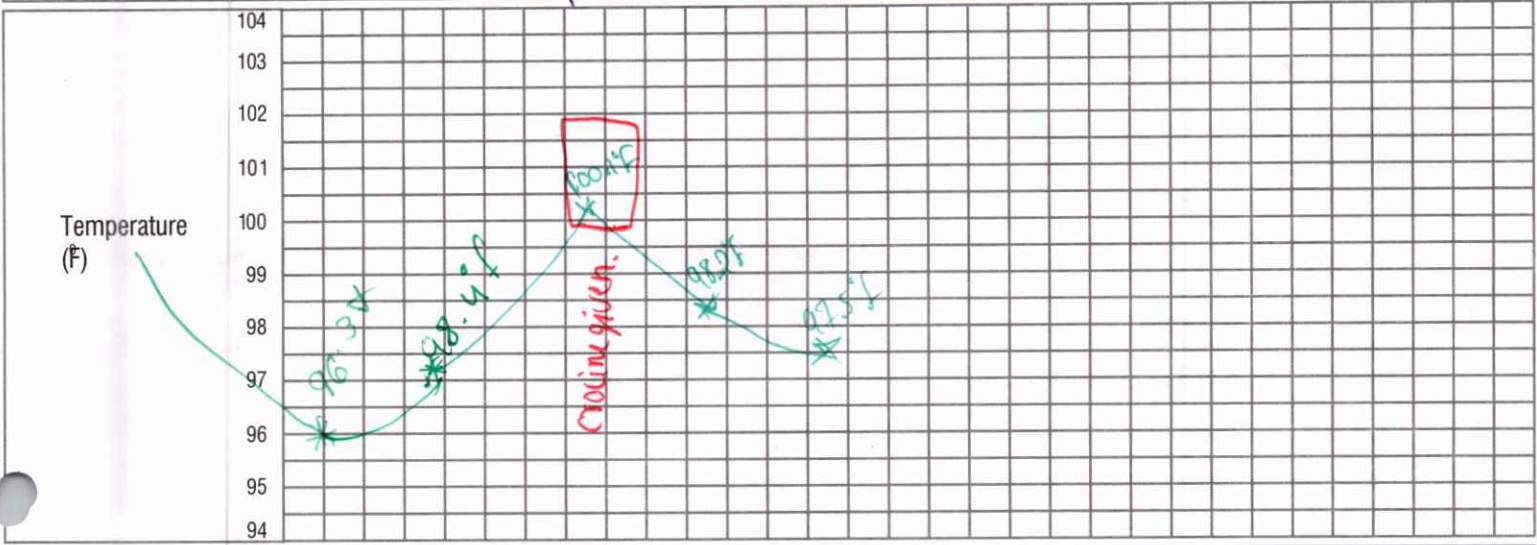
Patient SI



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 25/5 Time: 1pm 6pm 9:00 2Am 6Am

Doctor / Nurse / Family Concern? PM



Heart Rate (bpm) and Blood Pressure (mmHg) *	1pm	6pm	9:00 PM	2Am	6Am
Heart Rate (Number)	126 b/m	125 b/m	128 b/m	112 b/m	
Blood Pressure (mmHg)	99/59	100/50	99/60	93/55	

Resp. Rate (bpm) (Over 1 Minute) *	1pm	6pm	9:00 PM	2Am	6Am
Resp Rate (Number)	29 b/m	30 b/m	30 b/m	30 b/m	

Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)		
O ₂ Saturations (%)	100%	99%
Conscious Level	Normal	Altered
GCS *		

TOTAL SCORE	1pm	6pm	9:00 PM	2Am	6Am
Number of shaded boxes	0	0	0	0	
Pain Score	0	0	0	0	
Observer's Initials	AM	B	AM	AM	

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

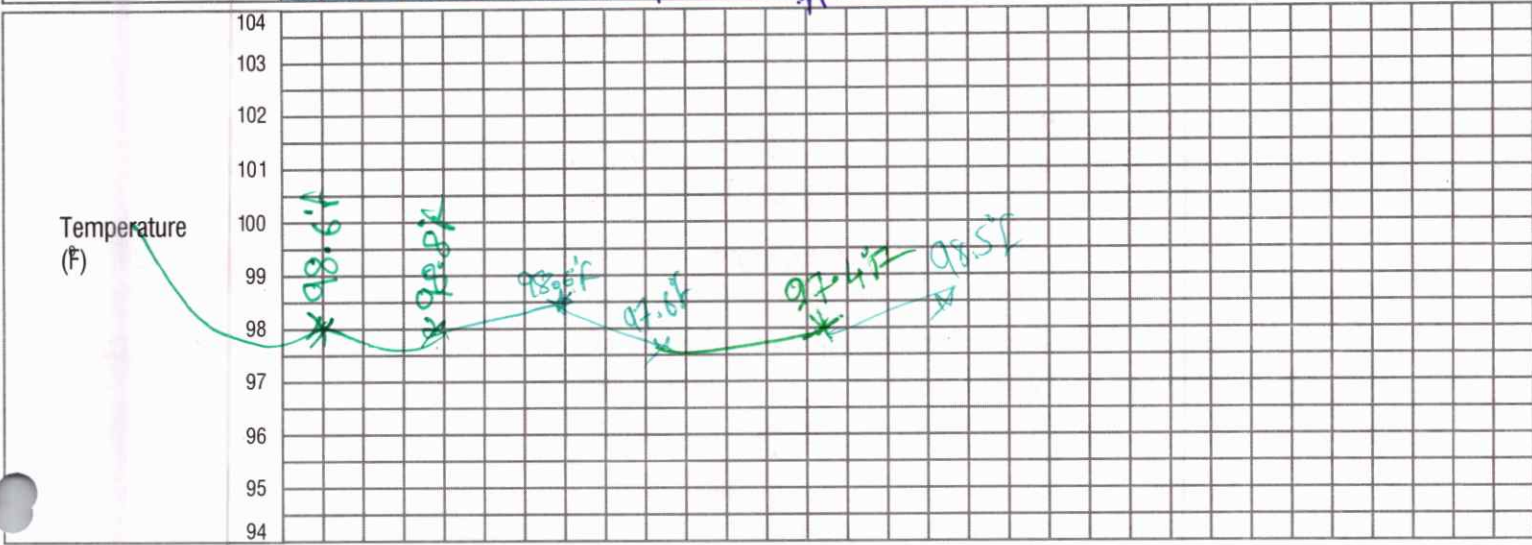
- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 20/5/25 Time: 10:00 AM 2:00 PM 6:00 PM 10:00 PM 2:00 AM 6:00 AM
 Doctor / Nurse / Family Concern? [Blank]



Heart Rate (bpm) and Blood Pressure (mmHg) *	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50
Note: BP does not score in early warning scoring	97	99	99	95	97	95	97	95	97	95	97	95	97	95	97
Heart Rate (Number)	114b/m	114b/m	118b/m	115b/m	114b/h	116b/h	116b/h	116b/h	116b/h	116b/h	116b/h	116b/h	116b/h	116b/h	116b/h

Resp. Rate (bpm) (Over 1 Minute) *	70	60	50	40	30	20	10
Resp Rate (Number)	30b/m	32b/m	30b/m	32b/m	30b/h	32b/h	32b/h

Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)		
O ₂ Saturations (%)	100%	100%
O ₂ Saturations (%)	99%	94%
O ₂ Saturations (%)	99%	94%
O ₂ Saturations (%)	99%	94%
O ₂ Saturations (%)	99%	94%

Conscious Level	Normal	Altered
GCS *		
TOTAL SCORE		
Number of shaded boxes	0	0
Pain Score	0	0
Observer's Initials	[Signature]	[Signature]

ACTIONS

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

NB: Scores 3 should be recorded overleaf

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

FLUID CHART

Sheet No. : 2

- 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			
25/5	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm	DNS	120	23 ml									
	01:00 pm			23 ml									
	Total Intake : Taken			Total Output : m=0 u=1									
25/5/26	02:00 pm			23 ml									
	03:00 pm			23 ml									
	04:00 pm			23 ml									
	05:00 pm	DNS		23 ml									
	06:00 pm			23 ml									
	07:00 pm			23 ml									
	Total Intake : Taken			Total Output : u=2 m=0									
25/5	08:00 pm			23 ml									
	09:00 pm			23 ml									
	10:00 pm			23 ml									
	11:00 pm	DNS		23 ml									
	12:00 am			23 ml									
	01:00 am			23 ml									
	Total Intake :			Total Output : u=2 m=0									
26/5	02:00 am			23 ml									
	03:00 am			23 ml									
	04:00 am	DNS		23 ml									
	05:00 am			23 ml									
	06:00 am			23 ml									
	07:00 am			23 ml									
	Total Intake :			Total Output : u=2 m=0									
Total 24 hrs. Intake			Total 24 hrs. Output										



FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output				IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	Diarrhoea	Vomit	Drainage	Urine			
26/5	08:00 am	↑	Milk	23ml	N/A				✓	0	B	
	09:00 am	↑	Milk	23ml								
	10:00 am	DNS		23ml								
	11:00 am	↓		23ml					✓			
	12:00 pm			23ml								
	01:00 pm	↓		23ml								
Total Intake :						Total Output : U-2 M-						
26/5/26	02:00 pm	↓	Milk		N/A				✓	0	D	
	03:00 pm	↓	Milk						✓			
	04:00 pm	↓										
	05:00 pm	↓	Milk									
	06:00 pm	↓										✓
	07:00 pm	↓										
Total Intake : taken						Total Output : U-M-						
26/5	08:00 pm	↓			N/A					0	(B)	
	09:00 pm	↓										
	10:00 pm	↓										
	11:00 pm	↓	Milk						✓			
	12:00 am	↓										
	01:00 am	↓										
Total Intake :						Total Output : U-M-						
27/5	02:00 am	↓			N/A					0	(B)	
	03:00 am	↓										
	04:00 am	↓	Milk									
	05:00 am	↓										
	06:00 am	↓										
	07:00 am	↓										
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output



NURSING CARE RECORD

Date: 25/5

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8 Am	→ Assess the pt condition	8 Am	→ Assessed the pt condition	→ pt is stable	→ Re-checked vitals	A
	1 pm	→ monitoring vitals checked and recorded	1 pm	→ Administration & medication given as per doctor order			
Afternoon	2 pm	→ to check vitals	2 pm	→ Assessed the patient general condition	Patient is stable	Rechecked vitals	D
	2 pm	→ monitor vitals	2 pm	→ monitored vitals.			
Night	8 pm	→ Administer medications as per doctor's orders.	8 pm	→ Administered medications as per doctor's orders	→ pt is stable	→ monitor vitals.	Sudh
	8 pm	Assess the pt condition, monitor vitals, maintain I/O, provide the comfortable position	8 pm	Assessed the pt condition, monitored vitals, maintained I/O, provided the comfortable position, medication given as per doctor order.			
	8 pm	medication given as per as doctor order	8 pm	medication given as per doctor order.	→ vitals normal	→ maintain the clear.	

HNH-00014097 IP26-00006425
 Baby JAANVI MAKADIA
 21-03-2025 1 Y 2 M 4 D (F)
 Dr. VINAY KUMAR M

Patient Sticker



NURSING CARE RECORD



Date: 26/5/26

- 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 2pm	- Assess the Pt Condition - Monitor the vitals - Maintain I/O Chart - Administer Medication as per drug chart	8Am 2pm	- Assessed the Pt condition - Monitored the vitals - Maintained I/O Chart - Administered Medication as per drug chart	Pt is Stable	Rechecked vitals	<i>[Signature]</i>
Afternoon	2pm 8pm	Assess the pt Condition - Monitor vitals & I/O chart → maintain I/O chart → IV cannula present → Administer medication as per drug chart	2pm 8pm	- Assessed the Pt condition → Monitored vitals & recorded → maintained I/O chart → IV cannula present → IV fluid stop → ct medication	→ Pt is stable	→ rechecked vitals	<i>[Signature]</i>
Night	8pm 8Am	→ Assess the pt condition → monitor the vitals → maintain I/O chart. → Administer medication as per drug chart.	8pm 8Am	→ Assessed the pt condition. → monitored the vitals. → maintained I/O chart. → Administered medication as per drug chart.	→ Pt is stable now	→ Reassessed the vitals	<i>[Signature]</i>



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date	25/5	25/5	25/5	26/5	26/5	
	Shift	M6	N1	M6	E2	N1	
	Medical Condition (Any special condition to be noted):	-	-	-	-	-	
ASSESSMENT	Diet:	-	-	-	-	-	
	Allergy:	<input checked="" type="checkbox"/> Yes <input 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	
	Vital Signs:	Temp:	98.4°f	99.2°f	98.6°f	97.2°f	97.9°f
		Res:	25b/m	24b/m	22b/m	20b/m	20b/m
		SpO ₂ :	98%	99%	99%	98%	98%
		Pulse:	121b/m	120b/m	122b/m	110b/m	110b/m
		BP:	101/62	102/62	101/61	100/70	100/62
		LOC:	-	-	-	-	-
Fall Risk Score:	-	-	-	-	-		
Pain Score:	-	-	0	0	0		
Skin Integrity	-	-	Good	good	Good		
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	-	-	-	-	-	
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	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	
	ADL (Dependent / Non Dependent):	NA	-	-	-	-	
Post Operative Procedure Special Orders:	NA	-	-	-	-		
Handed Over By Name :	Amruta	Snelle	Manisha	Divya	mahi		
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:	25/5	26/5	26/5	26/5	27/5		
Time:	2pm	8pm	2pm	8pm	8Am		
Taken Over By Name :	Snelle	Manisha	Divya	mahi			
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>			
Date:	25/5	26/5	26/5	26/5			
Time:	8pm	8Am	2pm	8pm			

HNH-00014097 IP26-00006425
 Baby JAANVI MAKADIA
 21-05-2025 1 Y 2 M 5 D (F)
 Dr. VINAY KUMAR M



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:								



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
25/5	10 AM	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	(A)
25/5	10 PM	0	MA	<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	MA	EA
25/5	2 AM	0	MA	<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	MA	EA
26/5	8 AM	0	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	EA
26/5	10 AM	0	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	EA
26/5/26	4 PM	0	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	EA
27/5/26	6 AM	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	EA
				<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:

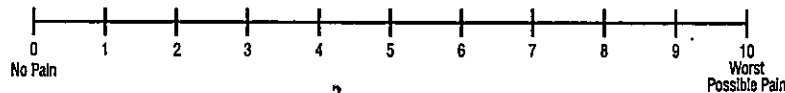
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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' brawn 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 or 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 (Pediatrics) Above 7 Years



HNH-00014097 IP26-00006425
 Baby JAANVI MAKADIA
 21-03-2025 1 Y 2 M 4 D (F)
 Dr. VINAY KUMAR M



BRADEN 'Q' SCALE



					Date :	25/5	26/5	26/5	26/5/20
					Time :	Mc	M	Mc	E2
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	3	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 of 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	29	29	28
Evaluator's Name						[Signature]	[Signature]	[Signature]	[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)
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 :	26/3/25			
					Time :	12			
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			
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					TOTAL SCORE	28			
					Evaluator's Name				

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

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



MEDICATION RECONCILIATION FORM

Drug Allergies: N/A 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: 3rd floor (302)

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. Rajendra

Date & Time : 25/05/26 @ 10:05 AM

Nurse Name & Signature : Shikha

Date & Time : 25/05/26 @

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

(. . .)



(. . .)



A - 8.4kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name: Baby Jaanvi Makadia Age: 1y Gender: Male Female
 Date: 25/3/26 Time of Arrival: 9:50am

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°F PR: 150bpm BP: RR: 28bpm SpO₂: 100%

Chief Complaints: no fever since 2 days could since 2 days

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

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: 10:02 AM

Communicable Disease Triage Screening

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

- Have you had fever (elevated temperature) in the past 2 weeks? Yes No
- Have you had cough or a rash in the past 2 weeks? Yes No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks? Yes No

PART B. For patients reporting fever and respiratory/rash symptoms: Not applicable

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? Yes No
 If yes, State Location:
- Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? Yes No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

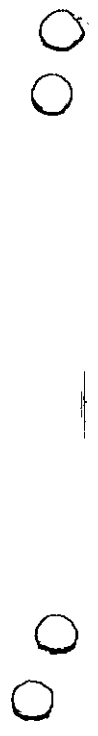
PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- The patient should be given a surgical mask immediately, if not already wearing one.
- Both patient and triage staff should perform hand hygiene.
- The staff should use PPE (as appropriate).

Name of Triage Nurse: shirish
 Date & Time: 25/03/26 @ 9:52 AM
 Docu. No.: RCH / FRM / CLINICAL / 085

Signature of Triage Nurse: [Signature]

12 A 2 11



12 A 2 11



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 25/3/26 Time of arrival : 9:54 AM
 Chief Complaints: do fever, cold since 2 days RBS:

Height : Weight : 8.4 kg BMI : Head Circumference (<2 years)

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

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

Character Location Frequency Duration

RISK FOR FALL:

- If patient is < 6 years
tick below fall risk intervention directly
- If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months Yes No

Ambulatory Aids:

- Wheelchair Yes No
- Uses furniture for support Yes No

Gait/Transferring:

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

Mental Status: Forgets limitations Yes No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With family

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

Time of Initial assessment completed by ER Nurse : @ @ 9:56 AM

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

Time	Nursing Notes
9:15 AM	Assess the pt condition monitor the vitals

Samples collected by: / *suganya*
 Samples sent by: / *suganya*

Time: /
 Time: / 10:20 AM

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
25/5/26	CROCEAN syp	oral	2.5ml	<i>Dr Naepung (B)</i>	

Condition of patient at time of shift - out :	Details of Shift - out
HR: 149 122 bpm BP: CFT: <i>NA</i> RR: 20 28 bpm SPO ₂ : 100% GCS: 15/15 Temperature: 100°F Pain Score: Repeat RBS (if applicable): <i>NA</i>	Shift - out from ER to: <i>350 ↓ 1008 (202)</i> Time of Shift - out: <i>11:37 AM</i> Handover given to: (Nurse's Name)

Tick as applicable: MLC LAMA BROUGHT DEAD

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

Name of the Nurse: *Shargan* Signature of the Nurse: *(B)*
 Date & Time: *25/5/26 @ 10 AM*

PATIENT TRANSFER FORM

HNH-00014097 IP26-00006425

Baby JAANVI MAKADIA

21-03-2025 1 Y 2 M 4 D (F)

Dr. VINAY KUMAR M



Date & Time of Admission <i>25/05/26 @ 10:20 AM</i>		Date & Time of Transfer Order <i>25/05/26 @ 11:37 AM</i>
Treating Consultant Name	Transfer Ordered by <i>Dr. Naipunya</i>	Reason for Transfer <i>Admission</i>
From Unit <i>ER</i>	To Unit <i>ward (302)</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>15-1-</i>	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 <i>shirika</i>		Name of Person Ordered Transfer <i>Dr. Naipunya.</i>
Patient & Clinical Records Received by : <i>Amrutha</i>		
Date & Time of Patient Received : <i>25/5/26 @ 11:39 AM</i>		

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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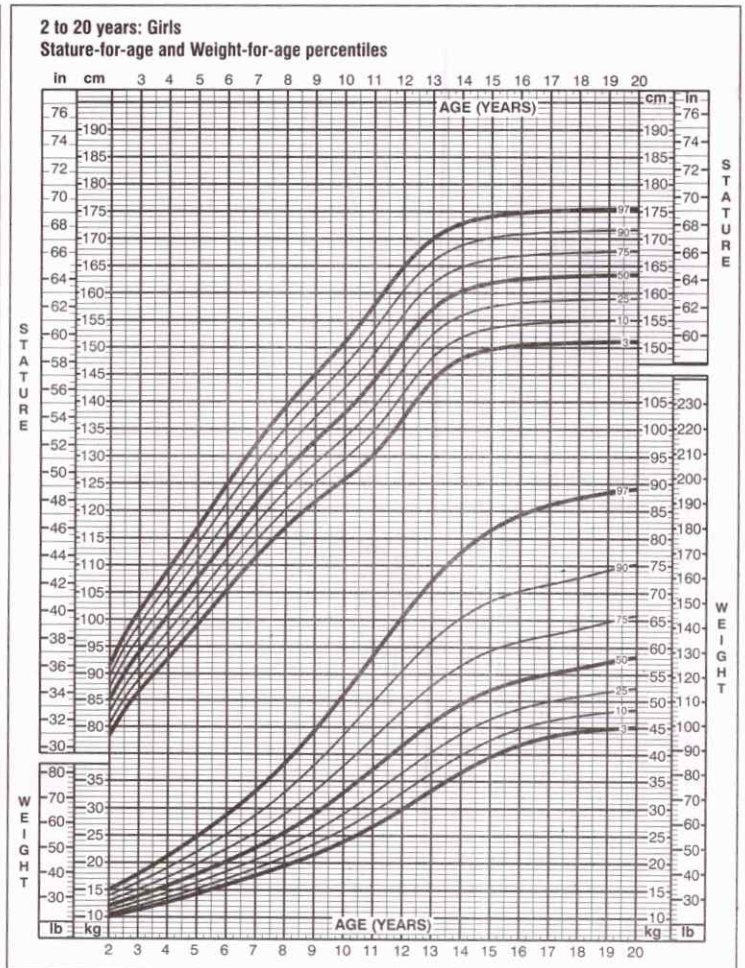
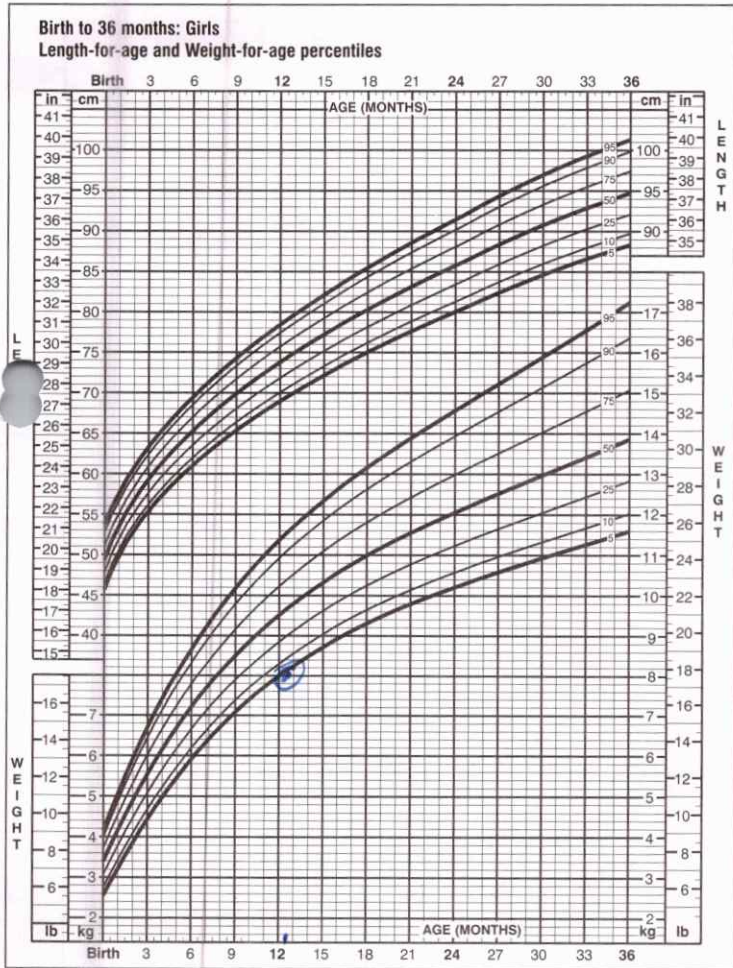
219

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 25/5/26 Time: 2:30 PM

Weight: 8.4kg Centile: 5th
 Height: Centile: -
 Inference: Underweight child.
 RDA: Calories: 1200kcal/day Protein: 20gm/day
 Diet Recommendations: Soft diet with liquids
 Re-Assesment: No Junk, oily, spicy food.
 Food Allergies: No FA Veg/Non-veg Non Veg
 Diagnosis: AFI, Dehydration, PVTI
 Nutritional Intervention - Oral Enteral Parenteral
 Patient's Signature: Sobai

GROWTH CHART (GIRLS)



Dietician's Name: Syeda Lobija Zaher Dietician's Signature: Lobija

